CORNWALL & ISLES OF SCILLY
ALCOHOL NEEDS ASSESSMENT
2014/15
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Alcohol Needs Assessment

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Introduction

This Cornwall Alcohol Needs Assessment is a partner document to the Drugs Treatment Needs Assessment.

Reducing the harms of alcohol has been a priority in Cornwall for many years and our first Alcohol Harm Reduction Strategy was published in 2006. Our current alcohol strategy “Taking Responsibility for Alcohol” draws on evidence compiled for the Alcohol Needs Assessment and has three overarching objectives:

- 1: Enable people to make informed choices about alcohol
- 2: Improve services to reduce the harm caused by alcohol
- 3: Promote partnerships to reduce alcohol’s impact on the community

The Alcohol Needs Assessment is one of the evidence sources within the Joint Strategic Needs Assessment and alcohol has also been identified as a priority area in the Health and Wellbeing Strategy (that the JSNA supports) under the outcome “Helping People to Live Longer, Happier and Healthier Lives.”

The Crime and Disorder Act (1998)

The statutory framework regulating Community Safety Partnerships (CSPs) requires partnerships to analyse and assess:

- Levels and patterns of crime, disorder and substance misuse;
- Changes in the levels and patterns of crime, disorder and substance misuse since the last strategic assessment;
- Why these changes have occurred;
- The extent to which last year’s plan was implemented;

In April 2010 this was extended to include reoffending in both adults and young people.

What is Needs Assessment?

Needs assessment is the cornerstone of evidence-informed commissioning. It is based on:

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

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1 The strategy and the needs assessment will be available to view and download from the alcohol pages of the Safer Cornwall website.
2 The Cornwall Council website provides more information on the Joint Strategic Needs Assessment and an online resource library of assessments and focus papers.
It is:
• A way of **estimating the nature and extent** of the needs of a population so services can be planned accordingly;
• A tool for **decision making**;
• To help **focus effort and resources** where they are needed most.

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

**Aims and objectives**

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

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

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

• **What works well**, and for whom in the current system, and what the unmet needs are across the system, in both community and prison settings;
• **Gaps for clients** in the wider reintegration and treatment system;
• Where the system is **failing to engage** and / or retain people;
• Who are the **hidden populations** and what are their risk profiles;
• What are the **enablers and barriers to treatment**, reintegration and recovery pathways;
• The relationship between **treatment engagement and harm profiles**.

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

The national guidance for the 2014/15 Drug and Alcohol Needs Assessments (including Young People’s assessments) was some of the **most comprehensive and challenging received to date**, in nine years of undertaking local assessments. The DAAT Needs Assessment Expert Group has **stretched to incorporate new areas** into the needs assessments each year, including this one, but, as can be seen in our rating of ourselves against the national checklist, **there remain some areas for improvement**.

**Appendix B** shows all the areas that have been successfully considered, those that have been partially explored and themes where we have not yet begun to gain access to the relevant data or found a means of investigating. These may **require assistance from partners in some areas for analysis** and will form the priorities for the 2015/16 Needs Assessment.
Strategic and legislative context

National Alcohol Strategy 2012

Our local alcohol strategy is set within the context of the national response to alcohol issues, as outlined in the Government’s 2012 Alcohol Strategy which seeks to reduce drinking above health guidelines or to excess. It intends to reduce alcohol-fuelled violent crime, binge drinking, alcohol-related deaths and underage drinking.

Measures introduced included a consultation on minimum alcohol unit pricing, and greater control on alcohol retail offers and advertising. However, minimum Unit Pricing (‘MUP’) was ‘postponed’ as Government policy for a decision until after the election. It was communicated that "We do not yet have enough concrete evidence that its introduction would be effective in reducing harms associated with problem drinking — this is a crucial point — without penalising people who drink responsibly."

This statement contradicts academic peer reviewed research evidence (e.g. British Columbia and Sheffield University) and was critiqued by the BMJ as bowing to disproportionate industry influence and undue pressure.3

Anti-Social Behaviour, Crime and Policing Act 2014: Reform of anti-social behaviour powers

New measures have been introduced to increase the range of responses to anti-social behaviour, including positive requirements addressing the root causes of offending behaviours, and to enable hospital emergency departments to better address on-site alcohol related offences. Various new sentencing options for alcohol-related offences have been piloted, and family and youth policies have been trialled in places.

Offender Rehabilitation Act (February 2015)

Coming into effect on 1 February 2015, the Offender Rehabilitation Act introduces a number of further measures intended to support the drive to reduce reoffending, including:

- A new drug appointment requirement for offenders who are supervised in the community after release;
- An expansion of the existing drug testing requirement after release to include Class B as well as Class A drugs;
- A more flexible Rehabilitation Activity Requirement for adult sentences served in the community which will give providers greater freedom to develop innovative ways to turn an offender’s life around.

3 http://www.bmj.com/content/348/bmj.g72
NICE Quality standard 83: Preventing harmful alcohol use in the community (March 2015)

This recent guidance compiles and summarises a range of approaches at a population level to prevent harmful alcohol use in the community by children, young people and adults.

It is expected to contribute to improvements in the following outcomes:
- Quality of life
- Admissions to hospital; alcohol-related, and for violence or accidents resulting from alcohol
- Alcohol-related deaths
- Anti-social behaviour and violent crime related to alcohol
- Prevalence of harmful and hazardous drinking
- Rates of under-age drinking

It is delivered through these 4 Quality Statements:

1: Using local crime and related trauma data
   “Local authorities use local crime and related trauma data to map the extent of alcohol-related problems, to inform the development or review of a statement of licensing policy.”

2: Under-age sales
   “Trading standards and the police identify and take action against premises that sell alcohol to people under 18.”

3: Alcohol education
   “Schools and colleges include alcohol education in the curriculum.”

4: Schools and colleges
   “Schools and colleges involve parents, carers, children and young people in initiatives to reduce alcohol use.”

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

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

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


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

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

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

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

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

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

Previous funding made available nationally is brought into the Public Health Grant, along with the local NHS contributions. The local Health and Wellbeing Boards and the Director of Public Health become jointly accountable for ‘strong leadership’ of alcohol and drug treatment.

**The Public Health Outcomes Framework (2012) - Drug and alcohol interventions lead to better public health outcomes**

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

The framework focuses on the two high-level outcomes we want to achieve across the public health system and beyond. These two outcomes are:

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

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

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

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

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<td>Successful completion of drug and alcohol treatment</td>
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Drugs and Alcohol provision is also responsible for making a significant and essential contribution to the following other key indicators:

- Securing employment for those with a long term health condition
- Reducing domestic abuse
- Reducing reoffending
- Reducing statutory homelessness
- Improving the emotional wellbeing of looked after children
- Reducing hospital admissions as a result of self-harm
- Self-reported wellbeing
- Reducing mortality from causes considered preventable
- Reducing mortality from communicable diseases
- Reducing mortality from liver disease
- Preventing suicide
- Reducing emergency re-admissions within 30 days of discharge from hospital
- 16-18 year olds not in education, employment or training
- People in prison who have a mental illness or a significant mental illness
- People presenting with HIV at a late stage of infection
- Sickness absence rate
- Pupil absence

The measure of **Alcohol Related Hospital Admissions is the key indicator** for the overall impact of all aspects of alcohol interventions in any given area. As such it is a definition of how much the system fails to prevent people arriving in...
a hospital bed with a condition for which alcohol is a direct cause or contributory factor.

When analysed, it can also provide guidance for preventative interventions in key community health treatment settings, in order to identify alcohol issues before they become severe enough to contribute to hospital admissions.

Similar analysis also provides guidance for treatment pathways for patients leaving hospital after episodes addressing conditions where alcohol is a direct cause or contributory factor.

We will continue to incorporate any new national policies and initiatives alongside our commitment to addressing local needs, and the continued development of our own good practice and strategy.
Local Objectives

- **To enable people to make informed choices about alcohol**: we aim to help people in Cornwall to become better informed about responsible drinking and safe alcohol intake levels, by giving relevant advice, information and support in order to reduce alcohol related harm.

- **To improve services to reduce the harm caused by alcohol**: we aim to reduce the risk of alcohol related harm to individuals and families by improving effective alcohol services in the community, in the NHS and hospitals, in the voluntary sector and in the Criminal Justice System, in order to reduce alcohol related hospital admissions and support recovery from problematic alcohol use.

- **To promote partnerships to reduce alcohol's impact on the community**: we aim to work effectively in partnerships to promote best practice around safe alcohol retail, maintaining safe localities and communities, and to have well planned responses to alcohol related issues with the long term goal of reducing disruption to the community.

These objectives will be **delivered across eight areas**:

| 1 | **Advice and Information**  
including Identification and Brief Advice, population level messaging and targeted social marketing |
|---|---|
| 2 | **Children, Young People, Parents and Families**  
including Together for Families |
| 3 | **Community Safety Schemes**  
including Anti-Social Behaviour (ASB), and Fire and Rescue |
| 4 | **Criminal Justice Interventions**  
including diversionary and sentencing pathways |
| 5 | **Domestic abuse and sexual violence**  
including treatment provider participation in the MARAC process |
| 6 | **Inclusion, Employment, and Deprivation**  
including Social Care, Homelessness and Housing |
| 7 | **Health, Treatment, Aftercare and Recovery**  
including hospital admissions, mental health and the treatment system |
| 8 | **Licensing, alcohol retail and the Night Time Economy**  
including Best Bar None and bar staff training |
Key findings and priorities

1: Advice and Information

- Identification and Brief Advice (IBA) is a simple intervention aimed at individuals who are at risk through drinking above the guidelines but not typically seeking help for an alcohol problem. It includes screening for problem drinking using an accredited tool, identification of the level of problem and brief advice to reduce alcohol-related harm (or onward referral for more intensive intervention if required);
- We have delivered IBA training to just over 2,000 staff in Cornwall in just under three years. In 2014/15, 400 people received IBA training at 41 events;
- 97% of attendees showed improvement across one or more of the key areas that were evaluated;
- A number of services have requested future IBA training.

Priorities

- Target services not yet reached for more IBA training:
  - Within front line community settings outside healthcare;
  - Within targeted health care settings and services for specified health conditions, as guided by the alcohol related hospital admissions evidence;
  - Within any healthcare commissioning, in line with the 2014 framework for all nurses and allied health professionals.
- Deliver ongoing support to remove any barriers to IBA delivery;
- Evaluate findings from IBA delivery monitoring to target service commissioning, training and delivery, and to focus further intervention training, e.g. Motivational Interviewing;
- Reassess agencies and services trained to ensure training is being used and screening is occurring.

2: Children, young people, parents and families

Young people

- The proportion of young people in treatment for alcohol as a primary substance is 11% of the treatment population, which is consistent with the national treatment population;
- A review of the National Drug Treatment Monitoring System data shows that alcohol is actually involved as either a primary, secondary or tertiary substance in 32 cases (23% of young people in YZUP, the young people’s specialist service) where the young person was aged under 18. This figure is significantly lower than the previous two years where 54% and 62% of young people had an identified alcohol treatment need respectively. This could therefore indicate that young people with lower complexity issues are less likely to be referred into YZUP;
Substance misuse was identified as a **risk factor in reoffending** in a greater proportion of young people who were assessed as medium to high risk (of reoffending) than in the previous year.

**Parents**
- Overall, adults in treatment for alcohol as their primary substance are **more likely than drug users to be parents** but there is a higher proportion that do not currently have their children living with them;
- In the 12 month period ending December 2014, **17%** (414 people) of adults in drug and/or alcohol treatment were **recorded as living with a child**, predominantly in a parental capacity;
- A further **26%** (640 people) of drug and/or alcohol users in treatment were **parents but not living with their children**.

**Families**
- Service user consultation found that every service user consulted knew 2-4 people who had problems and **did not contact services for help** due to the fear of “having their children taken away”;
- A report published by Together for Families in 2014 indicated that **substance use/alcohol is a factor for 44%** of the 1,404 families, but despite this **the referral pathway is not yet being effectively utilised** - families from the programme have taken up only 14% of the places commissioned and these were not directly referred.

**Priorities**
- Develop **effective identification and referral pathways** and ensure **joint working** arrangements are in place between **children and family services** and specialist alcohol treatment where there are safeguarding issues and with local Troubled Families provision where alcohol or drug misuse is a factor;
- **Referral rates and early identification**, of drug and alcohol use in the Troubled Families programme, requires more work though an **agreed defined pathway and workforce development.** A protocol for this was developed three years ago but was never fully implemented with children and family services and requires revision in line with developing early help and social work offers;
- **Address the fears of parents with drug and alcohol problems** in approaching services for help at the earliest opportunity.

**3: Community safety schemes**
- **Alcohol-related harm is one of the top two strategic priorities** (the other is Domestic Abuse and Sexual Violence) for Safer Cornwall going forward into the next three years;
- Domestic Abuse, of which **80%** of crimes relate to Violence Against The Person offences, presents the **highest overall threat** to communities in Cornwall, in terms of risk and harm, and reported incidence of domestic abuse is believed to be **higher locally** than the average for similar areas elsewhere in the country;
Alcohol is most strongly associated with Night Time Economy Violence (70%) and in assaults resulting in injury (41% compared with 28% for assaults with no injury);

Young males are the highest risk group, particularly those aged from 18 to 24 years. This is echoed in the statistics that we receive from the Emergency Department at Royal Cornwall Hospital Treliske (Truro) that shows young males as the most typical attendees for alcohol-related assault;

With the exception of Domestic Abuse, however, improving trends in violent crime, particularly in the Night Time Economy and alcohol-related violence, means that the risk to communities has substantially reduced;

Local evidence, therefore, supports putting greater emphasis on developing effective early intervention and prevention approaches rather than increasing the current array of activity related to the Night Time Economy;

Data from the Assault related Injuries Database is installed in the Emergency Department in Royal Cornwall Hospital Treliske and is now also being used by 5 Minor Injury Units across Cornwall;

There is an emerging at-risk group for road traffic collisions – pedestrians being involved in a collision between the hours of 9pm and 3am involving impairment through alcohol.

Priorities

- Continued focus on early intervention and prevention approaches rather than increasing the current array of activity related to the Night Time Economy;

- Align the new Alcohol Strategy with the new Domestic Abuse and Sexual Violence Strategy (the top two Community Safety Partnership priorities), particularly in terms of attendance at Multi-Agency Risk Assessment Conferences (MARAC) by treatment providers and IBA training for Domestic Abuse services;

- Closely monitor violence trends to ensure that there is no escalation of risk. In particular, ensure that the Night Time Economy continues to be managed effectively and best practice prevails;

- Continue to support the move to a coherent regional commissioning approach for the Assault Related Injuries Database (ARID) in 2015/16, improving opportunities for analysis and delivery, if inconsistencies in other parts of the Peninsula can be resolved;

- Continue to improve the design and implementation of evaluation techniques for community safety interventions. This should build on the initiative group adopted by the Community Safety Service which aims to ensure initiatives are evidence based and robustly evaluated and creates an interventions library of effective initiatives;

- Address pedestrian safety when drinking alcohol; including communication to increase prevention.
4: Criminal justice interventions

- Both the percentage of offenders that reoffend and the rate of reoffences that they commit are consistently **lower than the England and Wales average**;
- **Alcohol is the most prevalent risk factor amongst adult offenders** - 56% of adult offenders have an alcohol problem that is linked to risk of serious harm and/or reoffending, and a third of the offender population are assessed as having “significant” or “some” problems with alcohol;
- This provides an estimate of **450 offenders with a criminogenic need related to alcohol**. The change in legislation extending supervision requirements to all short sentence prisoners could mean an additional 110-140 offenders with an alcohol-related need. As of June 2015, however, the **anticipated uplift in the number of offenders has not yet been realised**;
- **Daily and heavy drinking** pre-prison were found to be more common amongst short sentence prisoners, although **only a small proportion wanted help** for an alcohol problem;
- **Offender engagement with community treatment services appears low**, with 61% of offenders with a criminogenic alcohol need not in contact with community treatment services. Offenders with significant alcohol problems were most likely to be in contact with treatment. This **potentially identifies a cohort of offenders with unmet needs**, but requires further clarification as to what the nature of those needs are;
- Alcohol and alcohol and non-opiate **successful completion rates in the Criminal Justice Team are lower** than the wider treatment population: 27% and 25%, compared with 41% and 34%, respectively. The finding is the same for drug users in the criminal justice team and may reflect the additional challenges in engaging offenders successfully.

Priorities

- **Offender manager workforce development**; we need to establish what the **specific training needs** are for offender managers;
- **Improve identification, referral and engagement** into specialist services and to **identify if there are any barriers** (staff or offenders) that we need to address. This is a priority for the new offender management structure under Dorset, Devon and Cornwall Community Rehabilitation Company (CRC) but also applies to the National Probation Service (NPS);
- **We need good quality local data** (from CRC and NPS) to inform our local reoffending needs assessment and inform the development of the packages required to reduce reoffending locally. **Management in these services** should monitor and share information about performance and outcomes;
- More work is needed to address the needs of **offenders with complex needs** in an **integrated** way in the community, including family-based interventions to address the “toxic trio” of domestic abuse, mental health and problem substance use;
- We need to do some work around improving **successful completion rates** for criminal justice clients;
- Review the interventions available to **target problem drinking in offenders**.
5: Domestic abuse and sexual violence

- **9% (211 people)** of the structured drug and alcohol treatment population in 2014 had been involved with domestic abuse services between 2008 and 2014. In these cases, alcohol was the major treatment issue;
- Of these, **32% (29 people)** also had a mental health issue (3% of the total structured drug and alcohol treatment population). These service users were more likely to be in treatment for problematic alcohol use, compared to drugs;
- **16% (218 families)** of families on the Together for Families register had drug and/or alcohol use, domestic abuse and mental health identified as an issue. Over half of these families were not known to drug and alcohol treatment and domestic abuse services.

**Priorities**

- To **improve screening and recording** in drug and alcohol and domestic abuse services to identify complex needs and enable joint working to occur;
- Implementation if the new **joint Domestic Abuse and Sexual Violence (DASV)/DAAT protocol** and greater joint working would be beneficial to identify the nature of the drug and/or alcohol use and whether treatment would aid the 50% of those identified with drug and/or alcohol issues in domestic abuse services who were not known to drug and alcohol treatment services.

6: Inclusion, employment and deprivation

- Cornwall has a **higher proportion of clients that enter treatment unemployed** than the national average (46% compared with 40%). This has a negative impact on recovery and the likelihood of successfully completing treatment;
- Rates of **incapacity claimants due to alcohol dependency** in Cornwall are **significantly above the England average**;
- In the last 12 months, **22% of people starting alcohol treatment presented with problems with their accommodation**. This is a strong negative factor in recovery and successful completions.

**Priorities**

- Ensure the **new housing pathway for clients leaving residential services** is effective in securing accommodation on completion of a rehabilitation programme;
- Ensure the **housing pathway for Prolific and other Priority Offenders** is effective in securing accommodation for those releases from prison, who would otherwise be homeless.
7: Health, treatment, aftercare and recovery

Health

- Just over a quarter of adults in Cornwall are estimated to drink above the recommended level, and 7% (or 26,700) are drinking at higher risk levels, drinking more than double the recommended levels. In addition, an estimated 84,000 (19%) people are binge drinkers, and 4,900 are estimated to be dependent drinkers;
- Cornwall has a higher level of high risk drinkers in our population than the national rate and a higher proportion of clients entering treatment drinking more than 1,000 units per month, or 33 units per day – which equates to 3 bottles of wine, or 11 Pints of export strength lager daily;
- Cornwall has a higher rate of alcohol specific hospital admissions for females and those under 18 years and an overall lower rate of liver disease;
- Alcohol-related admissions increased slightly in 2013/14, compared with 2012/13;
- In 2014, alcohol was detected in 8 of the 16 drug related deaths (DRDs). In 6 of these the alcohol levels were high enough to be part of the cause of the death or enhance the toxic effects of other drugs taken. Alcohol only treatment clients accounted for 3 of these deaths;
- Poly drug use has been further underlined this year as being problematic and raises the point that assumptions should not be made surrounding any client’s knowledge, or lack of knowledge, with poly drugs use and/ or alcohol.

Specialist treatment

- 22% of total dependent drinkers in Cornwall are in specialist structured alcohol treatment compared with 13% nationally, for the last full year, with the latest figure being 16%. The number appropriately in unstructured treatment continues to rise.

Mental health

- Of the estimated 11% (49071) of Cornwall’s adult population that has a mental health condition, an estimated 20% (9849 people) also have alcohol dependency. This would equate to 2.2% of Cornwall’s total adult population with both a mental health condition and alcohol dependency;
- 19% of service users in structured alcohol treatment had dual diagnoses. This equates to just 301 people, which suggests there may be a large unmet alcohol treatment need among those with mental health conditions;

Priorities

- To develop thorough pathways from hospitals to alcohol treatment services;
- To extend the training in IBA to wards and Emergency Departments, and monitor and support RCHT to ensure that it is fully embedded;
• To develop Royal Cornwall Hospital Trust multi-disciplinary monthly meetings to analyse and care plan frequent attenders on a monthly basis;
• Projects aimed at public messages about alcohol, treatment interventions, or IBA/preventative schemes need to address the population as a whole, but should consider whether women and under-18s have been specifically catered for, to avoid these trends developing;
• Hospital alcohol care teams should accelerate identification and brief advice (IBA) delivery throughout the hospital by supporting the training of colleagues in all clinical areas;
• Local partners should review the response to alcohol-related harm in all district general hospitals, using this document as a guide, and they should ensure that existing services are adequately integrated across primary and secondary care and that new services are implemented where there are none;
• Support the development of an RCHT alcohol team;
• Further investigation is needed to see why people have had drug related deaths who have been in treatment for alcohol problems only;
• Awareness and education is needed around the risks of poly drug use;
• To develop a consistent and effective method of investigating alcohol related deaths to inform lessons learnt and future practice;
• To examine the unmet need for alcohol treatment for those with mental health issues and the potential barriers to treatment;
• To develop and implement the Dual Diagnosis strategy and action plan to aid development of joint working to improve outcomes for people affected by more than one condition;
• Work with mental health providers would help to identify if those with mental health issues in domestic abuse and drug and alcohol services are accessing treatment for their mental health condition and what joint working could occur for those with complex needs;
• Primary focus on increasing successful completions by:
  o Examining and developing the treatment offer for the most complex service users, particularly those who are representations to treatment, to reduce these service users dropping out of treatment again;
  o Increase engagement of those not in contact through outreach and targeted activities, particularly people with children;
  o Providing more information for service users about what is available. A comprehensive directory of recovery pathways published and regularly updated;
  o Reviewing the treatment offer for people who have been in treatment for 4 years and over to assess the recovery potential and service design for this group;
  o Reviewing the options for getting treatment to people who have difficulty with transport costs;
  o Including stages of constructive activity and volunteering from the outset of treatment;
  o Clarifying the mental health offer within treatment services;
  o Increasing the solid network of volunteer drivers and peer mentors.
8: Licensing, alcohol retail and the night time economy

- **Night Time Economy violence continues to fall** (this is the third successive year) and as a result presents a **reduced level of risk** to communities;
- **Health now has more input in licensing decisions**, which may lead to serious consideration for a Public Health-related Licensing Objective in England;
- In Cornwall the **Licensing Policy has recently been updated** and two issues are currently more important here than the local Licensing Policy:
  - Operational application and swift responsive use of data already being gathered, e.g. through the Assault Related Injuries Database in hospital Emergency Departments and Minor Injuries Units, so that licensing practice is improved;
  - Staying engaged with the evolution of Public Health responsibility and legislation in connection with Licensing.

**Priorities**

- **Continue to communicate and lobby strongly for the evidence based policy of connecting the price of alcohol to strength** (either by MUP or by through targeted taxation) in any policy debates and consultations;
- Review and continue to **deliver the SMART training** for bar staff, in order to promote best practice and responsibility in alcohol sales;
- Continue to **evolve Cornwall Licensing Forum** in an event-based setting for dialogue and discussion about best practice, involving both trade and enforcement representatives;
- **Evolve Cornwall Best Bar None** to fit in with the national timetable, and make changes designed to create sustainability by increasing trade commitment to the scheme through sponsorship and by making the assessment process more efficient;
- Increase **Public Health engagement with licensing applications** and review processes, especially if relevant legislation or Licensing Objectives are updated;
- Work with the Office of the Police and Crime Commissioner to engage with **supermarket alcohol retailers**, and to encourage a national dialogue about improving alcohol legislation and enforcement;
- Work with the Office of the Police and Crime Commissioner on **local Night Time Economy schemes**, for example #RU2drunk and the nightclub breathalyser schemes, and with police as they review and improve their public messaging;
- Continue to work with Community Safety colleagues as they evaluate and refresh the “**What Will Your Drink Cost” campaign**, which impacts across the community including through the Night Time Economy;
- **Review the approach to criminal justice interventions** that address alcohol related offences and violence in Cornwall;
- **Improve operational usability and impact of data gathered** through the **Assault Related Injuries Database** in Emergency Departments and Minor Injuries Units, in order to improve practice in licensed premises, and make customers less vulnerable to violence and health harms.
The delivery landscape

Over recent years, changing national priorities, driven by a new government, evolving legislation, and the economic downturn have impacted partnerships and their delivery environment. This evolution is set to continue, with the following common factors likely to shape the work of public services in the coming year.

- **A challenging economic climate** driving up demand for services against a backdrop of accumulative cuts to budgets and resources across all partners;
- Significant **changes to and development of Government policy** in key areas, such as anti-social behaviour and the regulation of New Psychoactive Substances;
- Widespread **restructuring and change across the public sector**, creating a fluid service picture;
- **Increased devolution of accountability** to local councils, empowerment of communities to influence and change service delivery with a strong drive for local solutions to local problems;
- **More integrated working** across agencies and across geographic borders and increased reliance on **strong and effective partnerships**;
- Increasing **threat presented by on-line environments** as locations for criminality and the challenges that this presents for safeguarding people, detecting and investigating crime. This includes online availability of new psychoactive substances and home delivery;
- The **transition of Devon and Cornwall Probation Trust** into Dorset, Devon and Cornwall Community Rehabilitation Company and part of the South West and South Central Division of the National Probation Service is requiring partners to **rethink how we work together** to reduce reoffending;
- The **devolution of nationally commissioned victim support services** and the reallocation of funding to the Police and Crime Commissioners to commission effective support services for victims of crime;
- The introduction of **Restorative Justice processes** which will bring those harmed by crime or conflict, and those responsible for the harm, into communication, enabling everyone affected to play a part in repairing the harm and finding a positive way forward;
- The **election process for the next Devon and Cornwall Police and Crime Commissioner** will be in 2016;
- Significant changes contained in the **new Care Bill** will regulate the reforming of care and support in order to achieve the aspirations of the White Paper, “Caring For Our Future”. A key element of the Bill is the introduction of **personalised budgets**; whilst this allows people to have greater control over their care and support there is a potential risk for vulnerable people to be financially exploited through direct payment of personalised budgets;
- As concerns about **modern slavery** and **child sexual exploitation** increase, so does our awareness of the role that drugs and alcohol can play in these scenarios.
We are well placed to meet these challenges. We have a long established **evidence-led service planning and delivery process**, ensuring that resources are targeted where they are most needed.

We recognise that our priorities continue to impact upon each other and also on those of our partners. With resources and budgets increasingly squeezed, the **real efficiencies are to be made in pooling resources and joint commissioning**.

This extends to understanding how we can work more effectively with the **voluntary and community sector** and **local businesses** – not just in terms of delivering against our priorities but also involving these wider partners in identifying the issues for Cornwall, prioritisation and planning.

We know that we need to improve our methods for **evaluating initiatives**, including building an understanding of social return on investment, and further develop the ways that we **engage with our communities**.

Meanwhile, the services we commission continue to develop and adapt to the ever changing needs of Cornwall and the evolving Local Authority commissioning arena.
Local context

Cornwall is the second largest local authority area in the South West region and is an area of many contrasts. Issues in Cornwall can be understood by a number of contextual factors.

Population
- Dispersed and sparsely populated settlement pattern combined with Cornwall’s coastline present issues of accessibility and challenges for equal provision of services.
- Population clusters in the larger towns, which experience the same crime and disorder issues as urban areas elsewhere in the UK.
- Low representation of minority ethnic groups; more acute feelings of isolation and vulnerability and may lack access to support networks and a strong voice locally.
- 34% of Cornwall’s population lives in more isolated rural communities, where crime rates are significantly lower but the distance from support networks and services means that residents may feel more vulnerable.

Housing
- Housing affordability and availability is a major issue, placing extra pressures on families and extended families to co-habit.
- Providing suitable housing for vulnerable people is a constant problem and will be exacerbated by changes to the welfare system.

Labour market and economy
- Low wages, increased unemployment, an over-dependence on low paid jobs with a higher proportion of seasonal and part time jobs and lower earnings across many sectors of the economy. Fewer opportunities for young people.
- Weak local economy and decline from the recession has been worse than the national average.
- Areas of persistent worklessness, particularly due to disability and ill-health.

Deprivation
- Pockets of high deprivation where communities experience multiple issues: higher unemployment, lower incomes, child poverty, ill health, low qualifications, poorer housing conditions and higher crime rates.
- Hidden rural deprivation, not identified by national measures due to the dispersed nature of rural population.

Health and wellbeing
- Higher prevalence of limiting long term health problems, including mental health.
- Significantly higher proportion of working age people claiming health-related benefits due to alcoholism (i.e. alcohol dependence).

Geography
- Problems are not evenly spread and tend to be concentrated in geographic hotspots, particularly the centres of our larger towns.
- Many thousands of people flock to Cornwall each year for their holidays. This brings many benefits but also places increased pressure on local services in popular tourist towns and provides more opportunities for crime to be committed and more potential victims and criminals.
1: Advice and Information

Identification and Brief Advice

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

In Cornwall we have chosen to use the World Health Organisation AUDIT tool; the Alcohol Use Disorders Identification Test. This involves a 3 question evaluation of consumption levels (AUDIT-C) and if necessary the remainder of the full 10 question set, in order to produce a score that identifies the risk level of someone’s drinking. This then leads to an appropriate intervention or referral.

Brief interventions mean open access, non-care planned interventions. These include open access facilities and outreach that provide alcohol-specific advice, information, support and extended brief interventions to help people with alcohol problems to reduce harm, and to provide assessment and referral into care-planned treatment for those with more serious problems.

What the evidence says

Excessive drinking is a major cause of disease and injury, both short term due to alcohol poisoning and the consequences of risk taking behaviour, and longer term due to the effects of regular alcohol misuse on mental and physical health. Identifying problems with alcohol at an early stage and providing information and advice to help reduce drinking risk will potentially have the greatest long term impact on reducing alcohol-related harm.

Earlier identification has been promoted nationally through Health Checks and in key areas such as pregnancy, domestic abuse, and mental health services.

Evidence shows that for every eight at-risk drinkers who receive advice, one will reduce their drinking to within low-risk levels, leading to improved health and reduced demand on hospital services.4

- NICE5 guidance recommends that screening should target people who are at increased risk of harm from alcohol and those with an alcohol-related condition.

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5 Alcohol-use disorders: preventing the development of hazardous and harmful drinking (NICE, 2010)
• Local research into the health burden of alcohol misuse, in terms of hospital admissions, reiterates the national guidance and has highlighted a number of other areas where we need to focus our efforts.
• Both local and national evidence also make clear links between alcohol use and social problems, such as deprivation, crime and anti-social behaviour, financial worries and debt.

Identification and Brief Advice should be targeted at the following high risk groups:

**In Health & Primary Care settings**
- People:  
  - With relevant physical conditions, such as hypertension and gastrointestinal or liver disorders  
  - With relevant mental health problems, such as anxiety, depression or other mood disorders  
  - Who have been assaulted  
  - At risk of or known to be self-harming  
  - Who regularly experience falls, other accidents or minor traumas  
  - Who have been injured as a result of a road traffic collision  
  - Who present to Emergency Departments with acute alcohol intoxication/poisoning  
  - Who regularly attend GUM clinics or repeatedly seek emergency contraception

**In wider community settings**
- People:  
  - At risk of or known to be self-harming  
  - Involved in crime or anti-social behaviour  
  - Who have been assaulted  
  - At risk of or known to be a victim of domestic abuse or sexual violence  
  - Whose children are involved with child safeguarding agencies  
  - With drug problems  
  - Living in areas of social deprivation  
  - With debt and / or financial problems, such as housing or rent arrears  
  - Who are long term unemployed or unable to sustain employment

A focus on people in deprived areas particularly offers wider benefits for tackling health inequalities. Deprivation is strongly associated with poor health in a wide range of areas, including higher levels of obesity, physical inactivity, unhealthy diet, smoking and poor blood pressure control.

Cornwall DAAT has established an Alcohol Awareness (IBA) Toolkit in line with national guidelines, which forms the basis of what is being trained in Primary Care and other settings in the community. This includes the WHO identification tools **AUDIT-C and AUDIT** (The Alcohol Use Disorders Identification Test) as well as the Department of Health Brief Intervention advice guidance and handout. These can all be found at [http://www.cornwall.gov.uk/alcoholawareness](http://www.cornwall.gov.uk/alcoholawareness).
What are we doing about it?

Addaction provide a GP based service in almost every surgery across Cornwall, as well as a telephone helpline, and support is also available through Alcoholics Anonymous. The Emergency Department at Treliske Hospital in Truro can also provide extended interventions and the homeless can access services through outreach at St Petroc’s and Health for Homeless.

IBA training is being delivered in Cornwall and the Isles of Scilly across a wide range of medical, criminal justice and non-medical community settings, targeted to services that may see clients presenting with issues that may have an underlying link to problem alcohol use, such as debt, unemployment, housing problems, social care issues, depression, domestic abuse and offending.

The training enables those working in frontline services to identify whether a client has an alcohol problem, using common tools and guidelines, and provide the advice that they need to help them reduce their drinking risk and signpost into more intensive treatment if this is required.

We have delivered IBA Training to around 2,000 staff in Cornwall in just under 3 years. In 2014, 41 events were held in locations all over Cornwall, using 2 trainers, with a total of 400 people attending these events.

Agencies who accessed the training were:

- Newquay NTE Volunteers;
- The Stayathome Team, Pentreath;
- Children’s Social Care Team Care Co-ordinators, Lescudjack;
- ONGOING Support, Penzance;
- ASB team;
- North Cornwall Children In Need Team;
- Dolcoath Adult Social Care;
- Cornwall Housing, Independent Living, Bodmin;
- Family Contact team, Bodmin;
- Child Protection teams, Liskeard;
- CRCC/Carers, Truro;
- YMCA Penzance;
- CST, Sedgemoor;
- The Health Promotion Service, Wilson Way Ind Estate, Pool;
- Home Solutions Service, Penzance;
- Complex Therapy, Penzance;
- Early Intervention Service, Truro OCH;
- Onward Care, NHS, Truro;
- SARC/WRSAC, Truro;
- STEPS Team/EHSC, Liskeard;
- STEPS Team/EHSC, Camborne;
- Sea Sanctuary, Truro/Falmouth;
- Together for Families, NCH, Truro;
- Action for Children, Truro;
- Resource centre, Bodmin;
- Job Centre+, Truro;
- Prospects Team, St Austell;
- And CFT Mental Health Teams, including: Custody Mental Health team, Secure Unit, Adult Team, Early Intervention, Psychosis Team, CCD, Alexander House, Trevills House, Recovery Support Workers, Banham House, Health Visitor team, Art Therapy, Home Treatment Team.

In-session evaluation of learning was processed by means of a before/after knowledge quiz based on the key learning areas. The evaluation quiz started with knowledge based questions about safe unit levels for men and women, moved on to tools and skills questions about the AUDIT risk level tool, then
focused on confidence in the frequency of raising the issue with clients, and finally asked about appropriate and inappropriate referral processes.

These were designed to assess improvements and learning in staff with no prior knowledge of the issue, right through to experienced staff who may need to increase the focus on alcohol and use of assessment tools, as well as decision making about appropriate referrals or ongoing support from the existing service.

97% of staff adequately filling in and returning evaluation tests showed improvement across one or more of the following areas:

- Increased knowledge of alcohol units level for men;
- Increased knowledge of alcohol units level for women;
- Increased knowledge of the AUDIT screening tool and its use;
- Increased confidence and intention of increasing frequency of addressing alcohol issues in their client group as a result of the training;
- Improved ability to interpret AUDIT scores and address appropriately after training;

Additional requests for training for 2015/16 have been made by:

- Treliske Hospital (AUDIT-C) via Video modules and Volunteer reps;
- Fire and Rescue / Home Fire Safety Checks Observation and Conversation Training;
- Fire and Rescue / Home Fire Safety Checks IBA Follow Up Visitors;
- Stonham and other Housing services;
- CRC;
- NPS;
- Volunteers;
- Social Care Services;
- Health Visitors;
- Midwives;
- Mental Health / Outlook SW / Beme.

Priorities

- Target services not yet reached for more IBA training:
  - Within front line community settings outside healthcare;
  - Within targeted health care settings and services for specified health conditions, as guided by the alcohol related hospital admissions evidence;
  - Within any healthcare commissioning, in line with the 2014 framework for all nurses and allied health professionals.
- Deliver ongoing support to remove any barriers to IBA delivery;
- Evaluate findings from IBA delivery monitoring to target service commissioning, training and delivery, and to focus further intervention training, e.g. Motivational Interviewing;
- Reassess agencies and services trained to ensure training is being used and screening is occurring.
2: Children, young people, parents and families

Alcohol use amongst young people is always a cause for concern. **Perceptions of young people drinking alcohol are distorted**, which is partly due to over amplification in the media. Nationally the NHS Information Centre schools survey\(^6\) shows that the proportions of young people aged 11-15 regularly drinking alcohol (ever used in their lifetime) has fallen since 2001. This survey shows that the proportion of young people who report to regularly drink has reduced from 20% in 2001, to 7% in 2011.

**What the evidence says**

YZUP is the young person’s drug and alcohol service for Cornwall and the Isles of Scilly.

Along with cannabis, alcohol is the main substance for which young people access specialist services through YZUP. This is the case both nationally and locally where proportions of young people in treatment with cannabis, alcohol or both are similar.

- The proportion of young people in treatment for alcohol as a primary substance is **11% of Cornwall’s treatment population**, which is consistent with the national treatment population;
- A review of NDTMS data shows that **alcohol is actually involved as either a primary, secondary or tertiary substance in 32 cases** (23% of the YZUP cohort) where the young person was aged under 18. This is **significantly lower than the previous two years** where 54% and 62% of young people had an identified alcohol treatment need respectively. This could therefore indicate that young people with lower complexity issues are less likely to be referred to YZUP.

The risks of alcohol-related harm to young people come from their own problem use of alcohol and the **associated risks of involvement in crime**, injury and other health problems, as well as safeguarding risks around parental problem use of alcohol (discussed in more detail under Substance Use and Families).

Many of the risks for young males and females are shared, such as those related to adverse effects on health and wellbeing, but there are different risks in terms of involvement in crime – **young males are much more likely to be involved in public violence**, both as victims and offenders, and **young females are more likely to be victims of alcohol-related domestic and sexual violence**.

- Historically alcohol-related **hospital admissions for under 18 year olds were significantly higher than regional and national averages**. The

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\(^6\) As cited in Substance Misuse Among Young People 2011-12, NTA.

Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15

NOT PROTECTIVELY MARKED
latest data\(^7\) indicates that 52.5 young people (per 100,000 under 18 population) have had an alcohol specific hospital admission, which is greater than regional (47.7) and National rates (40.1). Note that this does not include attendance at Emergency Departments;

- Compared to our geographic neighbours, Cornwall is similar to Plymouth, Torbay and Somerset but significantly higher than Devon\(^8\);
- Young people admitted to hospital for alcohol-related causes are **more likely to have acute needs**, such as for alcohol poisoning or assault-related injuries.

### Substance use and families

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

**Dependent children are especially affected** – albeit differently at different ages – by a parent’s alcohol problem, since parents’ ability to rear, protect and care for their children, attend to their health, feed them and financially support them may be **greatly diminished by their alcohol use**.

- Overall, service users in treatment for alcohol as their primary substance are **more likely than drug users to be parents** but there is a higher proportion that do not currently have their children living with them;
- In the 12 month period ending December 2014, **17%** (414 people) of adults in drug and/or alcohol treatment were **recorded as living with a child**, predominantly in a parental capacity.
- A further 26% (640 people) of drug and/or alcohol users in treatment were parents but not living with their children.

The map highlights areas where there are high rates of adults in alcohol treatment who are living with a child.

- The map identifies the following areas as having high rate of adults in alcohol treatment living with a child; **Camborne, Penzance, Bodmin, Hayle and Redruth**.

\(^7\) [Local Alcohol Profiles for England](http://www.nwho.org.uk) (NWPHO, June 2015)  
\(^8\) Health Profiles Local Authority Summaries 2014  
Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15  
NOT PROTECTIVELY MARKED
The map also identifies Wadebridge, Camelford and the areas surrounding Truro and Penzance, which are typically more rural than the other areas highlighted;

- There are also higher rates of parents in treatment in coastal areas such as Padstow, Bude, St Ives and Looe.

The Health Visitors Assessment (HVA) found that **in 4% of families one or both parents disclosed a problem with alcohol**. This is based on around 500 families out of 14,000 disclosing a problem with alcohol. There are pockets in Liskeard and China Clay where this proportion rises to nearer 20%. This audit does not collect information on whether the parent/s is engaged in alcohol treatment, however.

- The HVA map shows that the highest proportions of parental alcohol users are located in **Newlyn East and Liskeard Town**;
- Other areas identified include **St Just, Hayle South and High Lanes and St Dennis North**;
- There are some areas that have been identified by the HVA that have low rates of parents in drug treatment. The identification of **St Just and the China Clays (St Dennis, Foxhole and Nanpean)** may indicate a possible treatment need for adults living with children in these areas.

**Young Offenders**

A **comprehensive assessment of the needs of young offenders** is undertaken annually to inform the Youth Justice Plan and the Safer Cornwall Strategic Assessment (published on the Safer Cornwall website).

The Youth Offending Service (YOS) identifies the needs of each young offender by undertaking a comprehensive assessment (known as an ASSET), which is a nationally adopted tool. It identifies the **specific problems that contribute to a young person offending, as well as measuring the risk that they pose to others**. This enables the YOS to identify suitable programmes to address the needs of the young person with the intention of preventing further offending.
The following information only takes into account those young people that have received a court order or have had a full ASSET completed in the time period covered.

Once a young person is assessed they receive an overall score which is generated through the ASSET. These scores are then assigned to a band which calculates overall risk of reoffending, assessing a young person as low, medium or high risk.

There were a total of 80 ASSETs linked to the start of a young person’s order that were completed within the financial year. In the case of a young person having multiple orders throughout the year (and therefore multiple starting ASSETs) the latest ASSET was used.

The next chart shows a comparison between ASSET scores in the 2014/15 and 2013/14 young offender cohorts.

![ASSET Scores Chart]

Proportionately there were **significantly more** young people scoring **medium to high risk** in 2014/15 compared with last year but it should be noted that the number of young people assessed has dropped by 31%.

- The implication for the service is that they are increasingly working with a much reduced cohort of young people but where the majority have highly **complex needs**;
- In 2014/15 there were substantially fewer low risk cases compared with the previous year, largely due to increased use of Police Restorative Disposals.

**Substance use**

- **Substance misuse** was identified as a **risk in reoffending in a greater proportion** of young people who were assessed as medium to high risk than the previous year;
- **Alcohol** was considered a factor, either as a **primary or secondary substance in 75% of start assessments**. This represents a significant increase compared with last year when approximately half of all cases identified alcohol as being a risk factor.
• 66% or 22 young people who were assessed as having a significant risk of reoffending due to substance misuse were referred into, or have been previously known to YZUP.

Assessing the “Toxic Trio”

The NSPCC has researched the relationship between the “toxic trio” factors; mental health, domestic abuse and substance use, and babies born into families where these factors are present. Brandon et al, (2008) looked into 47 serious case reviews and found that families shared many characteristics with domestic abuse, mental health difficulties and substance misuse issues being most prevalent amongst parents and carers.

The ‘toxic trio’ of domestic abuse, mental health and substance use were identified as factors in just over half of the families discussed at the three Cornwall Child Sexual Exploitation and Missing Forums over the 12 month period ending February 2014.

In regards to a young person’s ASSET the risk factors that cover the “toxic trio” are Family and Personal Relationships, Emotional and Mental Health and Substance Misuse. The questions that make up the score for these risk factors have been analysed and can be seen below.

Of the 67 young people identified as medium to high risk in regards to reoffending, a quarter of them were scored as significant risk in all 3 risk factors of the “toxic Trio”, 63% had 2 or more factors identified and 87% had one or more of these factors identified.

The relationship between mental health, domestic abuse and substance misuse issues is examined in more detail in Section 5. Domestic abuse and sexual violence.

What are we doing about it?

Services for young people

YZUP is the young person’s drug and alcohol service for Cornwall and the Isles of Scilly. It offers young people referred into the service with alcohol issues a comprehensive assessment, which details areas of a young person’s life where alcohol is having a negative effect. This can involve family relationships, criminality, anti-social behaviour, mental and physical health, school, work, personal safety and finance.

From this assessment the service is able to offer the most appropriate interventions in order to help in the young person’s recovery plan. These psycho-social interventions include a weekly drink diary, unit calculator and motivational interviewing to provide support. YZUP also work with young

people around confidence, self-esteem, peer pressure, personal safety and relationship skills.

Support is given to a young person through reduction programmes in order to improve negative aspects of their lives identified in their assessment. This can include family work, joint care plan with the Youth Offending Service, diversionary activities, advocacy to attend health appointments, liaison with school/ training provider or employer and advocacy with supported housing applications. YZUP also offer relapse prevention support for young people.

YZUP also currently provide 2 School worker’s (Countywide) who deliver a ‘stepped menu’ of interventions for Years 7 to 11 to include:

- Self Esteem and Goals
- Barriers to Learning
- Managing Emotions
- Drug & Alcohol Awareness
- Peer Pressure & Boundaries
- Support Networks

The Young Persons Substance Use Joint Commissioning Group have approved the investment to enable a wholesale review and system redesign to maximise the effectiveness of young people’s treatment services in Cornwall and the Isles of Scilly.

In order to do this, Addaction who deliver the service, have worked with Phil Harris, a leading expert in the field, and key partners in Cornwall to introduce a range of age and developmentally appropriate substance use interventions and assessments, in order to further improve the impact of services on young people’s long term outcomes. This will also include specific work in relation to young people subject to statutory interventions through the Youth Offending Service and Children’s Social Work services.

There is currently a YOS/YZUP joint working improvement plan that aims to detail collaboration which has to determine the gaps that seem to have developed in relation to joint working protocols and young persons needs, and to outline the pathways where improvements can be identified.

This method of Joint Working would ensure that young people identified by the YOS as at risk due to their substance use/needs are met by YZUP. It would create the expectation for young people that where they are deemed to be at risk themselves or putting others at risk through their substance use this risk is being met as a component of their contracted agreement with the YOS. Joint meetings between these young people their YOS case manager and YZUP would create better clarity for all involved.

The commissioning of Phil Harris to offer training support to all YOS managers and practitioners, alongside the training already completed with YZUP practitioners will help support and generate a more determined focus upon YOS clients’ substance use/needs.
Services for families

Cornwall has a range of services supporting families affected by substance use, including telephone advice, drop-in information and support, family groups in Liskeard, Truro and Penzance on a weekly basis.

**Breaking The Cycle**, a family-centred substance use programme to support and help turn around the lives of families with the most complex problems, is being delivered by our drug and alcohol treatment provider, Addaction.

**Breaking the Cycle** seeks to achieve three key outcomes:

- Reduction in the number of parents and children at risk of the significant harm associated with problematic substance use.
- Improvement in family functioning.
- Improvement in the health and wellbeing of parents and their children.

The Breaking the Cycle programme, delivered by Addaction, provides wraparound family support that includes:

- Prioritisation, assessment and care planning
- A range of motivational and solution focused interventions
- Advice and information
- One-to-one and family support
- Group work
- Family mediation
- Signposting
- Advocacy
- Home visits
- Work with children through coordination with partner agencies and schools
- Systemic family therapy

**Together for Families in Cornwall**

In December 2011, the government announced a new, determined, cross-government drive intended to turn around the lives of 120,000 of some of the country’s most “troubled” families. Figures from the Government estimate that each “troubled” family costs around £75,000 per year.

The “Troubled Families” programme locally, delivered under the name **Together for Families in Cornwall**, is a developing multi-agency approach that encompasses substance use, domestic abuse and mental health in addition to the government mandated issues of anti-social behaviour, worklessness, youth offending and school attendance.

In 2015 the programme expanded to include wider eligibility criteria. The headline areas in which success will now be measured are:

- Children back into school
- Parents on the road back to work
- Reduced crime and anti-social behaviour
- Families affected by domestic abuse
- Parents or children with a range of health problems
- Children who need help

This programme runs primarily on a **payment-by-results basis** with 40% paid up front and the remaining 60% payable only when they and their partners achieve success with families. The amount of funding available depends on the estimated size of the cohort of “troubled families” in each local area. The programme is now in its second phase of delivery with an estimated 4050 families eligible for the programme.

With the aim of **improving cross-agency working**, reducing duplication, and achieving better outcomes for families, a referral pathway from the programme into [Breaking the Cycle](#) (BTC) has been created. In 2014, the BTC team **successfully worked** (completed the programme in a planned way) with 40 families from the [Together for Families](#) programme (TfF).

The TfF programme collects information from a number of data sources on a number of complex issues to identify which families may benefit from an intensive package of care. This includes identifying when there are drug and alcohol, domestic abuse and mental health issues within the family.

In this analysis we have used this data to identify families with complex needs and which services are known to be currently working with them, with the aim of examining service gaps. Caution should be taken when interpreting this data, however, as it is unclear how, when and where the identification of these complex needs has occurred.

In December 2014, there had been 1404 families identified on the Together for Families register. Of these:
- 615 (44%) families had drugs and alcohol identified as a complexity factor. 18% (112 families) were known to drug and alcohol treatment services;
- 638 (45%) families had domestic abuse identified as a complexity factor. 24% (197 families) had engaged with specialist domestic abuse services;
- 688 (49%) families had mental health identified as a complexity factor.

Overall, 218 (16%) families had all three complexity factors identified as an issue. Of these 29 families (13%) were known to drug and alcohol treatment services, 42 families (19%) were known to domestic abuse services, and a further 20 families (9%) were known to both services.

**Over half of the families identified with complex needs were not known to either service.** This suggests better referral pathways from other services, promotion of service and increased outreach work may be beneficial. There were also 22% of families who were only known to one of the services, this suggest

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10 This is different to the figures published nationally. This is due to the programme working towards a target of 1270 families nationally (therefore this is the number of families that get reported), whereas locally 1404 families have been identified.
better pathways between drug and alcohol and domestic abuse services would be beneficial.

**Priorities**

- **Develop effective identification and referral pathways** and ensure **joint working** arrangements are in place between **children and family services** and specialist alcohol treatment where there are safeguarding issues and with local Troubled Families provision where alcohol or drug misuse is a factor;

- **Referral rates and early identification**, of drug and alcohol use in the Troubled Families programme, requires more work though an **agreed defined pathway and workforce development**;

- A protocol for this was developed 3 years ago but was never fully implemented with children and family services and requires revision in line with developing early help and social work offers;

- **Address the fears of parents with drug and alcohol problems** in approaching services for help at the earliest opportunity.
3. Community Safety schemes

Safer Cornwall: tackling alcohol-related harm

As part of the development of statutory Community Safety Partnership Plans, Community Safety Partnerships (CSPs) are required to set their priorities based upon the findings from the evidence presented in their local Strategic Assessments. Cornwall’s CSP, Safer Cornwall, sets new priorities every three years.

The partnership is currently operating in the last year of the three year Partnership Plan 2013-2016. Alcohol, violence and the Night Time Economy has been a priority area for Safer Cornwall for the last three years.

Over this period, Safer Cornwall has implemented a range of schemes to tackle alcohol-related violence, targeting persistent problem places and supporting a safe and vibrant Night Time Economy.

Schemes directly involving the licensed trade, such as Best Bar None, are discussed in Section 8: Licensing, Alcohol Retail and the Night Time Economy.

We are now preparing for the new cycle starting in April 2016 and this means that the partnership must review and reassess its priorities. Prioritisation involves understanding what poses the greatest threat or risk to the safety of the community. To achieve this, Safer Cornwall uses a strategic threat and risk assessment (STRA) approach, developed in partnership with the other CSPs across the Devon and Cornwall Peninsula and the Police.

Safer Cornwall has reviewed the levels of threat and risk associated with a wide range of community safety issues and identified the following two priorities for 2016-2019:

- Domestic abuse and sexual violence
- Alcohol-related harm

The high level of risk associated with alcohol is predominantly due to the impacts of alcohol on health, measured by alcohol-related hospital admissions and the number of higher risk drinkers in our population. With the exception of Domestic Abuse, improving trends in violent crime, particularly in the Night Time Economy and alcohol-related violence, means that the risk to communities has substantially reduced.

Problematic alcohol use is also frequently highlighted as a barrier that prevents services from helping individuals and their families with other issues, such as finding employment and addressing domestic and family abuse.

Local evidence, therefore, supports putting greater emphasis on developing effective early intervention and prevention approaches rather than increasing the current array of activity related to the Night Time Economy.
In addition to our two priorities, Safer Cornwall recognises the following as **key focus areas for delivery**, placing high importance on providing effective, innovative and improving services:

- Drugs, supported by the merger of the DAAT Board and Safer Cornwall
- Anti-Social Behaviour

The partnership has also reconfirmed its commitment to **develop a strategy to reduce reoffending**, in recognition that tackling reoffending underpins all of the work of the Partnership and is at the heart of reducing crime effectively and sustainably.

**Crime overview 2014/15**

Crime **continues to reduce over the longer term** and our overall crime rate is consistently amongst the lowest in the country. We have seen levels of crime both rise and fall over recent years, however, and **significant changes in the delivery landscape** have created a **complex picture** in terms of understanding the underlying factors.

The principal **overarching environmental threats relate to the current economic climate**. This includes **pressures on services** due to continued budget cuts and extensive restructuring across the public sector. Against this backdrop of cuts, we are seeing more **pressures on families and communities** due to increasing poverty, unemployment and the impacts of Welfare Reform.

Acquisitive and property crime are low compared with other similar areas in the country but **Violence (including Domestic Abuse crimes) and Sexual Offences** are comparatively high and increasing.

- In 2014/15 **all recorded crime reduced** by 7% or 1,743 crimes compared with the previous year;
- Overall performance compared with the average for our family group of 15 most similar community safety partnerships nationally saw some **improvement** and **we regained** fourth place\(^{11}\) in the ranking for crime rate in our group;
- Performance was strongest in reducing **Public Order Offences, Thefts, Criminal Damage, Burglary and Drug Offences**;
- **Acquisitive crime rates are consistently significantly lower** in Cornwall than the average for our most similar family;
- Rates of **Violence Against The Person and Sexual Offences are higher** than the average for our most similar family and incidence of Rape in particular is significantly higher than average. In these crimes we are ranked towards the upper third of our family group;
- Most types of crime reduced but there were three notable exceptions - **Violence without Injury, Sexual Offences and Robbery**;

\(^{11}\) Where first place means the lowest crime rate in our group
Crime follows a seasonal pattern in Cornwall with more offences in the summer months and fewer in the winter, although the summer bias has weakened over recent years;

Domestic Abuse, of which 80% of crimes relate to Violence Against The Person offences, presents the highest overall threat to communities in Cornwall, in terms of risk and harm, and reported incidence of domestic abuse is believed to be higher locally than the average for similar areas elsewhere in the country.

Violent crime: extent and trends

Alcohol is most commonly cited as a factor in violent crime, and in particular is linked to Domestic Abuse and Night Time Economy crime. The impact of alcohol cuts across all aspects of partnership service delivery, however, and represents a significant challenge in tackling other priority areas of criminality.

Overall recorded crimes of Violence Against The Person saw a small rise of 2% in 2014/15 compared with last year, with all of the increase coming from less serious “Without Injury” offences;

Both Violence With and Without Injury are above the averages for our ‘most similar family’ of community safety partnerships nationally but not significantly higher (these figures include Domestic Abuse crimes);

Domestic abuse presents the highest overall threat to communities in Cornwall, in terms of risk and harm. Violence coming under the definition of domestic abuse accounts for 37% of all recorded crimes of Violence Against The Person and the number of crimes reported continues to rise.

<table>
<thead>
<tr>
<th>Crime type</th>
<th>Crimes</th>
<th>Rate per 1000</th>
<th>Annual change</th>
<th>Trend</th>
<th>Comparison National</th>
<th>Trend MSF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence With Injury</td>
<td>3,155</td>
<td>5.8</td>
<td>0%</td>
<td>➔</td>
<td>Above average</td>
<td>➔</td>
</tr>
<tr>
<td>Violence Without Injury</td>
<td>2,903</td>
<td>5.4</td>
<td>6%</td>
<td>➔</td>
<td>Above average</td>
<td>➔</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>2,251</td>
<td>4.2</td>
<td>5%</td>
<td>➔</td>
<td>Above average</td>
<td>➔</td>
</tr>
<tr>
<td>Night Time Economy Violence</td>
<td>871</td>
<td>1.6</td>
<td>-12%</td>
<td>➕</td>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>Other Violence</td>
<td>2,538</td>
<td>4.7</td>
<td>2%</td>
<td>➔</td>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

Note that the figures above that are compared with our most similar family group include Domestic Abuse whereas the locally derived groupings for Night Time Economy and Other Violence do not.

For the purposes of this assessment, Night Time Economy (NTE) Violence is categorised as any Violence Against The Person offence (both with and without injury) taking place on the street, on licensed premises or in a food takeaway where we can establish that it was committed between the hours of 9pm and 5am.

Excluding domestic violence, the overall trend for Violence Against The Person has remained relatively stable in 2014/15 (a change of 1% over the year). Within this category and in a continuation of trends established over the last year, Night Time Economy violence reduced but was counterbalanced by a rise in Other Violence;

Night Time Economy violence dropped by 12% compared with last year. This is the third successive year to see a fall, and the trend continues on an
improving path. This is reflected in a **reduced level of assessed risk** to communities;

- **Other Violence** – predominantly comprising daytime violence and offences that do not take place in a public place – **presents a greater risk than Night Time Economy Violence** due to continued escalation in the number of reported crimes;
- Other types of violent crime that can be linked to the Night Time Economy include **Sexual Offences and Robbery** – together these crimes account for 61 offences. Sexual assaults on a female in a Night Time Economy setting have increased compared with last year, although the number remains comparatively small.

**Measuring the impact of alcohol**

The police resumed recording the link to alcohol last year, after a gap of a couple of years. Previously the alcohol marker could only be recorded against a violent crime but this has now been expanded to include any type of crime.

- Compared with 2013/14, the number of **alcohol-related crimes has declined** – both in terms of number (which we might expect with an underlying reducing crime trend) but also there has been a small drop in proportion. We had expected to see the proportion of crime recorded as linked to alcohol incrementally increase as the new process became embedded but this has not proved to be the case;
- As one would expect, **violence is most likely to be alcohol-related** at 35%. Although it is noted that this is significantly lower than it was historically (consistently around 50%);
- Alcohol is most **strongly associated with Night Time Economy Violence** (70%) and in **assaults resulting in injury** (41% compared with 28% for assaults with no injury). **Young males** are the highest risk group, particularly those aged from 18 to 24 years. This is echoed in the statistics that we receive from the Emergency Department at Royal Cornwall Hospital Treliske (Truro) that shows young males as the most **typical attendees for alcohol-related assault**;
- The rate of alcohol-related violence within **Domestic Abuse crimes was also slightly higher** at 40%. This concurs with the higher rates of alcohol-related need identified in the assessments of offenders known to be
perpetrators of Domestic Abuse, although we might expect the difference to be greater than 5%. Offender characteristics are discussed in more detail in Section 4: Criminal Justice Interventions;

- In terms of volume, the next largest categories are Thefts (predominantly Shoplifting offences), Criminal Damage and Public Order Offences.

What the public think

Safer Cornwall’s “Have Your Say” survey is an annual survey of public perceptions of crime and safety in their local area.

The response rate to the survey was much lower in 2015 compared with the previous two years so results should be interpreted with caution (the crude confidence interval is around 4%). In addition, the age distribution of respondents is not representative of the population, with an over-representation of people in the 45-64 age bands and a significant under-representation of younger people under the age of 35, prohibiting any meaningful analysis on the demographics of respondents.

- 13% of respondents to the Safer Cornwall “Have Your Say” survey in 2015 said that they thought Drunk or Rowdy Behaviour was a problem in their local area, which is similar to last year (15%);
- A further 8% were concerned about Street Drinking and this again was similar to last year’s result (11%);
- People who said that drunk or rowdy behaviour were a problem locally were much more likely to say that they felt unsafe out in their local area at night (38% compared with 13%).

Assault Related Injuries Database

The Assault Related Injuries Database (ARID) collects data on alcohol-related assaults and injuries from patients presenting at Emergency Departments (ED) across the Devon and Cornwall Peninsula. This includes 4 major hospitals (Exeter, Torquay, Barnstable and Treliske/Truro) but not Derriford, who collect similar data that is not mapped, and is cross referenced to police recorded crime data, rather than used as extra intelligence.

In addition, this year has seen the start of ARID usage in 9 Minor Injury Units, 5 in Cornwall and 4 in Devon.

In the coming year, as this additional data is gathered, Safer Cornwall (via Amethyst) will compile a report from a survey of the Peninsula ARID stakeholders, intended to test the current operational use of the ARID data, to generate improvement and best practice recommendations, and to promote the increased and compatible use of the ARID data, resulting in a more cost effective use of the database. This may involve a questionnaire and site visits, to make sure we get good data, engagement and case studies, and to increase the

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12 The confidence interval is around 4%, which means that none of the differences noted can be considered as significant.
impact and cost effectiveness of the data, and ultimately lead to improvements in safety in and around licensed premises across the Peninsula.

A report published last year provided a review of a full year’s Peninsula data from ARID, covering the period from 1 April 2013 to 31 March 2014.

Peninsula ARID key findings

The incident map currently reflects the locations of the 4 EDs involved, leaving hardly any data within this system that relates to Derriford/Plymouth, or the MIUs.

This will begin to change as the MIUs contribute data to the system.

This data is then shared in trigger lists for Police and Council Licensing teams, and contributes to Licensing applications and reviews, as well as in consideration of problem cases within the Responsible Authorities meetings. This is an aspect that needs improving, especially as reductions in staff and resources mean that Licensing teams need to target their work more efficiently.

- In the period from 01 April 2013 to 31 March 2014, a total of 712 people were recorded on ARID as attending the four Emergency Departments, in Truro, Torbay, Exeter and Barnstaple, after being assaulted;
- Any apparent seasonal patterns are likely to be misleading: The latest report on Cornwall has now been published, and consistent with previous years has suffered from the inverse seasonal issue of staff struggling to cover ARID when the ED is at its busiest. This will be addressed in the survey, in order to implement best practice from data input through to operational application;
- 335 (47%) said that they had reported the assault to the police;
• 310 (44%) people had not reported the assault to the Police and were not intending to report it, highlighting the potential gap in our knowledge of violent crime.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Barnstaple</th>
<th>Exeter</th>
<th>Torbay</th>
<th>Truro</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White - British</td>
<td>92</td>
<td>123</td>
<td>180</td>
<td>174</td>
<td>569</td>
<td>80%</td>
</tr>
<tr>
<td>No details</td>
<td>3</td>
<td>3</td>
<td>70</td>
<td>13</td>
<td>89</td>
<td>13%</td>
</tr>
<tr>
<td>White - Other</td>
<td>4</td>
<td>4</td>
<td>25</td>
<td>8</td>
<td>41</td>
<td>6%</td>
</tr>
<tr>
<td>Asian/Asian British - Bangladesh</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Asian/Asian British - Other</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>White - Irish</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Asian/Asian British - Indian</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Black - Other</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Mixed - White and Asian</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

• 39% (278 people) of all victims are aged between 18 and 24 years;
• The majority of victims reporting identified themselves as White British (80%, 569 victims). This proportion may not be representative as a significant number of incidents did not have a recorded ethnicity.

<table>
<thead>
<tr>
<th>Alcohol related</th>
<th>Yes</th>
<th>No</th>
<th>Not Known</th>
<th>Total</th>
<th>% Alcohol related</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnstaple</td>
<td>64</td>
<td>31</td>
<td>5</td>
<td>100</td>
<td>64%</td>
</tr>
<tr>
<td>Exeter</td>
<td>88</td>
<td>44</td>
<td>3</td>
<td>135</td>
<td>65%</td>
</tr>
<tr>
<td>Torbay</td>
<td>178</td>
<td>90</td>
<td>12</td>
<td>280</td>
<td>64%</td>
</tr>
<tr>
<td>Truro</td>
<td>123</td>
<td>52</td>
<td>22</td>
<td>197</td>
<td>62%</td>
</tr>
<tr>
<td>Total</td>
<td>453</td>
<td>217</td>
<td>42</td>
<td>712</td>
<td>64%</td>
</tr>
</tbody>
</table>

• 453 people (64%) specified that alcohol was involved in the assault and there was little variation across the Peninsula.
• Patterns of time and day clearly highlight the link between assaults and the night time economy, with the majority of assaults happening over the weekend and between the hours of 21:00 and 04:59. 93% of assaults occurring in this time period were said to be alcohol-related.

<table>
<thead>
<tr>
<th>Weapon</th>
<th>Body Part</th>
<th>Bottle</th>
<th>Firearm</th>
<th>Glass</th>
<th>Knife</th>
<th>Other</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnstaple</td>
<td>77</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>15</td>
<td>100</td>
</tr>
<tr>
<td>Exeter</td>
<td>105</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>9</td>
<td>14</td>
<td>135</td>
</tr>
<tr>
<td>Torbay</td>
<td>206</td>
<td>6</td>
<td>3</td>
<td>6</td>
<td>8</td>
<td>21</td>
<td>30</td>
<td>280</td>
</tr>
<tr>
<td>Truro</td>
<td>142</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>15</td>
<td>38</td>
<td>197</td>
</tr>
<tr>
<td>Total</td>
<td>530</td>
<td>10</td>
<td>4</td>
<td>11</td>
<td>9</td>
<td>51</td>
<td>97</td>
<td>712</td>
</tr>
</tbody>
</table>

• In the majority of cases (74%) injury was caused by part of the assailant’s body (punch, kick, head butt, etc.). Use of weapons is uncommon, with 21 (3%) assaults involving glass, 10 of which were bottles;
• There were 4 incidents where a firearm was recorded as being used (3 in Torbay and 1 in Exeter). One of these assaults had not been reported to the police but they did intend to report it. The definition of firearm is not recorded on ARID so these incidents could range from BB guns and air rifles to a registered firearm;
• Generally the majority of assaults were **committed by a stranger**. Where the assault took place in the home however they would mostly come under the definition of domestic abuse (partner/ex-partner or relative);
• 30% (213 individuals) of all victims reported being assaulted in or immediately **outside specific named premises**. A significant proportion (20 incidents) of these incidents was not reported to the police.

Although information about specific premises is shared with Licensing Teams, this is not included in this Needs Assessment, as it has to remain restricted. This is because the data is not proof of culpability, merely evidence of the location of a reported incident.

Incidents may have many starting points or underlying causes, and in many cases it is **good practice when a venue calls an ambulance and therefore is named in the ARID report**. The incident may have begun or occurred elsewhere, and may not have been reported by other premises trying to protect their reputation.

6 premises in the Peninsula’s 13 most reported repeat locations in ARID are in Cornwall. These need to be **responded to with a view to improving practice**, before actions pursuing a review or prosecution are undertaken.

**Cornwall ARID Key findings 2015**

• In the period from 01 April 2014 to 31 March 2015, a total of **284 people were recorded on ARID** as attending the Emergency Department and 5 MIUs after being assaulted. 120 (42%) of these claimed to have reported to the police;
• It was recorded as not known/not reported for 142 (50%) people who came into the Emergency Department or MIUs had **reported the incident to the Police**, highlighting a potential gap in our knowledge of violent crime;
• Use of weapons is rare and in the majority of cases (79%) the **injury was caused by part of the assailant’s body** (punch, kick, head butt, etc.). 13 (4%) of assaults involved glass, 4 of which were bottles, and a knife was used in two assaults;
• The **majority of assaults was said to have involved alcohol** (61%);
• Patterns of time and day clearly highlight the link between assaults and the **night time economy**, with the majority of assaults happening over the weekend and between the hours of 21:00 and 05:00;
• Looking at assaults that could be linked with the Night Time Economy between the hours of 21:00 and 05:00, 89% were said to have been alcohol-related, this is higher when compared with recorded crime (Violence against the person with Injury, excluding Domestic Abuse crimes) which is 64%;

• Generally the majority of assaults were committed by a stranger (42%). Where the assault took place in the home, however, they would mostly come within the definition of domestic abuse (partner/ex-partner or relative);

• The most represented age group are 18-24 years, accounting for 32% (98 people) of all reporting victims, the next highest reported group is 25-34 with 27% of the total. Police recorded crime also shows 18-24 as the most represented group of victims accounting for 23% of the total;

• 85 (30%) of all victims reported being assaulted in or immediately outside a specific named premises. Monthly trigger reports provided to partners highlight repeat locations to support targeted licensing activity. A significant proportion (17 incidents) of the incidents recorded at the top 3 repeat locations was not recorded as reported to the police.

Road traffic collisions

Safer Cornwall identified road traffic collisions as an area of increasing risk due to rising numbers of collisions resulting in death or serious injury.

• There were 23 fatal collisions in 2014/15. This is 2 less than our target meaning we achieved a 2% reduction in fatal collisions using three year rolling averages. In actual numbers we have seen the same number of fatal
collisions in 2014/15 as 2013/14. This reflects that of the rest of the country which also saw no year-on-year change. However, the South West region saw a significant reduction (by 12%) in the number of fatal collisions. Therefore, Cornwall is in line with national trends but not performing as well as regional trends;

- There were **195 serious collisions in 2014/15**. This is 46 (31%) greater than our target, meaning we **failed to meet a year end reduction of 2%**. With 180 last year, serious collisions have seen an **8% annual increase**. The annual difference in serious collisions in Cornwall is slightly higher than that of the rest of the country which saw a 5% increase. The South West region saw a larger increase (7%) which aligns much more closely to the increase seen in Cornwall.

Increased risk for fatal and serious collisions have been found for motorcyclists, older drivers, young drivers and passengers, and people who drive for work. **Emerging risks for cyclists and pedestrians** have also been identified.

Evidence papers have been completed for pedestrians and cyclists to identify whether these risk groups have influenced the increase in serious collisions. These have been reviewed by the Casualty Reduction Partnership.

The key findings indicate high risk to;

- **Male cyclists commuting to work** bring involved in a collision with a car where the **driver was at fault**, and
- **Pedestrians** being involved in a collision between the hours of 9pm and 3am involving **impairment through alcohol**.

Task groups with appropriate partners have been set up around these key areas, and will need to have a particular focus on pedestrian safety after dark, where alcohol is a factor.

**What have we achieved this year?**

Work with partners, including the licensed trade and other local businesses, to improve the Night Time Economy and reduce alcohol-related crime and disorder is proactive, evidence-based and innovative. Violence linked to the Night Time Economy continues to improve, indicating that **current approaches are having a positive impact**.

Schemes directly involving the licensed trade, such as Best Bar None, are discussed in Section 8: **Licensing, Alcohol Retail and the Night Time Economy**.

- Data from the **Assault Related Injuries Database** installed in the Emergency Department in Royal Cornwall Hospital Treliske is being used operationally by Cornwall Council and Police Licensing teams. We are continuing to support the move to a coherent regional commissioning approach in 2015/16, improving opportunities for analysis and delivery, if inconsistencies in other parts of the Peninsula can be resolved.

The **Safer Towns** programme delivered all planned activity in our highest risk towns in 2014/15. Full details of the programme are published on the Safer
Cornwall website – Cornwall, Redruth, Falmouth, Liskeard, Penzance, St Austell, Newquay and Bodmin.

Particular highlights included:

- Licensed premises in Newquay were visited and inspected under the Best Bar None criteria. All 3 clubs were seen to be maintaining a good standard with some excellent pro-active prevention activities. Premises in Newquay have now introduced “Chelsea hooks” in order to tackle acquisitive crime in the area, which is yet to be evaluated;

- Residents from Cosgarne Hall and Freshstart in St Austell have attended focus groups to examine attitudes to alcohol from the perspective of an offender and/or habitual drinker. A positive event, helping to inform the picture on effective campaigning regarding alcohol. The findings of this event will be used in the What Will Your Drink Cost Evaluation that is being undertaken in partnership with Plymouth University;

- The ‘Last Walk Home’ initiative was developed and delivered to increase pedestrian safety when walking home after drinking alcohol;

- Messages surrounding the No Blurred Lines campaign have been delivered at fresher events in both Falmouth and Penzance. There were over 80 people engaged with in Penzance and the campaign messages regarding sex and consent was delivered by Falmouth University through the student union. Local schools in Bodmin have also been targeted as part of the No Blurred Lines campaign in order to reduce sexting issues;

- There have been pop-up shops in Penzance town centre where members of the public could engage with services for advice and guidance on alcohol and domestic abuse issues. There have also been licensing enforcement campaigns to promote multiple safety messages alongside What Will Your Drink Cost in 5 residential areas around the town;

- Work in the Falmouth area also saw over 1000 people engage with the What Will Your Drink Cost campaign during Falmouth Week and Tall Ships. Over 1,000 homes were visited as part of Freshers’ week with advice and guidance offered from the Community Safety Team, Anti-Social Behaviour team, Police and Environmental health;

- The Town Square in Camborne continued to be a contentious issue in relation to the perceived behavior of a known group. As a result of actions taken to alleviate the situation and reassure the public, public anecdotal reports in relation to disorder in the town square reduced as well as a decrease in the number of incidents recorded by businesses in Anti-Social Behaviour diaries. Actions included:
  - Removal of high strength cider from shops;
  - Implementation of a Detached Criminal Justice Intervention Team worker;
  - Street cleansing in relation to drug litter;
  - The re-implementation of the Homelessness Action Group now administered by Coastline Homelessness Service.

We have delivered a wide range of public alcohol messaging and social marketing campaigns, including Dry January, 12 tweets of Christmas, What Will your Drink Cost, and Alcohol Awareness Week.
There is ongoing dialogue with Plymouth University, Drinkaware and the Portman Group about piloting a **new Alcohol population level message**, in order to improve impact compared with the messages relating to levels of units or periodic abstinence. These normal messages fail to impact dependent drinking or periodic excess patterns.

Task groups with appropriate partners have been set up around the key risk areas identified for road traffic collisions.

- **225 Year 10 students have received the WRECKED programme**, an educational resource aimed at generating discussion around topics relevant to young drivers/passengers people including mobile phone distraction, overloaded car, peer pressure, **drink driving** which includes facts sheets, case studies and videos to promote discussion and peer to peer review.

**The Peninsula alcohol retail agreement has not progressed to conclusion by the PCC over the last year.** This is discussed in more detail in Section 8: **Licensing, Alcohol Retail and the Night Time Economy**.

It is noted that in general, **evaluation** across the various initiatives delivered was patchy and further work is required to investigate what is working and delivering real outcomes and what may not be as effective. This will be a continued area of focus for 2015/16.

**Priorities**

- **Continued focus on early intervention and prevention** approaches rather than increasing the current array of activity related to the Night Time Economy;
- Align the new Alcohol Strategy with the new **Domestic Abuse and Sexual Violence Strategy** (the top two Community Safety Partnership priorities), particularly in terms of MARAC attendance by treatment providers and IBA training for Domestic Abuse services;
- **Closely monitor violence trends** to ensure that there is no escalation of risk. In particular, ensure that the **Night Time Economy continues to be managed effectively** and best practice prevails;
- Continue to support the move to a **coherent regional commissioning approach for the Assault Related Injuries Database (ARID)** in 2015/16, improving opportunities for analysis and delivery, if inconsistencies in other parts of the Peninsula can be resolved;
- Continue to **improve the design and implementation of evaluation techniques** for community safety interventions. This should build on the initiative group adopted by the Community Safety Service which aims to ensure initiatives are evidence based and robustly evaluated and creates an interventions library of effective initiatives;
- Although **pedestrian safety when drinking alcohol** has been addressed through the 'Last Walk Home' initiative, this may need some wider communication to increase prevention.
4: Criminal justice interventions

**Reoffending** has also been a priority area for Safer Cornwall for the last three years, with the overarching aim to reduce crime by tackling the underlying causes of offending and reintegrate offenders into their communities.

Over this three year period, there have been **fundamental changes** in policy, legislation and service delivery structure relating to the **management of offenders** under the **Transforming Rehabilitation** agenda. The last two years have seen a significant degree of uncertainty in the delivery of offender management and rehabilitation services, affecting not just Probation services but all of the wraparound services offered in wider community settings.

Going into the next three year cycle, which starts in April 2016, Safer Cornwall has reconfirmed its commitment to **develop a strategy to reduce reoffending**, in recognition that tackling reoffending underpins all of the work of the Partnership and is at the heart of reducing crime effectively and sustainably.

**Ministry of Justice: Indicators of reoffending (overview)**

The latest figures from the Ministry of Justice\(^1\) show that **nationally just over a quarter of offenders reoffend within 12 months** of caution, conviction or release from custody.

- Nationally, proven re-offending rates for **adult offenders have remained fairly flat since 2000** fluctuating between around 25% and 28%, and since 2004 have remained steady at around 25%;
- Around 1 in 5 offenders are female. **Female offenders are less likely to reoffend** than men;
- The offender cohorts with the highest rates of reoffending are:
  - Offenders with **larger numbers of previous offences**;
  - Offenders that commit **acquisitive crimes** (all types of thefts);
  - Offenders serving **custodial sentences**, particularly **sentences less than 12 months**. Historically offenders serving sentences of less than 12 months were not subject to supervision by Probation. This has changed with the introduction of the new provisions for offender management under Community Rehabilitation Companies;
  - **Prolific and other priority offenders** (PPOs), most of whom will also appear in one or more of the groups above;

The next table of figures relate to the cohort of offenders who were cautioned, convicted or released from custody in Cornwall between April 2012 and March 2013 and their reoffending behaviour over the **next 12 months**.

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\(^1\) Proven re-offending statistics – July 2011 to June 2012, Ministry of Justice April 2014

Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15

NOT PROTECTIVELY MARKED
- Both the percentage of offenders that reoffend and the rate of reoffences that they commit are consistently **lower than the England and Wales average**;
- Proven re-offending rates for **adult offenders in Cornwall have increased by 1.9 percentage points since 2005**, rising from 19.2% to 21.1% over this seven year period, with two notable peaks for the March 2009 and September 2010 cohorts (23% and 22.7% respectively). It has been fairly stable for the last two years at around 21%;
- Although separate reoffending rates are not currently provided for offenders with alcohol problems, in the future we may be able to obtain this information for some of this cohort (for example, those subject to **Alcohol Treatment Requirements**).

### Working in partnership to tackle reoffending

Two years ago, the Cornwall and Isles of Scilly DAAT commissioned a new recovery based treatment system, with the new drug and alcohol service in place from April 2013.

In recognition of the prevalence of alcohol problems amongst the offender cohort, the remit of the criminal justice team was extended to include alcohol and substances other than opiates in their engagement criteria. They provide a tiered and targeted approach based on risk and need (i.e. the most resources are targeted at those who are highest risk), rather than substance or criminal justice status.

The criminal justice team offer **advice and information** on all areas of substance misuse and provide **one to one support** together with **structured interventions** that are **tailored to meet the individual needs of offenders**. The team works in partnership with the police, courts, probation services and offender managers to assess needs and put together appropriate treatment plans, supporting offenders to make positive changes in their lives.

Since the criminal justice team was commissioned, there have been **fundamental changes** in policy, legislation and service delivery structure relating to the **management of offenders** under the **Transforming Rehabilitation** agenda.

Devon and Cornwall Probation Trust ceased to exist on 31 May 2014. The Probation Trust was replaced by the new **Dorset, Devon and Cornwall Community Rehabilitation Company** (CRC) and the **National Probation Service** (with Cornwall forming part of the South West and South Central Division).
The CRC provides services aimed at rehabilitating people given community sentences by the Courts and new legislation under the Offender Rehabilitation Act has expanded supervision arrangements to include short sentence (all sentences less than two years) prisoners. The new National Probation Service are tasked with protecting the public from the most high-risk (MAPPA\textsuperscript{14}) offenders, which account for around 20% of the offender population.

Coming into effect on 1 February 2015, the Offender Rehabilitation Act introduces a number of further measures intended to support the drive to reduce reoffending, including:

- A new drug appointment requirement for offenders who are supervised in the community after release;
- An expansion of the existing drug testing requirement after release to include Class B as well as Class A drugs;
- A more flexible Rehabilitation Activity Requirement for adult sentences served in the community which will give providers greater freedom to develop innovative ways to turn an offender’s life around.

The new legislation goes hand in hand with the Government’s wider reforms to probation services under the Transforming Rehabilitation agenda, which aims to bring together the public, private and voluntary sector to address reoffending in the community.

A nationwide network of resettlement prisons is also being created with the aim that the majority of offenders will be managed by the same provider in custody and the community, with a through-the-gate approach to rehabilitation.

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

Maintaining or improving business continuity during this period of immense change was highlighted in the last assessment as posing a potential risk to making any progress in this area during the course of 2014/15. We also hoped, however, that it would present opportunities to improve and move towards a more integrated working model with the new service providers, as well as improving information recorded, information sharing and the evaluation of delivery.

The CRC is now working alongside existing services but there is a lack of clarity, around processes for managing offenders, particularly risk management and reduction (especially in relation to domestic abuse and drugs and alcohol) and this has been added to the risk register of the community safety partnership, Safer Cornwall, to monitor and respond appropriately.

\textsuperscript{14} Multi Agency Public Protection Arrangements (MAPPA) is the name given to arrangements in England and Wales for the “responsible authorities” tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public.
The expansion of supervision arrangements to **include short term custody prisoners** from 1 February 2015 coupled with a **new sentencing framework**, means significant changes in how offenders are managed in the community, with the key implication being more offenders to manage with fewer dedicated resources.

Of particular concern in the context of this assessment is that Safer Cornwall have been advised that addressing the **drug and alcohol needs of offenders are not included in the priority areas of focus** for CRC "Through the Gate" services, which are:

- Employment
- Accommodation
- Family and relationships
- Finance and debt

**Identification and engagement of offenders with alcohol-related needs**

Historically it has been a **persistent trend** that a significant number of offenders under supervision by Probation services and assessed as having criminogenic drug and/or alcohol needs are not engaging with community treatment services. The group of offenders that are **not engaged** are predominantly non-opiate users and **problem users of alcohol** but there are also a small number of opiate users.

Further research into the cohort of drug using offenders, for the last needs assessment, highlighted some anomalies between identified needs and behaviour and was inconclusive as to the extent to which substance use related needs were being accurately identified and met. Due to capacity in the Probation service at the time, we were **unable to undertake any further research** into problem alcohol users.

Note that the criminogenic needs of offenders in the community can only be assessed where OASYs assessments have been conducted, around half the caseload.\(^{15}\)

- **Alcohol is the most prevalent risk factor amongst adult offenders** - 56% of adult offenders have an alcohol problem that is linked to risk of serious harm and/or reoffending, and a third of the offender population are assessed as having “significant” or “some” problems with alcohol;
- Extrapolating this to the whole population of 800 offenders in the community provides an estimate of **451 offenders with a criminogenic need related to alcohol** (with a range of 422-480);
- Of the group identified with a criminogenic alcohol need, in **41% of cases their use of alcohol was not assessed as problematic**. This

\(^{15}\) Total offenders in the community n=802, OASys assessment available n=384 Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15 NOT PROTECTIVELY MARKED
prompts the question as to the exact nature of the criminogenic alcohol-related need identified by the offender manager at the time of the assessment;

- **Engagement rates were lower than for drug using offenders** – 61% of offenders with a criminogenic alcohol need were not in contact with community treatment services up to and including December 2014. Offenders with significant alcohol problems were most likely to be in contact with treatment;

- Whilst we know that this **potentially identifies a cohort of offenders with unmet needs**, structured alcohol treatment will only have been suitable for some of this group, those who exhibited signs of **alcohol dependence**. We cannot quantify the type of need or suitability for treatment and we do not know what **other types of non-structured intervention** may have been offered/delivered by Probation or other services to reduce risks around alcohol use;

- We also **do not know the degree to which this is a normal feature** of the interactions between other criminal justice and treatment systems elsewhere in the country.

<table>
<thead>
<tr>
<th>Alcohol problem recorded in OASys</th>
<th>Alcohol need identified</th>
<th>Structured treatment</th>
<th>Non-structured intervention</th>
<th>No contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Problems</td>
<td>36</td>
<td>14</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Some Problems</td>
<td>92</td>
<td>19</td>
<td>14</td>
<td>59</td>
</tr>
<tr>
<td>No Problems</td>
<td>88</td>
<td>16</td>
<td>14</td>
<td>58</td>
</tr>
<tr>
<td>Grand Total</td>
<td>216</td>
<td>49</td>
<td>35</td>
<td>132</td>
</tr>
<tr>
<td>% of offenders</td>
<td>23%</td>
<td>16%</td>
<td>16%</td>
<td>61%</td>
</tr>
</tbody>
</table>

Separate examination of high risk MAPPA and non-MAPPA offenders shows no significant differences between the two cohorts in either the frequency of identification of criminogenic needs related to alcohol or the prevalence of significant/some alcohol problems.

**Estimating future needs: short sentence prisoners**

- The Probation caseload accounted for an estimated third of the total adult offender population in Cornwall in 2013/14. 157 MAPPA and 645 non-MAPPA offenders were under supervision by Probation in the community on 31 March 2014;

- Based on national figures for the use of custodial sentences of less than 12 months, we can estimate that the change in legislation will result in **200 to 250 additional offenders coming onto the CRC caseload** for supervision (an increase of around 25-30%). Based on the needs of the current cohort, this would indicate an additional 110-140 offenders with an alcohol-related need;

- As of June 2015, however, the **anticipated uplift in the number of offenders has not yet been realised** and this may be because the increase is being balanced by continued decline in overall numbers.
Although we could assume that the needs of the new cohort of short-sentence prisoners will mirror the existing cohort, instinct tells us that this cohort is actually likely to have its own particular characteristics.

Described as the archetypal “revolving door” group, we know that short sentence prisoners have **multiple needs** and an **exceptionally high rate of reoffending**. The local needs of this new cohort of offenders are currently unquantifiable, however, due to an absence of information collected during their contacts with the criminal justice system.

A **national study** into the social care needs of short-term prisoners, prompted by the concerns of central government over high reoffending rates, was published in May 2011. The research included an extensive literature review, interviews with key stakeholders and a focus group with former short-sentence prisoners.

- The research found that estimates of alcohol problems ranged from 20-45% (this compares with a third of the existing cohort). Daily and heavy drinking pre-prison were more common although only a small proportion wanted help for an alcohol problem.

**Numbers in the Criminal Justice Team**

At the start of 2014/15, the criminal justice drug and alcohol team was identified as a separate entity in the case management system from Addaction adult services.

Since then, the number of people recorded as in treatment with the team has seen **steady month on month growth as this separate cohort has become established**. Offenders were previously recorded within community treatment episodes rather than as a separate criminal justice function.

The next graph shows numbers in treatment for structured, non-structured and all service users.

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16 The Social Care Needs of Short-Sentence Prisoners (Anderson S. with Cairns C., Revolving Doors Agency, 2011), commissioned by the North East Public Health Observatory. Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15

NOT PROTECTIVELY MARKED
There are also anecdotal reports that service users are staying in treatment longer, therefore less are exiting treatment. Unfortunately, due to the change in recording we cannot examine this reliably.

The alcohol treatment population in the criminal justice team is predominately made up of alcohol only users (two thirds of people in structured treatment and 70% in non-structured).

- Cornwall has a higher proportion of people in structured alcohol treatment in contact with the criminal justice team compared with the national average: in September 2014, 10% of alcohol only users were in contact with the criminal justice team, compared with 6% nationally;
- For the alcohol and non-opiate structured treatment population the proportion in contact with the criminal justice system is similar at 17% (compared with 15% nationally).

Intervention and outcomes

Successful completions and representations

The table below shows successful completions and representations for those in treatment with the criminal justice team:

<table>
<thead>
<tr>
<th>Successful completions and representations as a proportion of all in structured treatment</th>
<th>Successful completions</th>
<th>Representations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and non-opiates</td>
<td>25% (15/60)</td>
<td>0% (0/5)</td>
</tr>
<tr>
<td>Alcohol</td>
<td>26.8% (11/41)</td>
<td>0% (0/5)</td>
</tr>
</tbody>
</table>

- Alcohol and alcohol and non-opiate successful completion rates in the criminal justice team are lower than the wider treatment population; 27% and 25%, compared with 41% and 34%, respectively. The finding is the same for drug users in the criminal justice team and may reflect the additional challenges in engaging offenders successfully;
- Representation rates are lower for alcohol only and alcohol and non-opiate users, compared with the wider treatment population. However, these are very small numbers and only amount to a total of 10 service users.

Complex needs linked to offending

Alcohol-related needs rarely sit in isolation and are more commonly seen in combination with a range of other issues, such as unsuitable housing, problems managing finances, drug problems and unemployment.

Identifying and understanding the obstacles to reintegration that offenders face is vital to ensure that their needs are addressed in an holistic and co-ordinated way.

Probation services utilise a comprehensive assessment tool, called OASys, to undertake a comprehensive assessment of offenders under their supervision to identify their criminogenic needs and put a plan in place to deal with those...
needs and divert them from future offending behaviour. Historically full assessments were carried out for around two thirds of offenders but this dropped to about half in 2013/14.

Undertaking a full OASys assessment is highly resource intensive and Dorset, Devon and Cornwall CRC have made the decision to phase out the use of full OASys as an assessment tool and are piloting less formal assessment methods, which will sit alongside a basic level OASys assessment. This means that currently the way in which criminogenic needs will be assessed and recorded is unclear and this presents a risk to our future ability to understand offender needs and make evidence-based decisions with regard to services in place to meet those needs.

The National Probation Service will continue to use OASys.

Analysis of these assessments reveals some key themes for Cornwall:

- Locally, the most prevalent issue linked to risk of reoffending or serious harm is alcohol at 56% and this has consistently been the case for many years;
- Drug use is a risk factor for just over a third of offenders. Examination of the type of drug use shows that two thirds of offenders with a criminogenic drugs need are recorded as only occasional drug users with cannabis the most commonly cited drug and as such would not be considered to be problem drug users. This is in contrast to last year’s caseload where there was a significant number of daily cannabis users whose use would be categorised as problematic;
- The risk related to financial difficulties has also seen a significant fall from 41% in 2012/13 to 34% this year and is back the same level as in 2012;
- Accommodation issues have remained stable at around a third and the proportion of homeless offenders in the community (11%) is also unchanged further to a drop last year;
- From a wider risk perspective, domestic abuse and responsibility for children also affect a high proportion of offenders (51% and 34% respectively). With regard to domestic abuse, offenders could be both perpetrators and victims with 30% of the cohort identified as a victim and 84% identified as a perpetrator (14% identify as both);
- 2 in every 5 offenders living in the community require support in five or more areas. This rises to 4 out of 5 for offenders with a drug problem linked to their offending, with a particularly high prevalence of financial issues. The risk of reconviction increases as complexity increases;
- Female offenders account for 13% of this sector of the offender population and are generally at lower risk of reoffending. Domestic abuse and parental responsibilities are more commonly risk factors for female offenders. OASys suggests that two thirds of these females are victims of domestic abuse (a small number also identify as offenders);
- There is very little information captured in offender assessments about their wider health needs, including mental health, however this can be captured in other types of assessment.

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17 Safer Cornwall Community Safety Partnership Strategic Assessment 2014/15
Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15
NOT PROTECTIVELY MARKED
Identifying the “toxic trio”

- The “toxic trio” of domestic abuse, mental health and drug/alcohol problems is experienced by 17% of the offender cohort being supervised in the community. In this caseload snapshot, the analysis identified 66 offenders, providing an estimate of 116-160 for the whole cohort of offenders in the community. In the majority of cases the offender is the perpetrator of abuse;
- The majority have an identified alcohol need (42% alcohol only with a further 47% in combination with drug-related needs).

Offenders with criminogenic alcohol needs were examined in more detail for this assessment and compared with offenders that had no alcohol related needs identified.

These findings are taken from the review of two years of data (snapshots from March 2013 and March 2014). Where an offender appeared in both, information was taken from the most recent and the duplicate excluded.

- Offenders with criminogenic needs related to alcohol show higher levels of multiple need and reoffending risk than those that do not have alcohol-related needs but they are less complex and chaotic than those with drug related needs;
- Offenders with criminogenic alcohol needs are more likely to reoffend – 40% had an OGRS score above 50 (medium/high risk or above) compared with 24% for offenders without an alcohol-related need;
- This review indicates a complex picture of needs with the majority (55%) of offenders with criminogenic alcohol needs requiring support in at least 5 other areas (compared with 30% without an alcohol-related need);
- 19% of the offenders in this cohort are recorded as having significant problems with alcohol and a further 41% have some problems. As previously noted, the nature of these problems may not be alcohol dependence and thus structured treatment with specialist services may not be appropriate;
- After alcohol-specific risk factors, involvement in an abusive relationship (predominantly as the perpetrator of abuse) presents the most increased risk compared with the offender population as a whole – 63% compared with 37% for offenders without an identified alcohol-related need. Offenders in this group are in general significantly more likely to have committed a violent offence (65% of this group compared with 34% for those without an alcohol-related need);
- Prevalence of mental health problems, accommodation problems and homelessness\(^{18}\) are also slightly higher for this group;
- Risk factors that show little or no difference are prevalence of disability and parental responsibility and criminogenic needs related to education, training and employment or drugs;
- The proportion of female offenders in this group is similar to the overall proportion at 11%.

\(^{18}\) Mental health problems +9%, Accommodation +8%, No Fixed Abode (NFA) +6%
Exchanging what works

National guidance

The National Offender Management Service (NOMS) Commissioning Strategies Group developed comprehensive evidence and segmentation to support their commissioning intentions for 2013/14.

Segmentation has been designed to provide commissioners and providers with information and advice to support evidence-informed and effective commissioning. This guidance was intended to provide commissioners and service providers with a shared picture of relevant characteristics of the offender population at national, regional and local levels so that they can apply the evidence in order to invest in services that are most likely to deliver better outcomes and value for money.

The agreed NOMS segmentation model for 2013/14 splits the population in two stages. Firstly by likelihood of reoffending, using five Offender Group Reconviction Score (OGRS) risk bands and secondly into seven index offence types.

This two stage process is set out below.

<table>
<thead>
<tr>
<th>Risk Bands</th>
<th>Offence Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>OGRS 1-24%</td>
<td>Sexual</td>
</tr>
<tr>
<td>OGRS 25-49%</td>
<td>Violent</td>
</tr>
<tr>
<td>OGRS 50-74%</td>
<td>Robbery</td>
</tr>
<tr>
<td>OGRS 75-89%</td>
<td>Acquisitive</td>
</tr>
<tr>
<td>OGRS 90-100%</td>
<td>Drugs</td>
</tr>
<tr>
<td></td>
<td>Motoring</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

For the purposes of our offender population, the last two OGRS groups were combined into one group (75-100%) due to very low representation in these groups.

To provide greater detail to the segmentation, the offender population is further split into three offender groups: adult males; young males and females. A similar distinction in age is not made for women for two reasons: there are too few young females in the population/caseload for statistically robust data tables to be provided, and there is limited evidence on how best to work with young females as a specific group.

Applying these segmentation criteria to our local cohort of adult offenders under supervision by Devon and Cornwall Probation Trust on 31st March 2014 shows

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19 The Offender Group Reconviction Scale (OGRS) estimates the probability that offenders with a given history of offending will be sanctioned (convicted or given a caution, reprimand or final warning) for any new recordable offence within two years of noncustodial (including suspended) sentence or release from custody. Version 3 of OGRS is the most recent and valid version.

20 Young males are those aged under 21 on 31 December 2013.
that the dominant segments are **men over the age of 21 who have committed violent offences**, accounting for the top 4 segments and **57% of the offender population with alcohol-related needs** (23% low risk, 15% medium/high risk, 14% low/medium risk and 5% high risk).

The **greatest representation of female offenders are also in the violent segments** with just under half of all female offenders equally split between low and medium/ high risk (accounting for 4% of the offender population with alcohol-related needs).

The guidance makes **evidence-based recommendations** as to the type of interventions that are likely to be **effective in reducing reoffending** in these segments.

### MALE OFFENDERS 21+

<table>
<thead>
<tr>
<th>General</th>
<th>Alcohol-specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Secure, manage and maintain employment and suitable accommodation;</td>
<td>• Programmes that address the interaction between alcohol and other causes of violence (such as hyper masculine or hostile/aggressive thinking) are promising for those whose violence always or mainly is committed when they have been drinking;</td>
</tr>
<tr>
<td>• Victim-offender conferencing where there is a clear victim</td>
<td>• Adding a component that addresses alcohol problems to a Domestic Abuse intervention should improve impact for offenders with this need</td>
</tr>
<tr>
<td>• Literacy, numeracy and life skills for higher risk segments (50+)</td>
<td></td>
</tr>
<tr>
<td>• Respond well to programmes aimed at addressing cognitive skills, violence or tempers but investment at lower risk levels may deliver less impact on reoffending compared with higher risk segments;</td>
<td></td>
</tr>
<tr>
<td>• Avoid requirements to complete multiple programmes which target the same factors e.g. cognitive skills and anger management, anger management and domestic abuse. As most programmes have highly overlapping aims, there is no evidence that completing multiple programmes will improve outcomes.</td>
<td></td>
</tr>
</tbody>
</table>

### FEMALE OFFENDERS

<table>
<thead>
<tr>
<th>General</th>
<th>Alcohol-specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Literacy, numeracy and life skills;</td>
<td>• Stabilisation of drug, alcohol and mental health programmes.</td>
</tr>
<tr>
<td>• Facilitating family contact for women in prison;</td>
<td></td>
</tr>
<tr>
<td>• Secure, manage and maintain suitable accommodation;</td>
<td></td>
</tr>
<tr>
<td>• Cognitive behavioural programmes with higher risk segments - problem solving, emotional management, assertiveness and negotiation – along with more practical help such as financial and time management, parenting and employment skills.</td>
<td></td>
</tr>
</tbody>
</table>
Local evaluation: Local Intensity Alcohol Programme

A short paper published by Devon and Cornwall Probation Trust in 2013 examined the reoffending rates (as measured by reconviction data) of a cohort of offenders who completed the Low Intensity Alcohol Programme. Reoffending rates were based upon criminal activity that occurred after the offenders had completed the programme and are thus proposed as an indication of the programme’s effectiveness.

Due to the lack of a control group, however, the paper concluded that it was not possible to assess whether a similar offender participating in a different intervention (or no intervention) would re-offend at a significantly different rate.

- 88 offenders completed the LIAP in Cornwall from January 2010 to July 2012. Cornwall was the only area that ran this intervention;
- The data is segmented by charges and convictions that occurred within the first 3 months, 6 months, 9 months and 12 months following the completion of the programme;
- The vast majority of offenders in this sample were Male (91%). There were 8 female participants. The largest proportion of offenders were aged between 25 and 34 years (50%);
- Within the first 3 months following the completion of the LIAP, 9% were convicted of a new offence;
- 17% were convicted within 6 months, 28% in 9 months and finally just over a third (36%) were convicted within 12 months.

What have we achieved this year?

Until recent legislative and structural changes, we had 11 different interventions in Cornwall that could be used to tackle problem drinking in offenders, dependent on the scale and seriousness of both the offending and alcohol as a factor in their behaviour:

- Alcohol Arrest Referral
- Alcohol Conditional Caution
- PND Alcohol Diversion Scheme
- ASB Alcohol Diversion Scheme
- Court Requirement: Low Intensity Alcohol Programme (LIAP)
- Court Order: Alcohol Treatment Requirement (ATR)
- ASB Drinks Banning Order (DBO)
- Inebriates Act
- Criminal Behaviour Order
- Follow You Home (seasonal intervention with young people visiting Newquay)
- TurnAround Integrated Offender Management Scheme (IOM)

These now need reviewing after the recent changes in Police Custody and ASB legislation, as well as the reorganisation of Probation into CRC and NPS.

It may be possible to replace some of these with local schemes, for example in Police Custody, as some have very low take-up or have been removed from the legislation.
We are continuing to develop the criminal justice team within the **Recovery Orientated Drug and Alcohol Treatment system**, which is delivering a more comprehensive range of services, more equitably and efficiently across Cornwall and Isles of Scilly, whilst also delivering savings.

Engage Centres are a new way of engaging offenders with complex needs in community settings. The CRC is developing **Community Engage Centres** away from Probation Offices, in existing community hubs throughout Devon and Cornwall. Development of the centres is ongoing, with Newquay Engage recently opening.

**Engage works in the community** alongside voluntary and community sector projects and organisations, often in their premises. It encourages a wide client base and will offer a **range of opportunities, support and information** in informal settings, enhancing community reintegration. Engage aims to promote more **collaborative working** and offer reciprocal **opportunities to share resources and expertise** as well as develop common approaches.

Addacton’s Criminal Justice Team are delivering an **innovative new project that addresses the “toxic trio”**, supporting women who come from an offending background and have complex needs and issues including living in abusive relationships. The work has been put forward for the Howard League for Penal Reform’s Community Award. This is described in more detail in Section 5: [Domestic Abuse and Sexual Violence](#).

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**Priorities**

- Offender Manager workforce development; we need to establish what the **specific training needs** are for offender managers;
- **Improve identification, referral and engagement** into specialist services and to **identify if there are any barriers** (staff or offenders) that we need to address. This is a priority for the new offender management structure under Dorset, Devon and Cornwall Community Rehabilitation Company (CRC) but also applies to the National Probation Service (NPS);
- **We need good quality local data** (from CRC and NPS) to inform our local reducing reoffending needs assessment and inform the development of the packages required to reduce reoffending locally. Management to monitor and share information about performance and outcomes;
- More work is needed to address the needs of **offenders with complex needs** in an **integrated** way in the community, including family-based interventions to address the "toxic trio" of domestic abuse, mental health and problem substance use;
- We need to do some work around improving **successful completion rates** for criminal justice clients;
- Review the interventions available to target problem drinking in offenders.
5: Domestic abuse and sexual violence

The ACPO\textsuperscript{21} definition of domestic abuse is defined as patterns and incidents of threatening behaviour, violence or abuse (psychological, physical, sexual, financial and emotional) between adults who are or have been intimate partners or are family members,\textsuperscript{22} regardless of gender.

- Any crime, violent or non-violent, can be recorded as domestic abuse. Domestic abuse does not always result in a crime being recorded and hence we record and complete risk assessments for incidents that may be precursors to or indicators of criminal behaviour (referred to as non-crime incidents).

Whatever form it takes, domestic abuse is rarely a one-off incident, and should instead be seen as a \textit{pattern of abusive and controlling behaviour} through which the abuser seeks power over their victim and it tends to \textit{escalate over time}.

Society’s preconceptions often extend to what is recognised by the term ‘sexual violence’. Sexual violence is usually depicted as ‘stranger rapes’, the sort of incidents most often reported by the newspapers, where the victim and the perpetrator do not know each other. The reality is that \textit{in the majority of cases the perpetrator is known to the victim}.

Alcohol use is associated with a fourfold increase in risk of violence from a partner\textsuperscript{23} and is more common when sexual violence is involved, but should not be seen as the \textit{cause} of the abusive behaviour, as the relationship is complex. Alcohol is \textit{consistently a feature in breakdown in families}, however, and inhibits effective engagement and intervention.

- In 2014/15, the rate of alcohol-related violence within Domestic Abuse crimes was slightly higher than for all violence at 40\% (compared with 35\%). This concurs with the higher rates of alcohol-related need identified in the assessments of offenders known to be perpetrators of Domestic Abuse, although we would expect the difference to be greater than 5\%.

**Problems with alcohol rarely exist in isolation** and both local and national research show that the combination of domestic abuse, mental health and substance misuse is one of the most harmful in terms of immediate and long term impacts on individuals and their families. The NSPCC has researched the

\textsuperscript{21} Association of Chief Police Officers. The ACPO definition excludes incidents or crimes where the offender or victim is less than 18 years of age. In July 2008 Devon and Cornwall amended the definition in use in crime recording locally to include victims aged 16 and 17 years
\textsuperscript{22} Including parents, grandparents, sons, daughters, siblings, any direct relatives or in-laws or step families
\textsuperscript{23} Cornwall & the Isles of Scilly Domestic Abuse & Sexual Violence Strategy 2011-2015
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relationship between these three factors and babies born into these families. Brandon et al, (2008\textsuperscript{24}) looked into 47 serious case reviews and found that families shared many characteristics with **domestic abuse, mental health difficulties and substance misuse issues** being most prevalent among parents and carers.

The analysis in this section was undertaken to assist with identifying needs relating to treatment services for those with complex needs, specifically those with families, and aims to **uncover any possible service gaps or unidentified treatment need** in Cornwall. In this document “complex needs” means a service user that experiences mental health, domestic abuse and substance use issues.

Information from treatment services (drug and alcohol, and domestic abuse) has been compared to examine links in service need for people with drug and alcohol dependency, domestic abuse and mental health issues. The aim is to identify the needs of service users with multiple, inter-related issues that require a **multi-agency approach**.

It is important to note that we do not assume that all service users with domestic abuse issues will also suffer with substance use issues and mental health difficulties.

**What the evidence says**

To examine service need around domestic abuse, data was extracted from the shared case management system, MODUS, relating to adults in contact with domestic abuse services; this includes the Susie project, IDVA service, Clear and the Recovery Toolkit. This data relates to **victims of domestic abuse**, not perpetrators. To examine service need around substance misuse, data was extracted from the Halo case management system relating to adult drug and/or alcohol users in treatment.

- Overall, in 2014, **60 domestic abuse service users (3%) were identified as having drug or alcohol problems**. Of these, **50% had been known to drug and alcohol treatment services** since April 2013. This suggests greater joint working between domestic abuse and drug and alcohol services would be beneficial to meet service user’s needs;
- In the 12 month period ending December 2014, **32% (585) of adults in contact with domestic abuse services had children**. A high proportion of adults did not answer (58%), so it is likely that this proportion is an under estimate;
- Of these adults, **27 (5%) were identified as having drug and/or alcohol problems**. Again, a high proportion did not answer so the real number is likely to be higher than this. This low reporting may be due to data quality issues, in which case an improvement plan on increasing reporting may be

beneficial, or staff not identifying drugs and alcohol as a problem, in which case training may be necessary;
- Domestic abuse is not specifically recorded or monitored in drug and alcohol treatment services.

Mental Health

Both service providers (drug and alcohol treatment and domestic abuse) record whether services users have mental health issues. This data was used to examine mental health prevalence among service users. Note mental health is only recorded for those in structured drug and alcohol treatment (not brief interventions).

- In 2014, **4% (76 people) of service users in contact with domestic abuse services were recorded as having mental health issues.** Of these, 57% (40) had children. Again, a high proportion of adults did not answer.
- **28% (506 people) of service users in structured drug and alcohol treatment had mental health issues.** Of these, 55% had children; 17% with children residing with them and 38% had children living elsewhere.

The following analysis identifies the proportion of services users in treatment services for substance misuse and domestic abuse, and those identified as having mental health issues.

- **9% (211 people) of the drug and alcohol treatment population in 2014 had been involved with domestic abuse services between 2008 and 2014. Just under half of these service users were in structured treatment (91 people);**
- Of those service users in structured drug and/or alcohol treatment, 32% (29 people) also had mental health issues (3% of the total structured drug and alcohol treatment population);
- These service users were more likely to be in treatment for problematic alcohol use (66%, 19 people) (includes both alcohol only or alcohol and non-opiates), compared with opiate use and non-opiate use;
- Of these service users, **7 were parents.**
A range of **complexity factors** were examined for these service users. The table below shows the factors that were most likely to be feature for those with complex needs:

<table>
<thead>
<tr>
<th>Strongly associated factors</th>
<th>Moderately associated factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• More likely to be unemployed at presentation to treatment</td>
<td>• More likely to have a disability</td>
</tr>
<tr>
<td>• More likely to be female</td>
<td>• Less likely to be injecting in the 4 weeks prior to starting treatment</td>
</tr>
<tr>
<td>• More likely to be between the ages of 19-34 years</td>
<td>• Less likely to have been in treatment over 4 years</td>
</tr>
<tr>
<td>• Less likely to be between the ages of 35-54 years</td>
<td>• Less likely to have been in treatment in the previous 12 months</td>
</tr>
<tr>
<td>• More likely to be single</td>
<td></td>
</tr>
<tr>
<td>• More likely to have a housing problem on presentation to treatment</td>
<td></td>
</tr>
</tbody>
</table>

There was no **difference in successful completions** from drug and alcohol treatment between those with the toxic trio, compared with the total structured treatment population.

**What are we doing about it?**

- A **working protocol** between Domestic Abuse and Sexual Violence and Drug and Alcohol Treatment has been developed, which includes identification, referral pathways and joint working;
- Offender Managers from the Dorset, Devon and Cornwall CRC staff are now **co-located in the REACH hub in Truro** to improve outcomes for victims of domestic abuse by increasing communication and information sharing with other agencies and ensuring better targeting of provision of the Building Better Relationships programme;
- Addaction’s Criminal Justice Team are delivering an **innovative new project that supports women who come from an offending background and have complex needs** and issues including living in abusive relationships.

The Addaction team worked with Redruth domestic abuse service, the **Susie Project**, to set up an empowerment group. The group work takes the emphasis away from drug use and supports women with life skills and decisions, with a key focus on getting them to believe in themselves. Women attend the group before working with the Susie Project, as many are still in abusive relationships. Part of the skills learnt at the empowerment group enable them to either leave the relationship or understand their options.

“From the first group, everything around the women starts falling in to place. The drug and alcohol use becomes less, relationships with children improve and offending behaviour stops. It is all about being listened to and not being told what to do,” said Sue. “The work from the team is excellent and a different way of looking at how we work.”

There are 14 members of staff in the Criminal Justice team across the county. Following on from the project’s huge success, they hope to spread the project to the rest of the county.
Priorities

- To **improve screening and recording** in drug and alcohol and domestic abuse services to identify complex needs and enable joint working to occur;
- Implementation if the new **joint DASV/DAAT protocol** and greater joint working would be beneficial to identify the nature of the drug and/or alcohol use and whether treatment would be aid the 50% of those identified with drug and/or alcohol issues in domestic abuse services who were not known to drug and alcohol treatment services;
6: Inclusion, employment and deprivation

What the evidence says

Employment in treatment

A problem with alcohol can affect a person’s ability to enter and remain in work, especially if they are disqualified from driving.

- Being employed when entering treatment has a positive impact on the likelihood of completing treatment successfully;
- Cornwall has a high proportion of clients that enter treatment unemployed (46%). This is higher than the national average (40%). As indicated above this has a negative impact on the chance of successfully completing treatment;
- This is a reduction compared to 2011/12 in which 55% of adults starting alcohol treatment were unemployed;
- The majority who start treatment in regular employment continue to work whilst in treatment;
- Overall rates of incapacity claimants due to alcoholism in Cornwall are significantly above the England average.

Deprivation

Around 10% of the population of Cornwall live in areas that are described as deprived, according to national measures of deprivation. These are predominantly found in town centres with the most deprived areas located in Penzance, Camborne and Redruth; we know, however, that there are pockets of deprivation in rural areas that are not identified by national measures due to the dispersed nature of our rural population.

- Many people living in these areas are disadvantaged by lower incomes, higher unemployment rates, ill health, child poverty, low qualifications, poorer housing conditions and higher crime rates;
- The Citizens Advice Bureau recorded a 56% increase in clients presenting with debt issues between 2007 and 2010, as well as a related 86% increase in problems with benefits. Of these, 15% of single people and carers also reported turning to alcohol or drugs as a means of escape, thereby adding to their financial pressure;
- Findings from the first round of Health Checks in Cornwall found that the health risk factor most commonly identified alongside higher risk drinking levels was raised blood pressure, and that this was most evident in patients from deprived areas.

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25 Based on a subset of 311 Treatment Outcome Profiles (TOP) examined in 2013/14 – this is primarily a (mandatory) tool designed to measure progress of drug users through treatment but just over a quarter of alcohol service users also have TOP.

26 Defined as the 20% most deprived areas in England, English Indices of Deprivation 2010

Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15

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Housing

Homelessness or threat of it and the importance of achieving safe and stable accommodation are recognised as constant threads across all the priority themes identified in the Safer Cornwall Strategic Assessment. Drug and alcohol misuse particularly can cause homelessness, perpetuate rough sleeping and impact on the wider community.

In order to successfully support people through alcohol treatment it is vital that they obtain and remain in suitable housing. Relapse can often lead to the loss of housing, causing problems in maintaining contact with treatment and support.

- In the last 12 months, 22% of people starting alcohol treatment presented to treatment with problems with their accommodation;
- The proportion of people with accommodation need on presentation to treatment has remained fairly constant over the last three years;
- Prevalence of housing issues for people presenting to alcohol treatment is in line with the national average.
- Although many people are helped to improve their housing situation whilst in treatment, homelessness at treatment start is a strong negative factor in recovery and successful completion of treatment.

On occasion when clients access tier 4 (residential) services they may be homeless or may become homeless/lose a tenancy during their stay. It may also put them at risk to return to the home that they left. It is critical that these housing needs are addressed. Housing is a first and crucial step in a process of rehabilitation into community living.

Cornwall Housing, local treatment providers and housing related support providers have worked together to develop a protocol to assist in the resolution of these housing needs during a client’s stay in residential services. The impact of this work upon successful completions and sustained recovery (not representing to treatment) is a priority for keeping under review.

The Government has the following vision for the role that housing can play in the successful rehabilitation of offenders.

‘Appropriate and sustainable housing is a foundation for successful rehabilitation of drug users and offenders. Appropriate housing provision and housing support is crucial to sustaining employment, drug treatment, family support and finances, and is a major resettlement need for those leaving prison, treatment and residential rehabilitation’.

Prolific and other Priority Offenders (PPOs) are identified locally as those people who cause the most harm to their communities. Their offending is generally of an acquisitive nature and the vast majority have substance misuse problems.
It is anticipated that in Cornwall **15-20 PPOs each year will require support with their housing.** In order to maximise these offenders opportunity for recovery Cornwall Housing, Addaction and the DAAT have been working in partnership to develop a housing protocol to address these housing needs. Addaction and Catch 22 (the new supplier of prison discharge services) will be working with clients and liaising with local housing providers whilst clients are still in prison as part of this protocol.

Catch 22 are working within the prisons and Addaction have extended their service to provide an ‘at the gate’ discharge service to facilitate this engagement. Reviewing the impact of implementation of this protocol in 2015/16 is a priority,

**What have we achieved?**

**Employment**

- **Pathways to and from treatment and employment services** have been developed and working well;
- The **referral methodology** has been localised to ensure that treatment providers and employment providers can capture outcomes of referrals made;
- The employment needs of those in treatment are being captured through new processes;
- Treatment providers are considering the use of volunteers to provide further support for clients in treatment to help them navigate the welfare system;
- The pathway that has been developed locally has included addressing concerns about sanctions and the impact on people in treatment and gives immediate contact numbers should sanctioning be adversely affecting clients in the treatment system and their outcomes.

**Housing**

- **Pathways and accommodation provision** locally has been developed and delivered to treatment staff;
- Consideration is currently being given by the Domestic Abuse commissioner as to the provision for the needs of those **fleeing domestic abuse** who also have a drug and/or alcohol problem;
- A regular **forum for complex needs housing providers** has now been set up to develop services jointly to meet the needs of those with the most complex and multiple problems.

**Priorities:**

- Ensure the **new housing pathway for clients leaving residential services** is effective in securing accommodation on completion of a rehabilitation programme;
- Ensure the **housing pathway for Prolific and Priority offenders** is effective in securing accommodation for those releases from prison, who would otherwise be homeless.
7. Health, treatment, aftercare and recovery

**Excessive drinking is a cause of disease and injury**, with only tobacco smoking and high blood pressure as higher risk factors. In the short term, alcohol misuse can result in injury or alcohol poisoning. In the long term, it can lead to a range of alcohol related conditions, including cancer, liver cirrhosis, high blood pressure, and even to death.

There is a **complex relationship between alcohol and mental health**. Many people drink to cope with stress, anxiety and depression. Individuals with high levels of consumption may be more susceptible to mental health problems.

Alcohol misuse leads to people being **admitted to hospital** for a range of conditions and causes. These include acute intoxication, alcoholic liver disease, fall injuries, hypertensive disorders and a number of cancers related to alcohol harm.

Evidence presented in this section has been drawn from national indicators and local research\textsuperscript{29} into the health burden of alcohol misuse in terms of hospital admissions.

- Of the total 444,000 population aged 16 and over in Cornwall, **just over a quarter (102,000) are drinking above the recommended safe levels**, according to public health estimates; in addition, an estimated 84,000 are 'binge drinkers’. This has remained the same since 2011/12.

There are an estimated **26,500 high risk drinkers** in Cornwall and Isles of Scilly that may benefit from some form of alcohol treatment or prevention, including Brief Interventions or Information and Advice. This is 1000 more than estimates for 2011/12, suggesting the need for treatment and/or prevention activity is increasing.

- **In Cornwall**, **7% or 26,700 people are drinking at higher risk levels**, double the recommended safe levels or above;
- Cornwall is **significantly higher than the England average** in relation to alcohol-specific hospital admissions for under 18s and women;
- Whilst the national picture remains relatively stable, we still appear to be much **more successful than the national average** in attracting dependent drinkers into treatment: Cornwall’s 22% of the estimated number of dependent drinkers engaged with treatment in 2013/14 compared with the national average of 13%. However this is still a reduction from 27% in 2012/13;

\textsuperscript{29} Roberts S., Report to Health and Adult Social Care Overview and Scrutiny Committee on Alcohol-Related Hospital Admissions, January 2013.

**Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15**

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• Local waiting times for treatment are below the national average and a higher proportion of people complete treatment successfully;
• Although the impacts of excessive alcohol use are evident in the younger population, recognition of a problem with alcohol frequently does not come until later life when dependency is well established and has taken a considerable toll, particularly on health, but also on families and the wider community. The average age on referral of those currently in contact with specialist treatment was 43 years.

Local area profile
Difference from National average:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Regional average</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking behaviour</td>
<td>Abstainers (% of population 16+)</td>
<td>14.67</td>
<td>14.27</td>
</tr>
<tr>
<td></td>
<td>Lower risk drinking (% of population 16+, ex. Abstainers)</td>
<td>73.3</td>
<td>72.65</td>
</tr>
<tr>
<td></td>
<td>Increasing risk drinking (% of population 16+, ex. Abstainers)</td>
<td>19.97</td>
<td>20.4</td>
</tr>
<tr>
<td></td>
<td>Higher risk drinking (% of population 16+, ex. Abstainers)</td>
<td>6.73</td>
<td>6.94</td>
</tr>
<tr>
<td></td>
<td>Binge drinking</td>
<td>18.8</td>
<td>20.7</td>
</tr>
<tr>
<td>Crime</td>
<td>Employees in bars - % of all employees</td>
<td>3.49</td>
<td>2.95</td>
</tr>
<tr>
<td></td>
<td>Alcohol-related crimes</td>
<td>4.76</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Alcohol-related violent crimes</td>
<td>3.9</td>
<td>4.03</td>
</tr>
<tr>
<td></td>
<td>Alcohol-related sexual offenses</td>
<td>0.13</td>
<td>0.14</td>
</tr>
<tr>
<td>Health</td>
<td>Alcohol-specific hospital admissions - under 18s</td>
<td>52.5</td>
<td>47.7</td>
</tr>
<tr>
<td></td>
<td>Alcohol-specific hospital admissions - males</td>
<td>514</td>
<td>480</td>
</tr>
<tr>
<td></td>
<td>Alcohol-specific hospital admissions - females</td>
<td>275</td>
<td>248</td>
</tr>
<tr>
<td></td>
<td>Alcohol-related hospital admissions (broad) - males</td>
<td>1650</td>
<td>1578</td>
</tr>
<tr>
<td></td>
<td>Alcohol-related hospital admissions (broad) - females</td>
<td>846</td>
<td>797</td>
</tr>
<tr>
<td></td>
<td>Alcohol-related hospital admissions (narrow) - males</td>
<td>602</td>
<td>550</td>
</tr>
<tr>
<td></td>
<td>Alcohol-related hospital admissions (narrow) - females</td>
<td>336</td>
<td>308</td>
</tr>
<tr>
<td></td>
<td>Admission episodes for alcohol-related conditions (broad)</td>
<td>1994</td>
<td>1939</td>
</tr>
<tr>
<td></td>
<td>Admission episodes for alcohol-related conditions (narrow)</td>
<td>678</td>
<td>625</td>
</tr>
<tr>
<td>Mortality</td>
<td>Alcohol-specific mortality - males</td>
<td>14.2</td>
<td>15.6</td>
</tr>
<tr>
<td></td>
<td>Alcohol-specific mortality - females</td>
<td>7.1</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Mortality from chronic liver disease - males</td>
<td>10.8</td>
<td>13.5</td>
</tr>
<tr>
<td></td>
<td>Mortality from chronic liver disease - females</td>
<td>6.9</td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td>Alcohol-related mortality - males</td>
<td>57.1</td>
<td>62.3</td>
</tr>
<tr>
<td></td>
<td>Alcohol-related mortality - females</td>
<td>27.7</td>
<td>27.7</td>
</tr>
</tbody>
</table>

The vast majority of the population consume alcohol and most people drink within the recommended level that presents a lower risk to their health.

• Just under a quarter of people, however, are estimated to drink at above the recommended levels, this equates to just over a
quarter of the drinking population.
- 7% of the drinking population or **26,700 people are drinking at higher risk levels**, double the recommended safe levels or above.
- In addition, an estimated 84,000 people (19%) are binge drinkers.

**Alcohol related hospital admissions**

**What the evidence says**

Whilst health-related indicators\(^{30}\) such as alcohol-related/specific hospital admissions and deaths (see [Local Alcohol Profile](#)) for males are higher than for females, the majority of **health-related indicators for females** are **above the regional average and some are also above the national average**.

Cornwall has seen higher than average admission rates for alcohol-specific conditions among **young people** (under the age of 18 years) but **admissions in this group have been falling**. The latest rate, however, is higher than both the regional and national averages. Despite a falling trend, the fact that patients as young as **early 20s** are being admitted to hospital with **alcoholic liver disease** is of great concern.

- We have also seen higher than national average admission rates for alcohol-specific conditions among females. The latest rate is higher than the South West region and the national average;
- The main causes of alcohol specific admissions in 2013 were:
  - Mental and behavioural disorders due to use of alcohol (64%)
  - Alcoholic liver disease (18%)
  - Ethanol poisoning (15%)
- It is known that people living in deprived areas are more likely to be admitted for alcohol-specific conditions than those living in the least deprived areas.

Both long and short term misuse of alcohol **increase the risk of suicide**. Over time, alcohol misuse can disrupt relationships, and lead to alienation and depression. The immediate effects of alcohol can be to increase impulsive behaviour, with a loss of regard for the consequences. It is known that **almost a quarter of people in Cornwall and Isles of Scilly** who have died by suicide in recent years had taken **alcohol at the time of death**, but where more detailed specific information was available this **rose to over a third**.

The number of hospital admissions for **alcohol-related conditions** is a key indicator used across the country to measure progress in reducing alcohol-related harm. It is one of two outcomes relevant to alcohol set out in the public health outcomes framework (the other relates to mortality from liver disease in people under the age of 75). The public health outcomes framework forms the

\(^{30}\) Alcohol-specific conditions are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose); alcohol-related conditions also include conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different related fractions are used to determine the proportion related to alcohol for males and females.
strategic direction for the public health system, in which local authorities will have increased responsibility for health and wellbeing. In 2013, following a stakeholder consultation, PHE announced that the current indicator for admission episodes for alcohol-related hospital admissions (previously National Indicator 39) would be supplemented by a new indicator. The Local Alcohol Profiles for England 2015 includes both the old (broad) indicator and the new (narrow) indicator.

The original indicator considers all reasons (primary and any secondary) that relate to a patient’s admission record, and if any of these reasons is alcohol-related then that admission would form part of the alcohol-related admission total. This can be seen as a broad measure. It provides evidence of the scale of the problem but is sensitive to changes in recording practice over time.

The new indicator seeks to count only those admissions where the primary reason is alcohol-related. This represents a narrower measure. Since every admission must have a primary reason it is less sensitive to recording practices but also understates the part alcohol plays in the admission.

This correction will take into account the increasingly detailed knowledge and understanding of alcohol related hospital admissions gathered over the years since this analysis began, stating that "estimates from earlier time periods are not directly comparable as they will have underestimated the number of secondary conditions related to alcohol."

This would mean that some of the year on year rising trends in both alcohol related and alcohol specific admissions (about 8-10% over at least the last 15 years) can arguably be explained by an improving use of coding leading to an increase in recorded secondary diagnoses.

Different recording expectations and conventions may also explain some of the regional variations. This observation is backed up by the fact that although health condition alcohol related and specific hospital admissions are rising, external cause alcohol related hospital admissions (poisoning, accidents, intentional self-harm and assault) are now falling.

- **Alcohol-related admissions (broad) increased slightly in 2013/14, compared with 2012/13.** The narrow indicator has remained stable. Overall, both show a small increase since 2008/09. Cornwall is similar to both the regional and national averages for the broad indicator and slightly above the national average for the narrow indicator. This is due to alcohol-related hospital admissions (narrow) for females being significantly higher than the national average, reducing our overall figures;

- Compared to our geographical neighbours, **Cornwall was similar for alcohol related hospital admissions to both Plymouth and Torbay, but significantly higher than Devon and Somerset.**

31 Health Profiles Local Authority Summaries 2014
Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15
NOT PROTECTIVELY MARKED
• For the broad definition, the **local trend has tracked a middle path** between the regional and national average for the last 5 years;
• For the narrow definition, **we have seen no change, compared to a slight national increase**.

Local data was examined in 2013 to determine the relative contribution of different conditions leading to hospital admissions. **The most common cause of admission is hypertensive disease**, accounting for nearly 16,000 admissions, four times as many as the most common alcohol specific disease (mental and behavioural disorders due to alcohol). The other category that stands out is ‘injuries’, reflecting the influence of alcohol on risk taking behaviour.
This data is valuable in targeting IBA training and interventions in hospital wards and departments, as well as Alcohol Champions/Link Nurses and pathways, including the Alcohol Multi-Disciplinary Team approach and improved connection between Hospital Alcohol liaison and the community alcohol treatment services, Addaction and Boswyns/Bosence.

Projects aimed at public messages about alcohol, treatment interventions, or IBA/preventative schemes need to address the population as a whole, but should consider whether women and under-18s have been specifically catered for, to avoid these trends developing.

Note that hospital admission data this does not include attendance at Emergency Departments (unless it results in admission).

**Liver Disease Pathways**

A report by NCEPOD (National Confidential Enquiry into Patient Outcome and death) in 2013 highlights the process of care for patients who are treated for alcohol-related liver disease and the degree to which their mortality is amenable to health care intervention. They developed 6 recommendations:

1. All patients presenting to hospital should be screened for alcohol misuse;
2. All patients presenting to acute services with a history of potentially harmful drinking, should be referred to alcohol support services for a comprehensive physical and mental assessment;
3. Each hospital should have a 7-day Alcohol Specialist Nurse Service;
4. A Multidisciplinary Alcohol Care Team, led by a consultant with dedicated sessions, should be established in each acute hospital;
5. All patients admitted with decompensated alcohol related liver disease should be seen by a **specialist gastroenterologist** / hepatologist at the earliest opportunity;

6. **Escalation of care** should be actively pursued for patients with alcohol-related liver disease.

A more recent report from Public Health (2014) showed that there is a widespread consensus on the need for, and the effectiveness of hospital alcohol services, led by a **senior clinician with dedicated time for the team**, and providing **evidence-based interventions**. Teams will facilitate **identification of alcohol misusers in hospitals and appropriate packages of care provided by multi-disciplinary teams**. Whether teams are large or small, set within the hospital or in-reach, they should be able to provide:

- Case identification/identification and brief advice (IBA)
- Comprehensive alcohol use assessment
- Contribution to nursing and medical care planning
- Psychotherapeutic interventions
- Medically assisted alcohol withdrawal management
- Planning of safe discharge, including referral to community services

The recommendations from this report were:

- Every district general hospital should consider the best way to provide **effective specialist alcohol care for its patients** in light of the benefit to patient care and the available efficiency savings;
- Local partners should engage with the **health and wellbeing board** to ensure existing services for alcohol and other drugs are maintained and developed on the basis of local needs assessment;
- Hospital alcohol care teams should **accelerate identification and brief advice** (IBA) delivery throughout the hospital by supporting the training of colleagues in all clinical areas;
- Local partners should **review the response to alcohol-related harm** in all district general hospitals, using this document as a guide, and they should ensure that existing services are adequately integrated across primary and secondary care and that new services are implemented where there are none;
- Local partners should consider **employing assertive out-reach or in-reach services** for high impact service users in all major hospitals and existing services should be comprehensively evaluated to assess their impact on hospital and community services;
- System planning should ensure that **community services are accessible** and available to ensure continuation of detoxification with psychosocial interventions outside of the hospital.

Currently, **referrals to specialist alcohol treatment from hospitals** are low and have remained low for the previous 3 years. In 2014, 18 referrals were made to treatment; all of these went on to receive structured or non-structured interventions. Currently, alcohol screening only occurs in Royal Cornwall Hospital Trust (RCHT) if it is an obvious case. There is also **no embedded culture of identification and brief advice (IBA) in the Emergency Department or onwards**.
Patients that are identified on the wards are referred via the psychiatric liaison service, however, this is not a thorough, catch all process, and lots of patients often slip through the net. This suggests that further IBA training across RCHT and pathways for referral into treatment would be beneficial. RCHT are currently looking at options for developing a 7-day alcohol care team.

What are we doing about it?

In the course of this year a Consultant Gastroenterologist at Treliske Hospital has initiated an alcohol multi-disciplinary team, which pulls together staff from within the Hospital and related services in the community, to assess and care plan complex cases.

So far this has focussed on a limited number of known cases. However, work is now in progress (between CCG, RCHT and DAAT) to make this a more data led identification process, backed up by an alcohol care team of 4 specialist nurses in addition to the ED based Psychiatric Liaison Team, and using a Hospital wide IBA approach to refer Increasing Risk drinkers and above.

This should create a number of referrals to community specialist alcohol treatment services, but hopefully it will also save repeat hospital attendance in the most complex cases, and prevent it in cases that are becoming more complex.

Priorities

- To develop thorough pathways from hospitals to alcohol treatment services;
- To extend the training of IBA to wards and emergency departments, and monitor the implementation to ensure it is fully embedded;
- To develop Royal Cornwall Hospital Trust multi-disciplinary monthly meetings to analyse and care plan frequent attenders on a monthly basis;
- Projects aimed at public messages about alcohol, treatment interventions, or IBA/preventative schemes need to address the population as a whole, but should consider whether women and under-18s have been specifically catered for, to avoid these trends developing;
- Hospital alcohol care teams should accelerate identification and brief advice (IBA) delivery throughout the hospital by supporting the training of colleagues in all clinical areas;
- Local partners should review the response to alcohol-related harm in all district general hospitals, using this document as a guide, and they should ensure that existing services are adequately integrated across primary and secondary care and that new services are implemented where there are none;
- Support the development of an RCHT alcohol team;
- Support RCHT to embed a culture of identification and brief advice (IBA) in the Emergency Department and on wards.
Alcohol Related Deaths

The following refers to alcohol-related deaths that include causes that relate directly to alcohol consumption. It does not include other diseases where alcohol has been shown to have some causal relationship, such as cancers of the mouth and liver.

The DAAT does not routinely review all deaths where alcohol was in the blood of the individual but it does attend inquests of people who have been in treatment at the request of HM Coroner for Cornwall, where the DAAT may be requested to review certain aspects of treatment or alcohol detoxification. It will also undertake Preventing Future Death directions on behalf of HM Coroner. There have been no requests of this type during the 2013/14 period.

It has been identified by the DAAT that there needs to be more work done to identify alcohol related deaths. There is not currently the capacity to monitor and investigate this type of death to the same degree as drug related deaths (DRDs). However, there is the capacity to monitor these deaths more closely than is currently the case.

The Drug Related Death Prevention Coordinator is now working more closely with the DAAT Alcohol Lead, in order to develop a process of monitoring these deaths with the data already available. This includes toxicology, register of deaths and the reporting requirement of agencies to HM Coroner for those dying whilst in alcohol treatment. This will give a better idea of the numbers involved and will assist in the production of the future alcohol strategy.

What the evidence says

In 2014, alcohol was detected in 8 of the 16 drug related deaths. In 6 of these the alcohol levels were high enough to be a part of the cause of the death or enhance the toxic effects of other drugs taken. 13 of the drug related death cases had been in drug and alcohol treatment prior to death, with one further case having been in treatment within 6 months of the death. Interestingly, 3 cases had been in treatment for alcohol use only.

Priorities

- Further investigation is needed to see why people have had drug related deaths who have been in treatment for alcohol problems only;
- Awareness and education is needed around the risks of poly drug use;
- To develop a consistent and effective method of investigating alcohol related deaths to inform lessons learnt and future practice;
Mental Health and Dual Diagnosis

The term ‘dual diagnosis’ covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex and includes:

- A primary psychiatric illness precipitating or leading to substance misuse
- Substance misuse worsening or altering the course of a psychiatric illness
- Intoxication and/or substance dependence leading to psychological symptoms
- Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses. (DH, 2002, p 7)

The Community Mental Health Profiles (published in 2014) highlight that the proportion of adults in Cornwall in 2012/13 suffering with depression (5.9%) is estimated as being higher than the England average. However, this is a 7% reduction from 2011/12. It also indicates we are significantly lower than the England average for the new incidence of depression and mental health problems for all ages.

Cornwall has significantly a lower proportion of the population accessing mental health services than the England average. Patients with mental health services are significantly less likely to be in settled accommodation or be in employment. Cornwall also has higher emergency admissions for self-harm, higher suicide rates and higher hospital admissions for unintentional and deliberate injuries.

Poor mental health is commonplace in people who are dependent on or have problems with drugs and alcohol. And, for many people, mental ill health and substance misuse combine with a range of other needs including poor physical health, insecure housing and offending.

Poor mental health also underlies risk behaviours, including smoking, alcohol and drug misuse. Problem drinking is heavily associated with mental illness (from anxiety and depression through to schizophrenia) and personality difficulties. Heavy drinkers are more than twice as likely to die from suicide as non-drinkers. Between 16% and 45% of suicides are thought to be linked to alcohol and 50% of those 'presenting with self-harm' are regular excessive drinkers.

While the need for integrated support for people with concurrent mental health and drug or alcohol problems is widely understood, the reality is often very different. Stakeholder feedback has indicated that this is a priority for improvement and whilst there are pockets of excellent joint working between alcohol treatment and mental health services, overall the approach is inconsistent, leaving service users bewildered and feeling that they fall between services.
**What the evidence says**

In 2014, analysis was undertaken by Public Health Cornwall to examine the **prevalence and comorbidity** of mental health illness in Cornwall. The method used to do this was to estimate levels of mental health illness from a national household survey to Cornwall’s population. The analysis showed that:

- 89% (397,000) of Cornwall’s adult population would have no mental health condition, leaving an estimated 11% (49,000) of Cornwall’s adult population that has a **mental health condition**;
- Of those with a mental health condition, **20% (9,800 people)** are estimated to also have **alcohol dependency**, this equates to 2.2% of Cornwall’s total adult population;
- Alcohol dependency is most evident in those with **externalising conditions** such as problem gambling and anti-social personality disorder, and those with **highly co-morbid disorders** (two other mental health conditions), such as depressive disorder, panic disorder, borderline personality disorder, generalised anxiety disorder, psychosis and anti-social personality disorder.

In the same time period, **19% of service users in structured alcohol treatment** had **dual diagnosis**. This equates to 301 people.

Although it is unclear from this analysis what the nature of the alcohol dependency among this population is, the large difference (9,500 people) between the number in alcohol treatment and the estimated number in need suggests there is a **huge unmet alcohol treatment need** among those with mental health conditions.

The national Adult Psychiatric Morbidity survey found that 14% of people dependent on alcohol were accessing treatment for mental or emotional health.

Risk factors for poor mental health in adulthood include unemployment, lower income, debt, violence, stressful life events, inadequate housing, fuel poverty and other adversity. Risk factors **disproportionately affect the mental health of people from disadvantaged and marginalised groups**. Those at higher risk include individuals who have experienced violence or abuse, Black and Minority Ethnic groups, people with learning difficulties and the homeless.

**Mental health problems can also lead to homelessness** and is often given as a reason for loss of tenancy. Conversely housing problems are often given as reasons for people being admitted or re-admitted to inpatient care.

**Prisoners have a twenty-fold higher risk of psychosis**, and it is estimated that 63% of male remand prisoners have an anti-social personality disorder, compared with 0.3% of the general population. Such groups are also at a **higher risk of stigma and discrimination**.

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What are we doing about it?

A sector review across community safety – Anti-Social Behaviour (ASB), Domestic Abuse and Sexual Violence (DASV), reoffending, problem drug and alcohol use – to identify and clarify the challenges and impact mental health problems are having upon delivery of positive outcomes is ongoing through 2015/16. The purpose of this project is to review the data, evidence, guidance and mental health provision, protocols and pathways with priority accorded to the co-existence of domestic violence, mental health and drug and alcohol dependencies.

The positive outcome rates sought to impact upon:
- Number and percentage of domestic abuse cases prosecuted;
- Percentage of adults not coming to attention for further act of Anti-Social Behaviour in a 3 month period after receiving warning/ intervention
- Adult reoffending rates.

What we can use to measure success will depend on what data can be cross-referenced with mental health data and this would be something that we would expect to come out of the sector review.

Priorities

- To examine the unmet need for alcohol treatment for those with mental health issues and the potential barriers to treatment;
- To develop and implement the Dual Diagnosis strategy and action plan to aid development of joint working to improve outcomes for people affected by more than one condition;
- Work with mental health providers would help to identify if those with mental health issues in domestic abuse and drug and alcohol services are accessing treatment for their mental health condition and what joint working could occur for those with complex needs.
Cornwall’s treatment population

Treatment numbers
Decrease in number of people accessing structured treatment and an increase in the number accessing brief interventions

Wait times
98% waited under the goal of three weeks to start treatment

Children
27% of service users in structured treatment lived with children, a further 30% were parents but not living with children;

Dual Diagnosis
19% of service users in structured treatment had a dual diagnosis;

Engagement
Cornwall is more successful at engaging alcohol users in treatment (19% of estimated dependent drinkers) than national average (13%)

Employment and housing
More service presenting to treatment as unemployed than national average;
More service users with a housing problem than national average.

Successful completions
- 41% locally for alcohol users, compared with 40% for our most similar LAs;
- 34% locally for non-opiate and alcohol users, compared with 43% for our most similar LAS

Representations
- 12% locally for alcohol users, compared with 11% nationally;
- 9% locally for non-opiate and alcohol users, compared with 5% for our most similar LAs.

Stakeholder priorities
- Mental health
- Outreach
- Wide range of services
- Consistency across the County

Tier 4
- 84 alcohol detox places (11% of treatment population)
- 98 alcohol residential rehab places (11% of treatment population)

Referrals
Cornwall has a lower proportion of referrals from hospitals/A&E, compared to national estimates

Wait times
98% waited under the goal of three weeks to start treatment

Children
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Dual Diagnosis
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How successful are we at getting people into treatment?

Modelling work based on results from the Adult Psychiatric Morbidity Survey (2007)\(^{34}\) has estimated that there are **770,000 dependent drinkers in England** who may benefit from some form of alcohol treatment, including Extended Brief Interventions or Brief Treatment. This will include those people who are severely dependent on alcohol and likely to require intensive specialist interventions.

Using the same methodology, there are an estimated **4,900 dependent drinkers** in Cornwall and Isles of Scilly. This is a significantly lower number than estimates provided by previous models.

Based on these estimates, we are more successful locally in attracting dependent drinkers into specialist treatment, compared to nationally.

Even though the number of **people accessing our local treatment system for problem alcohol use continues to fall**, dropping from 24% of our estimated dependent drinkers in 2013/14, to 19% in quarter 2 of 2014/15, we still appear to be much **more successful than the national average (13%) in attracting dependent drinkers into treatment**. The national target is 15%, with the national picture remaining relatively stable.

Numbers in treatment

In Cornwall, we have seen a pattern of **decline in the numbers of drug and alcohol users in treatment**. In 2013/14, there were 1006 alcohol users (includes alcohol and alcohol and non-opiate users) in specialist treatment, compared to 1322 in 2012/13. This has seen a further 16% decline in quarter 3 2014/15 to **850 users**. The graph below shows the number of alcohol only and alcohol and non-opiate users in treatment since 2012:

![Graph showing numbers in treatment](graph.png)
- Non-opiate and alcohol have shown a marked decline since April 2012, with a **40% reduction of users in structured treatment**, compared to a 5% decline nationally;
- **Alcohol only users** have shown a similar **decline of 36%**, compared with numbers remaining stable nationally.

However, in April 2013, a range of **unstructured treatment interventions were added to the drug and alcohol treatment system**. Non-structured treatment includes the provision of drug-related information and advice, triage assessment, brief psychosocial interventions, harm reduction interventions and aftercare, whilst structured treatment include provision of community-based specialised assessment and co-ordinated care planned treatment and specialist liaison. This has allowed us to examine numbers of clients in unstructured treatment (including brief interventions) against those in structured treatment.

The graph above identifies we have seen a **steady increase in the number of dependent drinkers** (alcohol and alcohol and non-opiate users) in **unstructured treatment since 2013/2014 (28% increase)**. This increase is in line with the decline in numbers in structured treatment (23% decrease).

The numbers in both structured and non-structured have remained relatively stable with a slight decrease of 2%. This has coincided with the transformation of treatment into one treatment provider in 2013. A review of the treatment system has indicated that **clients are now better placed, depending on their need, into either structured or non-structured** work whilst previously too many clients may have been put into structured treatment.

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35 Shows numbers in treatment over the previous year.
Successful Completions

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

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

The quarterly Diagnostic Outcomes Monitoring Executive Summary\(^{36}\) (or DOMES) report presents our performance information in the context of other Local Authorities with similar characteristics in terms of the complexity of their service user cohort, as well as comparing local performance with national averages. The latest figures are for quarter 2 2014/15 (12 month period ending 30th September 2014).

<table>
<thead>
<tr>
<th>Successful completions as a % of all in treatment</th>
<th>Baseline 2013/14</th>
<th>Latest actual</th>
<th>Direction of travel</th>
<th>Comparator local authorities</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-opiate and alcohol users</td>
<td>36.1% 100/277</td>
<td>34.3% 84/245</td>
<td>➔</td>
<td>42.8-59.4% 105-145</td>
<td>Red</td>
</tr>
<tr>
<td>Alcohol only users</td>
<td>43.2% 316/731</td>
<td>41% 248/605</td>
<td>➔</td>
<td>39.5% (national average)</td>
<td>Green</td>
</tr>
<tr>
<td>All alcohol users</td>
<td>41.2% 416/1008</td>
<td>39% 332/850</td>
<td>➔</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

NB higher % means better performance

Current performance indicates that:

- for every 100 people in treatment 34 people who have problems with non-opiates and alcohol together have completed treatment successfully;
- for every 100 people in treatment 41 alcohol only users have completed treatment successfully;
- This is a slight drop in performance since last year and we are now not within the top quartile for our similar local authorities for non-opiate and alcohol users. We are, however, still performing slightly above national average for alcohol only users. This suggests treatment services are less successful at achieving successful completions with people who use both alcohol and non-opiates.
- As a proportion of total exits, locally we have more alcohol users (all alcohol groups) leaving treatment successfully (65%), compared with the national average (59%).

The actual numbers of successful completions have also declined following an increasing trend over the previous year. This is due to the decline in

\(^{36}\) Provided by Public Health England as a monitoring tool for all DAATs
Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15
NOT PROTECTIVELY MARKED
treatment numbers. Due to less complex alcohol users now being placed in unstructured intervention, we are left with the most complex users in structured treatment who are less likely to successfully complete treatment.

The table below shows performance in successful completions for those in unstructured treatment. For all alcohol groups rates of successful completions are better than for those in structured treatment.

<table>
<thead>
<tr>
<th>Successful completions as a % of all in non-structured treatment</th>
<th>Baseline 2013/14</th>
<th>Latest actual</th>
<th>Direction of travel</th>
<th>Structured treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-opiate and alcohol users</td>
<td>38.2% 71/186</td>
<td>36.9% 56/208</td>
<td>➡️</td>
<td>34.3% 84/245</td>
</tr>
<tr>
<td>Alcohol only users</td>
<td>56% 358/638</td>
<td>45.5% 382/828</td>
<td>↓</td>
<td>41% 248/605</td>
</tr>
<tr>
<td>All alcohol users</td>
<td>52.1% 429/824</td>
<td>42.2% 438/1036</td>
<td>↓</td>
<td>39% 332/850</td>
</tr>
</tbody>
</table>

Although we have still seen a decline in successful completion rates these rates are better than structured treatment and the actual numbers of successful completions have increased for all alcohol users in unstructured treatment overall.
Factors affecting successful completions

The various factors that appear to affect the chance of completing alcohol treatment successfully are outlined in the graphic below:

**Positively affects successful completions**
- Being married
- Living with children
- Being employed
- Age 55 years and over

**No difference**
- Gender, referral source, dual diagnosis, disability

**Negatively affects successful completions**
- Alcohol and non-opiate use together
- Previous treatment journeys
- Previous unplanned treatment journeys
- Less time spent in treatment
- Housing problem
- Being separated or single
- Having children not living with them
- History of injecting
- Units consumed per month

No difference
Re-presentations

DOMES presents this measure as a proportion of total exits. The latest figures are for Quarter 2 2014/15 (12 month period ending 30th September 2014).

<table>
<thead>
<tr>
<th>% who complete successfully but represent within 6 months</th>
<th>Baseline 2013/14</th>
<th>Latest actual</th>
<th>Direction of travel</th>
<th>Comparator local authorities</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-opiate and alcohol users</td>
<td>14.7% 10/68</td>
<td>8.9% 4/45</td>
<td>↓</td>
<td>5.4-0% 2-0</td>
<td></td>
</tr>
<tr>
<td>Alcohol only users</td>
<td>10.1% 21/207</td>
<td>11.8% 16/136</td>
<td>↑</td>
<td>11.1% (national average)</td>
<td></td>
</tr>
<tr>
<td>All alcohol users</td>
<td>11.3% 31/275</td>
<td>11.6% 20/181</td>
<td>↑</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

NB lower % means better performance

- The rates effectively mean that for every 100 people exiting treatment 12 alcohol and 9 non-opiate and alcohol users re-present to treatment in the following 6 months;
- Since 2013/14, performance in re-presentations has improved for non-opiate and alcohol users (up by 5%), but slightly declined for all alcohol users (down by 2%);
- These rates means Cornwall is performing just outside the top quarter of our similar local authorities for alcohol and non-opiate users (3% or 2 people) and we are the same as the national average for alcohol users.

Complexity

Clients’ drinking is measured by units per month when entering structured alcohol treatment.

- Nationally a larger proportion of clients were drinking over 1000 units per month when entering treatment than in Cornwall; 11% compared to 8%;
- However, Cornwall has slightly more people drinking at higher risk levels (80%), than the national average (77%).

In comparison, those clients entering non-structured treatment in 2013/14, as alcohol or alcohol and non-opiate users, all consumed under 200 units per
month. This indicates these users are more **correctly placed in brief interventions**, as opposed to structured more intense interventions.

The following graph shows the complexity factors of all clients starting structured treatment for primary alcohol in Cornwall:

- This indicates Cornwall has a **high proportion** of clients that enter treatment **unemployed**. This is **higher than the national average** (40%). As indicated above this has a **negative impact on the chance of successfully completing** treatment;
- Cornwall also has slightly **higher proportions of alcohol users who use other drugs** (cannabis, opiates, crack and other) **on top of alcohol use**, compared with national averages.

**Measuring treatment outcomes**

In 2007/08, the National Treatment Agency (now within Public Health England) rolled out a treatment outcomes monitoring instrument – the **Treatment Outcomes Profile or TOP** – to be used at the start of treatment, in care plan reviews at approximately three month intervals and on leaving treatment. This information is reported through the National Drug Treatment Monitoring System (NDTMS).

By the summer of 2010 it was sufficiently embedded and recorded in NDTMS to justify the dissemination of quarterly outcomes reports at both a Partnership and individual provider level. This data is recorded for clients in structured treatment only.
The tool looks at four key domains for drug treatment:
- Drug and alcohol use
- Physical and psychological health
- Social functioning
- Offending and criminal involvement

Valid and robust data to evaluate progress across the treatment population in these four domains is dependent on services completing a minimum of 80% of TOPs within the time periods required; this is described as TOP compliance.

TOP compliance in Cornwall has a patchy history and this means that this rich source of data has not previously been routinely available to us. However, in 2014/15, Cornwall achieved 80% TOP compliance (as at Quarter); therefore information was able to be gained regarding the outcomes of clients in the treatment system. Unfortunately, TOP completion for alcohol clients only started to be collected in April 2014, therefore the only information we have regarding alcohol outcomes are those for drug users that use alcohol on top.

NDTMS calculates ‘abstinence’ as 0 days use in the previous 30 days and ‘reliably improved’ as a reduction of equal to or more than 10 using days for alcohol, in the previous 30 days. The table below shows the numbers and rates of service users that achieved abstinence or reliably improved from alcohol use 6 month review, in the 12 month period ending 30th September 2014:

<table>
<thead>
<tr>
<th>Drug use at 6 month review</th>
<th>Abstinence</th>
<th>Expected range</th>
<th>Reliably improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol use</td>
<td>30.5%</td>
<td>18.9-29.9%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>71/233</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 30% of those using alcohol at the start of treatment were no longer drinking at review stage, and 15% reliably improved. This is at the top of the range that Cornwall would expect to achieve based on the complexity of our treatment population.

There are a high proportion of drug clients in the treatment system who continue to use alcohol on top of their drugs of choice. 57% of non-opiate and 46% of opiate users were drinking alcohol at 6 months review, compared to 53% and 42%, respectively.

**Tier 4 services**

Tier 4 treatment covers in-patient assessment, stabilisation and detoxification and residential rehabilitation interventions.

**Boswyns** opened in May 2010 and this was the first time that residents of Cornwall and Isles of Scilly had access to a local dedicated specialist unit for assessment and detoxification. Prior to the opening of Boswyns in 2010,
Cornwall had previously relied heavily on out-of-county provision for residential detoxification.

Boswyns is registered with the Care Quality Commission to provide residential detoxification, stabilisation and assessment services. The service is available for adults who require a drug or alcohol detoxification, or whose drug use is out of control and need a period of stabilisation or a full assessment of their needs.

Bosence and Chy Colum are residential rehabilitation providers in Cornwall. In line with NICE recommendations, a stay in residential rehabilitation is appropriate for the most serious cases, and local areas are encouraged to provide this option as part of an integrated recovery-orientated system.

In 2014/15, 84 alcohol users (43% of total referrals) were referred from community to treatment to residential tier 4 treatment. 44 were approved and 3 were awaiting more information or not approved. 2 service users were referred without the tier four checklist complete.

In-patient interventions
The estimated need for in-patient interventions (assessment, stabilisation, and detoxification) is 10% of those in treatment so approximately 85 places (alcohol) per annum. At least 93% of these will be for detoxification.

The capacity gap between estimated and actual need was closed for the first time in in 2012/13. This has remained the same throughout 2013-2015 with 86 alcohol clients receiving treatment at Boswyns at quarter 3 2014/15. This was a reduction of 14 places since 2013/14.

The majority of clients receiving in-patient interventions are alcohol only users (62 in December 2014). 24 clients used alcohol and non-opiates.

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37 National Tier 4 Needs Assessment estimates (2003-2004), NTA, 2005
Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15
NOT PROTECTIVELY MARKED
Successful completions

In quarter 3 2014/15:
- 77% of people completed treatment successfully;
- 2 people had undertaken more than one episode of alcohol detoxification (or drugs and alcohol together) at Boswyns that year, meaning a representation rate of 2%.

Residential Rehabilitation

Research indicates approximately 5% of the total treatment population will go on to require residential rehabilitation.

98 adults using alcohol went to residential rehabilitation (Bosence and Chy Colom) between January 2014 and December 2014. This represents 11%, which is approximately double the estimated proportion, of the treatment population. This has remained the same since 2013/14.
Case study

At the age of 16, from the outside, my life appeared perfect. I was part of a close, loving family. I was doing well at school, I had a lot of friends, and I was talented at sport. Inside, I had cripplingly low self-esteem, was constantly ravaged by fear and felt disconnected from everybody. I took a drink and everything was suddenly ok, actually better than ok...brilliant! I felt alive, I felt confident, I felt part of.

Eleven years later, at the age of 27, I arrived at yet another detox, broken, empty, worthless, severely mentally damaged and full of hatred for myself, the world and everyone in it. I was a hopeless alcoholic and the only thing I could do, could think of, was drink.

I was in Boswyns for 6 weeks. I came off the alcohol, then came off the anxiety medication. For the first time in 10 years, my body was free of substances, and it was absolutely terrifying. I then went to Bosence Farm Secondary Rehab desperately hoping something would happen. I knew something had to change, something inside me, something in how I lived life, otherwise it wouldn't be long until I picked up a drink, and then all would be lost again.

Amazingly, it happened. I found some hope. I came to believe that the 12 Step programme would work for me – which I could be happy and content in life without needing to drink. I saw that it had worked for my keyworker, and I saw that it was working for other alcoholics I met at AA meetings.

I was resident at Bosence Farm for 8 months. I was given time, and an overwhelming amount of love, support and understanding; which allowed me to start to learn how to interact with people and live life. My journey through the farm was difficult. I faced many personal challenges. I felt like giving up at times. The community spirit saw me through. A miracle was worked there. I was able to build a strong foundation of recovery and have continued to grow in the AA/NA fellowships.

I am approaching 2 years sobriety and have been blessed with a love of life. I’m making positive contributions to my local community. My personal relations with family and friends have been restored. I have a self-confidence and self-assurance of which I could only have dreamed. I really cannot stress enough just how important Bosence Farm has been to me. Without it, death was the only option. With it, for the first time ever I am truly alive.
Stakeholder Consultation

Every year we consult users and providers of our services for their views about what has been helpful, what has been not so helpful and their priorities for improvement.

Service Users

34 service users attended at five locations across the county; Bude, St Austell, Truro, Liskeard and Penzance. This included a mix of both males and females and those in structured and non-structured treatment.

What has helped or is helping your recovery most this year?

- There are a lot more services available. A mix of both groups and 1:1 sessions is helpful, including day groups, breakfast clubs, life skills hub, keyworker sessions and brief interventions;
- Having offices across the county and easier access;
- Volunteering, training and extra activities to give constructive things to do with time outside of treatment;
- There was fairly quick access to a prescription.

What is not helping or would help more?

- The attitudes of some other services, specifically pharmacies;
- Mental health is not addressed by drug and alcohol treatment;
- The needle exchange is not confidential enough;
- Long delays to access rehab or in-patient;
- Additional services would be beneficial; mindfulness, acupuncture is missed and was useful in the past, evening or Saturday recovery cafes, lunch clubs, day trips and additional map groups;
- More information for new service users and potential service users about what is on offer;
- Better consistency of what is available and when;
- Cosgarne is good, but not good for those immediately leaving prison drug and alcohol free – too much heroin and alcohol consumption leading to overdoses;

What are the top priorities for improvement?

- More services on more days;
- Legal high groups;
- Outreach – getting to people who need treatment;
- More information for services users on what’s available;
- Travel costs to help get to treatment daily, it’s not possible on benefits;
- Stages of constructive activity & volunteering from the outset;
- Support with mental health.

Due to the apparent reduction in the number of service users in structured treatment, we asked people in treatment how many dependent or problem drug
and/or alcohol users they knew who were not in treatment. Respondents all answered that they knew 2, 3 or 4.

They indicated that a major barrier for coming to services was that they had children and the fear of the repercussions that coming into treatment may have.

Service Providers

Overall, 26 staff and 2 clinicians were consulted across the Mid, West and North and East of the County and within the criminal justice team.

What is working well/been most helpful to help reduce harm and promote recovery?

- The Naloxone programme to reduce drug related deaths;
- Needle exchange;
- Having multiple and increased groups and programmes for service users to choose from, including: brief interventions, open access interventions, breakfast club, mutual aid programme, club drug supper club, life skills hub, and intuitive recovery;
- Prescribing team are responsive and proactive;
- Staff training and workforce development, particularly DASH and ASSIST;
- Caseload management has improved
- Simplified care pathways;
- Halo case management and the new form-set
- HALO Helpline & Cloud team;
- Using the recovery plan tool effectively to chart client’s progress and provide structured focus to treatment;
- Text prompts for clients to increase take up and remembering to attend;
- Assertive outreach to engage those at risk of dropping out;
- Some good examples of joint drugs and alcohol and mental health work on the ground between individuals;
- REZOLV (but it’s still only in Bodmin);
- Staff enthusiasm;
- Community Hospital Alcohol Detox at Edward Hain hospital;
- Partnership working with those in the Criminal Justice System, which gives a bigger picture of the clients individual needs and areas of risk;
- Having a prescribing nurse in Falmouth;
- Naloxone has been excellent;
- Brief Interventions Group – good for low level drinkers but also for higher level who may need knowledge/awareness prior to deciding on next steps.
- Stepped approach to alcohol treatment

"The Naloxone programme has made an enormous difference"

"We’re not equally resourced"

"Staff morale has improved immeasurably"
What has not been working so well, been helpful or needs to improve?

- Needle Exchange is not currently available in the centre of Bodmin and not all staff are confident to deliver regardless of what clients are using. More on the job training about needle exchange is required, particularly about steroid injecting;
- Naloxone rates have reduced since Christmas and issues in getting second supply for housing providers in the east of the county;
- Access to treatment in rural location and travel costs for those on fixed low income/benefits;
- There is a need for more flexibility in Boswyns assessment location and the cost in attending;
- Services and resources are not equitably or rationally distributed across Cornwall;
- Nothing in the Redruth area for alcohol detox and aftercare – no Home and Dry or CHAD;
- Need brief interventions for cannabis;
- Need a service for gamblers and steroid users;
- Need to improved working relations with Boswyns and homeless clients;
- The Stepped Approach to Alcohol needs a review;
- Acupuncture and Mindfulness is missed by the service users and the staff;
- The Intuitive Recovery service gets clients to subscribe to an unrealistic and unsustainable plan in the heat of the moment, then they leave the keyworkers to deal with the fallout afterwards, as clients feel disheartened that they could not stick to IR agenda;
- IT access, reliability and instability plus old computers;
- Halo recording service is also clunky and very time consuming;
- Work is currently disproportionally administrative heavy;
- Not much face to face training;
- Dual Diagnosis – no clarity or agreement about who should do what and how;
- Apparent lack of communication between CMHT and other treatment services which has created a major issues with more complex clients;
- Access to female only accommodation;
- No venue in Newquay warps provision in favour of other towns. There is no facility to offer groups here;
- Boswyns unrealistic assessment process (i.e. face to face) although evidence that they are changing this.

If we could only improve 3 things in 2015/16, what would make the greatest improvement and difference?

- Better mental health connections and the ability to work with Dual Diagnosis clients;
- More external resources to target harder to reach clients. e.g. Assertive outreach workers;

“The paperwork on Halo is becoming so heavy that quality of treatment is being affected”

“Sometimes as workers the feeling is we are treating HALO and not clients”
- When service users leave CHAD they have no money to get to Truro (if they live outside of Truro) to help with travel for groups, the fare is £7 and JSA wouldn’t cover. Can we offer payment support?
- Prescribers, DAT and Recovery workers to agree a consistent policy towards prescribing. Each prescriber operating differently;
- Heroin users still resistant to attending groups. Could groups be made an obligation of treatment so clients begin engaging in recovery?
- Target short groups for heroin users ready to exit treatment to offset irrational clucking fear and speed up exit of motivated but scared clients;
- The Home and Dry service is not available in St Austell and there is a need identified;
- Improve waiting times for Detox bed in Bodmin;
- GPs to receive training on alcohol misuse issues;
- Training – ASSIST for all staff; Safer Injecting; mental health; Basic Life Support training for all staff to be updated annually;
- Needle Exchange - All staff to be confident to deliver needle exchange regardless of drugs being used;
- Stricter guidelines with regard to more problematic clients and their challenging behavior;
- A consistent approach to all areas of the county with regards to services and resource;
- An allocated building in Newquay;
- A solid network of volunteer drivers and peer mentors;
- More consistency in the discharge procedure and approach for client’s not engaging when on a script;
- Alcohol services – training, stepped approach, more detox facilities
- Increased capacity to run groups, especially abstinent aftercare groups for people who have just completed detox;
- IT – stability, infrastructure and up to date computers;
- Halo speed and system improvements;
- Streamlined Halo system that works to the client and the worker. There are often too many different forms in too many different places to complete. This is time consuming when with clients and waiting for forms to save;
- The SPUR form and COMP could become more relevant, as a lot of the questions are vague, invasive and confusing for the client;
- Additional admin support or ways to reduce admin demands on RCs time;
- Ability to be able to add partner agencies details to Halo which are populated on the Dashboard i.e. Offender Manager/Social Worker etc.

‘You can lose all of your work’
Priorities

- Primary focus on **increasing successful completions** by:
  - Examining and developing the treatment offer for the **most complex service users**, particularly those who are representing to treatment, to reduce these service users dropping out of treatment again;
  - Increasing engagement of those not in contact through **outreach and targeted activities**, particularly people with children;
  - **Providing more information for service users** about what is available. A comprehensive directory of recovery pathways published and regularly updated;
  - **Reviewing the treatment offer** for people who have been in treatment **for 4 years and over** to assess the recovery potential and service design for this group;
  - Reviewing the options for getting treatment to **people who have difficulty with transport costs**;
  - Including stages of **constructive activity and volunteering from the outset** of treatment;
  - Clarifying the **mental health offer within treatment** services;
  - **Increasing the solid network of volunteer drivers** and peer mentors.
8: Licensing, alcohol retail and the Night Time Economy

What the evidence says

Evidence shows that the best results are gained when there is a **constructive relationship between the licensed trade and local enforcement authorities**. When well run schemes are located in affected areas, both the number of violent incidents and the burden on hospital Emergency Departments are reduced, and schemes work at their best when all members of the licensed trade in an area commit to supporting them, so that there is no commercial disadvantage created\(^3\).

The term ‘Night Time Economy’ refers to leisure-related businesses that are open after normal shopping hours, such as bars, pubs, nightclubs and takeaway food outlets. It is a particular facet of the economy which poses both **major opportunities and challenges**.

It generates jobs and has the potential to **add vitality to local towns** and make them safer by increasing activity, patterns of movement and opportunities for natural surveillance. It can also be **associated with noise, crime, anti-social behaviour and community safety problems**, particularly in the case of nightclubs, drinking establishments and late-night take-aways.

The **Police Reform and Social Responsibility Act 2011** introduced new measures to tackle alcohol problems; they include introducing a **late night levy** to help cover the cost of policing the late night economy, **increasing the flexibility of early morning alcohol restriction orders** and **doubling of fines for persistent underage sales**. These may now be reviewed, as they have not been widely utilised.

New measures introduced included a consultation on **minimum alcohol unit pricing**, and **greater control on alcohol retail offers** and advertising. However, Minimum Unit Pricing (‘MUP’) was ‘postponed’ as Government policy for a decision until after the election. It was communicated that "**We do not yet have enough concrete evidence that its introduction would be effective in reducing harms associated with problem drinking—this is a crucial point—without penalising people who drink responsibly.**"

This statement contradicts academic peer reviewed research evidence (e.g. British Columbia and Sheffield University) and was critiqued BMJ as bowing to disproportionate industry influence and undue pressure.\(^3\)

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\(^3\) Department of Health
http://www.bmj.com/content/348/bmj.g72
Cornwall and Isles of Scilly DAAT, Public Health, the Safer Cornwall Partnership, the Office of the Police and Crime Commissioner and the Cornwall Health and Wellbeing Board will continue to communicate and lobby strongly for the evidence based policy of connecting the price of alcohol to strength (either by MUP or by through targeted taxation) in any policy debates and consultations that follow this election result.

For the moment, future developments appear to be awaiting the outcome of the continuing legal process towards MUP in Scotland, again opposed by the alcohol industry, and processes being attempted in Wales since July 2014.  

Meanwhile, pre-election lobbying in England did not yield anything very revealing about policies addressing alcohol, but as our regional Police and Crime Commissioner has taken a lead on these issues, the fact that the Conservative Party won the 2015 General Election – which leaves the Police and Crime Commissioners in place – may prove significant.

Health now has more input in licensing decisions, which may lead to serious consideration for a Public Health-related Licensing Objective in England – similar to the existing one in Scotland – and Criminal Justice commitment and funding will continue to be led by the Police and Crime Commissioners.

In Cornwall the Licensing Policy has recently been updated, using relevant data.

Two issues are currently more important here than the local Licensing Policy:

- Operational application and swift responsive use of data already being gathered, e.g. through the Assault Related Injuries Database in hospital Emergency Departments and Minor Injuries Units, so that licensing practice is improved;
- Staying engaged with the evolution of Public Health responsibility and legislation in connection with Licensing.

It is possible that this new Government may address the lack of a Public Health Licensing Objective in the Licensing legislation in England. This was a consultation issue in the previous Government, but one that yielded no actions. This may be revisited, as may Minimum Unit Pricing, depending on the outcome of legal processes relating to Scotland.

Violent crime and the Night Time Economy

Trends in violent crime are discussed in more detail in Section 3: Community Safety Schemes. The key message for this theme is that Night Time Economy violence continues to fall (this is the third successive year) and as a result presents a reduced level of risk to communities.
What have we achieved this year?

Work with partners, including the licensed trade and other local businesses, to improve the Night Time Economy and reduce alcohol-related crime and disorder continues to be proactive, evidence-based and innovative.

Violence linked to the Night Time Economy continues to improve, indicating that current approaches are having a positive impact.

- **Substance Misuse and Alcohol Awareness Retail Training** (training in responsible retailing of alcohol for frontline staff in pubs and clubs) has been delivered to a total of 461 staff in 119 licensed premises in 22 towns across Cornwall. The training has been reviewed and evaluated, and continues with the Office of the Police and Crime Commissioner interested in using our model as a regional approach;
- Last year's overall Cornwall Best Bar None winner was awarded the National Best Bar None award 2015 at the House of Lords. In January the assessments of the 19 applicant premises took place across Cornwall. The adjudication of the assessments took place in February followed by the Awards ceremony on Tuesday 24th February which was well attended and publicised, with Walkabout Newquay winning the overall CBBN award. 5 new assessors received their certificate for passing the National Best Bar None Assessor examination;
- Transition from Cornwall Licensing Strategy Group to a more event and dialogue-based Cornwall Licensing Forum with continued commitment from all partners in the Licensing arena;
- Data from the Assault Related Injuries Database installed in the Emergency Department in Royal Cornwall Hospital Treliske is being used operationally by Cornwall Council and Police Licensing teams. This is discussed in more detail in Section 3: Community Safety Schemes.

The **Safer Towns** programme, which focused partnership efforts on our highest risk towns, including a number of initiatives with the licensed trade including:

- Licensed premises in Newquay were visited and inspected under the Best Bar None criteria. All 3 clubs were seen to be maintaining a good standard with some excellent pro-active prevention activities. Premises in Newquay have now introduced “Chelsea hooks” in order to tackle acquisitive crime in the area, which is yet to be evaluated;
- Residents from Cosgarne Hall and Freshstart in St Austell, have attended focus groups to examine attitudes to alcohol from the perspective of an offender and/or habitual drinker. A positive event, helping to inform the picture on effective campaigning regarding alcohol. The findings of this event will be used in the What Will Your Drink Cost Evaluation that is being undertaken in partnership with Plymouth University;
- There have been pop-up shops in Penzance town centre where members of the public could engage with services for advice and guidance on alcohol. There have also been licensing enforcement campaigns to promote multiple safety messages alongside What Will Your Drink Cost in 5 residential areas around the town.
Priorities

- **Continue to communicate and lobby strongly for the evidence based policy of connecting the price of alcohol to strength** (either by MUP or by through targeted taxation) in any policy debates and consultations;
- Review and continue to **deliver the SMART training** for bar staff, in order to promote best practice and responsibility in alcohol sales;
- Continue to **evolve Cornwall Licensing Forum** in an event-based setting for dialogue and discussion about best practice, involving both trade and enforcement representatives;
- **Evolve Cornwall Best Bar None** to fit in with the national timetable, and make changes designed to create sustainability by increasing trade commitment to the scheme through sponsorship and by making the assessment process more efficient;
- Increase **Public Health engagement with licensing applications** and review processes, especially if relevant legislation or Licensing Objectives are updated;
- Work with the Office of the Police and Crime Commissioner to engage with **supermarket alcohol retailers**, and to encourage a national dialogue about improving alcohol legislation and enforcement;
- Work with the Office of the Police and Crime Commissioner on **local Night Time Economy schemes**, for example #RU2drunk and the nightclub breathalyser schemes, and with police as they review and improve their public messaging;
- Continue to work with Community Safety colleagues as they evaluate and refresh the **“What Will Your Drink Cost” campaign**, which impacts across the community including through the Night Time Economy;
- **Review the approach to criminal justice interventions** that address alcohol related offences and violence in Cornwall;
- **Improve operational usability and impact of data gathered** through the **Assault Related Injuries Database** in Emergency Departments and Minor Injuries Units, in order to improve practice in licensed premises, and make customers less vulnerable to violence and health harms.
Appendix A: Local Alcohol Profiles for England

Data released 02/06/15


Alcohol Specific Hospital Admissions Under 18

- Rate worse than national and regional, trend reducing on a similar track to national rate.

5.01 - Alcohol-specific hospital admission - under 18

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Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

5.01 - Alcohol-specific hospital admission - under 18

[Graph showing trend over years]

Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.
Alcohol Specific Hospital Admissions All

- Rate similar to national and regional, trend level, on a similar track to national rate.
Alcohol Specific Hospital Admissions Male

- Rate similar to national, worse than regional, similar level trend to national rate.

**6.01 - Alcohol-specific hospital admission (Male)**

Funnel plot is not available

**6.01 - Alcohol-specific hospital admission (Male)**

Export chart as Image

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Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.
```
Alcohol Specific Hospital Admissions Female

- Rate worse than national and regional, trend slightly above national rate.
Alcohol Related Hospital Admissions (Broad) All

- Similar rate to national and regional, trend similar to national rate.

### 7.01 - Alcohol-related hospital admission (Broad) (Persons)

#### 2014/15

**Cornwall**

- **Value**
  - **2008/09**: 5,474
  - **2009/10**: 5,891
  - **2010/11**: 6,402
  - **2011/12**: 6,843
  - **2012/13**: 6,796
  - **2013/14**: 7,002

**South West**

- **Value**
  - **2008/09**: 1,005
  - **2009/10**: 1,071
  - **2010/11**: 1,155
  - **2011/12**: 1,219
  - **2012/13**: 1,197
  - **2013/14**: 1,215

**England**

- **Value**
  - **2008/09**: 981
  - **2009/10**: 1,044
  - **2010/11**: 1,126
  - **2011/12**: 1,190
  - **2012/13**: 1,169
  - **2013/14**: 1,189

**Lower CI**

- **2008/09**: 931
  - **2009/10**: 1,009
  - **2010/11**: 1,068
  - **2011/12**: 1,134
  - **2012/13**: 1,172
  - **2013/14**: 1,198

**Upper CI**

- **2008/09**: 1,037
  - **2009/10**: 1,079
  - **2010/11**: 1,159
  - **2011/12**: 1,215
  - **2012/13**: 1,223
  - **2013/14**: 1,248

**Source**: Calculated by Public Health England, Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

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Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15

NOT PROTECTIVELY MARKED

Page 106 of 142
Alcohol Related Hospital Admissions (Broad) Male

- Rate better than national and worse than regional, trend similar to national rate.

7.01 - Alcohol-related hospital admission (Broad) (Male)

Funnel plot is not available

7.01 - Alcohol-related hospital admission (Broad) (Male)

Export chart as Image

Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15
NOT PROTECTIVELY MARKED

Page 107 of 142
Alcohol Related Hospital Admissions (Broad) Female
- Rate better than national and worse than regional, trend similar to national rate.

7.01 - Alcohol-related hospital admission (Broad) (Female)
Alcohol Related Hospital Admissions (Narrow) All

- Rate similar to national and slightly worse than regional, trend similar to national rate.
Alcohol Related Hospital Admissions (Narrow) Male

- Rate similar to national and slightly regional, trend similar to national rate.

### 8.01 - Alcohol-related hospital admission (Narrow) (Male)

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Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre – Hospital Episode Statistics (HES) and Office for National Statistics (ONS) – Mid Year Population Estimates.

### 8.01 - Alcohol-related hospital admission (Narrow) (Male) - Cornwall

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Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre – Hospital Episode Statistics (HES) and Office for National Statistics (ONS) – Mid Year Population Estimates.

Funnel plot is not available.
Alcohol Related Hospital Admissions (Narrow) Female

- Rate worse than national and regional, trend similar to national rate.

**8.01 - Alcohol-related hospital admission (Narrow) (Female)**

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<tr>
<td>North Somerset</td>
<td>315</td>
<td>285</td>
<td>354</td>
</tr>
<tr>
<td>Plymouth</td>
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<tr>
<td>Poole</td>
<td>279</td>
<td>242</td>
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<td>Somerset</td>
<td>316</td>
<td>295</td>
<td>335</td>
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<tr>
<td>South Gloucestershire</td>
<td>262</td>
<td>254</td>
<td>312</td>
</tr>
<tr>
<td>Swindon</td>
<td>205</td>
<td>251</td>
<td>302</td>
</tr>
<tr>
<td>Torbay</td>
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<td>348</td>
<td>445</td>
</tr>
<tr>
<td>Wiltshire</td>
<td>285</td>
<td>264</td>
<td>308</td>
</tr>
</tbody>
</table>

*Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.*

Funnel plot is not available
Alcohol Related Hospital Admission Episodes (Broad) All
- Rate better than national, similar to regional, trend similar to national rate.

### 9.01 - Admission episodes for alcohol-related conditions (Broad) (Persons)

#### 2013/14

<table>
<thead>
<tr>
<th>Area</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
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<td>2.115</td>
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<tr>
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<td>1.939</td>
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<td>1.951</td>
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<tr>
<td>Bath and North East Som.</td>
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<td>1.999</td>
</tr>
<tr>
<td>Bournemouth</td>
<td>2.461</td>
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<td>2.597</td>
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<tr>
<td>Bristol</td>
<td>2.487</td>
<td>2.343</td>
<td>2.641</td>
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<tr>
<td>Cornwall</td>
<td>1.984</td>
<td>1.957</td>
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<tr>
<td>Devon</td>
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<td>1.764</td>
<td>1.824</td>
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<td>Dorset</td>
<td>1.700</td>
<td>1.663</td>
<td>1.739</td>
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<td>Gloucestershire</td>
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<td>1.729</td>
<td>1.796</td>
</tr>
<tr>
<td>Isles of Scilly</td>
<td>1.606</td>
<td>1.137</td>
<td>2.163</td>
</tr>
<tr>
<td>North Somerset</td>
<td>2.054</td>
<td>1.994</td>
<td>2.116</td>
</tr>
<tr>
<td>Plymouth</td>
<td>2.290</td>
<td>2.229</td>
<td>2.352</td>
</tr>
<tr>
<td>Poole</td>
<td>1.934</td>
<td>1.664</td>
<td>2.005</td>
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<td>Somerset</td>
<td>1.946</td>
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<td>1.983</td>
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<td>1.946</td>
</tr>
<tr>
<td>Swindon</td>
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<td>2.003</td>
<td>2.136</td>
</tr>
<tr>
<td>Torbay</td>
<td>2.345</td>
<td>2.268</td>
<td>2.421</td>
</tr>
<tr>
<td>Wiltshire</td>
<td>1.748</td>
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<td>1.786</td>
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Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

#### 2008/09 to 2013/14

<table>
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<th>Period</th>
<th>Count</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
<th>South West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
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<td>1,817</td>
<td>1,583</td>
<td>1,851</td>
<td>1,579</td>
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<tr>
<td>2009/10</td>
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<td>1,735</td>
<td>1,700</td>
<td>1,770</td>
<td>1,651</td>
<td>1,813</td>
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<tr>
<td>2010/11</td>
<td>10,297</td>
<td>1,840</td>
<td>1,804</td>
<td>1,876</td>
<td>1,652</td>
<td>1,969</td>
</tr>
<tr>
<td>2011/12</td>
<td>11,126</td>
<td>1,976</td>
<td>1,951</td>
<td>2,005</td>
<td>1,507</td>
<td>2,052</td>
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<td>2012/13</td>
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<td>1,900</td>
<td>1,963</td>
<td>1,696</td>
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</tr>
<tr>
<td>2013/14</td>
<td>11,522</td>
<td>1,994</td>
<td>1,957</td>
<td>2,031</td>
<td>1,935</td>
<td>2,111</td>
</tr>
</tbody>
</table>

Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

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Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15
NOT PROTECTIVELY MARKED
Alcohol Related Hospital Admission Episodes (Broad) Male
- Rate better than national, similar to regional, trend similar to national rate.

9.01 - Admission episodes for alcohol-related conditions (Broad) (Male) 2013/14

9.01 - Admission episodes for alcohol-related conditions (Broad) (Male) Cornwall

Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.
Alcohol Related Hospital Admission Episodes (Broad) Female
- Rate better than national, similar to regional, trend similar to national rate.

### 9.01 - Admission episodes for alcohol-related conditions (Broad) (Female) 2013/14

<table>
<thead>
<tr>
<th>Area</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>1.426</td>
<td>1.421</td>
<td>1.431</td>
</tr>
<tr>
<td>South West region</td>
<td>1.333</td>
<td>1.320</td>
<td>1.347</td>
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<tr>
<td>Bath and North East Som.</td>
<td>1.268</td>
<td>1.185</td>
<td>1.334</td>
</tr>
<tr>
<td>Bournemouth</td>
<td>1.564</td>
<td>1.481</td>
<td>1.650</td>
</tr>
<tr>
<td>Bristol</td>
<td>1.605</td>
<td>1.546</td>
<td>1.665</td>
</tr>
<tr>
<td>Cornwall</td>
<td>1.366</td>
<td>1.326</td>
<td>1.411</td>
</tr>
<tr>
<td>Devon</td>
<td>1.249</td>
<td>1.214</td>
<td>1.283</td>
</tr>
<tr>
<td>Dorset</td>
<td>1.142</td>
<td>1.097</td>
<td>1.187</td>
</tr>
<tr>
<td>Gloucestershire</td>
<td>1.256</td>
<td>1.219</td>
<td>1.290</td>
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<tr>
<td>Isles of Scilly</td>
<td>0.758</td>
<td>0.736</td>
<td>0.771</td>
</tr>
<tr>
<td>North Somerset</td>
<td>1.448</td>
<td>1.377</td>
<td>1.521</td>
</tr>
<tr>
<td>Plymouth</td>
<td>1.590</td>
<td>1.520</td>
<td>1.662</td>
</tr>
<tr>
<td>Poole</td>
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<td>1.210</td>
<td>1.237</td>
</tr>
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<td>Somerset</td>
<td>1.359</td>
<td>1.316</td>
<td>1.402</td>
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<td>South Gloucestershire</td>
<td>1.297</td>
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<td>1.359</td>
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<tr>
<td>Swindon</td>
<td>1.563</td>
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<td>1.644</td>
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<tr>
<td>Torbay</td>
<td>1.565</td>
<td>1.493</td>
<td>1.681</td>
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<tr>
<td>Wiltshire</td>
<td>1.202</td>
<td>1.159</td>
<td>1.246</td>
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Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

### 9.01 - Admission episodes for alcohol-related conditions (Broad) (Female) Cornwall

<table>
<thead>
<tr>
<th>Period</th>
<th>Count</th>
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<th>Lower CI</th>
<th>Upper CI</th>
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</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>3.354</td>
<td>1.166</td>
<td>1.127</td>
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<tr>
<td>2009/10</td>
<td>3.468</td>
<td>1.193</td>
<td>1.153</td>
<td>1.234</td>
</tr>
<tr>
<td>2010/11</td>
<td>3.591</td>
<td>1.231</td>
<td>1.212</td>
<td>1.254</td>
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<td>2011/12</td>
<td>3.916</td>
<td>1.328</td>
<td>1.369</td>
<td>1.399</td>
</tr>
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<td>2012/13</td>
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<td>1.320</td>
<td>1.278</td>
<td>1.363</td>
</tr>
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<td>2013/14</td>
<td>4.061</td>
<td>1.368</td>
<td>1.326</td>
<td>1.411</td>
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</table>

Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.
Alcohol Related Hospital Admission Episodes (Narrow) All
  - Rate worse than national and regional, trend similar to national rate.

**10.01 - Admission episodes for alcohol-related conditions (Narrow) (Persons)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
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<td>636</td>
<td>644</td>
</tr>
<tr>
<td>South West Region</td>
<td>625</td>
<td>619</td>
<td>631</td>
</tr>
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<td>Bath and North East Som.</td>
<td>597</td>
<td>593</td>
<td>600</td>
</tr>
<tr>
<td>Lymington</td>
<td>671</td>
<td>665</td>
<td>677</td>
</tr>
<tr>
<td>Bristol</td>
<td>774</td>
<td>768</td>
<td>780</td>
</tr>
<tr>
<td>Cornwall</td>
<td>769</td>
<td>764</td>
<td>775</td>
</tr>
<tr>
<td>Devon</td>
<td>641</td>
<td>638</td>
<td>644</td>
</tr>
<tr>
<td>Dorset</td>
<td>504</td>
<td>499</td>
<td>509</td>
</tr>
<tr>
<td>Gloucestershire</td>
<td>653</td>
<td>650</td>
<td>656</td>
</tr>
<tr>
<td>Isles of Scilly</td>
<td>594</td>
<td>592</td>
<td>597</td>
</tr>
<tr>
<td>North Somerset</td>
<td>626</td>
<td>623</td>
<td>630</td>
</tr>
<tr>
<td>Plymouth</td>
<td>885</td>
<td>881</td>
<td>890</td>
</tr>
<tr>
<td>Poole</td>
<td>542</td>
<td>540</td>
<td>545</td>
</tr>
<tr>
<td>Somerset</td>
<td>626</td>
<td>623</td>
<td>629</td>
</tr>
<tr>
<td>South Gloucestershire</td>
<td>519</td>
<td>516</td>
<td>523</td>
</tr>
<tr>
<td>Swindon</td>
<td>600</td>
<td>597</td>
<td>603</td>
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<tr>
<td>Torbay</td>
<td>568</td>
<td>565</td>
<td>571</td>
</tr>
<tr>
<td>Wiltshire</td>
<td>559</td>
<td>556</td>
<td>563</td>
</tr>
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</table>

Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

**10.01 - Admission episodes for alcohol-related conditions (Narrow) (Persons) - Cornwall**

<table>
<thead>
<tr>
<th>Period</th>
<th>Count</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>3.379</td>
<td>635</td>
<td>613</td>
<td>657</td>
</tr>
<tr>
<td>2009/10</td>
<td>3.494</td>
<td>651</td>
<td>629</td>
<td>673</td>
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<tr>
<td>2010/11</td>
<td>3.618</td>
<td>669</td>
<td>647</td>
<td>691</td>
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<tr>
<td>2011/12</td>
<td>3.720</td>
<td>684</td>
<td>662</td>
<td>706</td>
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<tr>
<td>2012/13</td>
<td>3.623</td>
<td>660</td>
<td>638</td>
<td>682</td>
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<tr>
<td>2013/14</td>
<td>3.768</td>
<td>678</td>
<td>656</td>
<td>700</td>
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</table>

Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.
Alcohol Related Hospital Admission Episodes (Narrow) Male

- Rate similar to national and slightly worse than regional, trend similar to national rate.

10.01 - Admission episodes for alcohol-related conditions (Narrow) (Male) 2012/14
Directly standardized rate - per 100,000

<table>
<thead>
<tr>
<th>Area</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>635</td>
<td>832</td>
<td>839</td>
</tr>
<tr>
<td>South West region</td>
<td>700</td>
<td>769</td>
<td>791</td>
</tr>
<tr>
<td>Bath and North East Som...</td>
<td>745</td>
<td>687</td>
<td>687</td>
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<tr>
<td>Bournemouth</td>
<td>861</td>
<td>790</td>
<td>915</td>
</tr>
<tr>
<td>Bristol</td>
<td>1,038</td>
<td>938</td>
<td>1,086</td>
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<tr>
<td>Cornwall</td>
<td>666</td>
<td>830</td>
<td>903</td>
</tr>
<tr>
<td>Devon</td>
<td>791</td>
<td>763</td>
<td>821</td>
</tr>
<tr>
<td>Dorset</td>
<td>642</td>
<td>608</td>
<td>678</td>
</tr>
<tr>
<td>Gloucestershire</td>
<td>781</td>
<td>729</td>
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<td>Isles of Scilly</td>
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<td>1,717</td>
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<tr>
<td>North Somerset</td>
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<td>717</td>
<td>828</td>
</tr>
<tr>
<td>Plymouth</td>
<td>658</td>
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<tr>
<td>Poole</td>
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<tr>
<td>Somerset</td>
<td>700</td>
<td>717</td>
<td>764</td>
</tr>
<tr>
<td>South Gloucestershire</td>
<td>629</td>
<td>585</td>
<td>675</td>
</tr>
<tr>
<td>Swindon</td>
<td>711</td>
<td>656</td>
<td>768</td>
</tr>
<tr>
<td>Torbay</td>
<td>1,102</td>
<td>1,022</td>
<td>1,196</td>
</tr>
<tr>
<td>Wiltshire</td>
<td>690</td>
<td>656</td>
<td>725</td>
</tr>
</tbody>
</table>

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

10.01 - Admission episodes for alcohol-related conditions (Narrow) (Male) Cornwall
Directly standardized rate - per 100,000

Period | Count | Value | Lower CI | Upper CI | South West | England |
-------|-------|-------|----------|----------|------------|---------|
2008/09 | 1,973 | 769   | 746      | 816      | 789        | 806     |
2009/10 | 2,105 | 827   | 792      | 864      | 800        | 833     |
2010/11 | 2,198 | 854   | 819      | 891      | 817        | 848     |
2011/12 | 2,304 | 891   | 854      | 928      | 802        | 849     |
2012/13 | 2,213 | 845   | 809      | 881      | 778        | 829     |
2013/14 | 2,306 | 886   | 830      | 903      | 782        | 835     |

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.
Alcohol Related Hospital Admission Episodes (Narrow) Female

- Rate worse than national and regional, trend similar to national rate.
Overall LAPE Hospital Admissions Indicator Chart

Poorest performing Indicators:
- Under 18 Alcohol Specific admissions
- Female Alcohol Specific admissions
- Female Alcohol Related admissions (Narrow)
- Alcohol Related Admission Episodes (Narrow) All
- Alcohol Related Admission Episodes (Narrow) Female

Best Performing Indicators:
- Alcohol Related Admission (Broad) All
- Alcohol Related Admission (Broad) Male
- Alcohol Related Admission Episodes (Broad) All
- Alcohol Related Admission Episodes (Broad) Male
- Alcohol Related Admission Episodes (Broad) Female

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Cornwall Count</th>
<th>Cornwall Value</th>
<th>Region Value</th>
<th>England Worst/Lowest</th>
<th>Range</th>
<th>Best/Highest</th>
</tr>
</thead>
<tbody>
<tr>
<td>001 - Alcohol-specific hospital admission - under 18s</td>
<td>2011/12 - 13/14</td>
<td>165</td>
<td>52.5</td>
<td>47.7</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>010 - Alcohol-specific hospital admission (Persons)</td>
<td>2013/14</td>
<td>2,105</td>
<td>390</td>
<td>360, 374</td>
<td>1,074</td>
<td></td>
<td></td>
</tr>
<tr>
<td>010 - Alcohol-specific hospital admission (Male)</td>
<td>2013/14</td>
<td>1,350</td>
<td>514</td>
<td>490, 515</td>
<td>1,494</td>
<td></td>
<td></td>
</tr>
<tr>
<td>010 - Alcohol-specific hospital admission (Female)</td>
<td>2013/14</td>
<td>756</td>
<td>275</td>
<td>248, 241</td>
<td>668</td>
<td></td>
<td></td>
</tr>
<tr>
<td>011 - Alcohol-related hospital admission (Bread) (Persons)</td>
<td>2013/14</td>
<td>7,002</td>
<td>1,218</td>
<td>1,158, 1,253</td>
<td>2,070</td>
<td></td>
<td></td>
</tr>
<tr>
<td>011 - Alcohol-related hospital admission (Bread) (Male)</td>
<td>2013/14</td>
<td>4,496</td>
<td>1,620</td>
<td>1,570, 1,715</td>
<td>2,620</td>
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<td></td>
</tr>
<tr>
<td>011 - Alcohol-related hospital admission (Bread) (Female)</td>
<td>2013/14</td>
<td>2,515</td>
<td>846</td>
<td>797, 859</td>
<td>1,586</td>
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<td></td>
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<tr>
<td>012 - Alcohol-related hospital admission (Narrow) (Persons)</td>
<td>2013/14</td>
<td>2,032</td>
<td>450</td>
<td>422, 444</td>
<td>808</td>
<td></td>
<td></td>
</tr>
<tr>
<td>012 - Alcohol-related hospital admission (Narrow) (Male)</td>
<td>2013/14</td>
<td>1,581</td>
<td>602</td>
<td>550, 594</td>
<td>1,049</td>
<td></td>
<td></td>
</tr>
<tr>
<td>012 - Alcohol-related hospital admission (Narrow) (Female)</td>
<td>2013/14</td>
<td>951</td>
<td>336</td>
<td>308, 310</td>
<td>563</td>
<td></td>
<td></td>
</tr>
<tr>
<td>013 - Admission episodes for alcohol-related conditions (Bread) (Persons)</td>
<td>2011/12 - 13/14</td>
<td>11,522</td>
<td>1,994</td>
<td>1,939, 2,111</td>
<td>3,493</td>
<td></td>
<td></td>
</tr>
<tr>
<td>013 - Admission episodes for alcohol-related conditions (Bread) (Male)</td>
<td>2013/14</td>
<td>7,441</td>
<td>2,722</td>
<td>2,649, 2,917</td>
<td>4,848</td>
<td></td>
<td></td>
</tr>
<tr>
<td>013 - Admission episodes for alcohol-related conditions (Bread) (Female)</td>
<td>2013/14</td>
<td>4,081</td>
<td>1,368</td>
<td>1,333, 1,426</td>
<td>2,392</td>
<td></td>
<td></td>
</tr>
<tr>
<td>014 - Admission episodes for alcohol-related conditions (Narrow) (Persons)</td>
<td>2013/14</td>
<td>3,768</td>
<td>678</td>
<td>625, 646</td>
<td>1,231</td>
<td></td>
<td></td>
</tr>
<tr>
<td>014 - Admission episodes for alcohol-related conditions (Narrow) (Male)</td>
<td>2013/14</td>
<td>2,306</td>
<td>866</td>
<td>780, 835</td>
<td>1,538</td>
<td></td>
<td></td>
</tr>
<tr>
<td>014 - Admission episodes for alcohol-related conditions (Narrow) (Female)</td>
<td>2013/14</td>
<td>1,452</td>
<td>510</td>
<td>458, 475</td>
<td>940</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Overall LAPE Alcohol Related Mortality Indicator Chart

- Better than national rate on all mortality indicators
Overall LAPE Hospital Admissions Regional Comparison Chart

- Poorest areas: Liver disease, Neoplasm, Unintentional Injuries, Self-Poisoning
- Best areas: Mental and Behavioural, Cardiovascular

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>South West region</th>
<th>East and North East England</th>
<th>North East</th>
<th>Yorkshire</th>
<th>South West</th>
<th>South East</th>
<th>Wales</th>
<th>Northern Ireland</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Persons)</td>
<td>2013/14</td>
<td>170.9</td>
<td>169.2</td>
<td>165.5</td>
<td>169.2</td>
<td>176.0</td>
<td>124.1</td>
<td>223.0</td>
<td>371.7</td>
<td>168.0</td>
<td>159.5</td>
</tr>
<tr>
<td>9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Visits)</td>
<td>2013/14</td>
<td>210.0</td>
<td>190.2</td>
<td>185.8</td>
<td>190.2</td>
<td>196.6</td>
<td>139.3</td>
<td>230.1</td>
<td>367.6</td>
<td>160.6</td>
<td>150.4</td>
</tr>
<tr>
<td>9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Admitted)</td>
<td>2013/14</td>
<td>170.9</td>
<td>169.2</td>
<td>165.5</td>
<td>169.2</td>
<td>176.0</td>
<td>124.1</td>
<td>223.0</td>
<td>371.7</td>
<td>168.0</td>
<td>159.5</td>
</tr>
<tr>
<td>9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Persons)</td>
<td>2013/14</td>
<td>1049</td>
<td>919</td>
<td>852</td>
<td>1175</td>
<td>1108</td>
<td>887</td>
<td>741</td>
<td>924</td>
<td>821</td>
<td>652</td>
</tr>
<tr>
<td>9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Visits)</td>
<td>2013/14</td>
<td>1524</td>
<td>1351</td>
<td>1269</td>
<td>1798</td>
<td>1581</td>
<td>1260</td>
<td>1107</td>
<td>1565</td>
<td>1227</td>
<td>1175</td>
</tr>
<tr>
<td>9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Admitted)</td>
<td>2013/14</td>
<td>673</td>
<td>571</td>
<td>515</td>
<td>661</td>
<td>736</td>
<td>557</td>
<td>440</td>
<td>521</td>
<td>480</td>
<td>516</td>
</tr>
<tr>
<td>9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Persons)</td>
<td>2013/14</td>
<td>394</td>
<td>355</td>
<td>382</td>
<td>612</td>
<td>581</td>
<td>359</td>
<td>379</td>
<td>325</td>
<td>297</td>
<td>250</td>
</tr>
<tr>
<td>9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Visits)</td>
<td>2013/14</td>
<td>579</td>
<td>509</td>
<td>512</td>
<td>856</td>
<td>890</td>
<td>508</td>
<td>535</td>
<td>405</td>
<td>419</td>
<td>425</td>
</tr>
<tr>
<td>9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Admitted)</td>
<td>2013/14</td>
<td>218</td>
<td>209</td>
<td>222</td>
<td>388</td>
<td>276</td>
<td>223</td>
<td>231</td>
<td>211</td>
<td>162</td>
<td>210</td>
</tr>
<tr>
<td>9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Persons)</td>
<td>2013/14</td>
<td>1053</td>
<td>95.1</td>
<td>74.2</td>
<td>117.4</td>
<td>134.9</td>
<td>132.8</td>
<td>93.1</td>
<td>56.5</td>
<td>69.2</td>
<td>0.0</td>
</tr>
<tr>
<td>9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Visits)</td>
<td>2013/14</td>
<td>147</td>
<td>137.0</td>
<td>86.8</td>
<td>171.3</td>
<td>216.4</td>
<td>211.2</td>
<td>134.5</td>
<td>75.5</td>
<td>92.0</td>
<td>0.0</td>
</tr>
<tr>
<td>9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Admitted)</td>
<td>2013/14</td>
<td>65.8</td>
<td>54.0</td>
<td>46.9</td>
<td>103.2</td>
<td>104.4</td>
<td>67.0</td>
<td>54.0</td>
<td>39.2</td>
<td>47.0</td>
<td>0.0</td>
</tr>
<tr>
<td>9.06 - Admission episodes for alcohol-related alcoholic cirrhosis condition (Broad) (Persons)</td>
<td>2013/14</td>
<td>110.7</td>
<td>100.9</td>
<td>92.3</td>
<td>141.8</td>
<td>170.2</td>
<td>137.7</td>
<td>102.7</td>
<td>234.7</td>
<td>295.3</td>
<td>141.8</td>
</tr>
<tr>
<td>9.06 - Admission episodes for alcohol-related alcoholic cirrhosis condition (Broad) (Visits)</td>
<td>2013/14</td>
<td>154.7</td>
<td>161.8</td>
<td>126.4</td>
<td>181.1</td>
<td>169.4</td>
<td>177.2</td>
<td>166.2</td>
<td>114.8</td>
<td>210.0</td>
<td>553.6</td>
</tr>
<tr>
<td>9.06 - Admission episodes for alcohol-related alcoholic cirrhosis condition (Broad) (Admitted)</td>
<td>2013/14</td>
<td>145.3</td>
<td>162.1</td>
<td>95.4</td>
<td>136.9</td>
<td>130.6</td>
<td>150.3</td>
<td>148.2</td>
<td>93.2</td>
<td>224.4</td>
<td>304.4</td>
</tr>
<tr>
<td>9.06 - Admission episodes for alcohol-related alcoholic cirrhosis condition (Narrow) (Persons)</td>
<td>2013/14</td>
<td>141.9</td>
<td>129.6</td>
<td>123.2</td>
<td>155.1</td>
<td>158.3</td>
<td>157.0</td>
<td>146.9</td>
<td>134.6</td>
<td>115.0</td>
<td>147.2</td>
</tr>
<tr>
<td>9.06 - Admission episodes for alcohol-related alcoholic cirrhosis condition (Narrow) (Visits)</td>
<td>2013/14</td>
<td>218.2</td>
<td>210.7</td>
<td>204.9</td>
<td>230.0</td>
<td>247.4</td>
<td>224.9</td>
<td>211.9</td>
<td>204.4</td>
<td>176.5</td>
<td>220.6</td>
</tr>
<tr>
<td>9.06 - Admission episodes for alcohol-related alcoholic cirrhosis condition (Narrow) (Admitted)</td>
<td>2013/14</td>
<td>74.2</td>
<td>74.1</td>
<td>69.2</td>
<td>66.3</td>
<td>86.5</td>
<td>80.0</td>
<td>75.0</td>
<td>94.0</td>
<td>0.0</td>
<td>66.6</td>
</tr>
<tr>
<td>9.07 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Persons)</td>
<td>2013/14</td>
<td>97</td>
<td>90</td>
<td>74</td>
<td>161</td>
<td>177</td>
<td>63</td>
<td>70</td>
<td>57</td>
<td>55</td>
<td>40</td>
</tr>
<tr>
<td>9.07 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Visits)</td>
<td>2013/14</td>
<td>124</td>
<td>78</td>
<td>54</td>
<td>190</td>
<td>109</td>
<td>64</td>
<td>99</td>
<td>69</td>
<td>74</td>
<td>70</td>
</tr>
<tr>
<td>9.07 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Admitted)</td>
<td>2013/14</td>
<td>52</td>
<td>39</td>
<td>54</td>
<td>60</td>
<td>49</td>
<td>62</td>
<td>46</td>
<td>37</td>
<td>39</td>
<td>0</td>
</tr>
</tbody>
</table>

Cornwall & Isles of Scilly DAAT Adult Alcohol Needs Assessment 2014/15
NOT PROTECTIVELY MARKED
Main conclusions from Cornwall’s LAPE figures

A barometer of how alcohol is affecting health in Cornwall, as shown by our hospital admissions.

All Cornwall’s trends are similar to national trends. This means that overall the way we drink alcohol is impacting health in Cornwall in the same way as it is nationally, with only minor differences.

Our **Under 18 alcohol specific hospital admissions** are worse than national and regional rates, and although this rate is reducing, this **reduction is going more slowly here than the national trend**. The U18 admissions is the main downward trend picked out by LAPE as the national headline, but here it’s happening more slowly.

We have **slightly worse than average alcohol specific hospital admission rates** overall as a result of local female alcohol specific admissions being worse than the national rate.

Our rates for **female hospital admissions are worse than regional and national levels** for alcohol specific and alcohol related admissions (narrow primary diagnosis) and for alcohol related episodes.
There are two ways that alcohol related hospital admissions are measured:

- **Narrow** – just the main diagnosis, or the main health conditions being treated;
- **Broad** – every health condition someone may be treated for while in hospital, even if they weren’t the main reason for being treated there.

For women in Cornwall, the narrow definition of alcohol related hospital admissions (primary diagnoses as opposed to all health conditions) is worse than national and regional rates, but the broad measure (all diagnoses) is better than the national and regional rate.

All Cornwall’s alcohol related mortality indicators are better than national and regional rates, but we have worse alcohol related admission rates for Liver disease, Neoplasm, unintentional injuries and “intentional self-poisoning”, which is where someone drinks an amount that needs to be dealt with in A&E, from where they are admitted to hospital.

<table>
<thead>
<tr>
<th>Poorest health condition indicator areas</th>
<th>Best health condition indicator areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver disease</td>
<td>Mental and Behavioural</td>
</tr>
<tr>
<td>Neoplasm</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Unintentional Injuries</td>
<td></td>
</tr>
<tr>
<td>Self-Poisoning</td>
<td></td>
</tr>
</tbody>
</table>

The obvious main message would appear to be that alcohol is disproportionately impacting the health of women and the under 18s in Cornwall, compared to other parts of the country.

However, there is a risk that this might overlook the fact that the actual **numbers of men being admitted are still much higher than for women**, although our local rates for men tend to compare better with national averages.

Local application of this data will obviously need to address female and young peoples’ drinking patterns, as well as advice given to women and young people in early intervention and identification in health and community settings, in order to address those worrying trends.

However, in reality we will need to continue to focus on men at least as much, because they are still numerically a much heavier burden on our health services.

**Gender biased headlines**

One observation to note, where the media have given a particular spin to their headlines, based on how PHE themselves released the data:

"... PHE say the last year's rise was most significant amongst women - a 2.1% increase whilst only up 0.7% for men ..." 

---

Overall, the national main points seem to be:
- Young people’s drinking going down;
- Women’s drinking going up;
- Men drinking as ever, so not worthy of comment;
- Overall intake perhaps reducing but burden on NHS lagging behind this possible change.

Almost universally the main media headline (as fed by PHE) was to highlight a female drink problem:

"Hospital admissions directly linked to alcohol grew three times quicker among women than among men last year, according to figures released by Public Health England yesterday."  

"Alcohol-related hospital admissions rose last year in three out of five local authorities in England, according to new figures, with the biggest rise among women."

"Drinking themselves to death: More middle-aged women need hospital treatment: MIDDLE-AGED women drinkers are behind a sharp increase in hospital admissions for alcohol-related illnesses, statistics show."  

"... two-thirds of local authorities saw a rise in booze-related admissions last year. Hospitals saw a rise in admissions for women three times that of men."

These conclusions contain a problem, which is illustrated in the pairs of trend graphs for different categories of alcohol-related hospital admissions:
- 1: Alcohol specific: Male/Female
- 2: Alcohol related/broad: Male/Female
- 3: Alcohol related/narrow: Male/Female

In all cases, the trends are unspectacular and fairly stable, despite coming at the time when data definitions were changed. The actual numbers show, however, that in all cases, men are continuing on an unchanged high level, and are in hospital due to alcohol at a rate nearly twice that of women.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>515</td>
<td>241</td>
</tr>
<tr>
<td>2</td>
<td>1715</td>
<td>859</td>
</tr>
<tr>
<td>3</td>
<td>594</td>
<td>310</td>
</tr>
</tbody>
</table>

The rising trend in women drinking does need to be addressed, because increasingly men and women are drinking in the same patterns, for example as shown in this research by University College Cork into the drinking habits of female students.  

By focusing publicity on this trend, however, everyone is in
danger of overlooking the fact that most of the burden on the NHS is caused by male drinking habits.

So the learning should be:
• The major conclusion that men are still the highest risk drinkers who need to scale back their intake the most, and
• The secondary conclusion is that women need more education about the metabolic reasons for not drinking like the male drinkers with whom they are mixing.

Data and trend graphs
1: Alcohol Specific
A: Men
Trend – stable
Value = 515

B: Female
Trend – rising
Value = 241
2: Alcohol Related (Broad)

A: Male

Trend – stable
Value = 1715

B: Female

Trend – stable/slowly rising
Value = 859
3: Alcohol Related (Narrow)

A: Male
Trend - stable
Value = 594

B: Female
Trend - stable
Value = 310
Appendix B: Local audit against JSNA checklist

These are the good practice prompts for planning comprehensive interventions in 2015/16 – provided by Public Health England to support the development of Joint Strategic Needs Assessments and other needs assessments in relation to alcohol prevention, treatment and recovery for adults.

<table>
<thead>
<tr>
<th>JSNA Support Pack Sections</th>
<th>Where included in Needs Assessment, or ref. from other source document</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commissioning principles for adult alcohol and drugs prevention, treatment and recovery</td>
<td></td>
</tr>
<tr>
<td>1.1. Embedding in local systems</td>
<td></td>
</tr>
<tr>
<td>1.1.1. Do alcohol and drugs needs assessments, the local commissioning strategy, clinical commissioning group strategy, and joint health and wellbeing strategy demonstrate an explicit link between evidence of need and service planning?</td>
<td>The alcohol and drugs needs assessments so, but it has not been established how to reflect any links with the HAWB Strategy or CCG strategy/operational plan. The Dual Diagnosis strategy is reflected within the Crisis Care concordat and Hospital admissions plan is under consideration.</td>
</tr>
<tr>
<td>1.1.2. Does the local public health structure have mechanisms in place for reporting on alcohol and drugs to the health and wellbeing board and police and crime commissioner?</td>
<td>Reports to Community Safety Partnership, DPH and OPCC.</td>
</tr>
<tr>
<td>1.1.3. Has the local authority public health team responsible for commissioning alcohol and drug services, established partnership arrangements with clinical commissioning groups, local clinical networks, NHS England local area teams and criminal justice agencies?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.1.4. Is a joint commissioning approach adopted where there is a shared responsibility for commissioning and planning (eg, local authorities/clini-</td>
<td>In development</td>
</tr>
<tr>
<td>1.1.5. Is there a formal strategic partnership in place for alcohol and drugs involving key stakeholders and agencies (health, public health, housing, employment, social care, families and safeguarding, and criminal justice), the aim of which is to develop a fully integrated system of health improvement, treatment and recovery for alcohol and drug misusers?</td>
<td>DAAT Board transferring into CSP</td>
</tr>
<tr>
<td>1.1.6. Do the general public, service users and staff in other mainstream services have ready access to information that enables them to understand the alcohol and drug services available, the pathways between them and points of entry?</td>
<td>SPOC publicised. Pathways require updating.</td>
</tr>
<tr>
<td>JSNA Support Pack Sections</td>
<td>Where included in Needs Assessment, or ref. from other source document</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1.1.7. Are there clinical governance mechanisms for assuring the quality and safety of alcohol and drug treatment services? Are these clearly embedded in public health systems?</td>
<td>Yes.</td>
</tr>
<tr>
<td>1.2. Needs assessment</td>
<td></td>
</tr>
<tr>
<td>1.2.1. Does the local needs assessment, conducted as part of the JSNA, include a comprehensive section on alcohol and drug-related harm that reflects need across the whole spectrum of harm and readily acknowledges the impact of alcohol and drug work across the public health outcomes framework and the NHS outcomes framework, resulting in partnership collaboration and support?</td>
<td>Yes – pg 25 – health section</td>
</tr>
<tr>
<td>1.2.2. Is there a shared understanding of the local level of demand and need, based on a range of local and national data across a range of public services?</td>
<td>Yes – level of demand in D&amp;A services – not hospitals.</td>
</tr>
<tr>
<td>1.2.3. Are health and public health commissioners using a range of hard and soft intelligence to understand local need in relation to misuse of or dependence on prescription and over-the-counter medicines, including dependence arising inadvertently from the prescribed use of a medicine?</td>
<td>Yes - throughout</td>
</tr>
<tr>
<td>1.2.4. Do you use existing local networks for finding and sharing information with partners about new psychoactive substances?</td>
<td>Safer Cornwall website; training programme. Keeping under review,</td>
</tr>
<tr>
<td>1.2.5. Is local data on alcohol and drug interventions provided in hospitals, primary health care and other settings collected to inform needs assessment?</td>
<td>Gap - highlighted in health section</td>
</tr>
<tr>
<td>1.2.6. Do commissioners analyse the local levels of alcohol and drug-related admissions to hospital in order to target interventions?</td>
<td>Gap – highlighted in health section, and being addressed by CCG.</td>
</tr>
<tr>
<td>1.2.7. Do commissioners analyse and monitor local specialist alcohol and drugs treatment data, including specific breakdown by gender, age, postcode, condition, route of admission, repeat admission, etc, in order to compare current treatment provision with need?</td>
<td>Yes – treatment section</td>
</tr>
<tr>
<td>1.2.8. Has a mutual aid self-assessment tool1 been completed as part of the local needs assessment?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.2.9. Does the needs assessment take into account the availability and potential development of existing community support networks and other local assets, using a methodology such as asset-based community development?</td>
<td>No</td>
</tr>
<tr>
<td>1.2.10. Are the following identified:</td>
<td></td>
</tr>
<tr>
<td>JSNA Support Pack Sections</td>
<td>Where included in Needs Assessment, or ref. from other source document</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• gaps in delivery of primary, secondary and tertiary prevention for alcohol and drugs</td>
<td>Yes treatment section</td>
</tr>
<tr>
<td>• the extent of drug treatment penetration and access to alcohol treatment by the estimated dependent population</td>
<td>Yes treatment section</td>
</tr>
<tr>
<td>• the impact of services on health and wellbeing, public health and offending?</td>
<td>Yes value for money section</td>
</tr>
<tr>
<td>1.2.11. Does the local needs assessment take account of the needs of women and young girls vulnerable to alcohol and drug misuse (for example, those subject to domestic violence or sexual assault, or involved in prostitution, or with poor mental health)?</td>
<td>Yes – covers mental health and DA in complex needs section</td>
</tr>
<tr>
<td>1.2.12. Does the local needs assessment take account of other groups who may have specific needs in relation to their alcohol and drug use, eg, lesbian, gay, bisexual and transgender (LGBT) including men who have sex with men (MSM), black and minority ethnic groups (BAME)?</td>
<td>Still acting on the findings of the 2013-14 needs assessment. To be reviewed.</td>
</tr>
</tbody>
</table>

### 1.3. Finance

#### 1.3.1. Is investment sufficient for a range of prevention, harm reduction and treatment services commensurate with the level of identified need?

- Yes

#### 1.3.2. Can commissioners identify the total level of local investment by all partners who contribute to delivery?

- Yes

### 1.4. Effective commissioning

#### 1.4.1. Is commissioning based on the evidence base, such as NICE guidance, for effective interventions in tackling alcohol and drug-related harm?

- Yes

#### 1.4.2. Is there an alcohol and drugs planning document that describes how best to meet local need, which clearly identifies:

- the level of local demand
- existing strengths and ways in which services can be commissioned
- finance and resources made available?
- Yes

#### 1.4.3. Is investment in alcohol and drug prevention, treatment and recovery based on an understanding of expenditure, performance and cost-effectiveness?

- Yes

#### 1.4.4. Are there contracts in place for commissioned services that specify the outcomes to be achieved and that are regularly monitored and reviewed?

- Yes
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</thead>
<tbody>
<tr>
<td>1.4.5. Are care pathways and services geographically and socio-culturally appropriate to those for whom they are designed?</td>
<td>Partially – under review</td>
</tr>
<tr>
<td>1.4.6. Are pathways for both alcohol dependent and increasing/higher risk drinkers jointly agreed and regularly monitored and reviewed by all relevant local partners?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.4.7. Are service users, carers and people in recovery involved at the heart of planning and commissioning? Is this evident throughout needs assessment and key priority-setting processes both for community and prison based services?</td>
<td>Stakeholder consultation section</td>
</tr>
<tr>
<td>1.4.8. Are commissioning functions fit for purpose? Is there sufficient alcohol and drug misuse commissioning capacity and expertise, including information management?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.4.9. Is there a workforce strategy and improvement plan that covers the commissioning partnership itself? Does this ensure that all staff are competent to commission safe and effective services?</td>
<td>No</td>
</tr>
<tr>
<td>1.4.10. Do service specifications clearly indicate the level of professional competence required to deliver safe and effective services?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.4.11. Do commissioners include formal evaluation of the range of alcohol and drug interventions within the commissioning strategy?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.4.12. Do all agencies have agreed policies for monitoring the delivery of services in full compliance with the Human Rights Act and the protected characteristics within the Equality Act 2010?</td>
<td>Yes – Contract Review meetings</td>
</tr>
</tbody>
</table>

1.5. Commissioning services for individuals in contact with the criminal justice system

1.5.1. Are there clear pathways for alcohol and drug misusing offenders to access alcohol and drug treatment at every point in the criminal justice process (ie, police custody suites, courts, youth offending teams, community rehabilitation companies/National Probation Service, prisons, and the children and young peoples’ estate)? Are these pathways part of the local integrated offender management model? | Yes – CJ section |

1.5.2. Have discussions with police and crime commissioners taken place on investment in police custody-based alcohol and drug misuse interventions or other appropriate criminal justice pathways? | Yes – CJ section |
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<tr>
<td>1.5.3. Has the local authority engaged with the NHS England local area team responsible for health and justice to agree a jointly owned and collaborative approach to commissioning fully integrated services that effectively support and engage individuals as they transition between custodial and community settings?</td>
<td>No</td>
</tr>
<tr>
<td>1.5.4. Have commissioners engaged with their local National Probation Service and community rehabilitation company to agree capacity and treatment interventions required for offenders subject to statutory supervision in the community and on release from prison.</td>
<td>In process</td>
</tr>
<tr>
<td>1.6. Involvement with mutual aid significantly improves recovery from alcohol and drug dependency</td>
<td></td>
</tr>
<tr>
<td>1.6.1. Is there a shared, locally developed vision of recovery where mutual aid is appropriately integrated with alcohol and drug services (including in-patient and residential treatment)?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.6.2. Do people in treatment have access to a range of peer-based recovery support options, including 12-step, SMART Recovery and other community recovery organisations?</td>
<td>yes</td>
</tr>
<tr>
<td>1.6.3. Are local services encouraged to support service users to engage with mutual aid groups by including specific requirements in their service specifications?</td>
<td>yes</td>
</tr>
<tr>
<td>1.7. The home environment enables people to sustain their recovery</td>
<td></td>
</tr>
<tr>
<td>1.7.1. Have the housing needs of alcohol and drug users in the community, prison and residential treatment been identified and used to inform local commissioning plans for housing, homelessness and housing related services?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.7.2. Are the housing needs of alcohol and drug users and their families (where appropriate) assessed in a timely manner to prevent homelessness and/or to enable move-on to a suitable home? (This includes those in prison, in residential services and those living in their own home but at risk of homelessness)</td>
<td>Yes – covered in outcomes</td>
</tr>
<tr>
<td>1.7.3. Is good quality housing information and advice readily available?</td>
<td>Yes covered in outcomes</td>
</tr>
<tr>
<td>1.7.4. Is there a range of suitable housing options to meet different needs including: emergency bed spaces; direct access accommodation; refuges for</td>
<td>Yes</td>
</tr>
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<tr>
<td>those fleeing domestic abuse; supported housing; floating support available to those in their own home; accommodation specifically for women or young people, housing for people with complex needs (eg, Housing First)?</td>
<td></td>
</tr>
<tr>
<td>1.7.5. Are alcohol and drug users who are rough sleeping able to access emergency accommodation and appropriate support?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.7.6. Do housing services support homeless alcohol and drug users to access primary care?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.7.7. Have commissioners, service users and providers agreed a definition for a ‘suitable’ home? Is the definition based on the description of ‘suitable’ found in the Homelessness (Suitability of Accommodation) (England) Order 2012, 7 as a minimum? Is the local definition consistently applied in practice by staff working with alcohol and drug users when supporting them along the pathway? Are frontline housing staff (working in local authority services, for social landlords and housing support providers) trained in working with alcohol and drug users to meet their housing and related needs?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.7.8. Is there a hospital discharge policy and procedure in place for homeless alcohol and drug users (and others) to enable access to a pathway to suitable housing?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.8. Getting a job enables people to sustain their recovery</td>
<td></td>
</tr>
<tr>
<td>1.8.1. Are treatment commissioners and providers jointly planning with local Jobcentre Plus (JCP) and Work Programme (WP) leads how to meet the employment, training and education (ETE) needs of the alcohol and drug misusing population?</td>
<td>Yes – what we have achieved section</td>
</tr>
<tr>
<td>1.8.2. Are the ETE needs of alcohol and drug misusers reflected in local worklessness and employability strategies?</td>
<td>The ETE needs of alcohol and drug misusers are reflected in the DWP standards and strategies. The new ESF funding is due to be announced in October 2015, and it was recognised to be useful to ensure that the needs of those with drug and alcohol issues are embedded in the Inclusion strategy for Cornwall.</td>
</tr>
<tr>
<td>1.8.3. Are commissioners incorporating ETE in performance monitoring arrangements with treatment providers and providers as part of supervision for key workers?</td>
<td>Yes - outcome section</td>
</tr>
<tr>
<td>1.8.4. Have JCP, WP and treatment providers</td>
<td>Yes - what we have achieved section</td>
</tr>
<tr>
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<tr>
<td>agreed a process of joint working between agencies, including arrangements for three way meetings?</td>
<td></td>
</tr>
<tr>
<td>1.8.5. Are there jointly delivered training sessions between JCP, WP and treatment providers in each area focusing on structures, service offers and the mutually beneficial relationship between treatment and employment outcomes?</td>
<td>Yes – but could be repeated</td>
</tr>
<tr>
<td>1.8.6. Are key ETE service directories shared across JCP, WP and treatment providers, including the sharing of promotional materials?</td>
<td>Yes – what we have achieved section</td>
</tr>
<tr>
<td>1.8.7. Are there local single points of contact in JCP, WP and all treatment teams and have their details been circulated?</td>
<td>yes</td>
</tr>
<tr>
<td>1.8.8. Has the partnership considered establishing employment champions in treatment teams, whose role it is to liaise with JCP and WP, and to champion ETE?</td>
<td>yes</td>
</tr>
<tr>
<td>1.8.9. Is data sharing taking place effectively, using the TPR referral forms (TPR1 and TPR2)?</td>
<td>Yes – what have we achieved section</td>
</tr>
<tr>
<td>1.8.10. Has some form of co-location been considered, even if this is part time (eg, treatment workers spending two days a week in WP or JCP premises and/or vice versa)? Employability sessions could also be jointly delivered.</td>
<td>It has been considered, but not agreed as –practical.</td>
</tr>
<tr>
<td>1.8.11. Are treatment providers, JCP and WP engaging with local employers to make the case and address negative preconceptions and stigma about employing people with a history of alcohol and drug misuse?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.8.12. Are there case studies of successful employment outcomes shared across treatment provider, JCP and WP staff?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.8.13. Are discussions about employability introduced early on in treatment journeys, and are commissioners and treatment providers assessing the prioritisation of the ETE agenda in local recovery provision?</td>
<td>yes – outcomes section</td>
</tr>
<tr>
<td>1.8.14. Are treatment staff encouraging clients to consider appropriate disclosure of their alcohol and drug misuse within JCP and WP?</td>
<td>Yes</td>
</tr>
<tr>
<td>1.8.15. Are providers actively working with JCP and WP to address low levels of skills, training, education and work experience?</td>
<td>Yes – what have we achieved section</td>
</tr>
<tr>
<td>1.9. Commissioning hospital-based alcohol and drug services</td>
<td></td>
</tr>
<tr>
<td>1.9.1. Are there services in place to meet the needs of alcohol and drug misusing hospital</td>
<td>Yes – health section</td>
</tr>
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<tr>
<td>patients?</td>
<td></td>
</tr>
<tr>
<td>1.9.2. Is there a strategic understanding at health and wellbeing board level of how alcohol and drug services for people in hospital integrate into the overall local system of alcohol and drug interventions and treatment?</td>
<td>No</td>
</tr>
<tr>
<td>1.9.3. Are linkages to community alcohol and drug services offered to support patients requiring further treatment and recovery support?</td>
<td>Yes – health section</td>
</tr>
<tr>
<td>1.10. Young people, children and families</td>
<td></td>
</tr>
<tr>
<td>1.10.1. Are effective referral pathways and joint working arrangements in place with children and family services where there are safeguarding issues and with local Troubled Families provision where alcohol or drug misuse is a factor?</td>
<td>No</td>
</tr>
<tr>
<td>1.10.2. Have local protocols between alcohol and drug systems, and children and family services been developed in line with 'Supporting information for the development of joint local protocols between alcohol and drug partnerships, children and family service'?</td>
<td>Yes, but have not been reviewed for two years.</td>
</tr>
<tr>
<td>2. Drug misuse and dependence are prevented by early identification and interventions</td>
<td></td>
</tr>
<tr>
<td>2.1. Are local health improvement campaigns planned and are they based on and targeted at identified needs in the local population?</td>
<td>Yes</td>
</tr>
<tr>
<td>2.2. Where local alcohol social marketing campaigns are employed, do they reflect and amplify, national campaign messages when appropriate?</td>
<td>Yes</td>
</tr>
<tr>
<td>2.3. Is public health active in the licensing process?</td>
<td>Yes</td>
</tr>
<tr>
<td>2.4. Is local crime and health and social care data used to map the extent of alcohol related problems as part of licensing policy?</td>
<td>Yes</td>
</tr>
<tr>
<td>2.5. Is hospital and ambulance data shared routinely to inform improvements in community safety activity?</td>
<td>Hospital yes, ambulance no.</td>
</tr>
<tr>
<td>2.6. Has a 'cumulative impact' policy been adopted where an area is saturated with licensed premises informing the consideration and implementation of the range of measures and conditions available to the local licensing board?</td>
<td>Yes</td>
</tr>
<tr>
<td>2.7. Is optimal use made of existing legislation to target the prevention of under-age sales, sales to people who are intoxicated, proxy sales to minors, non-compliance with any other alcohol licence condition and illegal imports of alcohol?</td>
<td>Yes</td>
</tr>
<tr>
<td>2.8. Are local arrangements brokered with industry</td>
<td>A mixed picture.</td>
</tr>
<tr>
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<tr>
<td>partners to promote responsible marketing, promotion and selling of alcohol?</td>
<td>Some local agreements have been in place, including Off Licenses in Camborne. Responsible promotions are evaluated in the Best Bar None criteria, and by Licensing Officers generally. The OPCC was in dialogue with major chains about a regional responsible alcohol retail agreement, but so far this has not been forthcoming.</td>
</tr>
<tr>
<td>2.9. Are you working collaboratively with local statutory and third-sector organisations to improve pathways to interventions for specific hard-to-engage groups, eg, working with sexual health services, mental health services, LGBT charities?</td>
<td>Not sufficiently</td>
</tr>
<tr>
<td>2.10. Do prevention activities for drug misuse (including new psychoactive substances) include building resilience and social capital, as well as information and campaigns?</td>
<td>Yes</td>
</tr>
<tr>
<td>3. There is prompt access to effective treatment</td>
<td></td>
</tr>
<tr>
<td>3.1. Does the partnership have an integrated plan which sets out the partners’ agreed roles and responsibilities, including for workforce development, in rolling out IBA in a range of settings and is there a system in place to monitor activity?</td>
<td>IBA section</td>
</tr>
<tr>
<td>3.2. Are local hospitals part of the health-promoting hospitals network and, if so, do commitments include alcohol harm reduction?</td>
<td>Covered in health section</td>
</tr>
<tr>
<td>3.3. Do the services that deliver IBA collect, analyse and report data to demonstrate the level of delivery?</td>
<td>Not consistently, nor retrieveably.</td>
</tr>
<tr>
<td>3.4. Does local ‘making every contact count’ (MECC) activity include evidence-based alcohol IBA?</td>
<td>No</td>
</tr>
<tr>
<td>3.5. Are there any specific interventions to raise awareness of the harms of drinking for specific at-risk groups, such as pregnant women, older people and those with existing long-term conditions?</td>
<td>Some effort has been put into advice for older drinkers, but more effort is needed in communicating with specific population groups.</td>
</tr>
<tr>
<td>3.6. Do the NHS Health Check programme and enhanced service for alcohol misuse include evidence-based alcohol IBA in line with regulations and guidance?</td>
<td>Yes</td>
</tr>
<tr>
<td>3.7. Is there IBA delivery across a range of adult local authority services, criminal justice and health settings?</td>
<td>Yes</td>
</tr>
<tr>
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<tr>
<td>3.8. Are there clear pathways to specialist assessment for those who may be dependent?</td>
<td>Covered in health section</td>
</tr>
<tr>
<td>3.9. Is access to residential treatment and inpatient detoxification supported by clear</td>
<td>Yes</td>
</tr>
<tr>
<td>assessment processes and funding arrangements? Is access available at any point of the</td>
<td></td>
</tr>
<tr>
<td>recovery journey and is it based on need?</td>
<td></td>
</tr>
<tr>
<td>3.10. Is there effective continuity of care between community-based and residential drug</td>
<td>Yes</td>
</tr>
<tr>
<td>treatment services? Does this include a) preparation prior to entry to residential</td>
<td></td>
</tr>
<tr>
<td>services, and b) continued post-residential support to ensure recovery outcomes are</td>
<td></td>
</tr>
<tr>
<td>sustained?</td>
<td></td>
</tr>
<tr>
<td>3.11. Are there relevant information-exchange arrangements, using appropriate protocols,</td>
<td>Yes</td>
</tr>
<tr>
<td>to ensure effective inter-agency working and to support continuity of care (eg, between</td>
<td></td>
</tr>
<tr>
<td>community and custody-based services, and for specific groups such as those identified</td>
<td></td>
</tr>
<tr>
<td>under local integrated offender management and multi-agency risk assessment conference</td>
<td></td>
</tr>
<tr>
<td>arrangements)?</td>
<td></td>
</tr>
<tr>
<td>4. There are interventions to address the health harms of drug use</td>
<td></td>
</tr>
<tr>
<td>4.1 Are alcohol (and drug) services contracted and employed in all acute hospitals where</td>
<td>Yes- but question the efficiency and efficacy</td>
</tr>
<tr>
<td>they could have an impact?</td>
<td></td>
</tr>
<tr>
<td>4.2 Is senior medical/nursing support and leadership provided to the alcohol (and drug)</td>
<td>Yes health section</td>
</tr>
<tr>
<td>service to ensure that their role and function is understood and utilised by partners in</td>
<td></td>
</tr>
<tr>
<td>the system?</td>
<td></td>
</tr>
<tr>
<td>4.3 Has planning ensured that community services are accessible and available to ensure</td>
<td>Yes but not covered in NA</td>
</tr>
<tr>
<td>continuation of detoxification with psychosocial interventions outside of the hospital?</td>
<td></td>
</tr>
<tr>
<td>4.4 Is there a range of services to support and reduce frequent hospital attendances?</td>
<td>Yes - health section</td>
</tr>
<tr>
<td>4.5 Are commissioning and services coordinated or integrated to improve access to support</td>
<td>Healthcare assessments are provided, but responses are not comprehensive</td>
</tr>
<tr>
<td>for mental health problems (crisis, severe and common), wound care, sexual health and</td>
<td></td>
</tr>
<tr>
<td>dental health? Are service users offered general healthcare assessments that cover these</td>
<td></td>
</tr>
<tr>
<td>issues and, where appropriate, are they referred to specialist services?</td>
<td></td>
</tr>
<tr>
<td>4.6 There is a substantial body of evidence demonstrating that LGBT people experience</td>
<td>In last years and what have we achieved section</td>
</tr>
<tr>
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<tr>
<td>healthcare system. Has substance misuse been considered as part of a wider investigation into the health inequalities affecting LGBT people?15,16</td>
<td></td>
</tr>
<tr>
<td>4.7 Is there a good understanding of and effective responses to the health impacts of emerging drug-use trends, such as ‘chem sex’ among some men who have sex with men?17</td>
<td>Not covered</td>
</tr>
<tr>
<td>4.8 Are there any specific interventions to raise awareness of the harms of drug use, including new psychoactive substances, for specific at-risk groups, such as pregnant women, older people and those with existing long-term conditions?</td>
<td>Not covered</td>
</tr>
<tr>
<td>4.9 Are drug services addressing the very high rates of tobacco smoking among their service users and staff, using integrated, whole-service strategies and offering (or working with stop smoking services to offer) interventions that include stop smoking support (NRT and psychosocial)18 and harm reduction for people unable or unwilling to stop smoking?19</td>
<td>Yes</td>
</tr>
<tr>
<td>4.10 Are all relevant services (especially primary care and emergency departments) able to identify and refer to specialist care for the acute health harms caused by some NPS, such as ketamine and GHB?</td>
<td>Yes</td>
</tr>
<tr>
<td>4.11 Do local agencies have a good understanding of new psychoactive substance use in their area, and use this knowledge to develop local responses to these substances?</td>
<td>Covered in Non-opiate section</td>
</tr>
<tr>
<td>4.12 Do treatment services have links with A&amp;E and primary care services to pick up people with acute NPS problems who may need to receive treatment or harm reduction interventions?</td>
<td>Yes</td>
</tr>
<tr>
<td>4.13 Are effective overdose-awareness training and information, and naloxone provided for service users and their family/carers?</td>
<td>Yes DRD section</td>
</tr>
<tr>
<td>4.14 Is there ready access to an appropriate range of opioid substitution medications and to supervised consumption for all those starting opioid substitution treatment or needing continued (or a return to) supervision to ensure medication-compliance and to reduce overdose risk?</td>
<td>Yes – stakeholder consultation section</td>
</tr>
<tr>
<td>4.15 Is excessive or increasing alcohol use among drug users in treatment addressed?</td>
<td>Covered in outcomes – drinking on top</td>
</tr>
<tr>
<td>4.16 Are there appropriate local reviews of drug-related deaths and action in response to their findings?20</td>
<td>Yes DRD section</td>
</tr>
<tr>
<td>4.8 Are there any specific interventions to raise awareness of the harms of drug use, including new</td>
<td>Targetted publicity and specific service</td>
</tr>
<tr>
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<tr>
<td>psychoactive substances, for specific at-risk groups, such as pregnant women, older people and those with existing long-term conditions?</td>
<td></td>
</tr>
<tr>
<td>5. Treatment is recovery-orientated, effective, high-quality and protective</td>
<td></td>
</tr>
<tr>
<td>5.1 Is the alcohol prevention and treatment system integrated and configured to meet the needs of the local population across community and prison settings?</td>
<td>Yes - throughout</td>
</tr>
<tr>
<td>5.2 Is a joint commissioning approach adopted where there is a shared responsibility for commissioning and planning, eg, local authorities/NHS England around prison/community services pathways?</td>
<td>Not covered</td>
</tr>
<tr>
<td>5.3 Is there sufficient capacity in the treatment system to address the needs of the estimated local dependent population and are alcohol services being commissioned to target highest risk groups, wherever they are located in the community?</td>
<td>Yes – throughout</td>
</tr>
<tr>
<td>5.4 Is there an explicit information governance agreement across all services to ensure that information is shared routinely to support effective care delivery and risk management?</td>
<td>Yes – not covered in NA</td>
</tr>
<tr>
<td>5.5 Are service users, carers and people in recovery involved at the heart of planning and commissioning? Is this evident throughout needs assessment and key priority setting processes both for community and prison based services?</td>
<td>Yes – stakeholder consultation and involvement</td>
</tr>
<tr>
<td>5.6 Do alcohol treatment services in all settings offer evidence-based, effective recovery-orientated interventions in line with NICE guidance CG11516, CG10017 and quality standards QS1118 (including, where appropriate, quality statements 4, 5, 7, 8, 9, 10, 11, 13,), and, for example, service improvement tools such as clustering and packages of care tools?</td>
<td>Primary Care Review, but “clustering and packages of care tools” need attention. These are tools which emerged from the PbR pilots: (<a href="http://www.alcohollearningcentre.org.uk/Topics/Browse/Commissioning/PbR/?parent=6642&amp;child=6848">http://www.alcohollearningcentre.org.uk/Topics/Browse/Commissioning/PbR/?parent=6642&amp;child=6848</a>)</td>
</tr>
<tr>
<td>5.7 Is there a range of recovery support interventions and services accessible to facilitate the recovery journey, eg, peer support, mutual aid, family/parenting support, employment, training and housing?</td>
<td>Yes</td>
</tr>
<tr>
<td>5.8 Do all alcohol treatment providers report data to the National Drug Treatment Monitoring System (NDTMS) and is this data analysed locally to inform improvements?</td>
<td>yes</td>
</tr>
<tr>
<td>5.9 Do information systems for alcohol treatment comply with the NDTMS community minimum data set? Are there plans for investment in IT systems</td>
<td>yes</td>
</tr>
<tr>
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<tr>
<td>that meet the clinical and NDTMS needs of providers?</td>
<td></td>
</tr>
<tr>
<td>5.10 Do treatment providers have workforce plans that describe how specialist staff are trained and supported to ensure appropriate competence and supervision to deliver specialist interventions?</td>
<td>Yes – new one required for 15/16</td>
</tr>
<tr>
<td>5.11 Are services tailored towards women with, for example, women service users offered the option of a female keyworker and women only groupwork provision where practicable? Do services provide women-only sessions? Are there links with women’s services which can provide treatment and recovery support?</td>
<td>Yes – to be described</td>
</tr>
<tr>
<td>5.12 Are there specialist referral pathways in place for pregnant women?</td>
<td>Yes – to be reviewed now o longer a specialist midwife</td>
</tr>
<tr>
<td>5.13 Are the links between domestic violence and drug misuse considered in care planning and reviews? Is there joint working with and effective pathways to services for victims and perpetrators of domestic violence?</td>
<td>Covered in complex needs section – needs some more info around guidance and pathways between services</td>
</tr>
<tr>
<td>5.14 Are there protocols and pathways to support service users who have both alcohol and drug misuse and mental health problems, including those in crisis?</td>
<td>Covered in mental health</td>
</tr>
<tr>
<td>5.15 Is treatment and care, and the information people are given about it, culturally appropriate? Is it accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English?</td>
<td>Covered in what we achieved last year</td>
</tr>
<tr>
<td>5.16 Are service users who care for or have contact with children assessed and given information about the risks to children from drugs and medications, and about the need for safe storage? Are home environments visited and assessed for risks and for suitable storage?</td>
<td>Yes – check for evidence</td>
</tr>
<tr>
<td>5.17 Is care planning sufficiently recovery-oriented (ie, coordinated across services, covering all domains, including recovery support and reintegration)</td>
<td>Yes</td>
</tr>
<tr>
<td>5.18 Do recovery care plans empower service users to take responsibility for their own health and recovery?</td>
<td>Yes</td>
</tr>
<tr>
<td>5.19 Is a service user’s treatment regularly reviewed using appropriate measures of recovery?</td>
<td>Covered in what we achieved last year</td>
</tr>
<tr>
<td>5.20 Are service users encouraged to take opportunities to recover, and given the option to</td>
<td>Covered in what we achieved last year</td>
</tr>
</tbody>
</table>
### JSNA Support Pack Sections

<table>
<thead>
<tr>
<th>Question</th>
<th>Where included in Needs Assessment, or ref. from other source document</th>
</tr>
</thead>
<tbody>
<tr>
<td>come off medication with appropriate support when appropriate?</td>
<td></td>
</tr>
<tr>
<td>5.21 Do commissioners and providers use the recovery diagnostic tool to understand local system blocks to recovery and to help service users move through treatment and overcome dependence?</td>
<td>Yes – used for NA</td>
</tr>
<tr>
<td>5.22 Is recovery visible within the local system via recovery champions, mutual aid and peer support, and contact between people in treatment and others further in their recovery journeys?</td>
<td>yes</td>
</tr>
<tr>
<td>5.23 Do local services facilitate access to mutual aid and peer support groups by advocating for it, accompanying service users, providing meeting space, attending open meetings, providing or arranging transport, using peer supporters, supporting single-sex groups, etc?</td>
<td>Yes</td>
</tr>
<tr>
<td>5.24 Are partnerships using NDTMS/TOP data to measure the achievement of drug strategy outcomes and progress against public health outcomes framework measures? Are they using this information to improve local services and pathways?</td>
<td>Yes – treatment section</td>
</tr>
</tbody>
</table>

### Adult drug prevention, treatment and recovery

<table>
<thead>
<tr>
<th>Question</th>
<th>Where included in Needs Assessment, or ref. from other source document</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Treatment supports people to sustain their recovery</td>
<td></td>
</tr>
<tr>
<td>6.1 Does the partnership have a written strategic plan to increase service users’ access to education, training and employment?</td>
<td>Yes</td>
</tr>
<tr>
<td>6.2 Do people who have successfully completed treatment receive regular recovery check-ups? Are they given additional support or rapid re-entry to treatment if needed?</td>
<td>Rapid re-entry, yes. Recovery check ups?</td>
</tr>
<tr>
<td>6.3 Is ongoing support available to help people sustain their recovery? Does this include relapse prevention? Is there other support from mainstream and specialist services, and/or peer support and mutual aid?</td>
<td>Yes</td>
</tr>
<tr>
<td>6.4 Are there opportunities for those in recovery to support their own and others' recovery as peer supporters or recovery champions?</td>
<td>Yes</td>
</tr>
<tr>
<td>6.5 Does the partnership regularly monitor and review levels of successful treatment completion and sustained recovery using NDTMS, TOP, and other specific measures (where appropriate)?</td>
<td>Yes in treatment section</td>
</tr>
</tbody>
</table>
If you would like this information in another format please contact:

Community Safety Team,  
Cornwall Council

Telephone: 0300 1234 100

www.safercornwall.co.uk