Cornwall & Isles of Scilly Drug and Alcohol Action Team
Adult Drug Treatment Needs Assessment

2010/11
CORNWALL & ISLES OF SCILLY DAAT

ADULT DRUG TREATMENT NEEDS ASSESSMENT 2010/11

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Executive Summary

Problem drug use affects local communities, families and children as well as individual people with drug problems.

Problem drug use in Cornwall

- Home Office research estimates that Cornwall is home to between 2,000 and 2,700 users of opiates and / or crack cocaine. The estimated unmet need (people requiring treatment but not in contact with services) is between 550 and 1,300 people.
- Prevalence of opiate and / or crack use is estimated to be in line with the South west average but lower than the national average.

Who is getting in to treatment?

- 1,829 adult drug users were in structured treatment services in 2009/10, equating to a rate of 5.8 people per 1000 adult population. 1,332 opiate and / or crack users (all ages) were in treatment during this period.
- The number of adult drug users in effective treatment grew by 5% and the number of opiate and / or crack users by 7%. The local growth rate slightly exceeded the overall growth noted in the South West. The rate of growth has slowed since April 2010.
- Looking across all adult drug users in treatment, heroin is by far the most common primary problem substance and substitute prescribing is the most common type of treatment. There was a rise in primary opiate users entering treatment in 2009/10 and in drug users with a history of injecting. Reported crack use remains comparatively low in Cornwall.
- Almost two thirds of people in treatment are receiving treatment for more than one problem substance, with alcohol being the most common. Drug users in Cornwall are more likely than the national average to also have a problem with alcohol.
- Two thirds of parents in treatment have children living with them and there are 700 children in Cornwall living with substance using parents.
- In terms of geographical distribution, the main clusters of drug users in treatment are in Newquay, Penzance, Camborne, Bodmin and Truro. Camborne / Redruth and Newquay have seen the greatest growth in numbers in treatment.
- There were 794 referrals into treatment in 2009/10, half of which had never been in treatment before. The number of referrals increased by 35% compared with 2008/09.
- Nationally the most common route into treatment is self-referral. Locally GP referral is the most common, indicating that drug users are not being engaged early enough in their problematic use. Better publicity and information on how to get help is a key area for improvement.

Who is leaving treatment?

- 475 people left treatment in 2009/10 (a quarter of those in treatment). 53% completed treatment successfully, which is higher than both the regional and national averages. The rate at which people are discharged from treatment, however, is lower than average and around a fifth of people in treatment have been in for 4 years or longer.
- Increasing the number of people who leave treatment successfully will be key area of focus for the coming year and this means looking holistically at a range of factors that contribute to a person being prepared to leave treatment and continue with a drug-free life.

Increasing recovery from drug dependence

- Suitable housing and employment are important to achieving and sustaining recovery and reintegration into the community.
- There is a need for a qualitative assessment of service users’ education, skills and employment related needs and a map of provision of projects across Cornwall that service users could access.
- Service users identified a range of factors that would help to promote recovery including more flexible and family focused community services, better links with mental health
treatment and more structured programmes focusing on building life-skills, improving quality of life and getting back into employment.

- The 40% cut in the budget for Supporting People poses a severe risk to provision of housing related support to vulnerable people in Cornwall.

**Drugs and crime**

- Drug use, particularly of the class A drugs heroin and crack cocaine, is strongly associated with crime and offending. We know that offenders with drug problems are more likely to commit acquisitive crime, such as burglary, thefts and vehicle crime, to provide funds for their addiction and to be convicted of drug specific crime, such as possession and supply.
- Although rates of crime remain low in Cornwall compared with the national picture, the trend for dwelling burglary has been deteriorating for the last two years and continues to do so, largely driven by rising numbers of burglaries in persistent hotspot areas. There are proven links to problematic drug use and, based on the impact on crime of the last recession in the 1990s, it is reasonable to assume that the economic downturn is also a factor.
- The Value for Money (VFM) Model of adult drug treatment in England estimates that in 2009/10, an estimated 28,000 crimes were prevented by engagement of the current numbers of drug users in treatment, delivering £13.7 million in cost savings and natural benefits and an estimated reduction in actual crime of around 15%.
- Drug use is a risk factor for a third of offenders on the Probation caseload and the majority are PDUs, with cannabis the most common problem drug amongst non-PDUs. Prolific and Other Priority Offenders (PPOs) are more likely to have drug problems (two thirds).
- Across a range of performance indicators, in 2009/10 Cornwall did not compare favourably with the South West for getting offenders into treatment. Indicators for the year to date show significant improvement but there remains a substantial gap. Once in treatment, however, we are successful on the whole at retaining them and successful in diverting them away from crime.
- We have established routes into treatment from the various points of contact with the Criminal Justice System. Integrated Offender Management should present opportunities to attract and engage offenders at a community level, before their substance problem and their offending escalates.

**Drug Related Deaths**

- There were 17 drug related deaths in 2010. The majority of deaths are from heroin overdose and heroin deaths have remained fairly stable over the last 11 years. Over the last three years, a third of deaths were due to methadone overdose and methadone deaths have increased since 2001. Around 20% of people who died of drug overdose in Cornwall in the last 4 years were homeless.

**Value for money**

- Effective treatment delivers significant savings. Based on the current level of investment and numbers in treatment, the net benefit in real terms of drug treatment locally will be £78.6 million over the next four years, including £52 million associated with crime prevented. In other words, for every £1.00 spent on the local treatment system, £4.49 is gained in total benefits for crime, community safety and health.
Commissioning Priorities

Our overall aims are to continue to ensure that systems and services are recovery focussed, provide value for money and meet the needs of local communities.

Improving Access to Treatment

Attract and proactively engage earlier/increase self referrals for people using illicit drugs

Rationale: Levels of self referral are lower in Cornwall than the national or regional average. Younger adults are less likely to appear in drug treatment services. The full range of open access service to encourage self referral is not available. Few people are clear about what is available and how to access it.

People using illegal drugs are more reticent to disclose to statutory professionals than people experiencing problems related to alcohol and legally available substances and, thus, may have to develop quite significant, more complex or entrenched problems before they seek help. People will be more likely to access help if those who have successfully accessed services are involved in their delivery.

Aim: Increase the numbers of people accessing treatment and encourage self referral to free, confidential and credible help at the earliest opportunity, attracting and engaging younger adults, through provision of:

- Free, confidential telephone helpline;
- Drop in access;
- Outreach;
- Better publicity and information about what is available and how it can help. Anticipating peoples’ fears and misgivings related to the consequences of seeking help;
- Peer mentors and mutual aid.

Delivering recovery and progress within treatment

A more flexible system to respond to individual needs and improve outcomes

Rationale: Despite increases year on year, the full range of evidence-based interventions is still not available. Individual have to fit the system and what is available rather than the system adapting to meet the needs of the individual. We have people that need and request more or less intensive help at different stages of their recovery journey. Evidence points to the greatest gains being made in the first 6 months – 2 years.

Aim: More intensive and flexible packages of support for people when they first access help with a view to promoting recovery.

- Greater frequency and flexibility of contact and appointments;
- Daily activities in support of recovery plans, including education, training, skills, psychosocial interventions and groups;
- Taster sessions of treatment and recovery interventions open to all;
- Recovery maps for all to describe the system, how it works and routes of progression through it;
- Individually tailored packages of treatment and care drawn from a menu of service provision;
- Volunteers and peer mentors to support people in accessing the services they require and engaging with help;
- Preparation for change groups and individual interventions;
- Post-Detox Support Groups and individual support to maximise the gains from treatment interventions;
- Aftercare support groups and individual interventions to maintain recovery.
Recovery programmes

**Rationale:** There are a range of evidence-based programmes that promote recovery and reduce the risk of relapse. To choose one would go against our drive to deliver individualised packages of care (see above).

**Aim:** To provide choice of recovery programmes in each locality, to include:

- SMART Recovery
- Mindfulness
- 12 step programmes

Achieving positive outcomes and successful completions

**Rationale:** To make best use of public money and to meet the aspirations of individuals and families to lead healthy, independent lives. Whilst more people do well in our treatment system than in the majority of other systems in the country, others still do not.

Service characteristics are a greater factor in success. A balance of attending to peoples’ physical, psychological and social wellbeing is required. To date, we are more successful in attending to the physical and psychological needs than the social needs and sustainable recovery is dependent upon the balance of all three.

**Aim:** To increase the number of people successfully completing treatment and leading healthy, independent lives and improve outcomes for their children, families and local communities.

To maximise the gains from treatment and reduce the risk of relapse, we must actively support the re-integration of people into local communities. This requires co-ordinated individualised packages of help that include:

- Skills development
- Meaningful activities
- Education and training initiatives
- Employment
- Accommodation – tiered levels of support to secure and sustain accommodation
- Peer mentoring
- Preparation for change groups
- Post detox support
- Aftercare initiatives

Improving outcomes for children and families

**Rationale:** Substance misuse is a key risk factor in families with complex multiple problems and vulnerabilities. Few services working with children and families know what is available and who to refer to, despite a Joint Working Protocol, systems and family interventions being available. A key factor in recovery for adults is involvement, support and interventions for their families.

**Aim:** To increase referrals and engagement of adults with substance misuse problems from services for children and families and to improve the outcomes for children and families affected by substance misuse.

- Training staff in services for children and families in screening and identification for substance use
- Establish a single point of contact into treatment
- Delivering parenting and family interventions for families affected by substance misuse
Improving outcomes for communities and reducing reoffending

**Rationale:** Reducing reoffending is fundamental to reducing crime in local communities and benefits everyone. Adults and young people convicted of offences are often some of the most socially excluded within society. The majority of offenders have complex and often deep-rooted health and social problems, such as substance misuse, mental health problems, homelessness, high levels of unemployment and possibly debt and financial problems. Tackling these issues is important for addressing the offender’s problems and providing ‘pathways out of offending’, and to break the inter-generational cycle of offending and associated family breakdown.

**Aim:** Integrated Offender Management (IOM) is a system that provides all agencies engaged in local criminal justice partnerships with a single coherent structure for the management of repeat offenders. It is an overarching framework for bringing together agencies in local areas to prevent, deter, catch and convict offenders and to rehabilitate and resettle them, delivering long-term, sustainable benefits to the community.

The key areas for development locally are:

- Processes for sharing information, care plans and risk assessments
- Adapting the model to the local situation
- Learning from experience elsewhere
- Contributing to the development of a consistent model across the Peninsula
- Strategic ownership and leadership of IOM model
Chapter 1 - Introduction

What is needs assessment?

Needs analysis 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.

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 that can feed into and inform planning.

Key themes from research show that effectively configured services:

- Are accessible
- Are acceptable
- Are as non-stigmatising as possible
- Focus on early interventions
- Address the whole person
- Are based on evidence of what works
- Build upon existing successful networks and are sustainable
- Have effective assessment, planning and care co-ordination systems.

Aims and objectives

The purpose of a ‘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.

Effective needs assessment for drug treatment, recovery and reintegration involves a process of identifying:

- 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
- Where there are gaps for drug users 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 blocks to treatment, reintegration and recovery pathways
- What is 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 drug users to have their needs met more effectively and ultimately benefiting the communities that they live in.
Needs assessment process

This needs assessment has been developed alongside the strategic assessment produced by Amethyst for the Cornwall Community Safety Partnership “Crime, disorder and substance use in Cornwall” to ensure consistency of key messages and reduce duplication. The full evidence base can be found on the Amethyst website www.amethyst.gov.uk/strataudit.htm.

Cornwall & Isles of Scilly Drug and Alcohol Action Team (DAAT) has an annual needs assessment process, overseen by a Needs Assessment Expert Group. Each year this group focuses upon improving the information available, as an iterative process, by identifying gaps and prioritising improvements to the information upon which the needs assessment is based.

The needs assessment also draws on evidence from and informs other key assessments, such as the Supporting People Sector Reviews, Kernow Matters (the evidence base supporting the Children and Young People’s Plan), the Family Strategy and Carers’ Strategy (see Appendix C for a full list).

This assessment will form a key part of the overall Joint Strategic Needs Assessment for Cornwall.

The Expert Group is made up of service users, commissioners and managers, service providers, clinicians, intelligence and data analysts.

Strategic Context

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

The new national drug strategy has two overarching aims with regard to treatment:

• Reduce illicit and other harmful drug use, and
• Increase the numbers recovering from dependence.

This requires us to continue in our transformation of the local treatment system to ‘maximise the number of people recovering free from their drugs of dependency.

• Recovery is an individual, person centred journey

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, with the expectation that full recovery is possible and desirable.

• Recovery includes wellbeing, citizenship and freedom from dependence.

NHS White Paper ‘Equity and Excellence: Liberating the NHS’ (July 2010) introduces the re-organisation of healthcare, which, alongside other guidance, assists us by emphasising the focus upon delivering and improving outcomes and places drugs treatment within the remit of Public Health. The White Paper sets out proposals for the NHS to become a service that is: easy to access, treats people as individuals and offers care that is safe and of the highest quality

“No decision about me, without me”

• Patients should be put at the heart of everything the NHS does: giving them increased choice about where and, in some cases, how, they are treated;
• They should be able to access comprehensive information on many aspects of health allowing them to rate hospitals and clinicians according to the quality of care they provide;
• They will be given a stronger voice through the introduction of a new consumer champion, HealthWatch.

The focus needs incorporate more prevention, early intervention and increased wellbeing.

The best evidence and evaluation must be used, supporting innovative approaches to behaviour change:

- Recognise that society in entirety – business, employers, friends and family – influences our health decisions;
- Government will use an ‘intervention ladder’ ranging from the least intrusive actions (such as providing information) to the most intrusive (eliminating people’s choice about what they do through legislation).

Funding for 2012/13 will be determined by the ratio between the number of new people we can engage in treatment and the rate of successful completions. This reinforces the need to attract and engage people early enough in their problematic use and promoting recovery and positive outcomes at every possible opportunity.

Building Recovery in Communities¹ introduces the new national recovery–oriented service framework, which seeks to make recovery more visible to local communities. Essential components to be delivered are:

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

The commissioning of consistent evidence-based treatment, available to all, is needed to meet the requirements of the 2007 Clinical Guidelines on Drug Misuse and Dependence, which, alongside NICE guidance, set out a range of evidence-based treatment interventions. Some of these are well-established and effectively commissioned, others are relatively or entirely new, and will need commissioning implementation plans, based on a competent and strategic understanding of need.

In addition, the statutory framework regulating Crime and Disorder Reduction Partnerships (CDRPs) 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

¹ http://www.nta.nhs.uk/recovery-consultation.aspx
Priorities for improving our knowledge this year

In line with improving routes to recovery, our priorities for improving our understanding this year were:

- Who is in treatment for whom it appears to be meeting needs? What works for them?
- Who is in treatment for whom it does not appear to be working? What are the unmet needs?
- Who are the people with a treatment need who are known to local services but not currently in treatment? Where is the system failing to engage and retain?

These all inform this year’s assessment and commissioning plan.

Service user Voice

When we asked service users how they defined ‘recovery’ they said:

- Feeling safe, not frightened of the world
- Becoming fit and well
- A process by which I will get better
- Sorting my life out
- Making positive changes
- Not doing crime
- Learning and living a positive lifestyle
- Free to make my own choices

An essential element of our annual needs assessment is securing the widest range of views and experiences possible from service users. As part of this process, we feedback what has been done as a result of the previous year’s feedback to demonstrate that we act upon the priorities service users identify. This year’s plan and report can be found in Appendix A.

Individuals were consulted across the full range of treatment providers, interventions, localities and at different stages of their recovery ‘journey’. 54 people attended focus groups, a small number were interviewed individually and a further 58 responded to a questionnaire. In addition, we also interviewed 2 groups of carers (people affected by the drug use of a partner or family member).

Groups were facilitated by different people, but all covered the same basic questions:

- What does recovery mean to you?
- What has helped your recovery the most?
- What has been unhelpful/What could we do better?
- What are the top 3 priorities for improvement?

Comments and responses are included throughout this document and the priorities identified have been included in the commissioning priorities for 2011/12 as a result.

Carers Voice

For the first time, this year, we were able to meet with two carers groups to consult about their experiences and priorities. These followed the same structure as above and the findings have also been included.

Service Provider Voice

The voice of DAAT-commissioned service provider staff were sought through key focus groups and two ‘DAAT Days’ during the year. Reports from these events, including priorities identified, are also in appendix A.
Geographical scope

As a result of the Local Government Review (LGR) the six district councils and the county council within Cornwall underwent a transition into one unitary authority called Cornwall Council.

As a result of this, the district based Crime and Disorder Reduction Partnerships also came together to create a single Community Safety Partnership for the new local authority area of Cornwall. The Isles of Scilly Community Safety Partnership works alongside the Cornwall Community Safety Partnership, but as a unitary authority is required to produce a separate plan for the area it covers and a separate assessment of crime, disorder and substance use on the islands is produced for this purpose.

Cornwall and Isles of Scilly DAAT continues to have responsibility across both the county of Cornwall and the islands and are included within this needs assessment.

Following the dissolution of the districts, Cornwall Council now co-ordinates activities at a local level through the Localism Service and 19 community networks, working with elected members, town and parish councils, other key partners and the community.

The community networks are arranged into three service delivery areas, West, Central and East, which are managed by community network area managers.

The map shows the three service delivery areas, also known as localities, and their component network areas.

Interpretation – maps and data

Wherever possible, maps have been included to provide an understanding of the geographical spread of an issue. Although every care has been taken to ensure that the maps present a clear and accurate picture, it’s important to be aware of the following points when interpreting them:

- Maps can exaggerate differences between areas based on class divisions (the range of values used to determine different colours). Where values are close to a division threshold, there may be very little difference between two areas on either side of the threshold but their different colours may be interpreted otherwise.
- The fact that some geographic units are much larger than others means that their colours can dominate the map. This is a particular issue for the geography of Cornwall because the eye is drawn to the larger geographical areas in North Cornwall and away from smaller, more densely populated areas such as Penzance.
- Aggregating data to a large geographical boundary, such as a community network area, can mask pockets of crime and disorder that are concentrated in only a small part of that area. For this reason, data is also analysed at a small statistical area level, called a Lower Super Output Area (LSOA), which contains an average of 1500 people, and appropriate commentary provided.
Comparing performance

This report generally covers the 12 month period from 1 April 2009 to 31 March 2010, but to put the numbers into context a minimum of two years historical data is reviewed where possible. Where more recent data is available / relevant this has been incorporated and is clearly marked.

To make a meaningful comparison between Cornwall and other areas, it is useful to have a comparative measure and for the purposes of this interim assessment we have made temporal and geographical (regional and national) comparisons:

- Numbers for 2009/10 are compared to the previous year (2008/09).
- Rate per 1000 resident population (for example, number of PDUs) which allows comparison with regional and national averages, as well as between areas of differing population sizes within Cornwall (such as postcode sectors and community networks).

What is Cornwall?

There are many myths and misconceptions about Cornwall. The following statements are based upon facts and figures collated by the Council and challenge the common perceptions of Cornwall. All too often Cornwall conjures up idyllic images of childhood holidays to the seaside; however, there is much more to Cornwall than this.

Cornwall is more than... farms, fishing villages and second homes

Cornwall has over 250,000 homes, not all of which are occupied by full time residents. Its population is 531,000 and is growing steadily. The population increases significantly in during the summer months, the peak tourism season. There is a dispersed spread of towns, large and small across Cornwall, with a major city, Plymouth, on the eastern boundary.

We have three significant conurbations: Camborne, Pool and Redruth; St Austell, Tywardreath and St Blazey; and Falmouth and Penryn. While these towns are smaller than urban areas elsewhere in the UK, they, along with many other freestanding large and small towns, exhibit similar characteristics.

The distribution of dispersed smaller settlements and distances between towns of significant size (where services tend to be located) present significant challenges in service delivery – both in motivating service users to attend appointments (requiring additional commitment from the individual in terms of time, energy and finances) and for staff, meaning large chunks of time spent “on the road” rather than with service users. It also means that services in more rural areas are required to offer a varied range of options to smaller cohorts of clients with widely differing needs.
Comwall is more than... art galleries and campsites
Tourism clearly has a significant influence on the area but it has many other influential sectors, which are often be overlooked. For example, the better than average economic growth experienced between 2000 and 2005 was driven by strong performance in the housing market and the retail sector, as well as public sector investment in areas such as educational infrastructure. Furthermore, manufacturing makes up more than 10% of the local economy. 30% of this is food and drink manufacturing, rooted in the farms for which Cornwall is so well known. There are strong sales in cheese, clotted cream, pasties and beer. However, Cornwall still has persistently poor earnings relative to national averages.

Comwall is more than... exclusively poor or wealthy
Cornwall has concentrations of real visible wealth in terms of housing, cars, restaurants and hotels. However, there is also significant visible and hidden poverty, as evidenced by high benefits take up, part time and seasonal employment and low incomes. There are areas within Penzance, Camborne and Redruth that are ranked within the 5% most deprived nationally.

Comwall is more than ... older people
The percentage of older people living in Cornwall is growing, although recent migration trends have seen fewer younger people leaving. In addition to this, the majority of people moving to, or returning to, Cornwall, are of working age and getting younger. What it means to be older is changing as well, with longer working lives and longer retirement time. The rapid growth in the elderly population that Cornwall has experienced over the last 20 years is expected to slow during the next 20 years.

Comwall is more than ... a language
Interest and study of the Cornish language is increasing. Cornish history and culture is wider than this, captured by sports, arts, creativity and industrial heritage. But Cornwall is also an increasingly diverse area in terms of ethnic backgrounds, national origins and religions, in this the tradition of being a welcoming place, associated with a rich maritime heritage is continued.

Comwall is more than... postcard pretty
Cornwall has a historic built environment to be proud of, with striking remnants of a globally influential industrial heritage designated as a World Heritage Site status. It also has large housing and employment estates that are decaying, some of which were built with little reference to the area in which they are set or the long term needs of the community. Recent developments in the built environment have set higher standards with eco buildings such as Jubilee Wharf in Penryn.

Comwall is more than... Areas of Outstanding Natural Beauty
Cornwall has many nationally and internationally recognised landscapes, including a superb coastline, a variety of moors and hidden valleys, all of which offer valuable recreational opportunities. Cornwall is also making use of its natural resources for energy. It leads the South West counties in terms of renewable energy production, with eight currently operational wind farms, as well as a wide range of other renewable energy technologies. Cornwall also has a number of proposed renewable energy projects, which aim to harness wave energy and to build on pioneering research to extract heat and power from geothermal sources.

Comwall ismore than ... a place to live or visit, it’s a place to learn
Cornwall has a growing knowledge economy, and there has been significant growth in higher and further education courses and places in Cornwall. The Peninsula Medical School and the University College Falmouth complement the highly regarded courses run by Falmouth College of Arts and the School of Mines (both now part of University College Falmouth). There are now over 2,000 students at the Tremough Campus alone.
Chapter 2 – Analysis & Prevalence

Key findings

- Home Office research estimates that Cornwall is home to between 2,000 and 2,700 users of opiates and / or crack cocaine. Based on the number known to treatment in 2009/10, we currently have an estimated unmet need of between 550 and 1,300 problem drug users.
- In total 1,829 adult drug users were in structured treatment services in 2009/10, equating to a rate of 5.8 people per 1000 adult population. 1,332 opiate and / or crack users (all ages) were in treatment during this period.
- 95% of drug users in treatment are described as effectively engaged, meaning that they are retained in treatment for long enough to benefit from it (12 weeks or more) or they complete treatment successfully within 12 weeks.
- The number of adult drug users in effective treatment grew by 5% and the number of opiate and / or crack users by 7%. The local growth rate slightly exceeded the overall growth noted in the South West. The rate of growth has plateaued since April 2010 and there has been little change in the year to date.
- Looking across the whole adult treatment population, heroin is by far the most common primary problem substance and substitute prescribing is the most common type of treatment. We have seen a rise in primary opiate users entering treatment in the last year and in drug users with a previous history of injecting.
- Reported crack use remains comparatively low in Cornwall, both alone and in combination with opiates.
- Almost two thirds of people in treatment are receiving treatment for more than one problem substance, with alcohol the most frequently stated adjunctive substance. We have higher levels of adjunctive alcohol use than the national average.
- 31% of people referred into treatment are parents. NDTMS data indicates that two thirds of parents in treatment have children living with them and that there are 700 children in Cornwall living with substance using parents.
- In terms of geographical distribution, the main clusters of drug users in treatment are in Newquay, Penzance, Camborne, Bodmin and Truro. Camborne / Redruth and Newquay have seen the greatest growth in numbers in treatment.
- Penzance town consistently has the most drug users in treatment (particularly opiate and / or crack users) as a proportion of the resident population but this area has seen the least growth recently in treatment numbers. Prevalence of problem drug use is higher than other parts of Cornwall, but services are well established and there may be now less unmet need in this area, in terms of drug users not engaged with treatment.
- Effective treatment delivers significant savings. Based on the current level of investment and numbers in treatment, the net benefit in real terms of drug treatment locally will be £78.6 million over the next four years, including £52 million associated with crime prevented. In other words, for every £1.00 spent on the local treatment system, £4.49 is gained in total benefits for crime, community safety and health.

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2 Base population for rates per 1000 is taken from Office for National Statistics mid-2009 estimates: adults - all people aged 18 to 64 years; PDUs – all people aged 15 to 64 years.
### QUICK FACTS – ADULTS IN DRUG TREATMENT

Opiate and / or crack users are referred to throughout as problem drug users or PDUs

**Prevalence (PDU only)** 2,301 / 6.9 per 1000 population (Home Office estimate)

**In treatment 2009/10**
- **PDUs (all ages)** – 1,332 / 4.0 per 1000 population
- **All adult drug users** – 1,829 / 5.8 per 1000

**Change since 2008/09**
- All adult drug users – increase of 5% / PDUs (all ages) – increase of 7%

#### General trend – numbers in effective treatment

<table>
<thead>
<tr>
<th>Month</th>
<th>Adults</th>
<th>PDUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jun-08</td>
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<td>Sep-08</td>
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<td>Mar-09</td>
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<td>Jun-09</td>
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<td>Dec-09</td>
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<td>Mar-10</td>
<td></td>
<td></td>
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<tr>
<td>Jun-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep-10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Service user profile

People in the treatment system 2009/10

- **Entrants** 794
- **In treatment** 1829
- **Exits** 432

#### Rates by network area (all adults / PDUs per 1000 population)

- **Highest** – Newquay 206 people / 12.3 per 1000 population
- **Lowest** – Wadebridge 22 people / 1.9 per 1000 population

#### Top 5 hotspots (postcode sector)

<table>
<thead>
<tr>
<th>Postcode sector</th>
<th>Town</th>
<th>Adults</th>
<th>Rate per 1000*</th>
<th>PDUs</th>
<th>Rate per 1000*</th>
</tr>
</thead>
<tbody>
<tr>
<td>TR182</td>
<td>Penzance</td>
<td>79</td>
<td>21.5</td>
<td>68</td>
<td>17.7</td>
</tr>
<tr>
<td>TR7 1</td>
<td>Newquay</td>
<td>89</td>
<td>17.0</td>
<td>55</td>
<td>10.2</td>
</tr>
<tr>
<td>PL312</td>
<td>Bodmin</td>
<td>68</td>
<td>16.9</td>
<td>47</td>
<td>11.0</td>
</tr>
<tr>
<td>PL255</td>
<td>St Austell</td>
<td>53</td>
<td>14.3</td>
<td>47</td>
<td>12.0</td>
</tr>
<tr>
<td>TR148</td>
<td>Camborne</td>
<td>71</td>
<td>12.9</td>
<td>53</td>
<td>9.2</td>
</tr>
</tbody>
</table>

*Rate per 1000 is based on resident population
Prevalence of problem drug use

Estimates are drawn from research commissioned by the Home Office\(^3\) into the prevalence of opiate and / or crack cocaine use in England. Prevalence estimates were released for each DAAT area and provide the basis on which we can estimate the true level of problem drug use and the proportion of users who engage with treatment. The original study covered the period 2004/05 to 2006/07 and a follow-up was carried out 2 years later.

The results show that the national estimate of problem drug use has remained stable between 2006/07 and 2008/09 but there has been a significant decrease in opiate use over this time.

Nationally, the markedly highest prevalence rate is in the 25 to 34 age group, which was also the case across individual regions. There were statistically significant decreases in the 15 to 24 age group and the 25 to 34 age group estimates. There was also a statistically significant increase in the older 35 to 64 age group but this is explained by an ageing drug using population, not new users in this age group.

The table shows the prevalence (rate and number) for Cornwall compared with the South West and England, and the estimates by broad age band.

- The latest figures estimate that there are between 2,000 and 2,700 problem drug users (PDUs) in Cornwall and the Isles of Scilly, with a best estimate of 2,301.
- Estimated prevalence is significantly lower than the national estimate, but the apparent difference with the regional difference is not significant. Estimated prevalence in the 15 to 24 age group, however, is significantly lower than both the regional and national estimates.
- Over the last two years, there has been no significant change in the estimated prevalence of opiate and crack use in Cornwall.
- There have, however, been some changes by age group. There has been a significant drop in the 15 to 24 age group and a significant rise in the 25 to 34 age group, with no significant change in the older 35 to 64 age group.
- The figures may be explained by a decline in young adult PDUs (reflecting the national trend) and an ageing of the young adult drug using population between the two sweeps, combined with a proportion of those in the middle age group successfully leaving treatment.

PDUs in treatment

- 1,332 PDUs were in structured treatment in 2009/10, of which 95% (1,274 people) were engaged effectively.\(^4\)
- 55% of the estimated actual number of PDUs were in effective treatment in 2009/10 and a further 7% were known to treatment but not in the last year.
- We currently have an estimated unmet need of between 550 and 1,300 problem drug users (mid-point estimate is 900).
- The 15 to 24 age group make up a higher proportion of those not known to treatment.
- The number of PDUs in effective treatment grew by 7% compared with last year.

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\(^3\) The full report can be downloaded from [www.nta.nhs.uk/facts-prevalence.aspx](http://www.nta.nhs.uk/facts-prevalence.aspx)

\(^4\) In treatment for a minimum of 12 weeks or discharged within 12 weeks in a care planned way.
Drug users in treatment

NDTMS is used to record individuals receiving structured treatment, in tiers 3 and 4, so the term “in treatment” does not encompass everyone who comes into contact with treatment services.

Numbers in treatment 2009/10

- 1,829 adult drug users were in structured treatment services in 2009/10, equating to a rate of 5.8 people per 1000 adult population\(^5\). 94% were retained in effective treatment during the year. The number of adult drug users in effective treatment grew by 5% and the number of opiate and/or crack users by 7%.
- The latest performance data\(^6\) from NDTMS shows that since the baseline year (2007/08), both the number of PDUs and the total number of adults in drug treatment has increased by 16%. The local growth rate has exceeded the national rate by 5% and 4% respectively.
- Examination of trends over the period, however, shows that the majority of the growth has been achieved in the first two years. The rate of growth has slowed in the year to date with only a 1% increase in adult drug users and a 0.5% increase in the number of PDUs since April 2010.

Service user profile

- The age and gender profile is generally in line with the regional average and shows no notable change compared with last year.
- 71% of adults in treatment are male and 29% female. The majority are in the 25 to 39 age range (56%). We have a slightly higher proportion of service users aged 40+ than the regional average (32% compared with 28%).
- Where ethnicity was stated, 96% of service users are White British, 3% come from other white ethnic groups and 1% come from non-white ethnic groups.
- Where nationality was recorded, 1% (17 people) were non-UK nationals, with Portugal the most common country of origin.
- 31% of people referred into treatment are parents. NDTMS data indicates that two thirds of parents in treatment have children living with them and that there are 700 children in Cornwall living with substance using parents.
- Heroin is by far the most common primary problem substance, accounting for 62% of all service users. Cannabis is the next most common at 11%. Primary crack use is rare at only 2%, but crack is more common in combination with other drugs, usually heroin.
- 64% of service users are in treatment for more than one problem substance, with an adjunctive problem with alcohol the most frequently stated (19% as second substance and 9% as third substance).
- Locally we have lower proportions of service users in treatment for heroin and crack and higher proportions for amphetamines, primary cannabis use and adjunctive alcohol problems. This is consistent with previous years.
- 58% of adult drug users in treatment have a history of injecting and this is unchanged from last year and remains below the regional average (72%).
- PDUs are the most likely to have a history of injecting (69%) and users of cannabis, cocaine and ‘other drugs’ the least (22%, 31% and 32% respectively).

Change compared with 2008/09

- In terms of primary drug use, the substance profile is fairly similar to last year, with the only notable changes being a rise in the proportion of primary opiate users (+3%, heroin and to a lesser extent methadone) and a drop in the proportion of primary cannabis users (-3%).
- Numbers in treatment have increased across all class A drugs and users of amphetamines, cannabis and benzodiazepines have reduced.

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5 Base population for rates per 1000 is taken from Office for National Statistics mid-2009 estimates: adults - all people aged 18 to 64 years; PDUs – all people aged 15 to 64 years.
6 Rolling 12 months to September 2010
The number of PDU in treatment with a history of injecting has increased, making up 70% of those in treatment, compared with 63% the previous year.

The number in treatment for ‘other drugs’ has more than doubled compared with 2008/09 and the same is true for the South West. This suggests that additional service users may be counted in this group, although the needs assessment guidance is not enlightening as to what or who this might be. The same rise is not apparent when looking at the substance profile in the raw data.

Where in Cornwall?

Individual record data for mapping was drawn from NDTMS in August 2010 and includes all adults in treatment for the period 1 April 2009 to 31st March 2010.

- The highest numbers of both adults and PDU are in Central Cornwall with particular clusters in Newquay and St Austell. Central Cornwall has seen the greatest growth in numbers in treatment.
- West Cornwall continues to see the highest concentration of drug users in treatment in the resident population (measured by the rate). The difference is particularly marked for PDU. The West has seen the least growth and this would support the hypothesis previously suggested by the Expert Group that we may have achieved close to the maximum penetration in this area.
- North and East locality sees the lowest treatment numbers but there are pockets of high concentration, such as in Bodmin and Liskeard.

### Adult drug users

<table>
<thead>
<tr>
<th>Locality</th>
<th>Rate</th>
<th>Number</th>
<th>Change</th>
<th>Change %</th>
<th>Rate</th>
<th>Number</th>
<th>Change</th>
<th>Change %</th>
</tr>
</thead>
<tbody>
<tr>
<td>North &amp; East</td>
<td>4.5</td>
<td>450</td>
<td>39</td>
<td>9%</td>
<td>3.3</td>
<td>327</td>
<td>29</td>
<td>10%</td>
</tr>
<tr>
<td>Central</td>
<td>6.0</td>
<td>736</td>
<td>65</td>
<td>10%</td>
<td>4.2</td>
<td>511</td>
<td>51</td>
<td>11%</td>
</tr>
<tr>
<td>West</td>
<td>6.6</td>
<td>614</td>
<td>7</td>
<td>1%</td>
<td>5.0</td>
<td>463</td>
<td>17</td>
<td>4%</td>
</tr>
<tr>
<td>Cornwall &amp; Isles of Scilly</td>
<td>5.8</td>
<td>1,829</td>
<td>111</td>
<td>6%</td>
<td>4.0</td>
<td>1,332</td>
<td>113</td>
<td>9%</td>
</tr>
</tbody>
</table>

- Looking at the variation across Cornwall in the number of drug users in treatment as a rate per 1000 resident population shows that there are 6 network areas where the rates are higher than the Cornwall average for both all adults and PDU – Newquay, Bodmin, Penzance, St Austell, Camborne and Redruth and Liskeard and Looe.
North and East Cornwall

Numbers in treatment are generally much lower in North and East Cornwall but there are pockets of high concentration in Bodmin (particularly PDUs) and Liskeard.

- The North and East has a higher proportion of people in treatment under the age of 35 than the rest of Cornwall (57% compared with 47% average).
- This area also has a slightly higher proportion of parents in the treatment population at 35%.
- Service users are more likely to present to treatment in regular employment (15%) and less likely to be unemployed (53%)
- The substance profile is fairly similar to the Cornwall profile but there are fewer service users with a history of injecting.
- A quarter of service users in this area had been in treatment for 2 to 4 years (compared with the average of 19%) but the proportion in longer term treatment is in line with the Cornwall average, indicating that discharge is more likely to occur during this period.
- Analysis of successful completions indicates that service users living in North and East are less likely to be counted as having completed treatment successfully due to a higher than average rate of onward referrals (28% compared with 20% average).

Central Cornwall

40% of people in treatment live in Central Cornwall. The main service user clusters are in the larger towns of St Austell, Newquay and Truro (and to a lesser extent Falmouth).
Central Cornwall has a slightly higher proportion of males in treatment (74%).

Non-PDUs make up a slightly higher proportion of the in treatment population at just under a third. Cannabis is more common as a problem substance (29%) and crack use is also slightly higher at 11% (50% of all crack users in treatment live in this area).

Service users are more likely to present to treatment as unemployed (65%).

Shorter episodes of treatment are more common, with 56% of people in treatment in 2009/10 having been in for one year or less (although the additional growth in new service users will have an impact on this figure).

Service users living in Central Cornwall are more likely to complete treatment successfully, with both PDUs and non-PDUs achieving higher than average success rates (+7% and +6% respectively).

West Cornwall

West Cornwall has the highest concentration of service users in the local population, particularly PDUs. There is a significant cluster in the centre of Penzance and smaller ones in Camborne and Hayle.

- West Cornwall has the least young adults in treatment and a greater proportion in the 34 to 44 age group. Interestingly the proportion aged 45 and over is in line with the average for Cornwall, suggesting that older service users are leaving treatment.
- The proportion in long term treatment (4+ years) is highest at 25%.
- There are more opiate users (76% of service users) and more injectors in the treatment population. There is slightly less cocaine reported as a problem substance but the rest of the substance profile is in line with the Cornwall average.
- Service users living in West Cornwall are less likely to complete treatment successfully. The success rate for PDUs is in line with the Cornwall average but the non-PDU success rate is slightly lower.
Delivering value for money

The National Treatment Agency (NTA) has worked closely with the Department of Health and the Home Office in 2010 to develop a Value for Money (VFM) Model of adult drug treatment in England, which identifies the costs and benefits of drug treatment.

Building on this work, the NTA has developed a local tool which for the first time enables local areas across England to demonstrate the value for money of their local drug treatment systems. This will support local needs assessment and treatment planning and help local areas to identify ways in which to improve the value for money of their services.

- The model is still in development but early indications are that drug treatment in Cornwall delivered £19.4 million net cost benefits in 2009/10 and is forecast to deliver savings of £26.3 million in 2010/11.

This takes into account the cost of drug treatment, the numbers in treatment and rate of treatment effectiveness, alongside reductions in drug-related crime and improvements in health.

Based on the current level of investment and numbers of drug users in treatment:

Drug treatment is forecast to cost £22.5 million over the next four years. The benefits in terms of cost savings and natural benefits total £101.1 million, broken down into £52 million for crime and £49.1 million for health.

- Thus the net benefit in real terms over the next 4 years, based on the current level of investment and numbers engaged with treatment services, is £78.6 million.
- In other words, for every £1.00 spent on the local treatment system, £4.49 is gained in total benefits.

There are estimated to be around 2,300 problem drug users (users of opiates and/or crack cocaine) in Cornwall – if none of them are engaged with treatment services, the estimated total amount of harm in terms of costs to public services over the next four years is £300.2 million (£130,500 per person).

- The potential saving over the same period for each additional problem drug user in treatment is £71,100.

Conversely, the increased costs in local health and crime can also be estimated against savings made in drug treatment locally using the same tool.
Understanding the needs of diverse communities

Through the Equality Act, 2010, 9 characteristics are protected from discrimination.

These are:
- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and Maternity
- Race
- Religion and belief (including those with none)
- Sex (formally known as gender – male/female)

The DAAT is a member of the Equality and Human Rights partnership in Cornwall, through which it seeks to integrate understanding of drugs and alcohol across all groups as well as to improve our understanding of the needs of the entire community that the local treatment system seeks to serve. This includes developing an understanding of the relative needs and harms within minority groups in our communities as well as the wider population.

Where possible, consideration of the differing needs of service users according to group identity is integral to the analyses and has been included within the treatment mapping. Age and gender are considered throughout this and the Young Peoples’ needs assessments.

Ethnicity

- 96% of service users, where ethnicity was recorded, are White British and 2% come from a non-white ethnic group. The latest estimates of population by ethnic group indicate that 3% of people resident in Cornwall are from a non-white ethnic group, suggesting a slight under-representation in the drug treatment population.
- Ethnicity was recorded as ‘not stated’ for 5% of service users – whilst this represents a big improvement compared with last year (when it was 10%), it is still much higher than the regional average of 1%. There is no obvious reason why service users in Cornwall would be less inclined to have their ethnicity recorded.
- Inclusion Cornwall successfully won a bid and received the Migration Impact fund. They have subsequently awarded the DAAT a small sum of money to improve information around the drug and alcohol needs of Migrant Workers in Cornwall. This report has yet to be completed. It’s findings will be incorporated into the year’s plan.
- It is believed that there are around 12,000 Migrant Workers in Cornwall. In recent research the Migrant Worker PACT (Partners and Communities Together) led by the Police found that Drug and Alcohol was found to be problematic for Migrant Workers. Analysis of treatment data found there to be very few Migrant Workers accessing treatment services. Treatment providers who have been approached by Migrant Workers have experienced huge issues such as that of translation. Over 10/11, information was obtained or produced in a range of languages and sources of translation identified.
- Over 10/11 a primary care practice was commissioned to specifically meet the needs of gypsies and travellers in on particular locality. This practice also delivers the alcohol and drugs Locally Enhanced Services.
Disability

- Based on the level of claims for health-related benefits (ESA, Incapacity Benefit or Disability Living Allowance), Cornwall consistently has a higher rate of disability in the working age population than either the South West or England average.
- Details of disability amongst service users are not recorded in the current data collection for NDTMS so we do not currently know what proportion of the in-treatment population (tier 3 / 4) considers themselves to have a disability or what their different needs may be as a result. This is a priority for the new electronic case management system.
- A particular service gap was identified in the accessibility of tier 1 interventions and a priority for next year will be ensuring that all information is available specific to the needs of those who are hearing impaired or physically disabled.

Sexual orientation

- National research\(^7\) indicates that LGBT communities are more likely than the wider community to abuse drugs and alcohol. In Cornwall we have not historically collected information about gender identity or sexual orientation of those in treatment.
- Consultation with this client group suggests that they would like to be asked such questions, so the updated comprehensive assessment now includes questions around sexuality and gender identity.
- Additional information on support available to LGBT groups has been incorporated into the revised version of the drugs and alcohol directory and onto the DAAT website. Further work needs to be done with this community to ensure that all treatment services that are provided across Cornwall and Isles of Scilly are LGBT friendly.

\(^7\) Death by Diversity, Addiction Today (August 2009), www.addictiontoday.org.uk
Chapter 3 – Mapping the treatment system

The purpose of mapping the treatment system is to identify the numbers and case mix of service users that are entering into, exiting and moving between services. The map is used to identify if there is a local need for services that is not adequately met or where there is under-utilisation of services or blockages in the treatment system.

By the development of a simple treatment map from NDTMS data as part of the treatment planning process it is intended that partnerships will gain a better understanding of how the system is working and for whom and to evidence spending decisions in the treatment plan.

Key findings

- There were 794 referrals into treatment in 2009/10 and just under half had never been in treatment before. The number of referrals increased by 35% compared with 2008/09.
- Nationally the most common route into treatment is self-referral. Locally GP referral is the most common and this suggests that current open access services that act as a ‘gateway’ into treatment may not be sufficiently flexible or accessible.
- 31% of people referred into treatment are parents. Parents as a proportion of all referrals was in line with regional average but we are continuing to see a higher proportion of parents referred to treatment for the first time.
- We receive very few referrals and have low numbers in treatment for Black, Asian and other ethnic groups.
- Consistent with previous years, the proportion of referrals coming through criminal justice routes remains significantly below the regional and national averages. CARAT (prison) referrals and ‘other’ criminal justice (not Drugs Intervention Programme or Arrest Referral), however, saw a notable increase compared with the last assessment.
- Prescribing is the most common type of treatment.
- A fifth of service users in treatment in 2009/10 had been in for 4 years or longer.
- The proportion of drop outs slightly increased compared with last year and was 4% above the regional average at 26%.
- The proportion of onward referrals or transfers increased compared with last year but remained much lower than the regional average (a difference of 10%).
The map is divided into four stages of a person’s journey through the treatment system and it provides profiles for service users at each stage.

- **Treatment entry** - referral routes, all clients who started a new treatment journey in 2009/10. Agencies reported denote where the client started their treatment journey (as long as there are 5 or more presentations).
- **In treatment** – data reported for all agencies that have had 5 or more contacts with clients residing in partnership area.
- **Inter-agency transfers** – inter-agency transfers are reported where the number of transfers between two agencies is 5 or more.
- **Treatment exits** – reports exits from the treatment system, showing the agency where the client’s last episode was discharged from provided the number of discharges is 5 or more.
- **Presenting substance** – primary substance at triage, except PDUs where adjunctive substances are included. Individuals are counted once only.

It should be noted that the partnership level numbers provided by NDTMS for treatment mapping are summed from the agency data and thus some service users will be double counted. The basic treatment map for all service users is presented on page 27. Service user groups were also mapped through the system by characteristic (presenting substance, age, gender, injector / non-injector etc.).

### Treatment entry

- The number of referrals increased by around 35%.
- 51% of referrals were treatment naïve (never been in treatment before), a slight drop from 55% in 2008/09.
- GP referral is the most common route into treatment at 37% (self-referral is the most common in the South West). For problem drug use, this is of slight concern, as we hope to attract illicit drug users into treatment through self referral earlier in their problematic use.
- Referrals through Arrest Referral / Drugs Intervention Programme are fairly similar to last year (very low) and referrals through CARAT (prisons) and other criminal justice routes have seen a notable increase, although the numbers remain small. All of the referrals are into CDAT and the rise is attributed to Integrated Drug Treatment Service (IDTS) referrals. Despite the increase, consistent with previous years locally criminal justice referrals remain significantly below the proportion in the South West (20%).
- Very few referrals and low numbers in treatment for black, Asian and other ethnic groups.
- Increases in number of referrals across service users with all characteristics, but most notably opiate users (but not in combination with crack). Referrals for opiates and crack together remains significantly lower than the regional average (6% compared with 25%).
- Although there was an increase overall in injectors presenting to treatment (particularly previous injectors), the growth was lower than for non-injectors, particularly for treatment naïve referrals. At 40%, injectors as a proportion of all referrals was 19% lower than the regional average.
- Presentation to treatment with accommodation problems reduced compared with last year and was slightly lower than the regional average (both NFA and problem). The accommodation need field is still under-completed (22% missing compared with 12% regional average).
- 31% of referrals are parents. Parents as a proportion of all referrals was in line with regional average (29%) but we are continuing to see a higher proportion of parents referred to treatment for the first time (57% compared with 40%).

### In treatment

- Prescribing is the most common modality.
- Approximately 21% of service users have been in treatment for 4 years or more (based on figures derived from the raw data – this is covered in more detail in chapter 4 Diagnostics for a recovery focused treatment system). The proportion of long term service users is highest in CDAT (30%).
• Treatment mapping data shows 40 service users aged 18 years or over in treatment with young people’s services (Yz-Up) but the majority have been discharged or transitioned into adult services within the current year.

Treatment exits

Detailed analysis of treatment exits are shown in chapter 4 (Diagnostics for a recovery focused treatment system).

• The proportion of successful completions dropped compared with 2008/09, but this may be explained by changes to the categorisation of discharge reasons. The drop is in line with that noted for the South West.
• The proportion of drop outs slightly increased compared with last year and was 4% above the regional average at 26%.
• The number of inter-agency transfers doubled in number compared with 2008/09 with increased transfers from and to all agencies, particularly Addaction and Gwellheans.
• There were 7 transfers from Yz-Up to adult services (0 in 2008/09).
• The proportion of onward referrals or transfers increased compared with last year but remained much lower than the regional average (a difference of 10%), except for CDAT where it was in line with regional average.
### Treatment map 2009/10

<table>
<thead>
<tr>
<th>Referral Routes</th>
<th>Addaction</th>
<th>CDAT</th>
<th>Shared Care</th>
<th>Fairholme</th>
<th>Gwellheans</th>
<th>Yz-Up</th>
<th>Treatment length</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>24%</td>
<td>24%</td>
<td>24%</td>
<td>24%</td>
<td>24%</td>
<td>24%</td>
<td>Overall</td>
</tr>
<tr>
<td>Drug services</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>Overall</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>Overall</td>
</tr>
<tr>
<td>GP</td>
<td>57%</td>
<td>57%</td>
<td>57%</td>
<td>57%</td>
<td>57%</td>
<td>57%</td>
<td>Overall</td>
</tr>
<tr>
<td>Self</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>Overall</td>
</tr>
<tr>
<td>Drug services</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>Overall</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>Overall</td>
</tr>
<tr>
<td>GP</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>Overall</td>
</tr>
<tr>
<td>Self</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>Overall</td>
</tr>
<tr>
<td>Drug services</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>Overall</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>Overall</td>
</tr>
<tr>
<td>GP</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>Overall</td>
</tr>
<tr>
<td>Self</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>Overall</td>
</tr>
<tr>
<td>Drug services</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>Overall</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>Overall</td>
</tr>
</tbody>
</table>

**Caveats:**

- Partnership and regional totals (referrals and treatment exits) are aggregated from agency totals and hence double count any client referred into / exiting more than one agency.

---

**Adult Drug Treatment Needs Assessment 2010/11**

Promoting recovery
Chapter 4 – Diagnostics of a recovery oriented treatment system

How do we know the extent to which our local services and systems are recovery-focused?

Some key questions are:

• Do we reach people early enough?
• Do people leave treatment successfully?
• Do we meet the needs of people in long term treatment?
• Do we commission for outcomes and focus on results?
• Are we maintaining and improving access to treatment?
• Do we deliver recovery and progress within treatment?
• Do we achieve positive outcomes and successful completions?

Key findings

• Across a range of performance indicators, in 2009/10 Cornwall did not compare favourably with the South West for getting offenders into treatment.
• The majority of young adults in treatment with adult providers started using their problem substance before the age of 18, but have had no prior contact with young people’s treatment services. Young people with drug problems in Cornwall may not be approaching treatment services until their drug problem is fully established.
• Half of all new referrals have never been in treatment before.
• Successful completion rates by length of time in treatment indicate that the optimum treatment period is between 6 months and 2 years.
• Just over a fifth of people in treatment in 2009/10 had been in for 4 years or longer, which is higher than average. Local evidence suggests that we are not continuing to meet the needs of people in long term treatment and we need to understand what additional support may be required to progress their journey to recovery and successful completion. There is a particularly high concentration of long term service users in the Penzance area.
• 475 people (a quarter of those in treatment during 2009/10) left treatment and 53% of were successful completions. Our success rate is higher than both the regional and national averages.
• Increasing the number of people who leave treatment successfully will be key area of focus for the coming year and this means looking holistically at a range of factors that contribute to a person being prepared to leave treatment and continue with a drug-free life.
• The strong success rate for those exiting treatment combined with a slowing in growth of treatment numbers means that achieving an increase in successful completions will be challenging.
Do we reach people early enough?

"Trying to get help for the first time is difficult. This can involve banging on a lot of doors for a long time"

"Some GPs are OK but many are not helpful"

"My doctor didn’t know what was available"

"Some GPs only recommend NA and AA. They don’t mention detox and other treatment options. You walk away and think, what was the point of that? You need to be able to make an informed choice"

"There’s a lack of information about what is available"

"Some are quite judgemental and then you are left floundering"

"Social Services seem ill-informed and equipped to help in this area"

- Nationally the most common route into treatment is self-referral. Locally GP referral is the most common and this is of concern, as we hope to attract illicit drug users into treatment through self referral earlier in their problematic use. This suggests that current open access services that act as a ‘gateway’ into treatment may not be sufficiently flexible or accessible.

- It also appears that Cornwall faces similar issues to the rest of the region in needing to improve the effectiveness of engaging problem drug users under the age of 18 in treatment. Although we are significantly better than the regional average at attracting young adults into treatment, local data shows that the majority are over 18 years of age and in adult services. An estimated 51% of young adult PDUs were under 18 years, however, when they first started using.

- The majority of young adults had never previously engaged with young people’s services, suggesting that there may be a significant number of young adults not approaching treatment services until their substance use problem is fully established. This highlights a need to understand the reasons behind this and as a result, some focused work will be undertaken to capture the journey of those in Adult Treatment regarding their drug careers and opportunities to more effectively engage those users at earlier ages and stages. This work will be carried forward through the Young People’s Specialist Young People’s Specialist Substance Misuse Needs Assessment and treatment planning process.

- Across a range of performance indicators, in 2009/10 Cornwall did not compare favourably with the South West for getting offenders into treatment (see Chapter 5 Drug use and crime). Indicators for the year to date, however, show significant improvement.

- Referrals through Arrest Referral / Drugs Intervention Programme are fairly similar to last year (very low) and referrals through CARAT (prisons) and other criminal justice routes have seen a notable increase, although the numbers remain small. All of the referrals are into CDAT and the rise is attributed to Integrated Drug Treatment Service (IDTS) referrals.

- Offenders referred into drug treatment are less likely to be treatment naïve (they have been in treatment previously) and the proportion of treatment naïve offenders is in line with the South West average (30% locally compared with 28%).

There is a full analysis of young adults in treatment in the Young People’s Specialist Young People’s Specialist Substance Misuse Needs Assessment, which can be downloaded from the Children’s Trust website [http://www.cornwallchildrenstrust.org.uk/Default.aspx?page=242](http://www.cornwallchildrenstrust.org.uk/Default.aspx?page=242) or the Amethyst website [www.amethyst.gov.uk/strataudit.htm](http://www.amethyst.gov.uk/strataudit.htm)

One of the problems to overcome is the perception of what services maybe like.
Chapter 4 – Diagnostics of a recovery oriented treatment system

How could we improve?
When we asked people what would have helped them to access help earlier, they said:

- **Better publicity and information about how and where to get help**
  - Money to print publicity
  - Better signposting and information
  - Information should be available in GP surgeries, libraries and supermarkets
  - A recovery map of what is available
  - A telephone helpline

- **Education and training for GPs, Job Centre Plus and hospital staff**
  - There are those who “don’t understand”
  - Service users would be happy to be involved in educating agencies

- **More flexible and responsive community services**
  - “Instant help”
  - Services in Saltash, Bude and St Austell
  - Advocacy for service users
  - Quicker access to GP counsellors
  - Synchronised visits for couples
  - Being seen closer to home, including home visits
  - Support and advice for families
  - Help with transport
  - Childcare facilities
  - Improved waiting times for detox

Do people leave treatment successfully?

- NDTMS performance data shows that there were 432 treatment exits in 2009/10, of which 228 completed treatment successfully (53%).
- There was no change in the number of completions compared with the previous year but successful completions as a proportion of all exits dropped slightly by 2%.
- This relates to PDUs only – successful completions dropped from 44% of all exits in 2008/09 to 41% in 2009/10, and showed further decline in the first six months of this year.
- The success rate for non-PDUs is higher (around two thirds of all exits) and remains stable.

Performance information for the year to date for the South West indicates that the percentage growth in successful completions (compared with 2009/10) is falling behind the rest of the country. It has been noted that across the whole of the region, the most marked trend is the numerical decline in the number of non-PDUs successfully completing drug treatment, which is in stark contrast to the rest of the country.

- This is not true in Cornwall. The latest performance figures for the year to date (December 2010) shows an overall rise of 7% in the number of successful completions but this solely relates to non-PDUs (a rise of 13%); the number of successful completions for PDUs is unchanged.
- The next chart shows the rolling 12 month total of successful completions between March 2009 and December 2010.
- For the first six months of the year, the growth was due to an increase in exit rate, rather than an improvement in success rate. Although there has been little growth in the total treatment numbers this year, the number of exits from treatment increased and thus the number of successful completions also increased.
• The actual numbers of exits / successful completions per month varies slightly depending on which report you review but for the first six months of the year the growth in successful completions generally tracked just below the growth rate in treatment exits, explaining the decline in successful completions as a proportion of exits.

• The last quarter, however, has seen the growth rate in successful completions start to exceed the exit growth rate, which means an improved success rate.

Although in terms of numerical growth non-PDU successful completions are showing the most improved performance, and the success rate of those exiting treatment is good, the overall rate of discharge is below average (a lower proportion are exiting treatment, see next table).

<table>
<thead>
<tr>
<th>Cornwall &amp; Isles of Scilly</th>
<th>2009/10</th>
<th>12 months to December 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total in tx</td>
<td>Total exits</td>
</tr>
<tr>
<td>All clients</td>
<td>1,829</td>
<td>475</td>
</tr>
<tr>
<td>PDU</td>
<td>1,332</td>
<td>265</td>
</tr>
<tr>
<td>Non-PDU</td>
<td>497</td>
<td>210</td>
</tr>
<tr>
<td>National</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-PDU</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• Our success rate for those exiting treatment is high and further improvement may prove difficult to achieve. This combined with a slowing in growth of treatment numbers indicates that if we are to achieve increased numbers of successful completions we need to increase our discharge rate and / or increase our success rate.

• An increase in successful completions will only be achieved if the positive trend noted in the last three months, particularly for PDUs, is maintained.

Key factors impacting on treatment discharge outcomes

• Compared with regional patterns, although we see a higher success rate, we also have a slightly higher drop out rate and a much lower proportion of onward referrals.

The majority of service users who leave treatment in an unplanned way simply drop out (around two thirds of unsuccessful exits). The remaining third is predominantly made up of service users going into custody / prison or their treatment is withdrawn by the provider. A small proportion (around 4%) die each year.

Treatment discharge outcomes were reviewed across a range of factors. Factors that appear to have a negative impact on successful completion include:

• Referral via a criminal justice route or GP
• Presenting to treatment as currently injecting
• Prescribing treatment modalities
• Being in regular employment on presentation to treatment
• Presenting to treatment with accommodation problems (particularly NFA)
• Leaving treatment within 6 months
• Living in the West of Cornwall
Service users groups with higher rates of referrals on to other services (although not notably higher rates of unplanned exits) also show lower rates of successful completions, notable factors include:

- Opiate users
- Leaving treatment after 4 years or more
- Living in the North and East of Cornwall

Positive factors associated with successful completions include:

- Self or friends and family referral
- Non-PDUs (particularly primary cocaine users)
- Leaving treatment between 6 months and 1 year
- Being unemployed on presentation to treatment
- Presenting to treatment with no problems with accommodation
- Being a parent and / or living in a household with child/ren
- Day programmes and ‘other’ (non-psychosocial or prescribing) structured interventions
- Living in Central Cornwall

Successful completion rates are highest in those who have been in treatment between 6 months and 2 years. The success rate drops for those leaving treatment after 2 years or more, although the proportion of unplanned exits remains fairly similar with a much higher proportion being referred on or transferred.

Around 20% of service users who drop out or leave treatment unsuccessfully re-present for treatment the following year, of which around quarter drop out again. These are typically CDAT / Shared Care service users who drop out within 6 months and then re-present to CDAT / Shared Care the following year. A small number present to a different service provider or an additional service provider.

This analysis identified a very small number of service users who drop out and re-present for treatment year on year. It was agreed that further investigation on a case study basis would be useful to try and identify any common underlying factors, either personal or relating to the treatment system.

**Feedback from Service User Consultation**

When asked what would help to promote recovery further, service users identified a range of measures that would assist them. These included:

- **Community Services**
  - More information about how to get help/what is available and a recovery map showing the way through different services and pathways
  - More intensive help - Increase the length and frequency of appointments
    - More daily activities and programmes for people at the beginning of treatment
    - To be seen for an open amount of time until recovered
    - Synchronised visits for partners
    - Better funding for wider range of prescribing
    - Bring back ear acupuncture to Penzance once a week
    - Consider more ex-drug users as care co-ordinators or to provide support
  - More volunteering opportunities
  - Support whilst waiting between services
  - Support for partners and families, ‘affected others’
- **Advocacy** for service users
- **More help with mental health** - Mental Health & Dual Diagnosis Pathways and joint working
- **Better communication** between services who are working with you
- Education of other professionals involved in recovery:
  - GPs
  - Job Centre Plus
  - Hospital staff
  - “Social Services”
  - Service users are happy to be involved in educating agencies

- Primary Care
  - A drug and alcohol specialist in every surgery, “not just for alcohol”

- Increased availability of structured day programmes
  - For people ‘in treatment’ as well as those ‘in recovery’
  - Across each locality

- More groups
  - Saltash, Bude and St Austell
  - Evening sessions, “something on Mondays”
  - Access to more social activity
  - More aftercare/support facilities.

- Employment Services
  - Job Centre Plus staff need to forge closer links with treatment organisations like Gwellheans in order for them to gain more of an understanding of addiction and the issues faced by service users.
  - Consideration as to how medical assessments can pick up on a client’s mental well being

### Priorities from collated from responses to Service User Questionnaire

<table>
<thead>
<tr>
<th>Issue</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured day programmes/Life skills/Training</td>
<td>20</td>
</tr>
<tr>
<td>More counselling</td>
<td>16</td>
</tr>
<tr>
<td>Meetings closer to home</td>
<td>7</td>
</tr>
<tr>
<td>Home support/Visits</td>
<td>7</td>
</tr>
<tr>
<td>Tea and coffee, water</td>
<td>7</td>
</tr>
<tr>
<td>Better post detox treatment options</td>
<td>6</td>
</tr>
<tr>
<td>More group meetings</td>
<td>5</td>
</tr>
<tr>
<td>Day centre in every town</td>
<td>5</td>
</tr>
<tr>
<td>Meetings in the evening</td>
<td>4</td>
</tr>
<tr>
<td>Relapse prevention</td>
<td>4</td>
</tr>
<tr>
<td>Helpline</td>
<td>4</td>
</tr>
<tr>
<td>Out of hours support</td>
<td>3</td>
</tr>
<tr>
<td>Help with transport</td>
<td>3</td>
</tr>
<tr>
<td>More appointments</td>
<td>3</td>
</tr>
<tr>
<td>Access to doctors surgeries over the weekend</td>
<td>2</td>
</tr>
<tr>
<td>Family support (advice and education)</td>
<td>2</td>
</tr>
<tr>
<td>More information about services</td>
<td>2</td>
</tr>
<tr>
<td>More funding for services</td>
<td>2</td>
</tr>
<tr>
<td>Surgeries need to know more about CDAT &amp; Addaction services</td>
<td>1</td>
</tr>
<tr>
<td>CDAT available in the afternoon</td>
<td>1</td>
</tr>
<tr>
<td>Keep needle exchange in Liskeard</td>
<td>1</td>
</tr>
<tr>
<td>Improve recovery programme</td>
<td>1</td>
</tr>
<tr>
<td>Waiting entertainment i.e. music/magazines</td>
<td>1</td>
</tr>
<tr>
<td>Sembal open more regularly with someone from CDAT</td>
<td>1</td>
</tr>
<tr>
<td>Childcare facilities</td>
<td>1</td>
</tr>
<tr>
<td>Improve waiting times for detox</td>
<td>1</td>
</tr>
<tr>
<td>Keep same key worker throughout treatment</td>
<td>1</td>
</tr>
</tbody>
</table>
Do we meet the needs of people in long term treatment?

Previous needs assessments have highlighted that there is a higher proportion of service users in long term treatment locally than the regional and national averages.

Analysis for this section has been undertaken using the raw data and hence the figures differ slightly from the published performance figures.

In 2009/10 21% of service users had been in treatment for 4 years or more, which is around 10% higher than the regional average. There has been no notable change in the number of long termers compared with last year.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Total in tx</th>
<th>2 to 4 years</th>
<th>4+ years</th>
<th>2009/10 4+ years</th>
<th>2008/09 4+ years</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addaction</td>
<td>367</td>
<td>49</td>
<td>6</td>
<td>2%</td>
<td>2%</td>
<td>-1</td>
</tr>
<tr>
<td>Bosence Farm</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>CDAT/Shared Care</td>
<td>1192</td>
<td>269</td>
<td>359</td>
<td>30%</td>
<td>36%</td>
<td>-35</td>
</tr>
<tr>
<td>Freshfields</td>
<td>64</td>
<td>15</td>
<td>3</td>
<td>5%</td>
<td>4%</td>
<td>0</td>
</tr>
<tr>
<td>Gwelheans</td>
<td>434</td>
<td>26</td>
<td>3</td>
<td>1%</td>
<td>1%</td>
<td>-1</td>
</tr>
<tr>
<td>Yz-Up</td>
<td>33</td>
<td>6</td>
<td>6</td>
<td>18%</td>
<td>17%</td>
<td>-1</td>
</tr>
<tr>
<td>Total</td>
<td>1836</td>
<td>346</td>
<td>377</td>
<td>21%</td>
<td>22%</td>
<td>-38</td>
</tr>
</tbody>
</table>

The Treatment Outcome Profile Tool (TOP) (Appendix D) is the internationally validated outcome monitoring tool that must be used for all structured treatment interventions. Collection of Treatment Outcome Profile (TOP) data across the country has significantly improved in the last year and many partnership areas, as well as regionally and nationally, are using TOP to assess treatment outcomes across a range of client groups.

In order to achieve robust results, compliance must be 80% or above and in Cornwall, we have thus far failed to reach this level.

We are, however, approaching the required compliance level and TOP data provides a rich source of information about individual and collective outcomes that cannot be obtained from elsewhere.

In the group of clients that had been in treatment for four years or longer, 234 had paired TOPs within the 15 month period between 1 April 2009 and 30 June 2010, equating to 65%. 14 clients were excluded from this analysis because the period between the two assessments was less than 12 weeks – leaving 220 (65% of the client group).

CDAT / Shared Care was the TOP owner in the vast majority of cases.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Number</th>
<th>Mean length of longest open episode (years)</th>
<th>No. engaged with other agencies</th>
<th>Paired TOP in period</th>
<th>% paired TOP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addaction / CADA</td>
<td>7</td>
<td>4.6</td>
<td>5</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>CDAT / Shared Care</td>
<td>325</td>
<td>7.5</td>
<td>31</td>
<td>231</td>
<td>70%</td>
</tr>
<tr>
<td>Freshfields</td>
<td>3</td>
<td>5.0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Gwelheans</td>
<td>3</td>
<td>4.8</td>
<td>1</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Yz-Up</td>
<td>2</td>
<td>5.7</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
The first and last TOP in the period were compared for each client and analysis was undertaken in line with the most recent national guidelines\textsuperscript{8}.

The average period of time between TOPs was 38 weeks (ranging from 13 to 62 weeks).

- The overwhelming picture presented across all the elements of the TOP is one of no change. Whilst this could be viewed as evidence of stability it clearly doesn’t evidence improvement or meeting the recovery needs of individuals.

**Substance use**
- With the exception of alcohol use, the majority were abstinent during the previous 28 days for both TOPs.
- Where change was shown, a higher proportion of clients significantly reduced their drug use (in terms of days) or achieved abstinence than increased their drug use.
- A small proportion of clients significantly increased their drug use over the period and the highest increases were noted for cannabis, alcohol and opiates.

**Injecting risk behaviour**
- Prevalence of injecting and sharing remained the same, with the majority not injecting or sharing.
- Where change was shown, a higher proportion of clients significantly reduced their injecting (in terms of days) or stopped altogether than increased their injecting.
- A very small percentage of clients increased the number of days injecting.

**Offending**
- The level of offending disclosed was almost nil.

**Health and social functioning**
- The number of clients working full time (20+ days) dropped between the two periods, although only significantly (a reduction of 10 days or more) in a small number of cases.
- The vast majority showed no significant change (+/- score of 6) in their psychological or physical health or their general quality of life.
- A small proportion of clients had significantly deteriorated in terms of their self-assessment of their health and / or quality of life, and for psychological health a slightly higher proportion of clients felt that they had significantly deteriorated than improved.

\textsuperscript{8} Guidance for The Quarterly Outcomes Report Quarter 1 2010/11 www.ndtms.net
Chapter 5 - More flexible services, meeting individual needs

The emphasis of the new Government Drug Strategy (2010) is upon Recovery and key NTA and international guidance summarises the characteristics of a Recovery Oriented Treatment System (ROIS)

In a recovery oriented treatment system:

- Everyone in treatment is on a journey
- Everyone in treatment has a care plan/recovery plan that maps and guides the journey.
- Everyone in treatment uses the Treatment Outcome Profile (TOP) tool to review their progress against the whole range of outcome domains, using TOP on entry, review and exit.
- ITEP (International Treatment Effectiveness Project) mapping used to assist and guide the client through the treatment system.
- In a recovery oriented treatment system, everyone speaks the language of recovery.

Underpinning a ROIS, people with drug (and alcohol) problems and their families achieve their own recovery. The treatment system exists to facilitate them.

A recovery-orientated system should provide a single point of contact and a single point of assessment/access. The system focuses and builds upon the aspirations of service users and their families. Effectiveness is judged by how many people/services are involved in someone’s care rather than how few. The focus is on outcomes.

Fundamentally, treatment services work together as a system.

The service user journey is navigated and services work together with the client’s care (recovery) plan, TOP form and ITEP map. It is an integrated system where workers are trained together in recovery principles and practice and services are (contractually) required to integrate their practice with other services.

Recovered and recovering clients assist in training workers. Self Help (e.g. Intuitive) and Mutual Aid are an integral part of a recovery oriented treatment system.

Services in the system are performance managed by the DAAT on the number and quality of referrals made to other services.

A recovery-oriented system delivers outcomes for the money invested across the following areas:

- Physical and Psychological Health
- Crime reduction and community safety
- Social integration (employment and housing)
- Families

Recovery capital consists of three broad domains:

- Improving personal and life skills; esteem and efficacy
- Increasing beliefs and desires around recovery
- Involving and improving support and engagement in family and community
Key questions

- What have we got now?
- What does the treatment map look like?
- Are there services doing the same things?
- Are there any services that don’t refer to each other?
- Have we got an independent, single point of assessment and access to the system?
- Are there some current services that we don’t need?
- Are there some new services that we do need?

The drug treatment system in Cornwall

- Around a fifth of people in treatment have been in for 4+ years
- Low numbers entering through self referral or criminal justice routes
- Focus has been predominantly upon the substance and clinical treatment (and offending behaviour if in criminal justice treatment)
- Predominant interventions have been counselling and psychotherapy (lengthy)
- High numbers engaged
- Little or no wait
- Retention rates are good
- Successful completions are good
- Rates of discharge are low
- Little information about outcomes
- Few referrals to other services
- Care plans in their infancy of being used
- Low level of care co-ordination
- Little education, training and employment options
- Lack of supported accommodation impedes recovery

Values

- Harm reduction is vital
- Increased focus upon service users’ strengths and developing a positive identity outside of use
- Increased use of peer-based recovery mentors
- Integration of structured treatment and recovery support groups
- Greater emphasis on physical, social and cultural environment, e.g. shift from clinics to community-based services
- ‘Manners Matters’ - use the evidence regarding what works

Challenges

- Engaging people earlier in their problematic use
- More flexible delivery
- The range of community interventions required and delivering these equitably - a ‘rural’ model
- Co-ordinating care
- Balancing Tier 4 and Tier 3
- Delivery against a background of cuts
Recovery is an individual process – adapting the system to individual needs

Becoming better at improving and promoting recovery requires even more flexible packages of treatment and care to meet individuals’ needs at different stages of their ‘recovery journey’. For example, if the greatest gains are made in the initial stages of treatment, then we need to adjust our local system to make more intensive help available at that stage.

As part of this year’s assessment, service users cited a desire for greater frequency and length of appointments at times of significant change and the need for a wider range of interventions as examples of how we could help them more.

The priorities for development are:

- A single point of contact to facilitate early access
- Train all staff in recovery principles and practice;
- Utilise the ITEP maps and mapping more comprehensively;
- Ensure that people can be in treatment and be in employment at the same time;
- Work with providers together to ensure all are clear about the part played in the system by other services;
- Develop employment initiatives.

The previous section considers a range of indicators for identifying the extent to which our current treatment system is focused on recovery.

We have established that:

- Young people with drug problems in Cornwall appear not to be approaching treatment services until their drug problem is fully established.
- Cornwall does not compare favourably with the South West for getting offenders into treatment (although we’re good at retaining them when we get them in).
- Locally GP referral is the most common route into treatment (rather than self-referral elsewhere). This indicates that we are not attracting illicit drug users early enough in their problematic use and that open access services need to be more flexible and accessible.
- Half of all new referrals have never been in treatment before.
- Successful completion rates by length of time in treatment indicate that the optimum treatment period is between 6 months and 2 years.
- We have yet to make an assessment of the specific needs of people in treatment for between 2 and 4 years.
- Just over a fifth of people in treatment in 2009/10 had been in for 4 years or longer, which is higher than average. Local assessment of their progression through treatment and outcomes suggests that we are not adequately meeting their needs.
- A quarter of people in treatment drop out – this is up on last year and above the regional average. We have identified a small cohort of service users who drop in and out of treatment repeatedly.
- Analysis of local data has identified a range of both positive and negative factors in successful completion. This combined with the invaluable insights from service users, carers and providers into what works and doesn’t work will form the basis of work planning for the coming year.
Chapter 6 - Drug use and crime

Drug use, particularly of the class A drugs heroin and crack cocaine, is strongly associated with crime and offending. Based on national models (see page 32), drug users in Cornwall who are not currently engaged with the treatment system, around 1000 people, are estimated to have committed just under 19,000 crimes during 2010/11 (equating to around 1,200 recorded crimes, including 450 burglaries and 400 vehicle crimes).

Measuring the true extent of drug-related crime is problematic because, unlike alcohol-related crime, the link to drugs is not routinely recorded with the crime details within the Crime Information System.

We know that offenders with drug problems are more likely to commit acquisitive crime, such as burglary, thefts and vehicle crime, to provide funds for their addiction and to be convicted of drug specific crime, such as possession and supply.

An assessment of the extent to which drug use is a factor in offending behaviour draws on data from arrest referral and Probation and engagement with treatment and outcomes is drawn from the National Drug Treatment Monitoring System.

Drug specific crime is unlike other types of crime in that there is generally no victim to report the crime and the police have to be proactive to discover that crimes have been committed. Arrests and seizures rely on the degree of police activity and will reflect local policing priorities in response to local drug problems. For this reason it is unwise to use crime statistics alone to infer a level of drug use in the general population.

Key findings

- Drug use is a risk factor for a third of offenders on the Probation caseload and the majority are PDUs, with cannabis the most common problem drug amongst non-PDUs. Prolific and Other Priority Offenders (PPOs) are more likely to have drug problems (two thirds).
- Offenders with drug problems are more likely to have been convicted of either a drug-related offence or an acquisitive crime, such as burglary or theft, or drug specific crime such as possession or dealing in illegal drugs.
- Offenders with drug problems are more likely to also have other issues that contribute to their risk of reconviction, such as accommodation, education / training and employability (ETE) and financial situation.
- Central and West Cornwall see the highest numbers of offenders under supervision in the community who have drug problems and related issues.
- Across a range of performance indicators, in 2009/10 Cornwall did not compare favourably with the South West for getting offenders into treatment. Indicators for the year to date, however, show significant improvement.
- We have established routes into treatment from the various points of contact with the Criminal Justice System. Integrated Offender Management should present opportunities to attract and engage offenders at a community level, before their substance problem and their offending escalates.
- Once in treatment, we are successful on the whole at retaining them and the majority of offenders in treatment in 2009/10 had been with us for at one year. Offenders who leave treatment, however, are more likely to leave in an unplanned way and within 6 months.
- Reoffending rates for known class A drug-using offenders and PPOs are low and, in these areas, we are amongst the top performing DAAT / CJITs in the country. Almost two thirds of offenders commencing Drug Rehabilitation Requirements complete successfully.
- The Value for Money (VFM) Model of adult drug treatment in England estimates that in 2009/10, an estimated 28,000 crimes were prevented by engagement of the current numbers of drug users in treatment, delivering £13.7 million in cost savings and natural benefits and an estimated reduction in actual crime of around 15%.
- Police activity relating to class A drug crime has dropped since the last assessment, with 30% fewer offences recorded and significantly lower quantities of class A drugs seized. There has been very little activity related to crack in the last 18 months.
• The only area of notably increased activity is in respect of cannabis production and seizures of plants, particularly in the Truro and St Austell area.
• Mephedrone, which was categorised as an illegal drug from April 2010, accounted for 3% of recorded offences (mostly possession) between April and September 2010. The majority of mephedrone seized in Cornwall during this period was in 2 seizures in Saltash.

The Drugs Intervention Programme (DIP) was set up in 2003 to tackle drugs and reduce crime by getting adult drug-using offenders out of crime and into effective treatment. The DIP also enables drug using offenders to access other kinds of support, such as employment, housing and mental health, to help them to progress onto drug-free lives. Delivery at a local level is managed by the Criminal Justice Integrated Team (CJIT) with an holistic case management approach that begins at the offender’s first contact with the criminal justice system and continues that journey through custody, court, sentence, treatment and beyond into rehabilitation and resettlement. This function becomes part of Integrated Offender Management (IOM) in 2011/12.

Home Office research indicates that the programme has been successful attracting offenders with drug problems into treatment and thus reducing illicit drug use and associated crime.

The Home Office published an IOM Government Policy Statement in June 2009. Its purpose is to provide support and direction in bringing together the management of repeat offenders into a more coherent structure (IOM). A framework approved by the Community Safety Strategic Group in November 2010. Implementation of the framework will commence in 2011/12.

Building a comprehensive picture locally has been fraught with difficulties, largely arising from the varying systems and procedures used to capture the drug use and treatment outcomes for offenders, which is dependent on the nature of their contact with the criminal justice system and subsequent engagement with treatment agencies.

Analysis of drug use and offending in this assessment draws on data from arrest referral contacts, Probation, the National Drug Treatment Monitoring System and headline DIP reports provided by NDTMS. There is a parallel recording system for drug using offenders engaged with the Drugs Intervention Programme (DIP) which has proved difficult to triangulate with other data sets, due largely to differing data collection procedures and criteria. Further work is required in this area to allow the DIP data to be used effectively to inform future assessments. This is a national rather than purely local problem.

**Drug use as a factor in offending**

Arrest referral staff make contact with offenders following arrest where there appears to be a link with problem substance use. Arrest referral staff can provide information and advice (described as a brief intervention) where appropriate and / or refer the offender to one or more specialist treatment services. Offenders identified with a drug problem are referred to the DIP and a Drugs Intervention Record (DIR) is completed.

- Arrest referral staff made 1,067 contacts in 2009/10, an average of 90 per month. The majority of contacts (69%) were for suspected problem alcohol use, usually following either a violent offence or an incident specifically linked to alcohol use, such as being drunk and disorderly or drink driving.
- 30% of contacts were for suspected drug problems, of which just over a quarter were recorded as PDUs. Drug contacts were more likely to be following a drugs offence (such as possession or dealing) or acquisitive crime, such as theft or burglary. Offenders were much less likely to have been brought in for a violent offence.
- Where drug use was identified as a problem, 30% of contacts were subject to a DIR (20% new and 10% existing) and 2% were already subject to Drug Rehabilitation Requirement (DRR) orders.

Data collected by arrest referral staff to date is currently limited, particularly with respect to clear recording of onward referrals and outcomes. The process and recording mechanisms are
Chapter 6 – Drug use and crime

Currently under review with the aim of developing a more robust and consistent method for implementation in the coming year.

For any offender under supervision by Probation, so either serving a custodial sentence of 12 months or more or serving a community sentence, a comprehensive assessment is undertaken by their case manager that considers the risks to criminal behaviour and offender wellbeing across a range of factors including accommodation, education / training / employability (ETE), finances, relationships, mental health and problematic substance use. The findings are recorded in OASys\(^9\), a data snapshot of which is provided for this assessment.

On 1 April 2010, there were 765 offenders on the caseload for Cornwall and Isles of Scilly Probation.

- Almost two thirds of offenders were recorded as having some history of drug use, with 28% currently using drugs. Cannabis is the most commonly used drug, accounting for over half of current drug users.
- Drug use was assessed as presenting risk of serious harm and / or to be linked to offending for a third of offenders (252 offenders). In this higher risk group, the majority are PDUs (53%, 134 offenders), with cannabis the most common problem drug amongst non-PDUs.
- Offenders with drug problems are more likely to have been convicted of either a drug-related offence or an acquisitive crime, such as burglary or theft, or drug specific crime such as possession or dealing in illegal drugs.
- Offenders with drug problems who are under supervision in the community (not serving a custodial sentence) are more likely to be considered at risk due to issues relating to their accommodation, ETE and financial situation. They are less likely to be involved in domestic violence (either as a victim or a perpetrator).
- 41% of offenders with drug problems living in the community are parents, linked between them to 98 children, and this is in line with the offender population average.
- Consistent with previous years, Prolific and Other Priority Offenders (PPOs) are more likely to have drug problems (two thirds) and they are predominantly PDUs.
- The table below shows the number of offenders in the community with drug problems cross-tabulated with other risk factors.

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Central</th>
<th>North &amp; East</th>
<th>West</th>
<th>Cornwall</th>
<th>% of offenders with drug problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation</td>
<td>13</td>
<td>8</td>
<td>22</td>
<td>43</td>
<td>31%</td>
</tr>
<tr>
<td>ETE</td>
<td>16</td>
<td>10</td>
<td>11</td>
<td>37</td>
<td>27%</td>
</tr>
<tr>
<td>Finance</td>
<td>23</td>
<td>11</td>
<td>23</td>
<td>57</td>
<td>41%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>36</td>
<td>15</td>
<td>28</td>
<td>79</td>
<td>57%</td>
</tr>
<tr>
<td>Mental health</td>
<td>17</td>
<td>4</td>
<td>15</td>
<td>36</td>
<td>26%</td>
</tr>
<tr>
<td>Total offenders with drug problems</td>
<td>56</td>
<td>31</td>
<td>52</td>
<td>139</td>
<td>100%</td>
</tr>
<tr>
<td>Total offenders in community</td>
<td>191</td>
<td>98</td>
<td>198</td>
<td>487</td>
<td></td>
</tr>
<tr>
<td>% with drug problems</td>
<td>29%</td>
<td>32%</td>
<td>26%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Links to children</td>
<td>25</td>
<td>15</td>
<td>17</td>
<td>57</td>
<td>41%</td>
</tr>
<tr>
<td>No. of children</td>
<td>50</td>
<td>22</td>
<td>26</td>
<td>98</td>
<td></td>
</tr>
</tbody>
</table>

- In terms of number, need across the range of issues is greatest in Central and West Cornwall. In terms of proportion of the offender population, however, there are some notable differences by locality. Risk linked to drug use is generally slightly more likely amongst offenders living in North and East, prevalence of issues with ETE and the proportion of parents are also highest in this area. Accommodation issues are most prevalent in the West and adjunctive alcohol problems are most prevalent in Central Cornwall.

\(^9\) Offender Assessment System; used in the England and Wales by Her Majesty’s Prison Service and the National Probation Service from 2002 to measure the risks and needs of criminal offenders under their supervision.
Engagement with treatment

We would expect offenders identified with drug problems living in the community to be engaged with community drug treatment services.

- Previous assessments have highlighted a significant shortfall in numbers and this continues to be the case with 50% of this group not having any recorded treatment history (current or previous) in NDTMS. This group includes 17 PDUs.
- Although some of the shortfall may be explained by a gap in NDTMS recording (recorded in the DIP but not NDTMS), performance indicators for the CJIT / DIP in 2009/10 also indicate that we did not compare favourably with the South West for getting offenders into treatment. Indicators for the year to date, however, show significant improvement.

DIP performance reports are provided on a quarterly basis from NDTMS and reports covering 4 quarters have been aggregated together to make up the 12 months of 2009/10 (hence if an offender was referred in more than one quarter they will be counted twice).

- Over the 12 month period, 168 offenders had care plans agreed by the DIP, of which 24% were referred by the CJIT into specialist treatment. There was little change compared with 2008/09 (26%) and it remained considerably below the regional and national averages (40% and 50% respectively).
- Treatment take-up following DIP referral is shown in the table below – the NTA measure take-up by the number of offenders who subsequently appear in NDTMS and as we have already established, there is a significant gap between the two systems.
- Compared with 2008/09, there was a higher proportion of offenders entering the treatment system via DIP but a lower proportion already in treatment, hence treatment take-up was the same and less than half the regional average.

<table>
<thead>
<tr>
<th>Referrals (12 months)</th>
<th>Cornwall &amp; Isles of Scilly</th>
<th>South West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total clients referred</td>
<td>55</td>
<td>1340</td>
</tr>
<tr>
<td>Enter treatment system via DIP</td>
<td>10</td>
<td>548</td>
</tr>
<tr>
<td>In treatment already</td>
<td>7</td>
<td>345</td>
</tr>
<tr>
<td>No treatment take-up</td>
<td>38</td>
<td>447</td>
</tr>
</tbody>
</table>

- The situation has improved in the year to date, however, with 31% of offenders being referred into specialist treatment from CJIT (in line with the South West average, which has dropped to 29%) and the treatment take-up significantly up to 64%. This should be apparent in the next round of local data analysis.
- The number of referrals from CARAT\(^\text{10}\) is unchanged over the last 18 months but the proportion picked up by the CJIT has increased to just over a third, exceeding the regional average.

Offenders in treatment

- The treatment mapping data provided by NDTMS for needs assessment purposes shows that referrals through the criminal justice route (Arrest Referral / DIP, CARAT, Probation and other CJS) accounted for 9% of all referrals in 2009/10. Despite the increase, consistent with previous years locally criminal justice referrals remain significantly below the proportion in the South West (20%).
- Referrals through Arrest Referral / DIP are fairly similar to last year (very low) and referrals through CARAT and other CJS have seen a notable increase, although the numbers remain small. All of the referrals are into CDAT and the rise is attributed to IDTS referrals.
- Offenders referred into drug treatment are less likely to be treatment naïve (they have been in treatment previously) and the proportion of treatment naïve offenders is in line with the South West average (30% locally compared with 28%).

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10 CARAT stands for ‘Counselling, Assessment, Referral, Advice and Throughcare.’ Any person coming into prison that is identified as having a drug problem is assessed, given advice about their using and referred to treatment and other services (such as housing) as appropriate to prepare for release.
• We are on the whole successful in retaining offenders in treatment (over half of clients in treatment in 2009/10 who had entered via a criminal justice route had been in treatment for a year or longer) but those who leave treatment are more likely to leave in an unplanned way and within 6 months (60%).

The Drug Rehabilitation Requirement is an order given to offenders convicted of drug-related crime as part of their sentence and includes a referral, assessment and sentencing process to place offenders into appropriate treatment.

• We have an annual completion target of 40 DRRs and completions must account for at least 55% of all DRR commencements. We have consistently exceeded both of these targets over the last three years. In the year to date (up to and including January 2011), a total of 45 offenders have completed DRRs, with a completion rate of 65% of all DRRs commenced.

**Measuring the impact of treatment on reoffending**

The benefits of engaging drug users in treatment in terms of preventing crime are significant. The Value for Money (VFM) Model of adult drug treatment in England estimates that in 2009/10, an estimated 28,000 crimes were prevented (see breakdown in table below), delivering £13.7 million in cost savings and natural benefits. The vast majority of crime prevented is attributed to PDUs (94%).

Based on recorded crime in 2009/10 and associated estimates of actual crime this means that if the current number of drug users in treatment had not been effectively engaged their offending could have contributed an additional 15% to incidence of crime across this group of crime types.

<table>
<thead>
<tr>
<th>Crime type</th>
<th>Crimes prevented PDUs</th>
<th>Crimes prevented Non-PDUs</th>
<th>Total crimes prevented</th>
<th>Recorded crime 2009/10</th>
<th>Estimated actual crimes 2009/10</th>
<th>Estimated crime reduction achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robbery</td>
<td>362</td>
<td>23</td>
<td>386</td>
<td>72</td>
<td>266</td>
<td>145%</td>
</tr>
<tr>
<td>House burglary</td>
<td>181</td>
<td>12</td>
<td>193</td>
<td>921</td>
<td>2,026</td>
<td>10%</td>
</tr>
<tr>
<td>Business burglary</td>
<td>1,147</td>
<td>74</td>
<td>1,221</td>
<td>1,743</td>
<td>3,660</td>
<td>33%</td>
</tr>
<tr>
<td>Theft of a vehicle</td>
<td>302</td>
<td>20</td>
<td>321</td>
<td>480</td>
<td>576</td>
<td>56%</td>
</tr>
<tr>
<td>Theft from a vehicle</td>
<td>905</td>
<td>59</td>
<td>964</td>
<td>1,788</td>
<td>5,006</td>
<td>19%</td>
</tr>
<tr>
<td>Shoplifting</td>
<td>22,389</td>
<td>1,451</td>
<td>23,840</td>
<td>1,712</td>
<td>171,200</td>
<td>14%</td>
</tr>
<tr>
<td>Bag snatch</td>
<td>422</td>
<td>27</td>
<td>450</td>
<td>227</td>
<td>1,044</td>
<td>43%</td>
</tr>
<tr>
<td>Cheque/credit card fraud</td>
<td>483</td>
<td>31</td>
<td>514</td>
<td>131</td>
<td>5,581</td>
<td>9%</td>
</tr>
<tr>
<td>Total selected crimes</td>
<td>26,191</td>
<td>1,698</td>
<td>27,889</td>
<td>7,074</td>
<td>189,360</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Total savings £**

|                      | £12,800,000 | £800,000 | £13,700,000 |

Using the same model we can also estimate the crime committed by problem drug users who are not engaged with the drug treatment system. As we have previously established, prevalence estimates for Cornwall indicate that around 1,000 PDUs are not currently engaged with treatment. These individuals are estimated to have committed just under 19,000 crimes during 2010/11 (equating to around 1,200 recorded crimes, including 450 burglaries and 400 vehicle crimes).

There are currently two nationally prescribed indicators for measuring the extent of reoffending amongst drug using offenders – the class A drug-related reoffending rate (NI38) and the PPO reoffending rate (NI30). Whilst giving a useful indication of the impact of treatment interventions with specific groups of offenders, however, they cannot be used to estimate the overall impact of drug use on crime.

These indicators will cease in their current form on 31 March 2011 but central government are continuing to focus on reducing reoffending and similar replacement measures are anticipated as part of the new ‘Single List’ of indicators.
These indicators, calculated centrally by the Home Office and bringing together data from a range of sources, including from the police and probation, measure the volume of actual reoffending in the identified cohort of offenders against the volume of reoffending predicted by a statistical model that takes into account their historical offending characteristics (for drug-related reoffending) or against the national rate of reoffending (PPOs).

- Both measures indicate that we are successful in diverting drug using offenders from crime.
- 24 offenders were identified as class A drug users via their OASys assessment in the baseline period (January to March 2009). The reoffending rate in the 12 months following identification (April 2009 to March 2010) was just under half the level predicted by the model and we were ranked in the top performing 10% of DAATs nationally.
- The PPO cohort is larger, including 54 offenders, but reoffending performance was similar, with actual reoffending at just under half of the national rate. Cornwall was ranked in the top performing 20% of areas nationally.

### Drug specific crime

Drug crime is unlike other types of crime in that there is generally no victim to report the crime and the police have to be proactive to discover that crimes have been committed. Arrests and seizures rely on the degree of police activity and will reflect local policing priorities in response to local drug problems. For this reason it is unwise to use crime statistics alone to infer a level of drug use in the general population.

Nationally drug offences fell by 4% in 2009/10 and this was the first year-on-year fall since the police were given greater powers to issue warnings for possession of cannabis.

- Crime specifically related to production, possession and trafficking of illegal drugs accounted for 5% of all recorded crime in the 12 month period to 30 September 2010.
- There were 1,355 drug crimes recorded during this period; a rise of 21% compared with the last assessment.
- Locally the trend for drug offences continued to rise throughout 2009/10, predominantly accounted for by the continued growth in the number of recorded offences for cannabis possession. The rate of increase has slowed in the year to date and the trend is now flat, indicating that the impact of changes to police powers has finally settled.
- Recorded offences of production of cannabis also increased in number over the last 18 months, particularly around St Austell and the China Clay area.
- Generally crime rates in Cornwall are significantly lower than the average for similar areas nationally. Drug crime is one of the few areas where we are more closely aligned to our ‘most similar family’ and generally we tend to see slightly higher rates of possession offences locally but lower rates for trafficking.
- Offences relating to class A drugs make up 16% of all recorded drug offences and the most common drugs are cocaine (7%) and heroin (5%). The number of offences dropped by 30% compared with the last assessment.
- The main hotspots for drug offences in the 12 months to 30 September 2010 are St Austell (particularly cannabis offences), Penzance (all drugs), Truro (cannabis), Newquay (coca), Falmouth (coca and amphedamines) and Liskeard and Bodmin for heroin offences.
- Unique offence codes were created for mephedrone / methedrone in April 2010 and we have seen 18 recorded crimes in the first six months of year, predominantly possession offences and in East and Central Cornwall.
- There were 1711 seizures of drugs in the 12 month period to 30 September 2010, a fall of 8% compared with the number of seizures in 2008/09. The quantities of drugs seized were significantly less, however, partly due to a greater proportion of small seizures amongst the cannabis seizures and comparatively lower weights amongst the larger seizures.
- The exception was cannabis plants, with over 5,000 plants seized across Cornwall, with particularly high numbers (in excess of a 1,000 plants) seized in St Austell and Truro police sectors.
Other larger seizures of note in this period, all linked to trafficking offences, include amphetamine powder (930g, Perranporth sector) and cannabis (700g herbal and 500g resin in Penzance and 646g herbal in Camborne).

46g of mephedrone was seized between April and September 2010, the vast majority accounted for by 2 seizures in Saltash.

Consistent with previous years, Newquay sector saw the highest number of seizures but almost half were for small quantities (less than 1g in weight or 5 items in number).

**Acquisitive crime**

Dwelling burglary is grouped with vehicle crime and robbery under the heading of serious acquisitive crime.

Previously published research on the links between the economy and property crime has indicated that it would increase in times of recession and this has been highlighted in previous assessments as a potential threat. Nationally this has not been the case with recent trends in property crime found to be part of a long term decline over the last 15 years, with increasing security noted as a key factor. Both dwelling burglary and vehicle crime reduced nationally in 2009/10.

In Cornwall negative trends in both vehicle crime and dwelling burglary became apparent in 2008/09. Whilst the trend for vehicle crime has since resumed an improving path (and was one of our key areas of good performance in 2009/10), the trend for dwelling burglary has been more volatile.

Acquisitive crime is also linked to problem drug use. We know that offenders with drug problems are more likely to commit acquisitive crime, such as burglary, thefts and vehicle crime, to provide funds for their addiction.

- Although rates of crime remain low compared with the national picture, the trend for dwelling burglary has been deteriorating for the last two years and continues to do so, largely driven by rising numbers of burglaries in persistent hotspot areas. There are proven links to problematic drug use and, based on the impact on crime of the last recession in the 1990s, it is reasonable to assume that the economic downturn is also a factor.
- There are pockets of persistent higher crime in the West (Camborne / Pool / Redruth and Penzance) and in Central Cornwall (Newquay and Falmouth).
- Falmouth and Penryn are home to a significant number of students and young people make up a much higher than average proportion of burglary victims in these areas. National research also points to this group as being at increased risk of victimisation.
- National research also emphasises the importance of adequate home security measures to reduce the household risk of victimisation.
- Due to the underlying low crime rate, small changes can appear significant but may be indicative of the activities of one (often known) offender. The wider Community Safety Partnership has key roles to play both through working with communities to help them reduce their risk of becoming a victim of crime and through supporting positive work with offenders who have been identified as presenting a particular risk, such as Prolific and Other Priority Offenders and drug using offenders who use burglary and other acquisitive crime as a means to fund their drug habit.
- The highest priority areas for tackling dwelling burglary are Penzance, Camborne, Falmouth, Newquay, Pool and Redruth. Two further areas were rated as high – St Austell and Penryn – due largely to negative trends apparent over the last 12 months and above average proportions of younger victims.
Integrated Offender Management

It is estimated that around 50% of all crime is committed by a previous offender. Prison is not a cost effective solution and does not deliver sustainable benefits in terms of reduced harm to the community, apart from during the time served in custody.

- Previous research\textsuperscript{11} by the Government’s Social Exclusion Unit found that 1 in 5 crimes is committed by an ex-prisoner and nearly 3 in every 5 ex-prisoners are re-convicted within two years of release.

This research also identified the importance for reducing reoffending of managing an offender’s sentence from start to finish in a coherent and consistent way.

As of April 2010 reducing reoffending became a statutory responsibility for Community Safety Partnerships and Probation joined the Partnership as a responsible authority.

Reducing reoffending is fundamental to reducing crime in local communities and benefits everyone:
- Every offender who becomes an ex-offender means safer streets and fewer victims
- Turning people away from crime means less pressure on the resources of the criminal justice system and its delivery partners
- Offenders who stop reoffending get the opportunity to repay their debt to society and improve their own life chances, as well as those of their children and families.

Adults and young people convicted of offences are often some of the most socially excluded within society. The majority of offenders have complex and often deep-rooted health and social problems, such as substance misuse, mental health problems, homelessness, high levels of unemployment and possibly debt and financial problems. Tackling these issues is important for addressing the offender’s problems and providing ‘pathways out of offending’, and to break the inter-generational cycle of offending and associated family breakdown.

The statutory guidance accompanying the changes said that we should be ‘broadening the focus of local activity from offences to also considering offenders, particularly through Prolific and other Priority Offenders (PPOs) schemes and the growth of Integrated Offender Management (IOM)”. There is an expectation that all Partnership areas will introduce an IOM.

IOM is a system that provides all agencies engaged in local criminal justice partnerships with a single coherent structure for the management of repeat offenders. It is an overarching framework for bringing together agencies in local areas to prevent, deter, catch and convict offenders and to rehabilitate and resettle them, delivering long-term, sustainable benefits to the community.

The Partnership approved an IOM framework for Cornwall in November 2010 and implementation will continue throughout 2011/12.

The key aims of IOM are to:
- Reduce crime and reoffending, improve public confidence in the criminal justice system and tackle the social exclusion of offenders and their families
- Address potential overlaps between existing approaches and programmes to manage offenders and address gaps
- Align the work of local criminal justice agencies and their partners more effectively, expanding or improving on partnerships that already exist at the local, area and regional level
- Simplify and strengthen governance to provide greater clarity around respective roles and responsibilities.

\textsuperscript{11} Two key reports by the Government’s Social Exclusion Unit – Reducing Reoffending by Ex-Prisoners (2002) and Breaking the cycle: Taking stock of progress and priorities for the future (2004)
IOM works with any offender at high risk of causing serious harm and/or re-offending – intensity of management relates directly to severity of risk, irrespective of position within the criminal justice system or whether statutory or non-statutory.

The diagram below shows the four tiers of offenders by intensity of management. The two yellow tiers come under the management of the IOM.

<table>
<thead>
<tr>
<th>Offender Group</th>
<th>Threshold/definition</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent, dangerous and high risk of harm offenders</td>
<td>MAPPA Probation Tier 4 (non-PPO) (high risk) NIM Level 2 &amp; 3 (cross border offences) Home Office Tier 1 (Serious sexual and violence offenders) ‘Career’ criminals</td>
<td>Specialist management</td>
</tr>
<tr>
<td>Prolific and other priority Offenders (PPOs)</td>
<td>High persistence Very high risk of re-offending Significant substance misuse</td>
<td>Intensive joint supervision</td>
</tr>
<tr>
<td>Persistent and/or non-compliant offenders</td>
<td>High persistence High/Medium risk of re-offending Serious antisocial behaviour with ASBO in existence</td>
<td>Enhanced joint supervision</td>
</tr>
<tr>
<td>Compliant offenders</td>
<td>First time entrants Low risk of re-offending Limited breach history</td>
<td>Agency management</td>
</tr>
</tbody>
</table>

There is a strong emphasis on using a clear evidence base to direct the activities of the IOM and to inform the decisions about which offenders will be prioritised for interventions.

The current PPO scheme, which works with a rolling caseload of 50 persistent high risk offenders, the majority of which are drug users, will be brought into the IOM along with delivery of the Drugs Intervention Programme. The selection criteria for PPO has long been established, although may come under review as part of the overall implementation process.

Partners have not previously taken this multi-agency approach to working with offenders in the medium to high risk of reoffending tier and it is essential to first understand who they are and what their specific needs are.

Amethyst is currently working with the IOM to develop an evidence base around offenders in this tier, which will inform the prioritisation of resources and the selection criteria for offenders. This will be made available later in 2011/12.

Some work has already been undertaken with Probation and Youth Offending Service data to identify the needs of adult and young offenders, particularly in terms of substance use, but it should be stressed that analysis of need has not been specifically related to the risk of reoffending / reconviction.

- In 2009/10 there were 756 young people on the YOS caseload who were charged with offences during that year, the majority received community penalties or final warnings. Very few young offenders are given custodial sentences.
- A review of the core assessments for these young people shows that thinking and behaviour, relationships and lifestyle are the factors most commonly associated with increased risk of offending.
- Substance use was assessed as a risk for 40% of young offenders. Drugs were a factor in approximately three quarters of cases and for about half of those young people alcohol was cited as a concurrent problem. Persistent or heavy cannabis use was the most commonly mentioned problem drug.
- The OASys snapshot for 1 April 2010 indicates that there are just under 765 offenders on the caseload, of which just under two thirds are under supervision in the community.
- For the majority of offenders alcohol is identified as a problem, either their use presents a risk of serious harm to the offender or others and / or alcohol is linked to offending (58%). The next most commonly identified factors are drug use (33%) and accommodation...
issues (29%). Problem drug and alcohol use in the offender population is discussed in more detail previously in this assessment.

- A broad review of the needs of offenders in the community indicates that family / relationship issues, such as domestic abuse and children, and unemployment will also be key areas to consider.

**Performance monitoring**

There are currently 4 nationally prescribed indicators that measure reoffending in various cohorts of the offender population:

- NI 18 Reoffending rate for adult offenders under probation supervision
- NI 19 Rate of proven re-offending by young offenders
- NI 30 Reoffending rate of prolific and priority offenders
- NI 38 Reoffending rate of class A drug-using offenders

These indicators will cease in their current form on 31 March 2011. Central government are continuing to focus on reducing reoffending and we are anticipate that we will continue to receive performance data until the ‘single measure of reoffending’ is introduced in April 2012.

- We know that are successful in diverting drug users from crime with offending rates for PPOs and class A drug using offenders at around half the targeted rate.
- We are also successful in reducing reoffending in young offenders, with the rate of proven reoffending in 2009/10 reported at 14% better than target.

We have not had the same degree of success with the wider offender population. The measure of reoffending of adults on the Probation caseload compares the actual level of reoffending within our local cohort against the level predicted by a Home Office model (based on the particular characteristics of our offender cohort).

This indicator is within our Local Area Agreement and three years ago we set a target to achieve a rate of reoffending 11.3% lower than that predicted by the Home Office reoffending model by the 2010/11 cohort.

Quarterly performance figures to date have consistently tracked above (worse than) both the predicted rate and the target. The most recent data provided (June 2010) indicates a reoffending rate of 8.70% compared with a predicted rate of 8.10%, and a targeted rate of 7.46%.

Although the actual rate of reoffending is not significantly different from the predicted rate, the target to improve on the rate predicted by the model remains substantially off track.
Chapter 7 – Housing and employment

The NTA recently published additional guidance for expert groups to further understand the housing and employment needs of their local drug treatment population.\(^{12}\)

It is recommended that the following is considered:

- **Housing**
- Use of the Homeless Link ‘Clean Break Toolkit’ to assess needs, map provision and recommend a commissioning response
- Quantify levels of need using a range of data such as NDTMS, Supporting People, Drugs Intervention Programme data and TOP reports, as well as service user consultation.

- **Employment**
- Integrated pathways and partnership working
- Assessing level of employment need
- Understanding the range of/access to employment support services

**Key findings**

- 4% of people entering treatment in 2009/10 were homeless and a further 12% had problems with their accommodation. This has dropped from 7% homeless and 17% with problems in 2008/09. These figures do not take into account clients in supported housing projects, for whom future housing need must be considered and planned for.
- People who present to treatment with housing problems (particularly those who are homeless) are less likely to complete their treatment successfully.
- Mapping current provision of housing related support against the estimated level of need shows that whilst there is currently adequate provision for those who are ‘clean and dry’, there are significant gaps in provision for clients at an earlier stage of their treatment journey, particularly for those who may still be using drugs.
- A 40% cut in the budget for Supporting People has been announced and this represents a severe risk to provision of housing related support to vulnerable people in Cornwall. Floating support services, that provide support to clients who are not living in a supported housing project, have already been withdrawn.
- 9% were in full time employment when they presented for treatment but the majority were not working (two thirds). The drop out rate for people who present to treatment already in regular employment is higher than for those who don't, and those who are unemployed are more likely to complete successfully. This could indicate a lack of flexibility in the system to facilitate people who are trying to juggle a job and treatment.
- People who engage with day programmes and ‘other’ (non-psychosocial or prescribing) structured interventions are more likely to complete treatment successfully.
- There is a need for a qualitative assessment of service users’ education, skills and employment related needs to build a more comprehensive picture of support needs on which to base future work planning and commissioning.

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\(^{12}\) NTA (2011) Employment and Housing: Resource pack for needs assessment
Housing

The DAAT has led the Supporting People sector review process for the accommodation needs of substance misusers. Sector reviews were carried out to provide a clear evidence base across 11 different sectors of need to ensure future commissioning of robust services that support people in a way that meets their individual needs.

The sector review process considered the following:

- Needs analysis
- Service analysis
- Cost benefit analysis
- Gap analysis (needs versus provision)
- Commissioning: key themes and priorities

Some findings are as follows:

Table 1 - Drug Related Deaths by accommodation type

<table>
<thead>
<tr>
<th>Year</th>
<th>NFA Number</th>
<th>NFA %</th>
<th>Supported housing Number</th>
<th>Supported housing %</th>
<th>Other Number</th>
<th>Other %</th>
<th>Total DRD Number</th>
<th>% NFA / supported housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>4</td>
<td>33%</td>
<td>2</td>
<td>17%</td>
<td>6</td>
<td>50%</td>
<td>12</td>
<td>50%</td>
</tr>
<tr>
<td>2007</td>
<td>0</td>
<td>0%</td>
<td>6</td>
<td>33%</td>
<td>12</td>
<td>67%</td>
<td>18</td>
<td>33%</td>
</tr>
<tr>
<td>2008</td>
<td>4</td>
<td>22%</td>
<td>5</td>
<td>28%</td>
<td>9</td>
<td>50%</td>
<td>18</td>
<td>50%</td>
</tr>
<tr>
<td>2009</td>
<td>3</td>
<td>23%</td>
<td>3</td>
<td>23%</td>
<td>7</td>
<td>54%</td>
<td>13</td>
<td>46%</td>
</tr>
</tbody>
</table>

- Approximately 50% of DRDs are homeless or in supported accommodation
- In Cosgarne Hall, where on average there are 2 drug related deaths each year, a Naloxone programme trialled and over the past 15 months saved the life of one client and since the programme started Cosgarne Hall has had no drug related deaths.
- Rough sleepers need to be able to access accommodation that meets their needs and accommodation providers need to have programmes/treatment in place, such as Naloxone, to reduce the risk of drug related deaths.

As can be seen in the table below, the accommodation need appears to have reduced over the last 4 years. This has been influenced, however, by changes to the way accommodation is categorised in NDTMS, with only NFA and temporary counted as "problem". Those in supported accommodation, who also have housing-related support needs, are counted as having "no problem" and can no longer be identified separately in the data.

Table 2 – Immediate accommodation need

<table>
<thead>
<tr>
<th>Accommodation need</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09*</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>NFA</td>
<td>56</td>
<td>47</td>
<td>33</td>
<td>51</td>
</tr>
<tr>
<td>Temporary</td>
<td>300</td>
<td>156</td>
<td>90</td>
<td>151</td>
</tr>
<tr>
<td>Total (complete)</td>
<td>1,056</td>
<td>883</td>
<td>400</td>
<td>1,285</td>
</tr>
<tr>
<td>Total in treatment</td>
<td>1,414</td>
<td>1,142</td>
<td>511</td>
<td>1,458</td>
</tr>
<tr>
<td>% immediate</td>
<td>34%</td>
<td>23%</td>
<td>31%</td>
<td>16%</td>
</tr>
<tr>
<td>Supported housing</td>
<td>76</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>% supported housing</td>
<td>7%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Completion rates</td>
<td>75%</td>
<td>77%</td>
<td>78%</td>
<td>88%</td>
</tr>
</tbody>
</table>

*2008/09 drugs only taken from Q4 Green Report (alcohol not available)
Use of the Homeless Link ‘Clean Break Toolkit’ to assess needs, map provision and recommend a commissioning response is now recommended as best practice. Cornwall DAAT first utilised the Clean Break toolkit in 2007/08 and the resulting mapping of provision against need and gap analysis were presented in the needs assessment that year.

- The same exercise has been undertaken each year and the key findings with respect to gaps in tiered provision have not changed.

Following local data analysis, we revised the estimated total number with accommodation problems from the National Treatment Agency’s estimate of 50% to a local estimate of 30%.

**Figure 1: Model of provision as recommended by Clean Break Toolkit**

- When mapping the current provision within the Clean Break model as above, it was found that there is currently plenty of provision at stage 3, for clients who are ‘clean and dry’.
- There are huge gaps, however, in the other stages of provision, particularly at stage 1 when clients may still be using substances.

The table below shows the estimated need by locality across the four tiers of provision.

**Table 3 Clean Break model – need by locality**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Type of client</th>
<th>Type of provision</th>
<th>Central Locality</th>
<th>West Locality</th>
<th>East Locality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Chaotic drug/alcohol users</td>
<td>24hr supported accommodation (Based on 4 month stay)</td>
<td>91 people</td>
<td>84 people</td>
<td>65 people</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>30 units</td>
<td>28 units</td>
<td>22 units</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Attempting to reduce but are not yet stable</td>
<td>Supported accommodation (Based on 40% abandonment)</td>
<td>164 people</td>
<td>153 people</td>
<td>116 people</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>98 units</td>
<td>92 units</td>
<td>70 units</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Clean from illicit drug use and using prescribed substitutes</td>
<td>Mix of supported and independent accommodation (Based on 2 year stay)</td>
<td>73 people</td>
<td>68 people</td>
<td>52 people</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>146 units</td>
<td>136 units</td>
<td>104 units</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Clean from illicit drug use and prescribed substitutes</td>
<td>Independent accommodation with visiting support (Based on 6 month stay)</td>
<td>36 people</td>
<td>34 people</td>
<td>26 people</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>18 units</td>
<td>17 units</td>
<td>13 units</td>
</tr>
</tbody>
</table>

- A gateway into a staged system of provision with clear pathways and inclusive eligibility criteria is required in each locality that will accommodate substance misusers at each stage of their recovery journey.

13 DAAT needs Assessment, 2007/08, p. 95
The DAAT communication event in October 2010 highlighted the lack of provision for skilled assessments to take place (see Appendix A for the full report).

- Short term accommodation (6 week) where skilled assessments take place as to the needs or the clients and the level of ongoing support that they will require or whether stage 1 could meet the assessment facility that is currently lacking.

The substance misuse sector review also highlighted the need for:

- County wide outreach service is required to engage with homeless drug users;
- Floating support services to be further expanded to introduce additional surgeries to support clients in treatment to access/maintain accommodation;
- Gaps in personal and social resources (recovery capital) are understood and addressed through individual and group activities in supported accommodation projects;
- Reduced evictions from projects with a greater understanding of the chronic relapsing nature of addiction;
- Increased training for accommodation staff around the needs of substance misusers, that would also address prejudice;
- Greater flexibility in housing provision that understand changing needs over time or that would facilitate movement between areas of Cornwall or between provision if this is thought to be of benefit to the client;
- Greater co-ordination and collaboration between professionals working with clients.

These identified priorities need to be addressed against a backdrop of a 40% budget cut to Supporting People approved by Cornwall Council.

The current outreach service and floating support contracts are coming to an end, which will leave additional gaps / risks in the system of accommodation related support.

### Employment

#### Integrated pathways and partnership working

Pathways were put in place for Job Centre Plus staff to refer substance misusing claimants into treatment from the 27th April 2009.

Although it was initially a requirement to refer only opiate and / or crack users (PDUs) into treatment, Addaction, as the single point of contact, accepted referrals for all substances, including alcohol.

- Nationally, very low numbers have been referred from Job Centre Plus into treatment. NDTMS data indicates that 9 people have entered treatment via Job Centre Plus referral.
- Job Centre Plus data indicates that they have referred 28 opiate and / or crack users (PDUs) since May 2009, of which 7 were confirmed as attending their appointment with a treatment provider. Non-PDU referrals have been recorded since April 2010 and to date there have been 21, of which 1 is confirmed in treatment.

The DAAT and Job Centre Plus will also ensure clear pathways are in place for clients in treatment to access employment, training and education once the pre-work and work programmes are in place.

Job Centre Plus recruited drugs co-ordinators and, since April 2009, they have provided representation at DAAT commissioning and operational groups. These links need to be strengthened over the next 12 months to ensure that new DAAT contracts around the recovery and reintegration agenda dovetails with the provision offered by Job Centre Plus.
Following the DAAT conference in February 2011, treatment providers and service users suggested the following to improve partnership working, particularly in the Penzance pilot job centre but to be rolled out in other areas as deemed appropriate by staff:

- Treatment staff to enhance their relationships with employment staff by visiting Job Centre Plus and discussing the education, training and employment that their clients may require;
- Work shadowing to be developed as appropriate for employment and treatment staff to experience what happens in the opposite working environment;
- Job Centre Plus trial group work sessions at Wheal Northy, St Austell – to dispel fears of Job Centre Plus and highlight the range of options available to service users;
- Treatment staff to take responsibility to dispel myths/fears that service users have around Job Centre Plus – promoting the positives of working with Job Centre Plus and their partner organisations;
- Service users get involved in providing specific training to Job Centre Plus staff and those who are commissioned to deliver services to substance misusers;
- Treatment staff to attend 21st century event with Job Centre Plus and National Treatment Agency to better understand changes to benefits and the new national joint working protocol between treatment and Job Centre Plus;
- Job Centre Plus to offer private rooms for personal conversations as requested by service users;
- Good news stories of client achievements are collated and shared to encourage other staff and service users;
- Develop posters to highlight available services to staff and service users.

### Measuring the level of employment-related need across the local partnership

The next table shows the number of adults in treatment in 2009/10 by presenting employment status, broken down into each locality. Approximately 80% of those recorded on NDTMS had their employment status recorded.

- The majority of people present to treatment unemployed.
- We do not know what the needs of people in each of these groups might be. A qualitative assessment of service users’ education, skills and employment related needs would provide a more comprehensive picture of support needs and this could form part of a future work plan. This could be carried out through surveys and focus groups.

<table>
<thead>
<tr>
<th>Employment status</th>
<th>North</th>
<th>East</th>
<th>Central</th>
<th>West</th>
<th>Isles of Scilly</th>
<th>Out of county</th>
<th>Not completed</th>
<th>Cornwall and Isles of Scilly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular employment</td>
<td>68</td>
<td>71</td>
<td>54</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>240</td>
<td>481</td>
<td>357</td>
<td>1</td>
<td>1</td>
<td>16</td>
<td>1,089</td>
<td></td>
</tr>
<tr>
<td>Economically inactive</td>
<td>29</td>
<td>44</td>
<td>50</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>123</td>
<td></td>
</tr>
<tr>
<td>Pupil / student</td>
<td>6</td>
<td>15</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>23</td>
<td>27</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>102</td>
<td>124</td>
<td>131</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>360</td>
<td></td>
</tr>
<tr>
<td>Total by locality</td>
<td>455</td>
<td>742</td>
<td>618</td>
<td>3</td>
<td>1</td>
<td>36</td>
<td>1,836</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% by employment status by locality</th>
<th>Regular employment</th>
<th>Unemployed</th>
<th>Economically inactive</th>
<th>Pupil / student</th>
<th>Other</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cornwall and Isles of Scilly</td>
<td>15%</td>
<td>65%</td>
<td>8%</td>
<td>2%</td>
<td>4%</td>
<td>22%</td>
</tr>
</tbody>
</table>

| Total completed | 353 | 618 | 487 | 3 | 1 | 23 | 1,476 |
| Completion rate | 78% | 83% | 79% | 100% | 100% | 64% | 80% |
Chapter 7 – Housing and employment

The range of employment support services and the numbers accessing them

The DAAT is currently in the process of mapping activities/groups across major towns that are abstinent based and substance tolerant.

The pre-work and work programmes have not yet been commissioned. It will be possible to map the provision that is accessible to clients and the numbers accessing these services and the outcomes they are achieving once the provision is in place.

From the DAAT communication day in February 2011, treatment providers were keen to trial case conferencing with their clients and Job Centre Plus in order to access the wide range of opportunities available through Job Centre Plus.

The impact of employment and housing on successful completion

Employment status and accommodation need on presentation were included in the review of positive and negative factors in successful completion (see pages 31 and 32). This analysis indicates that:

- People who present for treatment either homeless or with accommodation problems are less likely to complete successfully than those who present to treatment without any problems.
- The drop out rate for people who present to treatment already in regular employment is higher than for those who don't, and those who are unemployed are more likely to complete successfully. This could indicate a lack of flexibility in the treatment system to facilitate people who are trying to juggle a job and treatment.

It is important to note that this takes into account only employment and accommodation status on presentation to treatment, and so does not provide any assessment of how a person's employment or accommodation situation changes during the treatment journey or how this impacts on final treatment outcomes.

Ongoing assessments of employment and accommodation are included under health and social functioning within the Treatment Outcome Profile (TOP) and TOP data is the means by which we could assess positive outcomes for people in treatment as they progress through their treatment journey. TOP reports are only robust, however, once a minimum threshold of 80% compliance (completion within the required timeframe) across the treatment population is reached. We are not currently achieving this in Cornwall.

We hope that when the TOP data is available it will prove that helping someone (who was unemployed / homeless on presentation) to gain employment or secure appropriate accommodation are positive factors in successful completion. We will revisit this when TOP reports become available to us.
Chapter 8 – Harm Reduction

Preventing the spread of blood borne viruses, drug related deaths and hospital admission are key health priority outcomes to be delivered in drug treatment

Blood-borne virus

Addressing current reporting and performance concerns

Reported rates of immunisation (Hepatitis A&B), testing and Treatment (Hepatitis C) fall well below the regional and national average and present one of the top 3 priorities for remedial action locally.

The main actions identified to improve performance are:
- Introduction of Dry Blood Spot testing as a priority to improve rates of testing for Hepatitis C
- Use of a new electronic case management system to enable all substance misuse practitioners to monitor and improve immunisation and testing for all clients
- Workforce development programme to keep the matter foremost in the minds of practitioners and assist all to recognise their roles
- Performance Review has prioritised this with all DAAT-commissioned providers and any provider not reaching target in year will be ineligible for future service provision.

Needle exchange

Provision
- Needle and syringe exchange services have been available in Cornwall for 24 years through 4 static sites and a domiciliary service provided by the Freshfield Service.
- Access increased over the past decade through 20 pharmacies (Cornwall and Isles of Scilly PCT), street outreach services and in police custody suites
- Last year, provision increased to be available through all clinics and specialist services

Activity
- Visits to pharmacy-based needle exchanges reduced by 3% compared with 2008/09, following successive rises over the last few years. Visits to Freshfield services also reduced (by 8%) but the number of clients seen increased. Similar geographic distribution of usage was noted for both services with the highest volume in West Cornwall, where there was also an increase in activity, and reduced activity in Central Cornwall.
- All specialist staff are now competent to delivery brief interventions for specific target groups including high-risk and other priority groups (e.g. steroid users).
- More / better information campaigns continue to be required through needle exchanges, such as overdose prevention, safer sex, blood-borne virus prevention, tissue viability initiatives and safer drinking.

Overdose call-outs
- In 2010, South Western Ambulance Service Trust (SWAST) clinicians attended 1,811 overdose incidents in Cornwall. The number of attendances has increased over the last two years, largely to overdoses where the drug is unspecified. The majority of overdoses attended are recorded as deliberate.
- Administration of Naloxone in cases of opiate overdose has reduced over the last two years.
- Towns in Central Cornwall saw the highest number of attendances and an increase compared with last year. The increase in largely relates to a rise in calls to deliberate non-

14 Based on provisional diagnosis by SWAST clinicians
15 An opiate antagonist that reverses the effects of opiate based drugs
Chapter 7 – Harm reduction

Opiate overdoses in Falmouth and Penryn. The town with the most attendances by a large margin was St Austell (260 attendances, 14% of the Cornwall and Isles of Scilly total).

- West Cornwall saw the greatest reduction in attendances and this mainly reflects a drop across all types of overdose call-out in Penzance.
- There is currently no formal process to advise treatment agencies and key workers of clients to whom ambulance clinicians have been called but who either decline further treatment / conveyance to hospital or discharge themselves following conveyance to hospital. Currently advice cards are issued to such clients but it is felt that more assertive action is needed.
- It has been clearly identified that service users are reluctant to call an ambulance in certain overdose situations for fear of police attendance and arrest. A short educational DVD ‘Busting the Myths of Calling an Ambulance’ is being circulated to all agencies.

Drug-related deaths

- There were 9 heroin deaths throughout Cornwall during 2010. Deaths from heroin overdose have remained relatively stable since DAAT records commenced in 1999 with 109 deaths in this twelve year period at an average of 10 per year
- There were 6 methadone related deaths during 2010 and 2 other deaths involving cocaine. Methadone related deaths have risen since 2001 and during the past four years result in 5-6 annually.
- Deaths are more likely to be male and this year there was a higher proportion of older (40+) deaths.
- Between 40 and 50% of people who die each year are in contact with treatment services.
- Whilst we have been unable to reduce the number and rate of drug related deaths locally, all deaths and significant incidents (near misses) are reviewed by all services involved as part of the Drug Related Death panel and the findings and learning acted upon. This has resulted in a number of major system changes, including the introduction of locked storage boxes for medication, overdose prevention and Basic Life Support training for service users and a Naloxone initiative in supported accommodation.

Hospital admissions

Drug-related hospital admissions can be an important indicator of unmet need or system weakness.

The overall number of hospital admissions related to drugs has increased over the last three years. This is due to an increase in drug related admissions to Royal Cornwall Hospital and Plymouth Hospital. Admissions to other providers have fallen.

Drug-related admissions by type of substance

- Between 2007/08 and 2009/10, ‘opioids’ have formed the most common drug group leading to drug-related hospital admissions, accounting for 48% of total drug-related admissions in the three year period, and an increasing proportion each year.
- ‘Multiple drug use and other Psychoactive substances’ is the second most common group of substances linked to drug related hospital admissions, followed by ‘Cannabinoids’ and then ‘other stimulants’.
- The proportion of total drug-related admissions attributed to ‘multiple drug use and other psychoactive substances’ has fallen over the three year period, from 34% to 15%, whereas the proportion attributed to Cannabinoids has risen from 8% to 15%.
- Admissions associated with the use of ‘other stimulants’ rose sharply in 2009/10.
- The most common type of drug-related admissions are emergency admissions.
- Within the group ‘emergency admissions’ those admitted via A&E or dental casualty department are most common, accounting for 43% of all drug-related admissions over the three years.
- Numbers of admissions through all routes (except the small numbers classified as ‘other means’) have increased between 2007/08 and 2009/10.
The local strategy should acknowledge the high (and rising) numbers of emergency admissions related to drug use, the higher proportional need in males but rising need in females and the changing trends of substance types associated with hospital admissions.

Further work could explore the nature of admissions in more detail.
Needle exchange

Current service provision and usage

- Needle and syringe exchange services are available in Cornwall through 20 pharmacies (Cornwall and Isles of Scilly PCT), 4 static sites and a domiciliary service provided by Freshfield and in custody suites.
- Needle exchange services are also now available through all clinics and specialist services where other treatment interventions are delivered.
- Visits to pharmacy-based needle exchanges reduced by 3% compared with 2008/09. The chart below shows the quarterly number of client visits and a rising trend is apparent until the end of 2008/09 but remained fairly flat throughout 2009/10. Two new services joined in 2007/08 and this accounted for a proportion of the increase (previously estimated at around 5% annually for the last two years).

- The highest volume of client visits continue to be in the West and this is the only locality to see an increase (predominantly in the Camborne service, an increase of 17% or 14 client visits per quarter). Alliance Pharmacy in Penzance saw the greatest increase in the number of client visits for any single service (almost 40% or an average of 18 visits per quarter), but this is almost counterbalanced by a drop in visits to Boots, suggesting a change in service user preference.
- The St Austell service also saw a fairly steep rise of 17% compared with the last assessment, or an average of 13 visits per quarter. Visits significantly dropped, however, in Falmouth, Newquay and Truro.
- The number of packs distributed through pharmacy needle exchanges, however, increased by 9%, which suggests that individual usage has increased (or that clients are increasingly picking up for others).

<table>
<thead>
<tr>
<th>Locality</th>
<th>Sites</th>
<th>Total packs 2009/10</th>
<th>Average per quarter</th>
<th>Change since 2008/09</th>
<th>Change %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Clients</td>
<td>Packs per client</td>
<td>(clients per quarter)</td>
<td></td>
</tr>
<tr>
<td>East</td>
<td>7</td>
<td>6,231</td>
<td>9</td>
<td>-10</td>
<td>-5%</td>
</tr>
<tr>
<td>Central</td>
<td>4</td>
<td>8,251</td>
<td>8</td>
<td>-25</td>
<td>-8%</td>
</tr>
<tr>
<td>West</td>
<td>9</td>
<td>11,956</td>
<td>8</td>
<td>12</td>
<td>4%</td>
</tr>
<tr>
<td>Cornwall</td>
<td>20</td>
<td>26,438</td>
<td>8</td>
<td>-22</td>
<td>-3%</td>
</tr>
</tbody>
</table>

Client contacts / visits to Freshfield services also reduced in 2009/10 but the number of clients increased (see next table).

- Service usage shows a similar pattern geographically – the highest volume of use is in the West, and there was also a rise in service use in this area. Central Cornwall also saw the greatest reduction in service use with Freshfield.
- Freshfield report that steroid users are the fastest growing group of clients using their needle exchanges. Due to the nature of steroid use, these clients visit far less frequently than heroin users. The influence of this on the statistics is reinforced by the fact that the greatest variation between clients and visits appears in Central Cornwall, which is where the majority of steroid users using Freshfield services are.
• Freshfield also expect to see a drop in both clients and visits in Central Cornwall, due to Falmouth (where one of the static sites is located) being moved for administration purposes from Central to West.

• Whilst the above helps to explain an increased gap between clients and visits, and the general decline in Central Cornwall, it doesn’t explain the overall drop in client visits. This may be just a natural fluctuation in demand.

<table>
<thead>
<tr>
<th>Area</th>
<th>Clients</th>
<th>Contacts</th>
<th>Change compared with 2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009/10</td>
<td></td>
<td>2008/09</td>
</tr>
<tr>
<td></td>
<td>Clients</td>
<td>Contacts</td>
<td>Clients</td>
</tr>
<tr>
<td>North &amp; East</td>
<td>83</td>
<td>395</td>
<td>-10</td>
</tr>
<tr>
<td>Central</td>
<td>133</td>
<td>498</td>
<td>-10</td>
</tr>
<tr>
<td>West</td>
<td>369</td>
<td>1,955</td>
<td>173</td>
</tr>
<tr>
<td>Total</td>
<td>585</td>
<td>2,848</td>
<td>57</td>
</tr>
</tbody>
</table>

Further to the gap analysis undertaken as part of last year’s assessment, this year we can report:

• More / better information campaigns continue to be required through needle exchanges, such as overdose prevention, safer sex, blood-borne virus prevention, tissue viability initiatives and safer drinking.

• All specialist staff are now competent to deliver brief interventions for specific target groups including high-risk and other priority groups (e.g. steroid users).

### Blood-borne Viruses

Injecting drugs and other risky behaviours associated with drug use, carry with them serious threats to health, one of which is exposure to blood borne viruses, such as hepatitis and HIV. Immunisation against Hepatitis B and testing for Hepatitis C form part of the treatment plan for drug users with a history of injecting behaviour.

### Blood-borne virus interventions for drug users in treatment

Information about blood-borne virus interventions with drug users in treatment should be recorded in NDTMS. Previously we have highlighted a significant shortfall in recording and this continues to be the case.

• We saw a rise in the number of primary opiate users entering treatment in 2009/10 and in drug users with a previous history of injecting. The proportion of adult drug users in treatment is fairly similar to last year, however, at 58% and remains below the regional average (72%).

• PDUs are the most likely to have a history of injecting (69%) and users of cannabis, cocaine and ‘other drugs’ the least (22%, 31% and 32% respectively).

• Recording of interventions for both hepatitis B and C remains inadequate. On average for the South West, this information is completed in 95% of cases; the latest performance data from NDTMS shows that the hepatitis C intervention status had been completed for only 70% of new presentations to treatment (injectors) and for hepatitis B it was only 79%.

• Interventions for hepatitis B and C are slightly less likely to be offered in Cornwall than the regional average but the difference becomes more marked when you factor in service users where no intervention is recorded (the measure of which our blood borne virus interventions are judged).

• In the year to date, 56% of injectors starting treatment were offered hepatitis C intervention and 69% of all new presentations were offered hepatitis B intervention (compared with 87% and 89% respectively in the South West). This shows some improvement since the last needs assessment, particularly for Gwellheans, but is falling a long way from the target of 90%.

• Recording of hepatitis C testing has deteriorated since the last needs assessment. 51% of injectors in treatment are recorded as having been tested, compared with the regional average of 63%. The target for hepatitis C testing is to achieve a test rate of 90% of all injectors in treatment.
Chapter 7 – Harm reduction

Hepatitis C – prevalence and testing

In October 2010 the Health Protection Agency (HPA) updated the ‘Shooting Up’ report regarding infection from blood borne viruses (BBV) in intravenous drug users (IDUs). This reinforced that IDUs have a high prevalence of blood borne viruses, most notably the Hepatitis C virus (HCV). The HPA predicts that approximately 50% of current IDUs in the South West region have antibodies to HCV infection, with almost 17% also having antibodies to Hepatitis B virus (HBV) and 1.5% antibodies to the Human Immunodeficiency Virus (HIV).\footnote{HPA: Shooting Up Infections among injecting drug users in the United Kingdom 2008. An update: November 2010, \url{http://www.hpa.org.uk} and HPA: Shooting Up Infections among injecting drug users in the United Kingdom 2008. An update: October 2009, \url{http://www.hpa.org.uk}}

The main route of transmission of BBVs in this group is through the sharing of contaminated injecting equipment, a practice that is common in one in five IVDUs. Once infected with HCV only one in three IVDUs will clear the virus, the rest will develop progressive liver disease. With HBV infection, about one in twenty will develop chronic infection of a variable course with some spontaneously developing immunity to HBV. All untreated HIV patients will typically lead to Acquired Immune Deficiency Syndrome (AIDS) after 10 years and death 3-5 years later.

Failure to identify and treat current and former IVDUs infected with HCV is the main reason for the doubling of HCV related deaths due to end-stage liver disease or hepatocellular cancer in the UK over the past decade (see Figure 1), and a four-fold increase in hospital admissions (see Figure 2). In recent years HCV infection has become a major cause for liver transplantation in the UK.

The following information is from the CIOS Hepatitis C Audit 2009 and the Health Protection Agency Tool for estimating Hepatitis C prevalence.

- Estimated 1,285 total infected population (Source: HPA Commissioning Template)
- Approximately 700 persons diagnosed with Hepatitis C within Cornwall and Isles of Scilly
- Number already identified who require treatment = 146 (Source: HPA Commissioning Template)
- Approx 65 persons receive treatment from Royal Cornwall Hospital Trust each year for Hepatitis C.

In Cornwall, approximately 50% per annum of the 1,200 registered IDUs that are currently in treatment have been tested for HCV infection using venepuncture. The main factor in this low result being the difficulty with venous access. IDUs may agree to being tested but often do not proceed to the stage of having blood taken due to difficulties in gaining access. This data suggests that HCV infection remains under diagnosed in Cornwall and that screening of IVDUs is, at best, ad hoc. Thus, a business case has been made to introduce dry blood spot testing as a much easier and more accessible means of testing.

Preventing the Spread of Blood Borne Viruses – Everyone’s Business

Improving performance has had a multi-pronged approach in 2010/11:

- Steps taken to improve rates of immunisation, screening, testing and, where appropriate, treatment;
- Care Co-ordinators have had the responsibility to co-ordinate immunisation and testing of all clients made clear;
- A training programme has been delivered to all specialist staff to clarify roles with regard to immunisation and testing;
- The new electronic case management system facilitates better recording and monitoring across caseloads;
- A business case has been made for dry blood spot testing in all services, to facilitate ease of testing;
- Performance reviews have required all services to submit improvement plans. This has contributed to major services design in some providers who have not made his a priority.
Overdose Call-outs

Extent and trends

- In 2010, South Western Ambulance Service Trust (SWAST) clinicians attended 1,811 overdose incidents\(^{17}\) in Cornwall. 2009 saw a rise of 250 attendances compared with the previous year but there was no further rise in 2010.
- The rise in 2009 was predominantly due to a 54% increase in calls to overdoses where the drug was unspecified. This type of call-out dropped in 2010 but remains at a higher level than in 2008.
- Opiate and non-opiate overdose attendances increased by 5 and 18 respectively in 2010, further to small rises noted in 2009.

Alcohol overdose is recorded separately and not included within these figures however clinicians attended an additional 818 cases involving alcohol alone.

<table>
<thead>
<tr>
<th>Type</th>
<th>2010</th>
<th>2009</th>
<th>Change n</th>
<th>Change %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate</td>
<td>244</td>
<td>239</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Non-opiate</td>
<td>1005</td>
<td>987</td>
<td>18</td>
<td>2%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>562</td>
<td>602</td>
<td>-40</td>
<td>-7%</td>
</tr>
<tr>
<td>Total</td>
<td>1811</td>
<td>1828</td>
<td>-17</td>
<td>-1%</td>
</tr>
</tbody>
</table>

| Naloxone administered | 64% | 72% | -8% |

- It was noted in the last assessment that administration of Naloxone\(^{18}\) in 2008 had seen a significant jump to 84% from 67% the previous year. The proportion of opiate overdose call-outs where Naloxone is administered has successively reduced over the last two years and in 2010 was back down at 64%.
- 71% of attendances in 2010 were to deliberate overdoses. The number of attendances to deliberate overdoses increased by 2% compared with 2009 and the majority of the rise is attributed to non-opiate overdoses in Falmouth and Penryn.

It was identified within the last needs assessment that a more detailed breakdown would be helpful to understand the distribution of overdose attendances. This has now been secured with the help of SWAST and future assessments will have collated data to assist.

The table below shows the breakdown by locality of attendances in 2010 and the change compared with 2009.

- Towns in Central Cornwall saw the highest number of attendances and the town with the most attendances by a large margin was St Austell (260 attendances, 14% of the Cornwall and Isles of Scilly total). The increase in Central Cornwall compared with 2009 largely relates to a rise in calls to deliberate non-opiate overdoses in Falmouth and Penryn.
- West Cornwall saw the greatest reduction in attendances and this mainly reflects a drop across all types of overdose call-out in Penzance.

<table>
<thead>
<tr>
<th>Locality</th>
<th>Total attendances</th>
<th>Change</th>
<th>Change %</th>
<th>Opiate</th>
<th>Non-opiate</th>
<th>Unspecified</th>
</tr>
</thead>
<tbody>
<tr>
<td>North and East</td>
<td>505</td>
<td>-6</td>
<td>-1%</td>
<td>82</td>
<td>256</td>
<td>167</td>
</tr>
<tr>
<td>Central</td>
<td>806</td>
<td>25</td>
<td>3%</td>
<td>84</td>
<td>478</td>
<td>244</td>
</tr>
<tr>
<td>West</td>
<td>499</td>
<td>-37</td>
<td>-7%</td>
<td>77</td>
<td>271</td>
<td>151</td>
</tr>
<tr>
<td>Isles of Scilly</td>
<td>1</td>
<td>1</td>
<td>new</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cornwall &amp; IoS</td>
<td>1811</td>
<td>-17</td>
<td>-1%</td>
<td>244</td>
<td>1005</td>
<td>562</td>
</tr>
</tbody>
</table>

\(^{17}\) Based on provisional diagnosis by SWAST clinicians
\(^{18}\) An opiate antagonist that reverses the effects of opiate based drugs
• Major towns (population 8,000 or more) throughout Cornwall had an average of 14 opiate attendances and 64 non-opiate attendances.
• Analysis of the current data for the 2010 calendar year identifies St Austell as having the highest number of both opiate and non-opiate attendances (25 and 162 respectively). There was little change compared with 2009.
• Penzance saw the highest number of opiate attendances in 2009 but this dropped by a just over a third in 2010 (from 38 attendances to 24).
• Falmouth and Penryn saw the highest rise in attendances, almost solely to deliberate non-opiate overdoses.
• Saltash and Redruth also saw a notable rises in attendances but across all types of overdose.

Near misses
• There is currently no formal process to advise treatment agencies and key workers of clients who may have been treated by ambulance clinicians and who subsequently decline further treatment and refuse to be conveyed to hospital. Advice cards are issued to the person concerned on leaving the ambulance but it is felt more assertive action is needed in this area.
• A similar situation can arise with those who are conveyed to hospital but then decline further treatment and discharge themselves, advice cards are again issued but there is no referral process unless the person is admitted to a ward and reviewed by the psychiatric liaison team.

At the South West Peninsula Drug Related Deaths Conference in May 2010 SWAST personnel assisted at a workshop with service users.
• It was clearly identified that service users are reluctant to call an ambulance in certain overdose situations for fear of police attendance and arrest.
• A short educational DVD has been prepared by the Peninsula DAATs and SWAST called ‘Busting the Myths of Calling an Ambulance’. This will be presented at the 2011 conference and circulated to all agencies.

Drug related deaths

Extent and trends
Research of all drug related deaths throughout Cornwall during the calendar year 2010 have been completed and allow direct comparisons with previous years.

There were 17 drug related deaths during 2010, 13 during 2009 and 18 during 2008.
Of these 48 deaths over three years 60% resulted from heroin overdose whilst 33% were attributed to methadone (only or with a non-relevant drug).

• Deaths from heroin overdose have remained relatively stable since DAAT records commenced in 1999 with 109 deaths in this twelve year period at an average of 9.8 per year. There were 9 heroin deaths throughout Cornwall during 2010.
• Methadone related deaths have risen since 2001 and during the past four years result in 5-6 annually. There were 6 methadone related deaths during 2010 and 2 other deaths involving cocaine.
• There is evidence that training in overdose management and take-home Naloxone for opiate users helps prevent opiate overdose. Naloxone is a life-saving intervention in reversing opiate overdose as it has pure antagonist activity. Therefore a Naloxone programme was implemented at Cosgarne Hall supported housing project in St Austell in December 2009 to address the issue of drug related deaths at the premises (on average 2 each year). In March 2010 a life was saved. Since the implementation there have been no drug related deaths at the premises.
Profile of deaths to date

- 88% of deaths during 2010 were male, this compares with 78% as in the national profile. The average age of the male deaths in Cornwall was 40 years, close to the national mean age at death for men and women combined (39 years). Five of the deaths in Cornwall during 2010 involved males over the age of 40 years. The age profile is older than the average reported last year (36 years for males and 35 for females).
- Only two of the deaths were women in 2009, 12% with an average age of 27 years compared with the national profile of 22% and 39 years respectively.
- Of the 13 deaths during 2009, 7 (54%) were actually in treatment for substance misuse with a further 2 referred for treatment but died before being seen. During 2010 there were again 7 in contact with treatment services (41%).
- There were no deaths of young people under the age of 25 in the last 12 months.

Where in Cornwall?

- There were no deaths in East Cornwall throughout 2009 but there were two deaths in 2010 (11%).
- All other deaths were in Central and West Cornwall. Newquay, Penzance and St. Austell were the most frequently recorded locations with 7, 6 and 4 respectively over the two years.

Learning from Experience

Whilst we have been unable to reduce the number and rate of drug related deaths locally, all deaths and significant incidents (near misses) are reviewed by all services involved as part of the Drug Related Death panel and the findings and learning acted upon. The major system changes implemented as a result have been:

- An Overdose Awareness Week each year, involving all partners
- The introduction of locked storage boxes for medication
- Overdose prevention and Basic Life Support training for service users
- The naloxone initiative in supported accommodation
- The DVD addressing fears regarding calling ambulances

A more specific audit of individual people in treatment and their knowledge and skills in preventing overdose is required and reducing drug related deaths remains a key priority in terms of outcomes required.

Hospital admissions

Hospital Episode Statistics (HES) data show the number of hospital admissions for residents of Cornwall and Isles of Scilly, due to mental and behavioural disorders attributed to psychoactive substance use.

For each hospital admission a number of different diagnosis codes are recorded to describe the reason for admission. Often when substance misuse has played a part in leading to a hospital admission the underlying admission (i.e. the first diagnosis code given) may not identify drug use. For that reason this report used a dataset of drug-related admissions including cases having one of the following diagnosis codes in any of the diagnosis code positions recorded at admission:

- F11: Opioids
- F12: Cannabinoids
- F13: Sedatives and hypnotics
- F14: Cocaine
- F15: Other stimulants
- F16: Hallucinogens
- F18: Volatile solvents, and
- F19: Multiple drug use and use of other psychoactive substances

Note: Data published in the last assessment implied higher rates of admissions for 2007/08 and 2008/09 than are reported here. The reason is that hospital ‘episodes’ were counted for that report, whereas in the current report the number of ‘spells’ has been counted. A ‘spell’ is equal to a stay in hospital, which might include several consecutive ‘episodes’, depending on the events that take place during the stay. ‘Spells’ will therefore provide a more accurate estimate of the number of drug related admissions.

Analysis of data

Drug-related admissions by provider services

The overall number of hospital admissions related to substance misuse has increased over the last three years. This is due to an increase in drug related admissions to Royal Cornwall Hospital and Plymouth Hospital. Admissions to other providers have fallen (table 1).

Table 1 Drug related admissions by provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospitals NHS Trust</td>
<td>163</td>
<td>190</td>
<td>225</td>
</tr>
<tr>
<td>Cornwall Partnership NHS Foundation Trust</td>
<td>49</td>
<td>39</td>
<td>23</td>
</tr>
<tr>
<td>Plymouth Hospitals NHS Trust</td>
<td>26</td>
<td>39</td>
<td>56</td>
</tr>
<tr>
<td>Other providers</td>
<td>13</td>
<td>9</td>
<td>&lt;5</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>251</td>
<td>277</td>
<td>308</td>
</tr>
</tbody>
</table>

Drug-related admissions by type of substance

- Between 2007/08 and 2009/10, ‘opioids’ have formed the most common drug group leading to drug-related hospital admissions, accounting for 48% of total drug-related admissions in the three year period, and an increasing proportion each year (table 2).
- ‘Multiple drug use and other Psychoactive substances’ is the second most common group of substances linked to drug related hospital admissions, followed by ‘Cannabinoids’ and then ‘other stimulants’.
- The proportion of total drug-related admissions attributed to ‘multiple drug use and other psychoactive substances’ has fallen over the three year period, from 34% to 15%, whereas the proportion attributed to Cannabinoids has risen from 8% to 15%.
- Admissions associated with the use of ‘other stimulants’ rose sharply in 2009/10.

Table 2 Drug related admissions by substance and year of admission

<table>
<thead>
<tr>
<th>Substance</th>
<th>2007/08</th>
<th>%</th>
<th>2008/09</th>
<th>%</th>
<th>2009/10</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids</td>
<td>102</td>
<td>41</td>
<td>127</td>
<td>46</td>
<td>157</td>
<td>51</td>
</tr>
<tr>
<td>Cannabinoids</td>
<td>20</td>
<td>8</td>
<td>26</td>
<td>9</td>
<td>47</td>
<td>15</td>
</tr>
<tr>
<td>Sedatives or hypnotics</td>
<td>12</td>
<td>5</td>
<td>23</td>
<td>8</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td>Cocaine</td>
<td>9</td>
<td>4</td>
<td>19</td>
<td>7</td>
<td>&lt;5</td>
<td>-</td>
</tr>
<tr>
<td>Other Stimulants</td>
<td>15</td>
<td>6</td>
<td>14</td>
<td>5</td>
<td>38</td>
<td>12</td>
</tr>
<tr>
<td>Hallucinogens*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Volatile Solvents*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>MDU/other Psychoactive Substances</td>
<td>85</td>
<td>34</td>
<td>63</td>
<td>23</td>
<td>45</td>
<td>15</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>251</td>
<td>100</td>
<td>277</td>
<td>100</td>
<td>308</td>
<td>100</td>
</tr>
</tbody>
</table>

* Some data have been suppressed for reasons of data confidentiality, to avoid identifying small numbers.
Drug-related admissions by sex

- Over the last three years, approximately two thirds of drug related admissions have been male and one third have been female (table 3).

**Table 3 Drug related admissions by sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>179</td>
<td>178</td>
<td>194</td>
<td>551</td>
<td>66</td>
</tr>
<tr>
<td>Female</td>
<td>72</td>
<td>99</td>
<td>114</td>
<td>285</td>
<td>34</td>
</tr>
<tr>
<td>TOTALS</td>
<td>251</td>
<td>277</td>
<td>308</td>
<td>836</td>
<td>100</td>
</tr>
</tbody>
</table>

- There have been more admissions of males than females for all substance groups except ‘sedatives or hypnotics’ (chart 1).
- The proportion of drug related admissions that are of female patients has been rising (chart 2).

**Chart 1 Drug related admissions by substance and sex, years 2007/8 – 2009/10 pooled**

**Chart 2 Proportion of male / female admissions by year of admission**
Types of admission

Admission types are defined as follows:

- **Elective admissions**, where the decision to admit is separated in time from the actual admission. These could be ‘waiting list’, ‘booked’ or ‘planned’.

- **Emergency admissions**, when admission is unpredictable and at short notice because of clinical need, requested by:
  - ‘Accidental and emergency’ (or dental casualty dept)
  - ‘General practitioner’
  - ‘Consultant clinic’ request for immediate admission
  - ‘bed bureau’
  - transfer of an admitted patient from another hospital provider

- **Maternity admission** of a pregnant or recently pregnant woman
  - Admitted ante-partum
  - Admitted post-partum

- **Admissions by other means**

Admissions have been grouped under the four headings described above and plotted in chart 3.

- The most common type of drug-related admissions are emergency admissions
- Within the group ‘emergency admissions’ those admitted via A&E or dental casualty department are most common, accounting for 43% of all drug-related admissions over the three years
- Numbers of admissions through all routes (except the small numbers classified as ‘other means’) have increased between 2007/08 and 2009/10.

Chart 3 Types of drug-related admissions

![Chart 3 Types of drug-related admissions](image)

Note: The previous report commented on the high rates of admissions that appeared to be attributed to dental emergencies. This was a misinterpretation of the definition of the emergency admissions category. Emergency admissions as a result of dental emergencies are not distinguished in the dataset from other causes of emergency admissions; they are grouped
together and described as “admissions that are unpredictable and at short notice because of clinical need, admitted through an accident and emergency or dental casualty department”.

Conclusions

- Next year’s report should use the data extraction criteria for drug related hospital admissions established in this report.
- The local strategy should acknowledge the high (and rising) numbers of emergency admissions related to drug use, the higher proportional need in males but rising need in females and the changing trends of substance types associated with hospital admissions.
- Further work could explore the nature of admissions in more detail.
Appendices
Appendix A – Consultation Reports

Service User and Carer Voice

An essential element of our annual needs assessment is securing the widest range of views and experiences possible from service users. As part of this process, we feedback what has been done as a result of the previous year’s feedback to demonstrate that we act upon the priorities service users identify.

Who participated?
Individuals’ were consulted across the full range of treatment providers, interventions, localities and at different stages of their recovery ‘journey’.

- 54 Service Users were consulted in groups across different treatment interventions, 6 different treatment service providers, in each of the localities across Cornwall and at different stages of their treatment journeys;
- A further 58 responded individually to a service user questionnaire;
- 1 person was interviewed individually;
- We also interviewed 2 groups of Carers (people affected by the drug use of a partner or family member).

What did we ask?
We asked every group the same open questions in 3 sections:

- What has been good about your experience of treatment locally? What has helped your recovery the most?
- What has not been good? Not helpful?
- What should be our priorities for change or improvement? What would help your recovery the most?

We have grouped answers where possible and made bold those responses that were made more than once and across different groups and settings.

Priorities for service development have been identified based on recurrent themes, gaps and wishes.
Priorities for service development

Publicise services available more
- Should be in GP surgeries, libraries and supermarkets

Provide a recovery map
- There is a natural progression across services and pathways
- Support is needed whilst waiting between services

Support for partners and families, ‘affected others’

Increase the length and frequency of appointments

Mental Health and Dual Diagnosis Pathways and joint working

Increased availability of structured day programmes
- For people ‘in treatment’ as well as those ‘in recovery’
- Across each locality

More groups
- Saltash, Bude and St Austell
- Evening sessions, “something on Mondays”
- Access to more social activity
- More aftercare/support facilities

Education of other professionals involved in recovery:
- GPs
- Job Centre Plus
- Hospital staff
- Social Services
- Service users happy to be involved in educating agencies

Primary Care
- A drug and alcohol specialist in every surgery, not just alcohol
- Quicker links from GP to Tolvean – direct link to access prescription for controlled drugs

Advocacy for service users

Employment Services
- Job Centre Plus staff need to forge closer links with organisations like Gwellheans in order for them to gain more of an understanding of addiction and issues faced by service users
- Consideration as to how medical assessments can pick up on a client’s mental well being

Community Services
- To be seen for an open amount of time until recovered
- Synchronised visits for partners “as he needs constant supervision”
- Better funding for wider range of scripts
- Bring back ear acupuncture to Penzance once a week
- Maybe more ex-drug users as care co-ordinators or to provide peer support

Criminal Justice Integrated Team
- Interface with mental health and forensic services
- Activities and mentoring
- Longer appointments, e.g. Probation.
- Help with travel problems and cost when living far away from services.
What has helped your recovery the most?

Community Services (Addaction, Freshfield Service, CDAT)
- The staff. Good relationship with workers, feeling respected, able to get long term help
- Individual counselling
- Cognitive Behavioural Therapy
- Social activities
- Good planning – an “action plan” to follow, an “aftercare plan”
- Help from peers
- Understanding mental health
- Learning patience

Gwellheans Recovery (Structured Day, Recovery & Work Programmes)
- Help in sourcing funding and in finding a course
- Providing legal advice
- Service users particularly appreciate the skills obtained from courses and the challenge of some of these activities – playing guitar, motorbike, woodwork and social skills.

Gwellheans Recovery (Structured Day, Recovery & Work Programmes)
- Help in sourcing funding and in finding a course
- Providing legal advice
- Service users particularly appreciate the skills obtained from courses and the challenge of some of these activities – playing guitar, motorbike, woodwork and social skills.

Pentreath Industries
Mental health support and skills

Groups
- Both peer and staff support
- Feeling listened to, understood and not judged
- Feeling part of something and social contact
- Sharing and listening, reducing feelings of isolation and exclusion

Appendix A – Consultation Reports
Appendix A – Consultation Reports

Tier 4
- Quick access to re-hab.
- Process groups
- Assignments
- Living under one roof with others
- Building trust with other people and building relationships again
- Honestly
- Empowerment
- Feedback and challenge from peers
- Being away from family
- Learning assertiveness
- Time to prepare for the outside world and “a clean life”
- Relapse prevention
- Meditation
- Acupuncture
- Help with family

"Learning to ditch false pride"
"Offload shame and guilt in a safe environment"
"Learning how to look after myself"
"People to lean on" "Asking for help"

Home detox nurse

"Previously had been given loads of different kinds of medication but didn't understand why?"
"CDAT have provided me with all the support and information I needed during my drug detox"

My GP / GPwSI
- The group named specific individuals they had come across and found really helpful.

Criminal Justice interventions
- CJIT case study
- Moving area, more anonymous in new area
- Getting support from the PPO team. Probation alone wasn’t enough, but the multi-agency DIP/PPO approach was very helpful
- PAS life-skills support around budgeting, shopping etc. Helps to learn self control.
- Help to develop a sense of self worth and determination for the first time
- Close support from persistent nominated staff
- Client control over treatment pattern

"I am on a DRR and I got no complaints about it. It is running well for me, despite having so many things to do each week."
"Good services from CJIT/probation helped me a lot"
What has been unhelpful?

**Lack of information**
- More needed in GP surgeries and chemists

  “There’s no map of treatment provision. You come out of one service and you have no idea where to go next”
  “Trying to get help for the first time is difficult. This can involve banging on doors for a long time”

**Waiting times**
- Quicker access to counselling.

**GPs**
- **Being misunderstood**
  - Many expressed experiences of not feeling understood by their GP, their GP not knowing what treatment was available or having a fixed idea regarding treatment options

  “Doctors have their own opinions and sometimes their advice makes it worse”
  “Some GPs are quite judgemental and then you’re left floundering”

**Mental Health Services/Dual Diagnoses**
- Many need help most with stress and anxiety
- Being belittled
- Some staff attitudes and behaviours

  “More dual diagnosis work”
  “I have mental health problems. My drugs CPN doesn’t work with my mental health problem and my mental health CPN won’t work with my drugs problem”
  “My son has a dual diagnosis, but mental health doesn’t work with the drug treatment service”
  “Having a personality disorder (finding out I’d been self medicating. I thought something was wrong with me, but doctors always said it was the drugs or drink)”
  “Social services seemed ill informed and equipped to help in this area”

**Prescribing services**
- Lack of privacy and dignity at the chemists
- 3 weeks viewed to be a long wait for scripts

**Not being allowed to detox when you want**
- Being told “no, you’re not ready”
Not enough structured day programmes
- Groups in Saltash (Shadow Centre or Surgery?), Bude and St Austell (Quaker House?)
- Something on Mondays

Community Services
- Having 5 different assessments
- Poor communication between agencies
- Lack of transport to get to help/visits to rehabs etc
- Not enough keyworker support
- No community day programme
- Only being able to have one service at a time
- Length and frequency of appointments
- Longer sessions would be helpful
- Access to evening sessions
- Not enough support for partners

Why can I only have CBT OR alcohol/drug treatment OR the eating disorder service? Why can't I have them all together?

Tier 4
- Boswyns has a really long waiting list
- Don’t accept GP referrals – only through drug and alcohol counsellors, which takes a long time if you are not already hooked in with the treatment system
- Length of time waiting pre-rehab
- Phone assessments [out of county providers]
- Bosence Farm and the 12-step approach is off-putting. More people might engage if they took the 12-steps out

Criminal Justice Interventions
- Longer appointments, e.g. Probation
- Travel problems and cost when living in Launceston

Non-specialist services
- Benefits medical assessments are not helpful – provide undue stress that does not support recovery
- More support for social services, because “they didn’t seem concerned about my child”

We need [structured day programmes] for the West
For the North
For the East
I would travel to a good service
I could do with a bit more time
I can only see a counsellor once a month
I'd do better if I knew someone was also helping my wife
Some workers keep in contact and some don't - we don't all get treated the same
How could they turn me down on a phone assessment?
Please educate police / coroner and their staff about cocaine addiction and the risk of use
What Would help more?

- Volunteering opportunities; other projects such as sailing and art classes.
- Housing solutions, especially if you have mental health and/or alcohol problems.
- Communication between services so that treatment is joined up.
- DRR’s are a waste of time if you do not enforce the conditions (probation are punitive), if you succeed on a DRR it is due to your relationship with the keyworker.
- Feeling understood by staff, especially needs and concerns.
- Understanding the options available for treatment.

What are your top priorities?

- Publicise services available more
- A recovery map
- Support while you’re waiting to access the service you want,
- Support for partners and families, ‘affected others’
- Increase the length and frequency of appointments
- Mental Health & Dual Diagnosis Pathways and joint working

- Increased availability of structured day programmes
  o For people ‘in treatment’ as well as those ‘in recovery’
  o Across each locality

- Groups
  o Saltash, Bude and St Austell

- Something on Mondays

- Evening sessions
- Access to more social activity
- More aftercare/support facilities

- Education of other professionals involved in recovery:
  o GPs
  o JC+
  o Hospital staff
  o ‘Social Services’

Primary Care
- A drug and alcohol specialist in every surgery
  o Not just alcohol

- Quicker links from GP to Tolvean
  o Direct link to access prescription for controlled drugs

- Advocacy for service users

- Employment Services

- Community Services
  o Be seen for an open amount of time until your recovered
  o Synchronised visits for my partner and myself
  o Better funding for wider range of scripts
Appendix A – Consultation Reports

- Ear acupuncture
- More ex drug uses as care co-ordinators

- CJIT
  - Interface with mental health and forensic services
  - Activities and mentoring
  - Longer appointments, e.g. Probation.
  - Travel problems and cost when living far away from services.

Priorities collated from responses to Service User Questionnaire

<table>
<thead>
<tr>
<th>Issue</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured day programmes/Life skills/Training</td>
<td>20</td>
</tr>
<tr>
<td>More counselling</td>
<td>16</td>
</tr>
<tr>
<td>Meetings closer to home</td>
<td>7</td>
</tr>
<tr>
<td>Home support/Visits</td>
<td>7</td>
</tr>
<tr>
<td>Tea and coffee, water</td>
<td>7</td>
</tr>
<tr>
<td>Better post detox treatment options</td>
<td>6</td>
</tr>
<tr>
<td>More group meetings</td>
<td>5</td>
</tr>
<tr>
<td>Day centre in every town</td>
<td>5</td>
</tr>
<tr>
<td>Meetings in the evening</td>
<td>4</td>
</tr>
<tr>
<td>Relapse prevention</td>
<td>4</td>
</tr>
<tr>
<td>Helpline</td>
<td>4</td>
</tr>
<tr>
<td>Out of hours support</td>
<td>3</td>
</tr>
<tr>
<td>Help with transport</td>
<td>3</td>
</tr>
<tr>
<td>More appointments</td>
<td>3</td>
</tr>
<tr>
<td>Access to doctors surgeries over the weekend</td>
<td>2</td>
</tr>
<tr>
<td>Family support (advice and education)</td>
<td>2</td>
</tr>
<tr>
<td>More information about services</td>
<td>2</td>
</tr>
<tr>
<td>More funding for services</td>
<td>2</td>
</tr>
<tr>
<td>Surgeries need to know more about CDAT &amp; Addaction services</td>
<td>1</td>
</tr>
<tr>
<td>CDAT available in the afternoon</td>
<td>1</td>
</tr>
<tr>
<td>Keep needle exchange in Liskeard</td>
<td>1</td>
</tr>
<tr>
<td>Improve recovery programme</td>
<td>1</td>
</tr>
<tr>
<td>Waiting entertainment i.e. music/magazines</td>
<td>1</td>
</tr>
<tr>
<td>Sembal open more regularly with someone from CDAT</td>
<td>1</td>
</tr>
<tr>
<td>Childcare facilities</td>
<td>1</td>
</tr>
<tr>
<td>Improve waiting times for detox</td>
<td>1</td>
</tr>
<tr>
<td>Keep same key worker throughout treatment</td>
<td>1</td>
</tr>
</tbody>
</table>
Provider Consultation

Two consultation events were held with treatment provider staff during the last year.

Participants were asked for the top priorities for improvement in:

- Making the treatment system more recovery focused
- Improving recovery and reintegration – accommodation and employment
- Improving the use of tier 4 interventions
- Integrated Offender Management

The second event provided further discussion on the treatment system generally and two workshops, one on employment and one on tier 4 interventions. A further two sessions were held with individual teams of drugs workers.

Making the treatment system more recovery focused

- To improve, we need a balance of attention to **time** with people, with **resources** we can offer in working with them and **skills**.
  - Changes in caseload sizes at CDAT are resulting in more time that can be spent with clients and the same needs to occur for others.
  - More ITEP and BTEI\(^\text{19}\) training is required.
  - Workers need biofeedback mechanisms re: outcomes for clients.

- **Care planning and interventions should be based on client abilities and needs across a spectrum of self efficacy.**
  - Look at models of Occupational Therapy
  - Look at who leaves treatment early
  - Look at how to get people into treatment earlier and younger

- **Mental health and dual diagnosis pathways** are required.

The second consultation event also identified:

- **Getting people into treatment earlier** in their problematic use – clear routes into treatment and pathways through

- **Share learning regarding ways to challenge people in prescribing treatment.**

Improving recovery and reintegration

Accommodation

- **Single point of access** (like floating support surgeries) to resolve accommodation issues
- **Tiered provision in each locality** that supports clients at all stages of their recovery journey, encompassing short term accommodation (6 weeks) where skilled assessments ascertain gaps in recovery capital.
- **More preparation for independent living** in supported housing projects with a much greater emphasis on structured activities to address their needs, with housing workers helping clients to find solutions to their problems and the most appropriate ways of addressing their needs.

\(^\text{19}\) International Treatment Effectiveness Project and Birmingham Treatment Effectiveness Initiative – a motivational model of working developed in collaboration between the NTA, the Institute of Behavioral Research at Texas Christian University, and The University of Birmingham.
Employment

- **Web-based interactive information on services available** that can be accessed by agencies and clients
- **Flexible contracts to prepare people for work** that enable providers to deliver to clients who most need their services, including increased provision for those who are more complex (along the lines of the Sembal model).
- **Discretionary funds** that enable access to small amounts of money that can make a huge difference to clients (travel costs etc).

The second consultation day included a workshop specifically on employment needs and increasing engagement in employment, training and education programmes. This highlighted a number of key areas for further development.

**The partnership between Job Centre Plus and the DAAT and pathways for clients from Job Centre Plus into treatment and from treatment into employment services.**

- Build relationships by treatment staff visiting Job Centre Plus and discussing with staff the types of services that clients might access and the support that they may need to do so;
- Service users and treatment staff to offer training / informal sessions around the needs of drug users;
- Consider work shadowing to get an understanding of diverse roles;
- Treatment staff to attend 21st Century Event to get a better understanding of benefit changes and to attend a workshop to understand the new joint working protocol between Job Centre Plus and treatment;
- Job Centre Plus to attend Wheal Northy to run groups with clients around the range of options (also used to dispel myths about employment services);
- Treatment staff, Job Centre Plus and clients to start case conference in order to jointly agree the best way forward for individuals;
- Share good news stories of client success / achievements to encourage other clients and practitioners;
- Check out the information that is currently available about each service and, if this is not adequate, develop additional leaflets / posters.

**Improve understanding service user needs and fears so that practitioners can address them**

- Some clients don’t like to discuss their issues in an open plan job centre – treatment staff can advise them that they can request a private room for such a discussion
- Some clients are put off by security staff – treatment staff can explain they are there just in case of an incident arising but generally they are helpful. Perhaps suggest to clients that they could try asking for help with something and see what a positive response they get!
- Some clients struggle with forms / processes / appeals – consider how volunteers could be used to support other clients.
- Clients fear disclosure to employers about their drug use – clients can be advised that self employment may be an option and there is a lot of support / finance available should they wish to explore this option.

**Improve the understanding of the range of employment, education and training options in Cornwall and clients access to them**

- Map out the range of provision that may accessed by clients through Job Centre Plus so treatment workers can be aspirational for their clients – for example, those who fear disclosing their drug history to employers could consider self-employment
- Map out provision of other positive activities / projects available in major towns that could be used to engage service users before they are ready to link with job centres. This could consider initially which services are specific to drug users and whether they support either those in recovery or those that are still using.
Improving the use of tier 4 interventions

• **Preparation**
  - People are still very poorly prepared for tier 4 interventions, both physically and psychologically (e.g. pets, medication)
  - All providers are required to look at the preparation for change manual and demonstrate that they understand the evidence base.
  - Preparation work needs developing more for people with literacy issues and staff should be aware of the impact that this can have

• **Empty purse / capacity gap**
  - More funding is required for rehabilitation placements

• **Training**
  - All key workers need training regarding tier 4 options, research and evidence base and how to make the best use of these. “Good Practice in Preparation” for key workers.

The second consultation day also identified the following areas as important:

• **Post-discharge support** – more recovery programmes and peer mentoring; the role of the care co-ordinator to be examined.

• **Interfaces / working relationships** – better communication between agencies, to see the system as a whole rather than individual providers with their own agendas / ways of working, seamless working together practices, care-co-ordination, full information sharing with clients, no repetition of assessments and transparent referral processes with accurate expectations of waiting times.

**Integrated Offender Management**

The following local strengths were highlighted:

- Good history of partnership working between health, probation and the police
- This has been extended further through inclusion of Coastline delivering Drugs Intervention Programme
- Co-located premises in Redruth and Bodmin

All the participants considered the Integrated Offender Management model to be an appropriate framework for partnership working.

The areas identified for development locally are:

- Sharing information, care plans and risk assessments
- Applying a consistent model across the peninsula
- Adapting the model to the local situation
- Learning from experience elsewhere
- Strategic ownership and leadership of the Integrated Offender Management model
Drugs worker consultation

What is going well?

Waiting times
Transfers to primary care
Safeguarding developments
Standards of care improving
Record keeping improving
Integration of services - “we know each other now”
Diamorphine reductions
Working with CMHTs / mental health
Housing accepting drug users
Other providers accepting drug users
Better facilities for services
Structured day programmes for people in recovery
Preparation for change work

What is not going so well?

Stimulant work with people with ADHD
Dual diagnosis work and network - needs more impetus and backing
Training for front-line staff in LES practices
Rate of uptake of hepatitis C testing - not accepting / refusing treatment and high DNA rate
Low level of LES in Central Cornwall
Pathways from Derriford by comparison to Treliske, such as maternity, BBV and A&E
Discharge summaries needed from tier 4 providers
Preparation work (for tier 4) still needs to improve
A separate structured day programme for people “in treatment” is needed
A post-detox programme for drugs is needed
“The relentless pace of change”

Priorities for improvement

Dual diagnosis / mental health pathways
Structured day programmes for people “in treatment”
Drugs post-detox programme
Drug-related deaths form to include alcohol and prescribed medication
More specialist drug staff
AUDIT assessments
Appendix B – Data sources

National Drug Treatment Monitoring System (NDTMS) data

The National Drug Treatment Monitoring System (NDTMS) is the key source of information about drug users engaged with treatment services. NDTMS is used to capture data on clients who reach the assessment / triage stage at any drug treatment service agency.

It should be noted that NDTMS does not represent the whole client group referred to treatment services. A service user receiving only a brief intervention (such as one-off advice or information) is not usually recorded and also a small proportion of service users do not give consent to be recorded on NDTMS.

Figures are taken from reports drawn from NDTMS data and provided by the NTA, either year-end reports or, where applicable, summary reports provided specifically for needs assessment purposes.

The National Treatment Agency (NTA) definition of the drug in-treatment population excludes adult service users receiving drug treatment if alcohol is the primary problem substance.

Offender data

Offender data is provided by Devon and Cornwall Probation Area (DCPA) and is a caseload ‘snapshot’ drawn from OASys (Offender Assessment System). The caseload includes adult offenders subject to a court order or released on licence from prison that are being supervised in the community and offenders serving a prison sentence of one year or more. The ‘snap shot’ used for this assessment was drawn on 1 April 2010.

Police data

Devon and Cornwall Police (Performance and Analysis Department) provided two key sources of data for this assessment:

- Sanitised recorded crime data extracted from the Crime Information System (CIS). Only crime records with accurate co-ordinates for mapping are included within this data set and hence there is a small shortfall of 5%.
- Drug seizures log completed by Drug Liaison Officers and coded and collated centrally.

National comparisons of crime rate per 1000 population are made using the Home Office ‘iQuanta’ family groupings20, which enable us to put crime in Cornwall into a wider geographical context.

Other data sets

A wide range of other complementary data sets were provided by partners and a full list of sources can be supplied on request.

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20 iQuanta is a web-based tool for policing performance information and analysis, developed by the Police Standards Unit and the Home Office. One of its key functions is that it allows Police forces, BCU and CDRP to compare their crime performance with other Police forces, BCU and CDRP with similar characteristics, by grouping them into ‘families’.
Appendix C – Further reading

Crime, disorder and substance use in Cornwall – Strategic Assessment Evidence Base 2010/11
Download from [www.amethyst.gov.uk/strataudit.htm](http://www.amethyst.gov.uk/strataudit.htm)

There is a supplementary report to this assessment that looks at crime involving young people in detail ‘Community Safety and Drugs Strategic Assessment; Supplementary report – focus on young people’ (including the Young People’s Community Safety Index) and this can also be downloaded from the Amethyst website as above.


# Treatment Outcomes Profile form

## Section 1: Substance use

Record the average amount on a using day and number of days substances used in each of the past four weeks.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Average</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>unit/day</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-28</td>
</tr>
<tr>
<td>Opiates</td>
<td>g/day</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-28</td>
</tr>
<tr>
<td>Crack</td>
<td>g/day</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-28</td>
</tr>
<tr>
<td>Cocaine</td>
<td>g/day</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-28</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>g/day</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-28</td>
</tr>
<tr>
<td>Cannabis</td>
<td>g/day</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-28</td>
</tr>
<tr>
<td>Other problem substance?</td>
<td>g/day</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-28</td>
</tr>
</tbody>
</table>

## Section 2: Injecting risk behaviour

Record number of days client injected non-prescribed drugs in the last four weeks.

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Section 3: Crime

Record days of shoplifting, drug selling and other categories committed in the last four weeks.

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Section 4: Health and social functioning

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Appendix D – Treatment Outcomes Profile (TOP) form

Treatment Outcomes Profile (TOP)

About the TOP
The Treatment Outcomes Profile (TOP) is a new drug treatment outcome monitoring tool that has been developed by the NTA in partnership with drug treatment providers in over 70 sites across England. It is applicable for use in all of the structured treatment modalities as defined by Models of Care for Treatment of Adult Drug Misusers: Update 2006. For the first time, service users, clinicians, service managers and commissioners will be able to obtain objective and comparable data about real improvements in service users’ lives that will be able to inform and improve practice on both an individual and strategic level.

The TOP is a simple set of questions that will improve clinical practice by enhancing assessment and care plan reviews for clients. The data it provides will improve performance monitoring. Data will be reported into the National Drug Treatment Monitoring System (NDTMS) from October 2007 and results fed back to providers and commissioners from March 2008. There will also be monthly exception reports from NDTMS on non-return and multiple submissions.

The TOP should be completed within 2 weeks either side (+/-2 weeks) of the first modality start date at the beginning of each client’s treatment journey to record a baseline of behaviour in the month leading up to starting a new treatment journey. If the Treatment Start TOP is completed after the first modality start date, it should focus on the 28 days before this date. Review TOP scores should be recorded in regular 12-week review periods during treatment (it may be helpful to do this at the same time as a care plan review) to capture changes in behaviour. The first Review TOP can be completed 4 weeks or 28 days after the first modality start date. It should also be completed at Treatment Exit and may be used by some services to measure post Treatment Exit outcomes. Note that services are introducing TOP, existing clients (as well as new presentations) should also have the TOP completed with them as part of the review process.

How to complete the TOP
Start by entering:
- Name and identifiers of your client (date of birth and gender)
- Your name
- Date of assessment
- The stage at which the TOP is being completed – Treatment Start, Review, Treatment Exit, or post Treatment Exit.

Types of responses:
- Timeline – invite the client to recall the number of days in each of the past four weeks on which they did something – for example, the number of days they used heroin. You then add these to create a total for the past four weeks in the blue NDTMS box.
- Yes and no – a simple tick for yes or no, then a “Y” or “N” in the blue NDTMS box.
- Rating scale – a 20-point scale from poor to good. Together with the client, mark the scale in an appropriate place and then write the equivalent score in the blue NDTMS box.

You should aim to ask and complete every question. Do not leave any of the blue boxes blank. Enter “NA” if the client refuses to answer a question or, after prompting, cannot recall.

(See TOP keyworker guidance and Interim revised guidance (August 2008) for more detailed information: www.nhs.uk/TOP)

Alcohol units converter

<table>
<thead>
<tr>
<th>Drink</th>
<th>%ABV</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pint ordinary strength lager, beer or cider</td>
<td>3.5</td>
<td>2</td>
</tr>
<tr>
<td>Pint strong lager, beer or cider</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>440ml can ordinary strength lager</td>
<td>3.5</td>
<td>1.5</td>
</tr>
<tr>
<td>440ml can strong lager, beer or cider</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>440ml can super strength lager or cider</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>1 litre bottle ordinary strength cider</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>1 litre bottle strong cider</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

Drink

<table>
<thead>
<tr>
<th>Drink</th>
<th>%ABV</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glass of wine (175ml)</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Large glass of wine (250ml)</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Bottle of wine (750ml)</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Single measure of spirits (25ml)</td>
<td>40</td>
<td>1</td>
</tr>
<tr>
<td>Bottle of spirits (750ml)</td>
<td>40</td>
<td>30</td>
</tr>
<tr>
<td>275ml bottle alcopops</td>
<td>5</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Thank you for your contribution to the TOP