Cornwall & Isles of Scilly Drug and Alcohol Action Team

Adult Drug Treatment Needs Assessment

2011/12
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Executive Summary

New in this year’s needs Assessment

This is the sixth annual Drugs Needs Assessment undertaken in Cornwall. Every year we seek to build upon the evidence of previous years, to answer new questions and to improve our evidence base. As many changes occur in the wider world, we strive to show how these relate to needs in relation to drug treatment.

This year, as part of continuing to explore what an increased focus upon recovery means for local people, we have increased the consultation with stakeholders to include affected others (families and carers) and clinicians as well as providers and service users. We have looked at the needs of families affected by problematic drug use and other complex problems in detail for the first time.

We have also prioritised increasing our understanding of dual diagnoses (mental health, drug and alcohol problems) and the needs related to the new Integrated Offender Management programme, TurnAround. Finally, we have improved our understanding of costs in relation to effectiveness and how we compare to other areas in the country.

Prevalence and service user overview

- The latest figures estimate that there are between 2,100 and 2,500 opiate and / or crack users (OCUs) in Cornwall and the Isles of Scilly, with a mid-point estimate of 2,285.
- Estimated prevalence is significantly lower than the national estimate but the percentage known to treatment is similar.
- Contrary to the national picture, we are not seeing a drop in opiate and / or crack users in the 15-24 age group and injecting prevalence is estimated to have increased.
- Young people make up a larger proportion of the “unmet need” group than the known to treatment groups.
- The prevalence model appears to underestimate the number of injectors in Cornwall. It is likely, however, that drug users not known to treatment are less likely to inject.
- The latest effective treatment count at the time of this assessment was for the 12 month period to August 2011 and shows that we have 1,635 adults and 1,242 OCUs (any age) in effective treatment.
- The rising trend in effective treatment numbers levelled off last year and there was a small reduction in the total number of adults in 2010/11. The declining trend for all adults in effective treatment has continued into 2011/12 – the decline is in non-OCUs, the trend for OCUs has remained static.
- Trend data by agency indicates a significant fall over the last 15 months in the number of people in treatment with Cornwall Community Drug Team (CDAT). Within CDAT, there is a continued shift from primary to secondary care. Gwellheans has also seen a significant drop in numbers.
- These reductions have been balanced by a rise in treatment numbers Addaction, Freshfield and Bosence.
- The service user profile is unchanged from previous years. The population is predominantly male (70%), of White British ethnicity and aged 30 years of over. Generally our local profile is in line with the South West, with the exception of representation of non-white ethnic groups (2% compared with 4%).
- Consultation with migrant workers on substance use and health issues indicates that a significant proportion are not registered with their local GP and that “more friends” locally would improve their experience of living in Cornwall.
- Information on sexual orientation is not being collected for the majority of service users and failure to ask about a person’s sexuality could mean that their care plan does not adequately address some of the potential risks associated with their lifestyle, including risks of blood borne viruses and suicide.

1 www.ndtms.net
• HALO will be able to provide information on service user needs relating to disability from 2012/13. In the last 12 months a range of accessibility audits were undertaken for services based in Truro and Redruth, which led to additional work to improve accessibility in Truro. Audits in Penzance and Liskeard are planned in 2012/13.
• Just under a third of service users in treatment are recorded as living with children and this is around 5% lower than both the regional and national average. This was previously in line and is believed to be the result of a drop in recording rather than an actual trend.
• Compared with the regional profile, our local treatment population has a fewer OCU’s and more cocaine, amphetamine and cannabis users. Crack use continues to be comparatively low in Cornwall and police intelligence indicates that this is genuinely the case. Adjunctive alcohol use is also more common locally.
• Three quarters of OCU’s have a history of injecting behaviour and this shows a small uplift of 2%.

Mapping the treatment system

• GP referral remained the most common route into treatment in 2010/11 but has seen a significant drop. Self referrals are rising and it is anticipated that self-referral will exceed GP referral as the most common route into treatment by year end, as was our intention.
• Referrals through criminal justice routes are up on last year but remain significantly lower than the regional and national averages.
• There has been a drop in parents accessing treatment compared with last year but this is thought to be due to poor recording rather than a genuine trend.
• There is a rising trend in the proportion of service users starting new treatment journeys that are injecting drug users (either currently or previously).
• Prescribing remains the most common treatment modality but with continued migration from secondary to primary care.
• 19% of people in treatment overall in 2010/11 had been in for 4 years or longer, which shows little change (+1%) compared with the previous year.
• More people left treatment in 2010/11 and successes as a proportion of all treatment exits remained around the same at 49% (a little above the regional and national averages)
• A third of people leaving treatment in 2010/11 dropped out. This has increased for a second year in a row and is now around 10% higher than the regional and national averages. This finding is of particular concern because Cornwall is considered to be fairly low level in terms of service user complexity.
• Injecting behaviour appears to be one of the key influencing factors in drop-out rate – particularly those who presented to treatment as currently injecting and were receiving prescribing treatment from a GP. Frequent drop-outs are typically male, aged in their late twenties and opiate users with a history of injecting
• We continue to see a relatively small percentage of service users “referred on”. Transfers to service providers outside Cornwall dropped by two thirds, more than matched by an uptake in local provision at Boswyns.
• The proportion of expenditure on structured community interventions may be considered too low for a recovery-orientated treatment system and warrants additional attention.
• Local treatment costs are significantly lower than national costs, with the exception of community prescribing (the high day costs of which necessitate priority attention).
• The treatment population segmentation exercise (CDAT and Addaction) indicated that:
  o The greatest improvements are achieved in the first 12 months
  o Once the drug problem is stabilised, if other issues (such as housing and access to employment or training) haven’t been addressed effectively they begin to impact on health and social functioning
  o Increased poly drug use, particularly alcohol, is common after year one
  o Addaction see a much higher than average proportion of parents (around half) across all segments
  o A number of recommendations to improve treatment options based on service user segmentation – including increased opiate detox options, more employment and training opportunities, more intensive interventions in first 12 months, clearer care planned interventions (treatment and goal setting to achieve this in a multi-agency way), pathway interventions for stimulant users and increased mutual aid.
What our people think

Priorities for improvement were drawn together from the responses for each of the consultation groups.

Service users

- More flexible, open access support and provision
- More information
- More consistency and continuity of care
- Recovery-oriented substitute prescribing
- More groups and activities
- Employment and education
- Housing
- Peer Support and mentoring ‘for everyone’
- Practical help

Service Providers

- Improving care co-ordination and support packages across local agencies
- Making clear what is available – developing a Recovery Map
- Reduce money being spent on infrastructure and managers and increase number of frontline services
- Increase availability of community detoxification
- More aftercare and recovery groups
- Continued professional updating, continue training programme, but utilise local staff

Clinicians

- Redefining and reorganising community detoxification
- Communications and training

Drug use and mental health

- The complexity of dual diagnosis issues makes all aspects from diagnosis to care to treatment all the more important. This is made more so by ongoing challenges and risks which include:
  - Re-admission rates to hospital are high
  - Drop out rates high
  - Engagement poor
  - High suicide rates
- Increased rates of substance misuse are found in individuals with mental health problems, affecting around half of people with severe mental health problems
- Alcohol misuse is the most common form of substance misuse and where drug misuse occurs it often co-exists with alcohol misuse
- Community Mental Health Teams (CMHTs) typically report 8-15% of their clients have dual diagnosis problems although higher rates are found in inner city areas.
- Local data indicates that service users with a dual diagnosis made up 12% of new treatment journeys in 2010/11, which was in line with the regional average and a little lower than the national average.
- Local research into the distribution of mental health prevalence drew on data from the Indices of Multiple Deprivation (2010, mood and anxiety disorders). Areas with the highest prevalence included St Austell Mount Charles Ward North West, Camborne West Ward East Central and Penzance Lescudjack and Ponsandane. The majority of areas highlighted tend to be located in the West of the county.
Commissioning Priorities

- Mosaic consumer profiling suggests that the best way to communicate with households that are likely to experience long term mental health issues is to use word of mouth techniques rather than internet communications (due to lack of access).
- Many of the households have good access to local services via walking or local transport as they do not have access to a car. This therefore emphasizes the importance of locally based services.

Working with families

- Evidence suggests that effectively supporting and involving family members and carers can lead to improved outcomes for the whole family.
- For the drug user, effective involvement of family members and carers helps increase the chances of:
  o Entering treatment
  o Reducing or stopping their drug misuse
  o Engaging with treatment if they do enter
  o Being retained in treatment
  o Successfully concluding treatment
  o Drug users are also less likely to suffer major relapses. This leads to better quality of service provision overall.
- We have a wide range of interventions in Cornwall that are tailored to the needs of different family types. Interventions are both for the individual (parenting for example) and collective (family group work), moving us towards a comprehensive family work programme;
- We are well placed to meet the needs of families targeted by the Troubled Families programme.
- West Cornwall has the highest concentration of areas identified as having complex needs. Most of the identified Lower Super Output Areas (LSOA) fall within the Camborne and Redruth network area with other areas highlighted in Penzance, Hayle and Helston.
- Illogan Highway South, Redruth North South West and Penzance Treneere have been identified as areas that have the highest levels of complex needs based on these issues. These areas are ranked within the top 10% for each one of the parental risk factors.
- There is a strong positive correlation between mental health disorders and domestic abuse incidents where the child is resident. This means that LSOAs that experience high rates of domestic abuse are likely to experience higher rates of mental health disorders.
- There is also a significant relationship between substance misusing parents and mental health disorders. There is a moderate relationship between the two variables, meaning that areas with high percentages of substance misusing parents may also have high rates of mental health disorders.
- The relationship between substance misusing parents and domestic abuse incidents is also significant, although it is weaker than between other variables.

Drug use and crime

- There are pockets of good evidence relating to the overall offender health picture, but they are not well connected and there are some clear gaps in our knowledge;
- Crime and drugs are well documented, as are the impacts of drug use on offenders’ health and outcomes. We know very little about mental and physical health and the impact of family and relationships on outcomes;
- Analysis of offender needs to support the commissioning of wraparound services for TurnAround highlighted a significant number of higher risk offenders with drug and alcohol problems that were not engaged with community treatment services (the majority).

2 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.
Commissioning Priorities

- Offenders who have not engaged with community treatment services are mostly cannabis users (no class A drugs) and tend to be younger (under 30 years of age). They are also slightly more likely to be living in the West of Cornwall.
- NDTMS data also indicate that offenders are not coming into community treatment services. Despite a small rise in referrals through criminal justice routes, at 14% the proportion remains considerably below the national average of 31%.
- It is vital to the success of TurnAround that the selection criteria identifies offenders based on risk and incorporates a range of risk factors (such as substance use and mental health) that align the methodology to the priorities for IOM highlighted in the offender needs assessment.
- The recent DIP review found that there is much enviable good practice in Cornwall; particularly excellent communication amongst partners, a general ‘can-do’ attitude and a high level of commitment to the objectives of the programmes. Co-location has been a key factor in this.
- Broadening the DIP context to consider the wider interface between substance misuse and offending required by TurnAround, there are a number of areas where need is either not being met or being met in a limited way, including:
  o Substance misusers (both in treatment and not) prior to their CJS involvement
  o Alcohol misusing offenders not otherwise in programmes (e.g. not under ATR, PPO, DRR, DIP, etc)
  o Offenders misusing drugs other than opiates and stimulants (e.g. solvents, alcohol)
  o Ex-prisoners released on licence and case managed by Probation
  o Ex-prisoners who are not opiate or crack/cocaine users
  o Substance misusing offenders no longer under any kind of licence, e.g. some ex-prisoners, ex-DRRs, etc
- Assertive outreach and engagement with people with drug problems who come to the attention of neighbourhood policing teams (but not currently in the criminal justice system) has been highlighted as a gap that would assist in reaching some of these groups.
- Contrary to the national trend, in 2010/11 drug offences increased by 4% compared with 2009/10, further to a rise of 21% in the previous year. Previous rises have been attributed to changes in police powers with regard to possession of cannabis, the impact of which appears to have now ceased. Rises this year were noted in possession of heroin, cocaine and mephedrone (which was made illegal in April 2010) and trafficking cannabis.
- In 2010/11 police recorded drug trafficking offences increased, contrary to the trend elsewhere in the country, and the rate of crime climbed fractionally above the average for our ‘most similar family’ group.
- Police intelligence on drug markets locally indicates that the purities of heroin and cocaine remain very low. There are signs of increased use of benzodiazepines, believed to be influenced by easy access via the internet. The use of Tramadol has also been notable with pockets of illegal use becoming apparent. Tramadol and Diazepam are common features in drug related deaths and the drug combinations coupled with alcohol and other depressants is causing some concern.
- The emergence and continual dynamic emergence of new psychoactive substances (NPS, sometimes referred to as ‘legal highs’) is becoming problematic. The NPS world is new and evolving with little or no historic evidence to support health and rehabilitation schemes.
- Trends in acquisitive crime show that, following a sustained period of reduction, dwelling burglary started to rise in October 2008 and has followed a gradual declining path since then. The rate of dwelling burglary remains lower than the national average but the gap has shrunk significantly over the last two years. Other types of acquisitive crime, such as thefts and shoplifting, have also started to rise in the last 6 months. Wider evidence for Cornwall highlights that the impact of the economic climate, public sector cuts and changes to benefits are now becoming apparent, with disadvantaged households potentially at greater risk.
- Although nationally the latest crime statistics show no consistent evidence of upward pressure across the range of acquisitive crime, it is reasonable to assume that these factors may have a stronger influence on crime trends where the underlying rate of crime is low.
Housing and employment

Following, the publication of the Employment and Housing resource pack3, a housing and employment working group have been set up to deliver the recommendations suggested by the NTA.

- Supported housing provision has yet to be re-commissioned so there continues to be significant gaps in provision for clients at an earlier stage of their recovery journey, particularly for those who may still be using drugs. This remains the single most significant gap in our ability to deliver recovery locally.
- There is an increase of people presenting to treatment services with housing needs from 19% to 24%.
- 9% of people in treatment in 2010/11 had been at risk of eviction at some point since 01 April 2010 and 16% were recorded as having an acute housing problem. This is consistent with findings the previous year.
- Key findings required from St Petroc’s / Addaction winter provision report
  - There is an increase from 12% to 14% of people presenting to treatment services in employment despite fewer clients being triaged.
  - 22% of people in treatment in 2010/11 undertook one or more days of paid work in the 28 days prior to a TOP being completed, with a mean number of days worked of 18 days. This is a 3% rise on last year
  - 9% were recorded as having attended school or college on one or more days in the 28 days prior to a TOP being completed. The mean number of days is 9 days, although the most common is 4 days. Again this is up 3% on last year
  - For both housing and employment, the information recorded in NDTMS has been more complete this year than in previous years so we believe it depicts a more accurate picture.

Harm Reduction

Needle exchange

- Trends in usage of pharmacy-based services have not been updated this year due to data not having been provided in time for this assessment.
- Numbers accessing Freshfield needle exchange services has remained stable compared with last year, although the number of client visits has dropped. This discrepancy may be explained by an increasing number of steroid users in the client base, who visit less frequently.
- Freshfield issued 232,400 syringes over the course of the year, 98% of which were known to be disposed of safely (96% at Freshfield services).
- New presentations continue to be predominantly male and heroin users. The age profile for new clients is younger than for Tier 3 treatment services, particularly in terms of young adults (under 25 years of age).

Infections amongst injecting drug users

- People who inject drugs (PWID) are vulnerable to a wide range of viral and bacterial infections. These infections can result in high levels of illness and in death.
- Around one-third report having a symptom of a bacterial infection (such as a sore or abscess) at an injecting site in the past year. Staphylococcus aureus and Group A Streptococcal infections continue to cause severe illnesses among people who inject drugs in the UK.
- Since 2000 there have been 163 cases of wound botulism, 93 of Clostridium novyi infection, 52 confirmed cases of anthrax and 35 of tetanus associated with injecting drug use in the UK.
- Combined data from across the UK suggest that around one in six PWID have been infected with hepatitis B and about half with hepatitis C. They also indicate that at around

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3 NTA (2011) Employment and Housing: Resource pack for needs assessment
Commissioning Priorities

one in 100 has HIV. Interventions that aim to prevent infections among PWID therefore need to be sustained and the levels of provision reviewed to ensure adequate coverage.

- The HPA estimates that there are approximately 410 current (and 643 former) PWID infected with HCV in Cornwall. Between 62 and 92 new cases are diagnosed per year. In total, approximately 600 cases have been diagnosed over the last 12 years. In Cornwall and Isles of Scilly, 70% per annum of the PWID in treatment have been tested for HCV infection using the current method of venepuncture. This is comparable with the national rate of testing at 75% but significantly below the national target of 90% (National Treatment Agency).

- 89% of service users starting new treatment journeys in the year to date (April to December 2011) were recorded as being offered Hepatitis B vaccination (compared with 69% in 2009/10) – an increase of 20%.

- There is good Needle and Syringe Exchange scheme coverage in Cornwall and the Isles of Scilly, which include infection control advice. However, we do not have local data pertaining to bacterial infections in PWID.

- Services to prevent and treat blood borne viruses (BBV) are well developed, and access to HBV immunisation and HCV testing have improved significantly in the past year, to above the national average, but have yet to meet our target of 90%.

- The priority for 2012/13 is to ensure 90% of people accessing our treatment services that have a history of injecting have been immunised and tested.

Drug-related deaths

- The number of recorded drug related deaths has reduced by 7 deaths (38%) compared with 2010. Included within the currently recorded drug related deaths are three suspected heroin/morphine deaths.

- Of the 11 recorded drug related deaths 5 were in treatment for drug dependency at the time of their death and one other had been discharged from treatment following residential de-toxification. The other 5 had no previous involvement with any known treatment provider nor were they awaiting appointments for assessment for any such treatment.

Hospital admissions

- The overall number of hospital admissions related to substance misuse has increased over the last three years.

- Between 2008/09 and 2010/11, ‘opioids’ have formed the most common drug group leading to drug-related hospital admissions. ‘Cannabinoids’ was the second most common group of substances linked to drug related hospital admissions, followed by ‘other stimulants’, and ‘Multiple drug use and other Psychoactive substances’

- Admissions associated with the use of ‘other stimulants’ rose sharply in 2009/10 and 2010/11.

- The most common type of drug-related admissions are emergency admissions.

- The local strategy should acknowledge the high (and rising) numbers of emergency admissions related to drug use, the higher proportional need in males and the changing trends of substance types associated with hospital admissions.

- Nearly half of all hospital admissions are related to the use of opioids. Cannabinoids and MDU/other psychoactive substances each accounted for 15% of drug related admissions over the last three years but whereas those related to cannabinoid use have been rising, those related to MDU/other psychoactive substances have been falling.

Drug misuse and the risk of suicide and self harm

- People who misuse drugs are at increased risk of mental health problems, self harm and suicide.

- Hospital admissions in the South West due to self harm (overdose) by drugs of abuse have been rising for males and females.

- Opportunities for ASIST training should be promoted for staff working with people who misuse drugs and suffer from depression.
Commissioning Priorities

The priorities for commissioning in 2012/13 are detailed below and these build on some of the themes identified last year. A year-end progress report against the commissioning priorities identified in the 2010/11 needs assessment is shown in Appendix E.

Continue to Improve Access to Treatment – open access

Attract and proactively engage people earlier, increase self referrals.

Rationale: Whilst levels of self referral improved in 2011/12 considerably, they remain lower in Cornwall than the national or regional average.

People using illegal drugs are more reticent to disclose to statutory professionals than people experiencing problems related to alcohol and legally available substances. Thus, they may develop more complex or entrenched problems before seeking help.

Aim: Continue to increase the number of people accessing treatment and encourage self referral to free, confidential and credible help at the earliest opportunity, attracting and engaging through:

- Increasing the availability of drop in access, including evening and weekend services to more localities in 2012/13;
- Outreach and detached services to attract and engage people experiencing problems earlier;
- Better publicity and information about risks and what help is available, anticipating peoples’ fears and misgivings related to the consequences of seeking help.

Delivering recovery and progress within treatment

Increasing the range of services available, through a more flexible system to respond to individual needs and improve outcomes. Recovery to be made more visible to people immediately upon entry.

Rationale: People need different levels of intensity and combinations of interventions at different stages of their recovery journey. Evidence points to the greatest gains being made in the first 6 months to 2 years. The full range of evidence-based interventions is required to promote recovery and meet the needs of individuals.

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

- Care Planning and goal setting at the beginning of treatment to look at visible exits and offering the full range of treatment interventions, particularly detox options;
- Daily activities and individually tailored programmes for everyone in the first 6 months of treatment, including structured day programmes for people in the earliest stages of treatment who are not yet stable;
- Greater frequency and flexibility of contact and appointments;
- Increased availability of community detoxification provision;
- Preparation for change groups and individual interventions;
- Pre-detox groups available to all;
- Post detox groups available from the day of completion of detox, to maximise the gains and prevent relapse, for as long as required;
- 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;
- Support and interventions for couples to maximise positive outcomes;
- Recovery maps and pathways 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 options;
• Peer mentors available to all – to support people in accessing the services they require and engaging with help;
• Online tools in support of treatment
• Aftercare support groups and individual interventions to maintain recovery.
• One recovery care plan per person, not per service, including mental health and dual diagnosis specifically.

Achieving positive outcomes and successful completions

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 make best use of public money and to meet the aspirations of individuals and families to lead healthy, independent lives.

Rationale: Whilst many people do well in our treatment system, by comparison with other areas in the country, others still do not.

Aim: In addition to the steps identified above, to maximise the gains from treatment and reduce the risk of relapse, we commit to actively supporting the re-integration of people leaving treatment into local communities.

This requires co-ordinated individualised packages of help that include:
• Skills development (including Intuitive Recovery)
• Meaningful activities
• Education and training initiatives
• Employment
• Accommodation – tiered levels of support to secure and sustain accommodation

Mutual Aid

To provide choice of mutual aid programmes and to increase availability and accessibility.

Rationale: Experiential knowledge is the basis of expertise. People experiencing similar problems can help each other to jointly recover and sustain recovery. Groups are organised and facilitated by members themselves. One type will not suit all. Groups are also required for family members.

The mutual aid programmes we will be supporting the development of in 2012/13 are:
• Alcoholics Anonymous
• Narcotics Anonymous
• Mutual Aid Programme (MAP)
• Family Support Groups

Development will be supported through:
• Referrals
• Provision of premises and resources for groups
• Training and support of service users and family members to establish and deliver groups themselves
• The creation of an online network to support people out of hours and at distances
Improving outcomes for children and families

**Rationale:** Substance misuse is a key risk factor in families with complex multiple problems and vulnerabilities. A key factor in successful recovery for adults is the involvement, support and interventions for their families.

**Aim:** To improve the outcomes for children and families affected by substance misuse through:
- Training staff in services for children and families in screening and identification for substance use
- Establish a single point of contact and pathways into treatment
- Increasing joint working between children, families and treatment services
- Delivery of 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, benefits everyone and is the principal aim of the delivery of drug treatment.

**Aim:** Integrated Offender Management (IOM, delivered under the name TurnAround in Devon and Cornwall) is the 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.

In 2012/13, we must broaden the Drug Intervention programme (DIP) locally to consider the wider interface between substance misuse and offending, there are a number of areas where need is either not being met or being met in a limited way, including:
- Substance misusers (both in treatment and not) prior to their CJS involvement
- Alcohol misusing offenders not otherwise in programmes (e.g. not under ATR, PPO, DRR, DIP, etc)
- Offenders misusing drugs other than opiates and stimulants (e.g. solvents, alcohol)
- Ex-prisoners released on licence and case managed by Probation
- Ex-prisoners who are not opiate or crack/cocaine users
- Substance misusing offenders no longer under any kind of licence, e.g. some ex-prisoners, ex-DRRs, etc
- Further develop active police involvement in arrest referral and feeding into TurnAround
- Assertive outreach approaches, including gate ‘pick-ups’ for prisoners being released
- Develop volunteer input
- Agree if and how ex-prisoners on licence are monitored
- Ensure TurnAround service users are involved in all developments involving peer support
- Further work at strategic level on housing, particularly tiered supported housing options
- Further strategic development and oversight of offender health and associated pathways
- Links and pathways to be developed between alcohol provision and domestic abuse and anti-social behaviour provision
- Ensure mental health pathways and provision are integrated into TurnAround planning
- Ensure safeguarding for children of substance misusers has a sufficiently high profile in TurnAround planning.
- Maintain the benefits of integration and co-location within a dual-site approach for TurnAround/DIP
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

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 Community Safety Strategic Assessments (locally and at Peninsula level), 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 (JSNA) 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 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 and recognises that ‘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

The NHS White Paper ‘Equity and Excellence: Liberating the NHS’ (July 2010) introduces the re-organisation of healthcare, which, alongside other guidance, assists us by requiring a focus upon delivering and improving outcomes and places drugs treatment firmly 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.

This paper recognises that drugs and alcohol represent a large proportion of the Public Health budget. The local Health and Wellbeing Boards and the Director of Public Health are now jointly accountable for strong leadership of alcohol and drug treatment.

The Public Health Outcomes Framework (2012)

This includes the drug treatment outcomes:
• Successful completion of drug treatment, and
• Identification of people entering prison with substance dependence issues who are not previously known to treatment
as key outcomes described within the domain of health improvement.

Building Recovery in Communities

This introduced 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 Crime and Disorder Act

The statutory framework regulating Community Safety Partnerships (CSPs) requires partnerships to analyse and assess:
• Levels and patterns of crime, disorder and substance misuse
• Changes in the levels and patterns of crime, disorder and substance misuse since the last strategic assessment
• Why these changes have occurred
• The extent to which last year’s plan was implemented
• In April 2010 this was extended to include reoffending in both adults and young people

TurnAround – Integrated Offender Management

Integrated Offender Management, delivered under the name TurnAround in Devon and Cornwall, is an overarching framework that allows local and partner agencies to come together to ensure that the offenders, whose crimes cause the most damage and harm locally, are managed in a coordinated way.

Local integrated offender management approaches differ from area to area, reflecting local priorities, but there are common key principles.

These include:
• All partners tackling offenders together. Local partners (both criminal justice and non-criminal justice agencies) encourage the development of a multi-agency problem-solving approach by focusing on offenders, not offences.
• Delivering a local response to local problems. All relevant local partners are involved in strategic planning, decision-making and funding choices.
• Offenders facing their responsibility or facing the consequences. Offenders are provided with a clear understanding of what is expected of them.
• Making better use of existing programmes and governance. This involves gaining further benefits from programmes (such as the prolific and other priority offenders programmes, drug interventions programme, and community justice) to increase the benefits for communities. This will also enable partners to provide greater clarity around roles and responsibilities.

• All offenders at high risk of causing serious harm and/or re-offending are ‘in scope’. Intensity of management relates directly to severity of risk, irrespective of position within the criminal justice system or whether statutory or non-statutory.

Priorities for improving our knowledge this year

• To what degree have we built an effective recovery orientated drug treatment system?
• How to improve successful outcomes and deliver sustainable recovery
• How to increase the numbers successfully discharging from treatment
• Benefiting from lessons learnt so far
• Identifying barriers to recovery
• Analysing the factors inhibiting successful completions, i.e. factors stopping people leaving treatment free of their drug of dependence or preventing them from sustaining their recovery after leaving treatment

Through:

• Data analysis (NDTMS) of successful completions, representations, TOP and inter-agency referrals
• Service user and carer focus groups and consultation
• Service user questionnaire
• Care plan audit
• Review of prescribing practice
• Review structured psychosocial interventions
• Review of multi-agency working
What our people think...

An essential element of our annual needs assessment is securing the widest range of views and experiences possible from service users, families, clinicians and other stakeholders. 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 stakeholders identify.

Two focus groups were held with service users and a further 104 responded to the annual questionnaire. Individuals were also consulted through the annual DAAT Conference.

Service users

All activities covered the same basic questions asking people to describe their treatment journey and answering:

- 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.

What has been helpful?

- All could say who their Care Co-ordinator was and knew what a care plan was, for the first time since we carried out any consultation.
- Some very positive experiences of good therapeutic relations with individual care co-ordinators and people who go above and beyond their jobs and duties to be helpful were cited.
- The drop-in element was appreciated, less pressure and planning.
- Positive feedback on group support, particularly strongly appreciated by those in recovery.
- Preparation for detox and residential rehabilitation was cited as very good for many who had used or were using tier 4 services. Most responded that they felt well prepared before arriving.
- Boswyns - Having a local detoxification unit and the services it provides.
- This year services users could better describe clear pathways across and through the system, e.g. GP to Addaction to Group options – to Boswyns.
- Those who had had peer support and mentoring described it as a very helpful addition, making their support more productive.
- Aftercare plans – “knowing what is going to happen next means you can relax and focus upon your recovery and what you’re doing now.”

‘As far as I’m concerned it’s an excellent service and feel that if it’s not broken don’t fix it.”
“The treatment I am offered covers all my needs and there are no areas that have been problematic.”
“To be honest I cannot think of anything about the service I have received that could possibly be improved.”
“The acupuncture group is already becoming more frequent which is the only suggestion I could have made.”
“Increase the availability of acupuncture groups as I feel this really helps. Otherwise I cannot fault the excellent service you provide, thank you very much.”
What has not been helpful?

- The appointments system was described as ‘a nightmare’
- Changing appointments and poor attendance by workers were described as demoralising.
- Short and infrequent appointments and nothing to help in between appointments

“It's really demoralising when people don't keep appointments”
“I'd arrive and the worker was off ill and no one told me”
“No one else was there to see me. I just went home and gave up”
“No outreach or contact between appointments makes it a really slow process”
“It's hard to remember what you were working on”

- Lack of support whilst waiting for an intervention, appointment, treatment or activity.
  - Participants described their first 2 years in treatment as a very stressful period ‘in and out and starting all over again’.
  - Lack of aftercare
  - Once you stop using illegal drugs, there is little support to help you not develop another problem, like alcohol.
  - Input from Care Co-ordinator varied considerably and service users compared Co-ordinators.
  - Responses ranged from “excellent: lots of support and follow up” to “very little”.
  - Two people described very different experiences with the same worker.

- Mentoring good, but again, not all have had.
- Waiting times for tier 4 interventions varied from 4 months to 2 days (standby).
- Standby short notice described positively
- Concern about the lack of support whilst waiting
- GP attitudes and experiences were cited, with pleas to do more work to train GPs and gain more understanding
- Stigmatisation is perceived as a problem “STOP making addicts in shelter be out by day in the cold, there’s nothing to do, more likely to relapse”
- Financial concerns – losing benefits and / or DLA, payment of travel expenses.
Chapter 1 - Introduction

Priorities for improvement
Nine areas identified:
1. More flexible, open access support and provision
2. More information
3. More consistency and continuity of care
4. Recovery-oriented substitute prescribing
5. More groups and activities
6. Employment and education
7. Housing
8. Peer Support and mentoring 'for everyone'
9. Practical help

More flexible, open access support and provision
- Better out of hours service
- More proactive personal telephone contact and contact numbers for crisis support
- More accessible day services and better coverage geographically – travel is a real issue for many (cost / health / mobility issues)
- 24/7-post detox support
- Support workers to provide more daily support in the home – previous support through Stonham no longer available

More information
- A more transparent “open” menu of service options – what is available and where
- More information about recovery and how it works – both available in the community, such as in doctors’ surgeries, and online
- Information on what help is available following serious relapse
- Greater staff awareness about what’s available and passing it on
- More support from hospital staff about what help was available

More consistency and continuity of care
- Better continuity of care
- Consistency, seeing the same person every time
- More 1:1 support
- More workers with smaller case loads, more time spent on individual cases enabling more care and less pressure, increase frequency of contact rather than waiting ages for appointments

Recovery-oriented substitute prescribing
- More home detox nurses and quicker home Subutex detox
- Designated chemist especially for the administering of methadone
- Better and quicker communication with prescribing GPs
- Hepatitis C treatment reinstated
- Addaction and CDAT to inform GP surgeries more about use outside national guidance – information to GP re Subaxone and substitutes (some GPs currently unaware)
- More locally based and more flexible appointments “Appointment with CDAT at local GP surgery would be helpful – then don’t have to travel”, “More days for drop in to see CPN as illness and hospital appointments make it hard and coincide.”
- An understanding of which prescribed medications (e.g. SNRIs) are allowed in residential treatment centres
- Consistency throughout the agencies – different agencies say different things about drugs/facts/withdrawal
- More involvement of CPNs in addressing other health related issues
- Dedicated CPN within CDAT for child protection issues
- ‘It would be nice to be able to see my CPN in a café so they see our outside life; it would give them more knowledge.’

Someone to talk to when things not going well and likely to relapse

More local pick up of medication

I would benefit more if my CPN could be involved in my health instead of writing from A to B to C to D
Chapter 1 - Introduction

More groups and activities
- More PODS (Post Detox Support) groups – provision to stay on longer, expansion of PODS, support groups post-PODS
- 8 week mindfulness courses and mindfulness drop in groups
- Pre-detox and after-care groups
- More meetings/groups throughout the week and separate groups for alcohol and drugs
- More people to talk to, more rehabs, other places to attend and social events.
- Hypnotherapy
- Move Narcotics Anonymous meetings in
- Having no time limit for aftercare and support
- More challenge to group members to combat dishonesty/denial
- Daily activities in support of recovery plans, including education, training, skills leisure activities and relaxation:
  - Getting out to walk and exercise a bit more
  - Have a bit more contact with the community
  - Natural therapy, head massage, body massage
  - Day centre like the old Sembal
  - Activity sessions such as swimming, kick boxing and tai chi
  - Allotments

Employment and education
- Links into careers advice – access to appropriate re-education
- Volunteer opportunities
- Continuation of different courses for building self-esteem and confidence

Housing
- More support and advice, better access to housing options

Peer Support and mentoring ‘for everyone’
- Separate key workers for extended family
- More visits/interest/help from care managers whilst in/after secondary treatment

Practical help
- Clothing packs, t-shirts, underwear, leggings, trainers (Tesco value/Primark).
- Pay travel expenses.
- Food pack, vegetables and fruit.

Carers
Two focus groups were held with affected others (family members/partners of people with alcohol and drug problems) in Liskeard and Penzance.

- All described mental anguish, guilt and feeling isolated.
- They described their own anger and frustration and resentment both against their partner’s addiction and the system...“the addict gets lots of support we get nothing”
- When asked why it took so long to get support – only a few weeks of support against a background of years in a relationship with a dependent drinker/drug user: carers reported feeling as if they just needed to keep going and were concerned that making it “public” would mean that they would be seen as unfit to look after their children.

I had to be strong. I had to cope. Shame and stigma kept it hidden

You are in the thick of it, have to keep going

The carer has to make all the bloody choices

Fear of falling apart

I’m so angry; I’ll drive her back to using

It’s always one or other of us can come off, but not both

How are we going to manage when she gets out of rehab?

Improvement could be made by increasing what is already done.
What is helpful about the services provided?

- The family groups are friendly and non-judgemental
- Mindfulness sessions
- Groups reduce the isolation
- Positive experience with Breaking the Cycle family workers and more intensive support

What is not so good?

- Carers said that they wanted the equivalent of one-to-one support like AA but not based on AA philosophy, which was described as too closed and "cultish"
- Waiting times of over 3 months were cited for access to help for mental health problems as a carer
- Lack of family support for the majority of the time and when agencies became involved at points of crisis there was no co-ordination and no outcome.
- Experience of the intervention offered to their partners was described positively but all experienced feeling left out of the process.
- More social activities are needed – carers feel that they get isolated and forget how to socialise.

What would help – priorities for improvement

- Greater awareness of the needs of families and better support for children
- Services need to be more visible and easier to access; better maps and signposting; “the support that is there is too invisible”
- Improve access to groups, in terms of both time and place
- Main purpose of the groups has been peer support but also thought that they need to have a laugh – fun and social events occasionally.
- Suggested better geographic spread…one in each major town and that they should be available in the evenings and weekends as well as Monday to Friday.
- Play based therapy for children not talking therapies.
- Better couples help is needed
- Some places need more family groups and ones that are easier to access; transport is a big issue.
- Groups are not frequent enough and not long enough – it was suggested that they should be at longer than the current 1½ hours currently offered and should be twice a week not once.

Service Providers

Service Providers meet on a monthly basis to improve the local treatment system and identified the following as priorities to improve recovery:

- Improving care co-ordination and support packages across local agencies
- Making clear what is available – developing a Recovery Map
- Reduce money being spent on infrastructure and managers and increase number of frontline services
- Increase availability of community detoxification
- More aftercare and recovery groups
- Developing the inspiring recovery-oriented workforce – through continued professional updating, continue training programme, but utilise local staff

Clinicians

The Integrated Medical Management Group (IMMG) of primary and secondary care clinicians in drug treatment reviewed the ‘Strang’ Report (2010) which provides guidance to clinicians about the more effective provision of recovery-orientated opioid substitution and other drug
treatments as part of broader personalised recovery plans and outlines 12 steps which can improve recovery-orientated opiate substitute treatment.

In responding to the paper the IMMG identified measures in Cornwall that can be taken, and made to happen quite quickly (quick wins) and some other more complex and longer-term measures that need further discussion and information before being implemented (for future consideration).

**Quick wins**

- **Redefining and reorganising community detoxification**

  It should be easier for clients to opt for detoxification than it currently is. Formal community detoxes from drugs (heroin) are currently the job of a part-time CPN at CDAT. Whilst she is very expert and experienced we feel it is something that more keyworkers should be able to implement.

  The 2007 NICE guidelines suggest that the evidence favours buprenorphine detoxes over lofexidine detoxes for people detoxing from heroin. Community detoxes using both buprenorphine and methadone can be provided by any keyworker over e.g. one to three months. The process of prescribing is not dramatically different to ‘maintenance prescribing’ but there is also scope to use adjunctive medication to alleviate some of the symptoms.

  Detoxification and short-term maintenance (e.g. maximum 1 year) should be offered to all new clients. This should occur through the process of care-planning where treatment goals, milestones and time-frames can be established in a flexible and realistic way.

  There are separate, but related, issues relating to people who have been on long-term prescriptions.

- **Communications**

  There are teaching needs around both recovery and detox. A first step is to write new protocols related to both. Additional teaching may also be necessary.

**For future consideration**

- **Segmentation**

  Some services are moving towards highly protocol-driven segmented treatment. The assumption here is that people who are most likely to ‘recover’ and leave treatment deserve more resources to enable them to do this. This will lead the service to have better outcomes overall (in a sense that will affect ‘payment by results’).

  For example we have talked about having ‘fast’ and ‘slow’ treatment streams where people are defined as being in one or the other, and given differing types of keyworker and resources.

  ![Assessment Diagram](image)

  There are some problems with this, however. For example there is no evidence that more resources will necessarily improve outcomes for those that are motivated to progress through treatment more quickly. It also begs the question of how to manage the relatively high risks of...
those who are e.g. still using heavily who would end up in the slow stream with less resources.

It may be easier to conceptualise segmentation more simply as the harm-reduction stream vs the recovery stream. The former being defined as people who are still chaotic and using on-top regularly.

which is similar to:

- **Psychosocial**
  A central information hub (web-based) describing the psychosocial interventions available might help service users, families and professionals to navigate and negotiate their way through what is increasingly available.

- **Contingency management**
  Consideration of the form of contingency management we should consider using to assist people to move through treatment.

- **Locally Enhanced Services (LES) contract**
  The LES contract does not really encourage detoxification/recovery in the way that it’s currently set up.
Chapter 1 - Introduction

**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 at postcode sector (the first five characters of the postcode, for example TR113) and appropriate commentary provided.
Comparing performance

This report generally covers the 12 month period from 1 April 2010 to 31 March 2011, 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 2010/11 are compared to the previous year (2009/10).
- 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).
Chapter 2 – Prevalence and service user overview

Key findings

- The latest figures estimate that there are between 2,100 and 2,500 opiate and/or crack users (OCUs) in Cornwall and the Isles of Scilly, with a mid-point estimate of 2,285.
- Estimated prevalence is significantly lower than the national estimate but the percentage known to treatment is similar.
- Contrary to the national picture, we are not seeing a drop in opiate and/or crack users in the 15-24 age group and injecting prevalence is estimated to have increased.
- Young people make up a larger proportion of the “unmet need” group than the known to treatment groups.
- The prevalence model appears to underestimate the number of injectors in Cornwall. It is likely, however, that drug users not known to treatment are less likely to inject.
- The latest effective treatment count at the time of this assessment was for the 12 month period to August 2011 and shows that we have 1,635 adults and 1,242 OCUs (any age) in effective treatment.
- The rising trend in effective treatment numbers levelled off last year and there was a small reduction in the total number of adults in 2010/11. The declining trend for all adults in effective treatment has continued into 2011/12 – the decline is in non-OCUs, the trend for OCUs has remained static.
- Trend data by agency indicates a significant fall over the last 15 months in the number of people in treatment with Cornwall Community Drug Team (CDAT). Within CDAT, there is a continued shift from primary to secondary care. Gwellheans has also seen a significant drop in numbers.
- These reductions have been balanced by a rise in treatment numbers Addaction, Freshfield and Bosence.
- The service user profile is unchanged from previous years. The population is predominantly male (70%), of White British ethnicity and aged 30 years of over. Generally our local profile is in line with the South West, with the exception of representation of non-white ethnic groups (2% compared with 4%).
- Consultation with migrant workers on substance use and health issues indicate that a significant proportion are not registered with their local GP and that “more friends” locally would improve their experience of living in Cornwall.
- Information on sexual orientation is not being collected for the majority of service users and failure to ask about a person’s sexuality could mean that their care plan does not adequately address some of the potential risks associated with their lifestyle, including risks of blood borne viruses and suicide.
- HALO will be able to provide information on service user needs relating to disability from 2012/13. In the last 12 months a range of accessibility audits were undertaken for services based in Truro and Redruth, which led to additional work to improve accessibility in Truro. Audits in Penzance and Liskeard are planned in 2012/13.
- Just under a third of service users in treatment are recorded as living with children and this is around 5% lower than both the regional and national average. This was previously in line and is believed to be the result of a drop in recording rather than an actual trend.
- Compared with the regional profile, our local treatment population has a fewer OCUs and more cocaine, amphetamine and cannabis users. Crack use continues to be comparatively low in Cornwall and police intelligence indicates that this is genuinely the case. Adjunctive alcohol use is also more common locally.
- Three quarters of OCUs have a history of injecting behaviour and this shows a small uplift of 2%.

4 www.ndtms.net
Chapter 2 – Analysis and prevalence

QUICK FACTS – ADULTS IN DRUG TREATMENT

Opiate and/or crack users are referred to throughout as OCUs

Prevalence (OCU only) 2,285 / 6.8 OCUs per 1,000 resident population
In effective treatment (latest, November 2011) OCUs (all ages) – 1,242 / 3.7 per 1,000 population
All adults – 1,635 / 5.2 per 1,000 population

General trend – numbers in effective treatment

Service user profile

People in the treatment system 2010/11

Entrants 528 New 55%
In treatment 1771 4+ yrs 19%
Exits 631 Drug free 49%

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

Highest – Newquay (Adults 200 / 11.9, OCU 143 / 8.1)
Lowest – Wadebridge (Adults 27 / 2.3, OCU 19 / 1.3)

Top 5 hotspots (postcode sector)

<table>
<thead>
<tr>
<th>Postcode sector</th>
<th>Main town</th>
<th>Adults</th>
<th>Adults rate per 1000</th>
<th>OCUs</th>
<th>OCUs rate per 1000</th>
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<td>Penzance</td>
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<td>64</td>
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</table>
Prevalence of problem drug use

Estimates are drawn from research commissioned by the Home Office\(^5\) 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 structured treatment. The original study covered the period 2004/05 to 2006/07 with follow-ups carried out so far for 2008/09 and 2009/10.

Following a period of relative stability, there was a statistically significant decrease in the prevalence of opiate and / or crack cocaine use between 2008/09 and 2009/10.

Nationally, the markedly highest prevalence rate is in the 25 to 34 age group, which was also the case across individual regions, and prevalence is around three times higher for men than it is for women. There were statistically significant decreases in the 15 to 24 and the 25 to 34 age groups with an increase (but not statistically significant) in the 35 to 64 age group. The increase of about in the older age group is likely to be an artefact of an ageing drug using population, rather than older people beginning to use drugs such as opiates or crack cocaine.

The prevalence of drug injecting has also significantly decreased, compared with the last sweep where injecting was included within the study (2006/07).

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

<table>
<thead>
<tr>
<th>Opiate and / or crack users</th>
<th>Prevalence estimate (n)</th>
<th>Rate per 1000 pn</th>
<th>Injecting estimate (n)</th>
<th>Injecting %</th>
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<td>Cornwall &amp; IoS</td>
<td>2,285</td>
<td>6.8</td>
<td>858</td>
<td>38%</td>
</tr>
<tr>
<td>South West</td>
<td>27,694</td>
<td>8.2</td>
<td>11,444</td>
<td>41%</td>
</tr>
<tr>
<td>England</td>
<td>306,150</td>
<td>8.9</td>
<td>103,185</td>
<td>34%</td>
</tr>
</tbody>
</table>

- The latest figures estimate that there are between 2,100 and 2,500 opiate and / or crack users (OCUs) in Cornwall and the Isles of Scilly, with a mid-point estimate of 2,285.
- Estimated prevalence is significantly lower than the national estimate for all age groups except the 25-34 year olds, but the difference from the regional estimate is not significant in any age group.
- Between 2008/09 and 2009/10 there has been no significant change in the estimated prevalence of opiate and crack use in Cornwall and this applies to all age groups.
- Contrary to the wider picture, we are not seeing a drop in OCUs in the 15-24 age group. The local estimate is higher for 2009/10 (although not significantly so) compared with lower estimates for both the South West and England.
- Also contrary to the wider picture, injecting prevalence is estimated to have increased since the last sweep where injecting was included in the study (2006/07), although the difference is not significant. It should be noted that the range for the 2009/10 estimate is very high (between 398 and 1,312 people), symptomatic of either reporting weakness or lack of robust data (this was highlighted as an issue in the original methodology paper but is considerably more apparent in the latest sweep).

\(^5\) The full report can be downloaded from [www.nta.nhs.uk/facts-prevalence.aspx](http://www.nta.nhs.uk/facts-prevalence.aspx)
Using prevalence estimates to measure unmet need

The treatment “bullseye” exercise was undertaken using data provided by NDTMS expressly for this purpose. The treatment numbers represent the picture at the point this snapshot was taken and thus differ from the latest published (as quoted in Quick Facts).

- This data shows that 1,293 OCUs were engaged structured in treatment in 2010/11, of which 94% (1,217 people) were engaged effectively. This is in line with the national average.
- A further 257 people had been in contact with the treatment system in the last two years (but not in the last year) and 48 people were engaged in treatment in a criminal justice setting (either the Drugs Intervention Programme or in Prison).
- This indicates an estimated unmet need of between 500 and 950 (mid-point estimate 700).
- The diagram below shows the four groups of OCUs split by age band. We can see that young people make up a larger proportion of the “unmet need” group than the known to treatment groups.
- Injecting prevalence is estimated at between 398 and 1,312 people, with a mid-point estimate of 858. Treatment data shows that 868 service users who engaged with treatment in 2010/11 had a history of injecting (currently or previously), suggesting that actual prevalence is likely to be closer to the upper estimate than the mid-point estimate. The same is apparent for the South West.
- What we can say about our “unmet need” population, however, is that they are more likely to be non-injectors.

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6 In treatment for a minimum of 12 weeks or discharged free of dependency within 12 weeks
Drug users in treatment

Key findings

Extent and trends

- The latest effective treatment count at the time of this assessment was for the 12 month period to August 2011\(^7\) and shows that we have 1,635 adults and 1,242 OCUs (any age) in effective treatment.
- The static data for 2010/11 indicate that numbers in treatment reduced by around 3% for both adults and OCUs over the course of the year and that this trend has continued into 2011/12. The latest performance report from the NTA (which also works from static data) notes that numbers in effective treatment are declining more rapidly than the national average.
- NDTMS is subject to constant update through the case management system as episodes are opened, closed and corrected, and thus the numbers in treatment are dynamic. The latest update\(^8\) confirms that the total number of adults in treatment is following a declining trend. The decline is in the number of non-OCUs; the trend for OCUs in effective treatment has remained relatively static (a drop of less than 1% since March 2010).
- Trend data by agency indicates a significant fall over the last 15 months in the number of people in treatment with Cornwall Community Drug Team (CDAT). It is difficult to quantify the drop exactly due to movements over the year following the amalgamation into one agency code of CDAT and GP Prescribing, but it looks to be around 10% in 2010/11 and a further 5% in the first 5 months 2011/12.
- Within CDAT we have seen a continued migration from specialist (secondary) prescribing to GP (primary) prescribing. Based on the raw data extracted from NDTMS in August 2011, in 2010/11 the number of people in primary prescribing increased by around 5% compared with the previous year and the number in secondary prescribing dropped by around 20%.
- Gwelheans has also seen a significant drop of around a third in 2010/11 followed by a further fall of 7% OCUs / 10% all adults in the first 5 months of 2011/12.
- These reductions have been balanced by a rise in treatment numbers Addaction, Freshfield and Bosence.

Service user profile

- The service user profile is unchanged from previous years. The population is predominantly male (70%), of White British ethnicity and aged 30 years of over.
- Generally our local profile is in line with the South West, with the exception of representation of non-white ethnic groups (Black, Asian, Mixed or Other, 2% locally compared with 4% in the South West). We continue to see a higher proportion of service users for whom ethnicity is not recorded or not stated (6% compared with 2%).
- Just under a third of service users in treatment are recorded as living with children and this is around 5% lower than both the regional and national average. The gap is slightly wider for service users who are parents but not living with their children (a difference of around 7%).
- Our most recent performance report flagged up non-completion of parental status / child with fields as an issue for us locally (12% of those in treatment in the year to date). In previous years we have reported similar levels of parents in our treatment population and a much better completion rate so this suggests that under-recording is the most likely reason for the recent disparity.
- This raises further issues related to safeguarding and ensuring that appropriate and effective protocols and mechanisms are in place to ensure that the needs of children with drug using parents are actively identified and appropriate actions taken.

\(^7\) www.ndtms.net
\(^8\) Numbers in effective treatment are published monthly with updates for the previous 12 months. Trend data was taken from the latest viewable estimate for any 12 month period – 12 month period to January 2012.
Three quarters of drug users in treatment are opiate and/or crack users (OCUs), the vast majority of which are opiate users. Known crack use remains comparatively low in Cornwall at 10% (compared with 30% in the region), and in fact saw a small reduction in 2010/11.

Compared with the regional profile, our local treatment population has a fewer OCUs and more cocaine, amphetamine and cannabis users. Adjunctive alcohol use is also more common locally. These differences are consistent with previous years.

The level of injecting behaviour is fairly similar to the regional average across all groups of drug users, with the exception of amphetamine users – although we have more of them, they less likely to inject.

Around three quarters of OCUs have a history of injecting behaviour and this shows a small uplift of 2%.

Comparison of 2010/11 with the previous year shows a comparable reduction in line with the general trend across all types of drug use, except for cocaine where the drop was notably higher at 23%. A drop in cocaine users was also apparent in the regional data.

Where in Cornwall?

Record level data for mapping was drawn from NDTMS in August 2011 and includes all adults in treatment at any point during the period 01 April 2010 to 31 March 2011. Note that the numbers in treatment differ slightly from the previously quoted (dynamic) figures from www.ndtms.net due to the time difference for data extraction.

<table>
<thead>
<tr>
<th>Area</th>
<th>ADUs Rate</th>
<th>ADUs Number in tx</th>
<th>ADUs Change %</th>
<th>OCUs Rate</th>
<th>OCUs Number in tx</th>
<th>OCUs Change %</th>
</tr>
</thead>
<tbody>
<tr>
<td>North &amp; East</td>
<td>4.2</td>
<td>411</td>
<td>-11 -3%</td>
<td>3.1</td>
<td>325</td>
<td>18 6%</td>
</tr>
<tr>
<td>Central</td>
<td>5.6</td>
<td>688</td>
<td>-22 -3%</td>
<td>3.5</td>
<td>456</td>
<td>-28 -6%</td>
</tr>
<tr>
<td>West</td>
<td>5.9</td>
<td>543</td>
<td>-51 -9%</td>
<td>4.2</td>
<td>408</td>
<td>-39 -9%</td>
</tr>
<tr>
<td>Isles of Scilly</td>
<td>0.8</td>
<td>1</td>
<td>-2 -67%</td>
<td>0.8</td>
<td>1</td>
<td>-1 -50%</td>
</tr>
<tr>
<td>Cornwall &amp; IoS</td>
<td>5.4</td>
<td>1,708</td>
<td>-56 -3%</td>
<td>3.7</td>
<td>1,245</td>
<td>-21 -2%</td>
</tr>
</tbody>
</table>

The distribution of the treatment population is unchanged from previous years.

The highest numbers of both adults and OCUs in treatment are in Central Cornwall, with particular clusters in Newquay and St Austell.

West Cornwall has the highest concentration of drug users in treatment in the resident population (rate) with the most significant cluster in Penzance. The difference is particularly marked for OCUs.

The North and East locality sees the lowest treatment numbers but there are pockets of high concentration in Bodmin and Liskeard.

Looking at the variation across Cornwall by network area highlights three areas where the rates are substantially above average – Newquay, Penzance and Bodmin.
Key features of the treatment population in each locality

A wide range of service user characteristics were reviewed by locality with the aim of identifying key differences by geography.

A number of features showed no significant variation by locality (the range is +/-3% around the Cornwall average); these include:

- Proportion of female service users
- Primary cannabis use
- Parents who are not living with their children
- “Referred on” exits from treatment
- Presenting to treatment as unemployed
- Presenting to treatment with accommodation problems (excluding NFA)
- Referral into treatment via a Criminal Justice route

A full breakdown of numbers by feature by locality is shown at Appendix C for reference.

North and East Cornwall

Numbers in treatment are much lower in North and East Cornwall but there are notable clusters in Bodmin (particularly OCUs) and Liskeard.

Key features:

- Highest proportion of young adults in treatment
- Highest proportion of parents / service users living with children
- Above average proportion of OCUs (largely reflecting Bodmin cluster)
- The area of PL144 is one of the few areas in Cornwall to have seen a notable rise in service users in treatment in 2010/11
- Lowest prevalence of adjunctive alcohol problems
- Highest recorded prevalence of dual diagnosis
- Highest proportion of GP referrals
- Very few service users presenting to treatment with accommodation problems / NFA
- Service users are more likely to present to treatment as economically inactive (rather than unemployed)
- Service user ratings at most recent TOP for both physical and emotional health are on average 1 point (out of 20) higher than the rest of Cornwall
- Lower than average rate of successful completions; highest drop out rate
Central Cornwall

42% of adults in treatment reside in Central Cornwall. The main service user clusters are in the larger towns of Newquay, St Austell and Truro.

Key features:
- Highest recorded crack use in the treatment population at 10%
- Highest proportion of stimulant users in treatment (particularly cocaine and amphetamines)
- Lowest prevalence of injecting behaviour overall; significantly lower proportion of current injectors presenting to treatment
- Lowest proportion of service users in long term treatment (four years or more)
- Significantly higher proportion of service users with no parental responsibility
- Higher than average successful completion rate; lowest drop-out rate
- Service users most likely to present to treatment in regular employment, but also more likely than average to be economically inactive (rather than unemployed)
- Highest levels of self-referral and lowest GP referrals
West Cornwall

West Cornwall has the highest concentration of service users in the local population and opiate use is particularly entrenched in Penzance. There is a significant cluster in the centre of Penzance and another in the conurbation of Camborne / Pool / Redruth.

Key features:
- Highest prevalence of injecting behaviour (all people in treatment); new presentations to treatment currently injecting, however, are in line with the Cornwall average
- Highest proportion of service users in long term treatment (four years or more, a third)
- Lowest throughput (exits as a proportion of everyone in treatment)
- Lowest successful completions as a proportion of all exits; higher than average drop-out rate
- Service users least likely to present to treatment in regular employment, but also less likely to be economically inactive; highest presentations unemployed

![Map of West Cornwall showing drug treatment rates](image-url)
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.

Age

In the last needs assessment we noted that Cornwall faces similar issues to the rest of the region in needing to improve the effectiveness of engaging problem drug users in treatment under the age of 18. Although based on a comparison of prevalence with treatment numbers, we are significantly better than the regional average in attracting young people (15 to 24 years age group) into treatment, local data shows that the majority are over 18 years of age and in adult services.

The majority of young adults in treatment had never previously engaged with young people’s services, suggesting that there might be a significant number of young adults not approaching treatment services until their problem is fully established. This analysis was refreshed for the Young People’s Specialist Substance Use Treatment Needs Assessment 2011/12 and a questionnaire was conducted with a small sample of young adults in treatment with adult services.

- Consultation with YZUP service users has indicated that they don’t feel old enough to be going into adult services at aged 18 / 19 years. The young adults surveyed, however, felt young people’s services were for children and, as they weren’t children, felt that adult services better met their needs suggesting that an assessment of the level of maturity, engagement and choice is more important than age in determining which service best meets the needs of young adults.
- All of the young people who responded to the questionnaire started using drugs at a young age (under 15 years) and all said that they had previously tried to stop, recognising that drugs were particularly affecting their relationships and their emotional / physical health. For the majority, parents and friends had also suggested that they needed help to stop.
- The most common reason for engaging with adult services was the influence of friends and family. Other reasons were equally distributed between being encouraged by another agency / service that they were in contact with (such as needle exchange or GP), self-
motivation (wanting “it to stop”) and wanting to specifically go into adult services (“I’m old enough to use it now”, wanting a script).

- Very few knew about young people’s treatment services, despite a significant number being already involved with other services, such as social services, the youth service and mental health services.
- When asked what young people’s services should look like, more information, and to be more like adult services were the most common themes.

Ethnicity

- 96% of service users, where ethnicity was recorded, are White British, 2.6% are from another White ethnic group (for example, White Irish) and 1.7% 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 6% of service users. Levels of non-completion have improved over the last few years, but it is still much higher than the regional average of 2%. There is no obvious reason why service users in Cornwall would be less inclined to have their ethnicity recorded.
- Over 2010/11 a primary care practice was commissioned to specifically meet the needs of gypsies and travellers in one particular locality. This practice also delivers the Alcohol and Drugs Locally Enhanced Services (LES).
- 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 2010/11, information was obtained or produced in a range of languages and sources of translation identified.
- Last year, Inclusion Cornwall successfully bid for and won some funding from 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 resulted in the commissioning of a survey in June 2010, the key findings of which are shown below.

Migrant workers survey 2010

In June 2010 a survey regarding the health of migrant workers in Cornwall was conducted in order to establish any needs surrounding drugs, alcohol and sexual health. 110 workers completed the survey, which included 61 females and 44 males (gender was unknown for 5 individuals who not answer this question).

Within the analysis of the survey percentages of the total cohort are used (unless stated) with the number of migrant workers displayed in brackets.

- Over three quarters of the migrant workers surveyed are aged between 19 and 35.
- 29% (32) of migrant workers surveyed are not registered with a GP, with two thirds of these workers being resident in Cornwall for less than a year. The amount of time that they have been resident in Cornwall ranges between 3 months and 10 years, although the majority have been resident for less than 2 years. Most common reasons for GP services not being accessible are difficulties of opening times (10 individuals) and the language barrier (5 individuals).
- The survey showed that the workers’ knowledge of chlamydia was fairly comprehensive with roughly 60%-70% knowing where they can get advice and access to services, what affect the infection can have and how it is contracted. 47 workers have been tested for an STI (Sexually Transmitted Infection) in the past.
- 78% (86) have had sex with one or more people in the past 12 months with 60% (52) having a long term partner resident in either Cornwall or their country of origin. 45% (39) use condoms, 20% (17) sometimes use condoms and 35% (30) do not use condoms.
• 17% (11) who answered the question on alcohol consumption stated that they had an alcoholic drink either 4-6 days or everyday. Of the 7 workers who drink every day, all of them state that they drink more in Cornwall than they do in their country of origin yet all of them answered “no” to the question “do you feel that your drinking is causing you problems?”. Over a third of individuals (26) who answered this question stated that they drank more in Cornwall than in their country of Origin.

• There are 4 workers who have not accessed drug or alcohol treatment issues for a variety of reasons. The most common reason for services not being accessible was the language barrier. All of these individuals answered questions surrounding alcohol and not drugs which implies the treatment need concerns alcohol. There is one individual who is currently accessing treatment services who uses both alcohol and cannabis

• 6% (6) of workers state that they use drugs, all of which use cannabis. No workers have said that they use heroin, crack cocaine, amphetamines, ecstasy or any other illicit substances.

• 39% (43) of workers feel “happy” in Cornwall whereas 70% (77) feel “happy” in their country of origin. Although few workers feel isolated (10), 83% (91) would welcome the opportunity to make new friends in order to enhance living and working in Cornwall.

• Although the numbers of people completing the survey are low, gender differences show that female workers are more likely to feel happy, isolated, lonely or sad whereas male workers are more likely to feel accepted and sociable whilst living in Cornwall. There are little or no gender differences in workers feeling supported or ok when living in Cornwall.

• In their country of origin, female workers are more likely to feel sociable and accepted with males more likely to feel lonely. There are little or no gender differences in workers feeling happy, isolated, supported, sad or ok in their country of origin.

• Both female and male workers on the whole would welcome opportunities to meet more people who are either local or other migrant workers. Female workers are also more likely to welcome opportunities to meet more people who share the same language.

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 was identified as a priority for the new electronic case management system (Halo, implemented over the last 18 months in Cornwall) and information will be captured on disability from 01 April 2012.

• 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.

• In the last 12 months a range of accessibility audits were undertaken for services based in Truro and Redruth, which led to additional work to improve accessibility in Truro. Audits in Penzance and Liskeard are planned in 2012/13.

Sexual orientation

• National research\(^9\) indicates that people in the lesbian, gay, bi-sexual and transgender community 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.

• Sexual orientation was added into the core data set for NDTMS in April 2009 but this information was not recorded for almost 60% of service users triaged in 2010/11 (either

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\(^9\) Death by Diversity, Addiction Today (August 2009), www.addictiontoday.org.uk
not completed or not disclosed, see chart) – we do not know how this completion rate compares with the regional or national picture.

- Failure to ask about a person’s sexuality could mean that their care plan does not adequately address some of the potential risks associated with their lifestyle, including risks of blood borne viruses and suicide. This issue is going to be highlighted with providers, with the aim of increasing reporting over the course of the next 12 months.

- 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. An initial piece of work was undertaken with Health Promotion to ensure that treatment services are more LGBT friendly. This needs to be developed further over the next 12 months.
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 mapping 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.

Key findings

- GP referral remained the most common route into treatment in 2010/11 but has seen a significant drop. Self referrals are rising and it is anticipated that self-referral will exceed GP referral as the most common route into treatment by year end, as was our intention.
- Referrals through criminal justice routes are up on last year but remain significantly lower than the regional and national averages.
- There has been a drop in parents accessing treatment compared with last year but this is thought to be due to poor recording rather than a genuine trend.
- There is a rising trend in the proportion of service users starting new treatment journeys that are injecting drug users (either currently or previously).
- Prescribing remains the most common treatment modality but with continued migration from secondary to primary care.
- 19% of people in treatment overall in 2010/11 had been in for 4 years or longer, which shows little change (+1%) compared with the previous year.
- More people left treatment in 2010/11 and successes as a proportion of all treatment exits remained around the same at 49% (a little above the regional and national averages)
- A third of people leaving treatment in 2010/11 dropped out. This has increased for a second year in a row and is now around 10% higher than the regional and national averages. This finding is of particular concern because Cornwall is considered to be fairly low level in terms of service user complexity.
- Injecting behaviour appears to be one of the key influencing factors in drop-out rate – particularly those who presented to treatment as currently injecting and were receiving prescribing treatment from a GP. Frequent drop-outs are typically male, aged in their late twenties and opiate users with a history of injecting
- We continue to see a relatively small percentage of service users “referred on”. Transfers to service providers outside Cornwall dropped by two thirds, more than matched by an uptake in local provision at Boswyns.
- The proportion of expenditure on structured community interventions may be considered too low for a recovery-orientated treatment system and warrants additional attention.
- Local treatment costs are significantly lower than national costs, with the exception of community prescribing (the high day costs of which necessitate priority attention).
- The treatment population segmentation exercise (CDAT and Addaction) indicated that:
  - The greatest improvements are achieved in the first 12 months
  - Once the drug problem is stabilised, if other issues (such as housing and access to employment or training) haven’t been addressed effectively they begin to impact on health and social functioning
  - Increased poly drug use, particularly alcohol, is common after year one
  - Addaction see a much higher than average proportion of parents (around half) across all segments
  - A number of recommendations to improve treatment options based on service user segmentation – including increased opiate detox options, more employment and training opportunities, more intensive interventions in first 12 months, clearer care planned interventions (treatment and goal setting to achieve this in a multi-agency way), pathway interventions for stimulant users and increased mutual aid.
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.

The mapping 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, in treatment, inter-agency transfers and treatment exits.

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 counted more than once.

**Treatment entry / referral**

Treatment entry - referral routes, all clients who started a new treatment journey in 2010/11. These figures do not include episodes of treatment started within 21 days of completing a previous episode (and counted as continuous).

- The number of people entering treatment dropped by around a third in 2010/11 compared with the previous year, with just over half (55%) treatment naïve at presentation.
- Concern has been raised in previous years over the dominance of GP referral as a route into treatment, which was at odds with the regional / national picture and, it was suggested, demonstrated a lack of accessibility of services.
- At 31%, GP referral remained the most common route into treatment in 2010/11 but there was a significant drop from 37% in 2009/10.
- Self-referrals accounted for around a quarter of all new treatment journeys in 2010/11, compared with only 16% in 2009/10. The latest data from Halo indicates around equal proportions of GP and self-referrals for new episodes started in year.
- 14% of referrals in 2010/11 came via a Criminal Justice route; considerably lower than the regional and national averages (25% and 31% respectively). This represents some improvement from 9% last year – the actual number of referrals is down compared with 2009/10 but this is due to the overall drop in referrals.
- The proportion of service users starting new treatment journeys that live with children dropped from 31% to 23% in 2010/11 and the latest performance data indicates that it has stayed around this level in the year to date. As previously noted this may reflect reporting weakness rather than an actual trend downwards in parents engaging with services.
- The proportion of service users starting new treatment journeys that are injecting drug users (either currently or previously) has increased, rising to 45% in 2010/11 and again to 53% in the year to date, steadily bringing us closer to the regional average (55% to 60%).

**In treatment**

In treatment data is reported for all agencies that have had 5 or more contacts with clients residing in partnership area.

- Prescribing is the most common modality but as previously noted there has been a continued shift from secondary into primary care.
- 19% of people in treatment overall in 2010/11 had been in for 4 years or longer, which shows little change (+1%) compared with the previous year. The majority of long term service users are in CDAT, accounting for a third of their treatment population.
Treatment transfers and exits

Inter-agency transfers are reported where the number of transfers between two agencies is 5 or more. Treatment exits report all 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.

- More people left treatment in 2010/11 than in the previous year so the number of successful completions increased. Successes as a proportion of all treatment exits, however, remained around the same at 49%. This is a little above the regional and national averages (45% and 43% respectively).
- A third of people leaving treatment in 2010/11 dropped out. This has increased for a second year in a row and is now around 10% higher than the regional and national averages. Other types of unplanned discharge (prison and “other”) are in line.
- The main area of disparity, and this is consistent with previous years, is in the level of service users discharged from treatment as “referred on”. Locally this figure is 11% compared with around a quarter for the region / nationally.
- Inter-agency transfers reduced overall compared with 2009/10, with CDAT and Gwellheans seeing the greatest change. One notable (positive) difference is a drop of two thirds in the number transfers to service providers outside Cornwall, such as Broadreach House, with the uptake in local provision at Boswyns. CDAT make the most transfers out to other agencies and in 2010/11 Bosence (Boswyns) saw the most transfers in (including some transfers in from agencies outside Cornwall).

Tier 4 treatment provision

Tier 4 treatment means in-patient interventions and residential rehabilitation. Previously Cornwall has relied heavily on out-of-county provision for Tier 4 treatment but in 2010, Boswyns was opened, the first drug and alcohol detoxification centre based in Cornwall.

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

As previously noted, NDTMS data demonstrates that there was a significant drop in 2010/11 in the use of out of county service providers compared with the previous year.

The latest client monitoring data provided by Boswyns shows:

- 195 service users in 2011/12, engaged in 203 episodes of treatment (8 service users presented twice). There was an average of 27 service users in treatment per month.
- The dominant referring agencies were CDAT (48%) and Addaction (45%), with the remaining 8% coming via a criminal justice route (CJIT, DIP or Probation).
- The majority of service users went into Boswyns for detox, with only a small number (less than 5) receiving help with stabilisation.
- The numbers of treatment episodes by substance and discharge outcome are shown in the chart below.
Overall rates of planned discharge from detox were above the general treatment average at 73%. Alcohol detoxes were more likely to complete successfully than drugs or combination drugs and alcohol detoxes successfully (81%). Of the 8 service users who represented for treatment during the 12 month period reviewed, half had completed their first detox successfully.

**Improving the use of tier 4 interventions**

**Preparation**

Whilst there is still room for improvement, all people accessing tier 4 interventions reported being better prepared for tier 4 interventions this year, both physically and psychologically (e.g. pets, medication) and all knew who their care co-ordinator was. The majority knew what their care plan was.

Preparation work needs more development 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. The DAAT put additional funding in place to increase the capacity available and all people assessed as eligible and fitting the criteria were able to access the residential service they required in-year.

**Training**

All key workers received 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. A recovery programme and peer mentoring were developed and care co-ordination champions meetings convened. The role continues to develop.
- **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.
- **Whilst the new electronic case management system does assist to some degree in improving communication between agencies and pathways to and from tier 4 interventions were actually described as ‘seamless’, the rest of the system was not described in that way. Information sharing remains limited and assessments are still repeated. Few people described the experience as a ‘system’. The majority described confusion as to the role of different agencies and how they relate to each other.**

**Treatment Segmentation**

In evaluating what can be done to improve successful completions the two largest service providers (Addaction and Cornwall Foundation NHS Trust Community Drug and Alcohol Team – CDAT) have reviewed clients by different groupings as a step towards changing the day to day service delivery to meet the varied needs of service users.
different groups and to inform the development of future recovery-orientated treatment.

This was done by examining the numbers in treatment and breaking them down into groups, based on their date of entry into treatment.

- The findings for CDAT are presented for those in treatment for 0 to 12 months, one to four years and four years or more.
- The findings for Addaction are presented for those in treatment for 0 to 12 months, one to two years and two years or more.

The pie chart shows treatment segmentation of the CDAT OCU and non-OCU treatment population as of 1st October 2011.

Short term – 12 months or less

Dr John Strang’s work around effective treatment systems describes clearly the benefits achieved early in treatment.

This is reflected within the CDAT prescribed treatment group in the first twelve months of their treatment journeys.

- In the first six months it is noted that 80% of those within this cohort were using on top on a daily basis. This reduces to 20% by the end of month twelve.
- 60% were injecting on a daily basis and by the end of month twelve this had reduced to 20%.
- Reported crime reduced from 42% to less than 5%. Unstable housing however remained an issue with between 25-40% of those within this treatment population describing their housing as being unstable.

Addaction service user group in treatment for 0 to 12 months

606 service users have been accessing Addaction services for up to 12 months, 454 of these individuals are accessing support for alcohol use and 152 for drug use.

Age of service group and age of first use

- The age range of the service user group engaged with Addaction for up to 12 months is roughly evenly split between 25-34, 35-44 and 45-54.
- The number of 18-24 year olds accessing the service represents just 10% of the population.
- The age of first use data indicates that the majority of individuals commenced use prior to the age of 21. It may be that the ages detailed do not relate to problematic first use, but there is a clear indication of early first use suggesting that earlier intervention could take place and that efforts to engage the 18-24 cohort should be undertaken.

Referral source

- Referral sources have shifted significantly although GP referrals are still the most frequent referrers – with 280 individuals from this cohort having been referred by their GP.
However, the second most frequent referral route is now Self Referral, representing a significant shift that can largely be attributed to the introduction of open access services across the service. **216 individuals** from this cohort self referred.

After this, ‘Other’ is the next most frequent referral route (**21 referrals**) and this will be investigated to establish the referral source.

This is followed by Social Services (**12 referrals**), Statutory Drug Service (**11 referrals**) and Probation (**10 referrals**).

Non Statutory Drug Services made 9 referrals. These figures would indicate that inter-agency referrals between drug services are low, which may mean that service users are not accessing the full range of interventions that are available within the system. This is an issue that requires further exploration.

There is a distinction between the drug and alcohol referral routes, with the primary source of referrals for primary drug users being **self referral** and the primary source of referrals for primary alcohol users being via **GP**s. The graphs below detail the distribution.

**Drug of choice**

- Alcohol remains the primary drug of choice (443), with Heroin (36) and Cannabis (27 + 8) being the next most frequently identified.
- The bar chart demonstrates that numbers for other drugs of choice are fairly negligible.
- However, in 44 cases ‘Not Disclosed’ has been indicated. This figure will be investigated and the impact of this ‘non-disclosure’ in NDTMS reports will be explored as this is a significant figure and the second highest allocation within the HALO report. Addaction will explore all non disclosed primary drugs and address this issue.
- Alcohol referrals are significant in number and there are some challenges to address in relation to appropriate referrals including the receipt of AUDIT scores from referrers and the deliver of screening and IBA. By addressing this, greater capacity could be established to further increase drug numbers.
- Addaction have introduced the delivery of interventions (including day programmes and complementary therapies) that should support an increase in drug numbers. Further promotion is required and service user involvement alongside the recovery champions framework, mutual aid developments, increased open access sessions (at identified locations such as supported housing environments) and the introduction of Breaking Free Online should release capacity and enable the service to engage more drug users.

**Parental Status**

![Parental Status Chart]
Further analysis is required in relation to parental status as there may be some overlap in relation to the detail collated above.

- However, it appears that up to 51% of service users are either a parent of a child under 16 or have children living with them. This is a significant proportion and is reflected in the capacity challenges for the Breaking the Cycle service.

### Medium term

CDAT’s medium term group are those in treatment for between one and four years.

- Within the prescribed treatment cohort with CDAT it appears that between years one and four although a degree of stability is achieved unless the client actively moves away from their drug using behaviour, there appears to be an increase in their poly drug use with on average 52% admitting some poly drug use on a regular basis during this period, alcohol being the most commonly used substance.
- If poly drug use continues during this period between one and four years the effects on physical and psychological health appear most acute.
- In addition during this one to four year period if housing and lack of access to education, training and employment are a problem at the commencement of this period, it is harder for individuals to improve their personal circumstances.

Addaction’s medium term group refers to those in treatment between one and two years. There are 32 service users who have been engaged with Addaction for 1 to 2 years. This is a significant reduction in relation to previous years. 6 of these service users are primary drug users and 26 are primary alcohol users.

### Age

- Again, the age group accessing treatment for 1-2 years is primarily within the 25-34, 35-44 and 45-54 age range, with a low percentage (2.6%) in the 19-24 age range.
- Age of first use (see below) is primarily under the age of 23, suggesting that a focus on engaging a younger population could be considered. Further analysis will take place to establish experience of treatment and the age of first treatment access, as is could also be the case that individuals may have accessed treatment previously.

### Referral Source

- Referral sources for service users who have been engaged for 1-2 years are primarily (59%) from GPs. This is reflective of the previous service structure. 31% of referrals are self referrals with very few referrals from other areas.
- This is in significant contrast to the 0-12 month cohort and demonstrates an improved engagement with partner agencies across Cornwall over the last year.

### Drug of Choice (primary substance)

- For those individuals who have been engaged with Addaction for 1 to 2 years, the primary substance of use is alcohol. 22% of the cohort remain engaged and have a primary substance other than alcohol.
- This may be indicative of (a) a shift in the type of referrals/presentations in relation to primary substance or (b) alcohol users remaining in treatment for a longer period of time. Detailed caseload analysis will be undertaken to establish this.

### Parental Status

- A similar percentage (53%) of service users are parents (of children under 16) or have children living with them.
- The growth in family interventions (Breaking the Cycle, MPACT, Solihull Parenting Training) is being specifically and independently evaluated and is clearly key to the wider treatment population.
Long term

The long term cohort for CDAT means four year to more. The CDAT treatment cohort of four to six years appears to be split into two polarised groups.

- One who continue to poly drug use on top of prescribed medication, although this is at a lesser rate than in earlier cohorts, it appears to have a significantly higher detrimental effect on their psychological and physical health as well as their quality of life.
- The second group in the four to six year cohort have established themselves in regular education, training and employment and the benefits are significantly different to those who remain entrenched in their drug using behaviour.

There is on average a 32% difference in the scores attributed to their TOPS psychological health, physical health and quality of life scores compared to the cohort who have not engaged in education, training and employment. These factors are also noticeable in the cohort of six years plus where those who are firmly engaged in regular education, employment and training are scoring themselves almost 40% more than those who are not similarly engaged.

For Addaction, the long term cohort refers to those in treatment for two or more years.

- There are 13 service users accessing treatment with Addaction for two or more years.

This suggests that the DOMEs data is either based on an earlier data slice (as Addaction have addressed long term service user work since April 2011) or that individuals are in longer term treatment elsewhere in the treatment system.

- 10 of these individuals present with a primary alcohol issue and were primarily referred via primary care. The majority of these individuals are within the 35-44 and 45-54 age groups.

The sample size is small so analysis can tell us little about the population, for example, there are less than 40% of service users with children (including children living with them), but the sample size is not sufficient to make a meaningful comparison to the 1 to 2 year and 0 to 12 month population.

Priorities for action

- Joint work between partner agencies to deliver front end intensive interventions for new referrals to treatment services and to ensure that drug users are able to access the full range of interventions available to them and to support recovery outcomes;
- Opiate detox options from point of referral onwards;
- Street Heroin Detox;
- 28 day and 56 day Subutex detoxes;
- Long term prescribing for those who have tried the above only.
- Partnership working to get more ETE opportunities for the client cohort.
- Clearer care planned interventions with service users about exiting treatment and goal setting to achieve this in a multi-agency way.
- Pathway interventions for stimulant users.
- Implement ROIS pilots, based on Addaction’s work with George de Leon, focussing on service users who have been in treatment for 4+ years or any other specified cohort
- Introduce Payment by Results model to further focus the system on outcomes
- Resource service user engagement (e.g. credit scheme that operates in Bournemouth) to support in engaging drug users and to promote positive outcomes
- Increase Mutual Aid choice and availability – plan in place to roll out from January 2012 (full-time resource to train and support recovery champions)
- Introduce Breaking Free Online from January 2012 to increase capacity and promote outcomes
- Increase Recovery Café provision as low threshold pre- and aftercare support which supports sustained recovery outcomes through peer, volunteer and staff intervention.
Key factors impacting on treatment discharge outcomes

A third of people leaving treatment in 2010/11 dropped out and drop-out rates are above both regional and national averages. Drop-outs are discussed in more detail in the next section. Other types of unplanned discharge (prison and “other”) are in line with averages.

Treatment discharge outcomes were reviewed across a wide range of factors to ascertain the degree of impact each may have had on the outcome.

- Age and gender does not notably impact in either a positive or negative way.
- Across a wide range of factors (including employment status, accommodation need, parental status and injecting status), higher levels of unplanned discharge were noted for service users that were missing information. This may be indicative of poor engagement with the service user at the start of treatment.
- Service users with no parental responsibility had the highest proportion of planned discharges at 54% (6 percentage points above the average of 48%). The successful completion rate for parents living with children, however, was also slightly above average at 51%.

The factors that appear to have the strongest negative impact on successful completion (in order of lowest rate of successful completion) are:

- Referral via a Criminal Justice route
- Being in specialist prescribing treatment, although this is balanced by a much higher proportion of onward referrals (rather than unplanned discharges)
- Presenting to treatment as currently injecting
- Being in GP prescribing treatment
- Presenting to treatment as NFA
- Leaving treatment within 6 months

The following factors also appear to have some negative impact, albeit less strong:

- Being an opiate user
- Being resident in either the North and East or West localities

Positive factors associated with successful completions include:

- Being a user of ecstasy or cocaine
- Presenting to treatment in full time employment – this is the reverse of the finding for last year and may be a result of the increase in open access and out of hours provision
- Self referral
- Being in treatment for longer periods of time, particularly four or more years – this is likely to be an artefact of the drive to move long term service users on and out of treatment, showing that those who did leave treatment in the last eighteen months were ready to go.
- Presenting as having never injected
- Being in structured psychosocial treatment
- Being a cannabis user
- Being treatment naïve – this indicates that we are not identifying and addressing why someone failed on previous attempts
- Being resident in Central Cornwall

Dropping out of the system

The majority of service users who leave treatment in an unplanned way simply drop out (around three quarters of all unsuccessful exits).

- A third of people leaving treatment in 2010/11 dropped out. This has increased for a second year in a row and is now around 10% higher than the regional and national averages.
• This finding is of particular concern because Cornwall is considered to be fairly low level in terms if service user complexity.

Who is most likely to drop out?

A review of the factors impacting on drop out rates shows that they are similar across the gender and age groups (less than 3% difference from the average for all people leaving treatment).

As for unplanned discharges generally, some of the highest drop out rates are for service users where the review factor had not been recorded (in the case of drop outs – whether they had previously been in treatment, injecting status, parental status and employment status) and this may be indicative of poor engagement at the start of a treatment journey.

• Injecting behaviour appears to be one of the key influencing factors in drop-out rate – particularly those who presented to treatment as currently injecting and were receiving prescribing treatment from a GP.
• Being in treatment less than 6 months
• Presenting to treatment as NFA

Factors that appear to have a positive influence on reducing the drop-out rate include being a student on presentation to treatment (this largely reflects positive outcomes for young adults discharged from the young people’s service Yz-Up), being a user of cocaine or ecstasy and having been in treatment for 2 years or more.

Repeated drop-outs

A review of all service users discharged since 01 April 2007 indicates that, off the third who had dropped out once or more in the last 5 years, most had dropped out only once.

There are 18 service users, however, who have dropped out either 3 or 4 times in the last 5 years.

Typically this group of frequent drop-outs are male, aged in their late twenties and opiate users. Just over a third are current injectors when they present for treatment but the majority have a history of injecting. They are much less likely than average to have any parental responsibility.

The majority dropped out in under 6 months (average 10 weeks) but 5 had been in treatment for two or more years at the point of drop out. Re-presentation is on average 30 weeks.

Ten individuals remain dropped out and not in current contact with the treatment system; seven are currently back in treatment and one has subsequently completed treatment. Here are two case studies that illustrate some of the challenges in reducing drop-out rates, such as housing (featuring in both cases), children and criminal justice processes.
Delivering value for money

The Cost Effectiveness Tool (CET) brings together 2010/11 expenditure, output and outcomes data from areas across England enabling Partnerships to determine the cost effectiveness of all the treatment pathways within their treatment system. The CET also facilitates comparisons against national averages, and the average for the best performing areas (Top quartile areas).

Expenditure

Expenditure for 2010-11 is set out below. While all treatment costs were collected, the CET has only used the expenditure from the six structured interventions (highlighted in bold) to cost the treatment pathways.

Colin is a 22 year old man, NFA, mainly staying with friends. He had only been using drugs for a short period of three months or less when referred and was committing crime to fund his habit.

Following referral he did not attend his first appointment. On assessment it transpired that he was pending a court case for acquisitive crime and due in court. He was committing crime to fund his habit. He was assessed for a Drug Rehabilitation Requirement order and placed on methadone prescription. This involved attendance twice weekly and he had 11 episodes of non attendance in 5 months. When he was charged with another offence, the Probation order was breached and he went to prison.

Colin re-entered community treatment within 2 days of release as per prison release process. His prescription had continued in custody. The DRR continued his current treatment episode. He was re-sentenced on 7 July and sent to custody, and subsequently released 30 September – no longer on the DRR. He was seen within 2 days of release by duty worker as per prison release process. His script was continued in the community on release. He attended a prison release appointment briefly. He was then transferred to another key worker, did not attend his next two appointments and his script was placed on hold until contact made. A letter was sent to him asking him to contact the team. He has attended probation instead by mistake.

Issues with re-engagement

- Different engagement requirements of criminal justice treatment and non-criminal justice treatment.
- Client remains homeless until worker can see him and look at pursuing housing opportunities.
- Unable to discuss with client due to failure to attend and no contact number.

This highlights the challenges of engaging young male drug users with transient lifestyles.

Marnie is a 32 year mother of three children who are subject to safeguarding.

She has had 3 treatment episodes, being previously discharged for non-attendance. She is currently residing at a bed & breakfast public house and receiving a prescription of 90ml of methadone, prescribed for by her GP. She continues to use heroin intravenously. She was poorly engaging with treatment due to fear of discovery of injecting in addition to receiving prescription and fear of losing her children. This led to a breakdown of the relationship with her keyworker and she was discharged.

Subsequent re-entry has involved a new keyworker, a referral to the ‘Breaking the Cycle’ family programme, a focus upon attachment to injecting behaviour and upon finding permanent accommodation.
Chapter 3 – Mapping the treatment system

### Expenditure profile

<table>
<thead>
<tr>
<th>Expenditure profile</th>
<th>Expenditure</th>
<th>Cornwall &amp; IoS %</th>
<th>National %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Structured community prescribing</td>
<td>£3,299,519</td>
<td>39.2%</td>
<td>27.8%</td>
</tr>
<tr>
<td>2. Structured community day programmes</td>
<td>£214,028</td>
<td>2.5%</td>
<td>4.9%</td>
</tr>
<tr>
<td>3. Structured community psychosocial interventions</td>
<td>£554,474</td>
<td>6.6%</td>
<td>7.9%</td>
</tr>
<tr>
<td>4. Other structured drug treatment</td>
<td>£134,930</td>
<td>1.6%</td>
<td>6.8%</td>
</tr>
<tr>
<td>5. Inpatient treatment</td>
<td>£222,000</td>
<td>2.6%</td>
<td>3.3%</td>
</tr>
<tr>
<td>6. Residential rehabilitation</td>
<td>£209,930</td>
<td>2.5%</td>
<td>3.9%</td>
</tr>
<tr>
<td>7. Alcohol services</td>
<td>£1,949,370</td>
<td>23.2%</td>
<td>9.5%</td>
</tr>
<tr>
<td>8. Unstructured treatment (formerly Tier 2)</td>
<td>£348,977</td>
<td>4.2%</td>
<td>8.6%</td>
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<tr>
<td>9. Drug Interventions Programme (DIP)</td>
<td>£820,088</td>
<td>9.8%</td>
<td>11.4%</td>
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<tr>
<td>10. Prison based drug treatment</td>
<td>£0</td>
<td>0.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>11. Treatment overhead costs</td>
<td>£613,560</td>
<td>7.3%</td>
<td>8.7%</td>
</tr>
<tr>
<td>12. Below the line</td>
<td>£40,000</td>
<td>0.5%</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£8,406,876</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

- The proportion of expenditure on structured community interventions may be considered too low for a recovery-orientated treatment system and warrants additional attention.
- Expenditure on In-patient interventions significantly increased in 2011/12 through the development of the Boswysns service so will be similar to or above the national percentage.

### Cost per day

<table>
<thead>
<tr>
<th>Expenditure profile</th>
<th>Cornwall &amp; IoS</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Structured community prescribing</td>
<td>£10.64</td>
<td>£5.32</td>
</tr>
<tr>
<td>2. Structured community day programmes</td>
<td>£5.14</td>
<td>£19.98</td>
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<tr>
<td>3. Structured community psychosocial interventions</td>
<td>£8.81</td>
<td>£10.40</td>
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<tr>
<td>4. Other structured drug treatment</td>
<td>£2.81</td>
<td>£10.33</td>
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<tr>
<td>5. Inpatient treatment</td>
<td>£115.53</td>
<td>£402.92</td>
</tr>
<tr>
<td>6. Residential rehabilitation</td>
<td>£44.98</td>
<td>£138.25</td>
</tr>
</tbody>
</table>

- Whilst local costs are significantly lower than national costs, apart from community prescribing, we have identified the need to increase the availability of all of the other interventions.
- The high day costs of community specialist prescribing indicate a priority for attention.
Chapter 4 – Drug use and mental health

The term ‘dual diagnosis’ is used to describe the situation where a person has been diagnosed with both a mental health condition and a problem with drugs and / or alcohol.

Previous research has estimated that up to half of people diagnosed with a mental health condition also misuse substances. People with a dual diagnosis are likely to have problems with their physical health, social functioning, money management, housing and are more likely to be in contact with the criminal justice system.

Key findings

- The complexity of dual diagnosis issues makes all aspects from diagnosis to care to treatment all the more important. This is made more so by ongoing challenges and risks which include:
  - Re-admission rates to hospital are high
  - Drop out rates high
  - Engagement poor
  - High suicide rates
- Increased rates of substance misuse are found in individuals with mental health problems, affecting around half of people with severe mental health problems
- Alcohol misuse is the most common form of substance misuse and where drug misuse occurs it often co-exists with alcohol misuse
- Community Mental Health Teams (CMHTs) typically report 8-15% of their clients have dual diagnosis problems although higher rates are found in inner city areas.
- Local data indicates that service users with a dual diagnosis made up 12% of new treatment journeys in 2010/11, which was in line with the regional average and a little lower than the national average.
- Local research into the distribution of mental health prevalence drew on data from the Indices of Multiple Deprivation (2010, mood and anxiety disorders). Areas with the highest prevalence included St Austell Mount Charles Ward North West, Camborne West Ward East Central and Penzance Lescudjack and Ponsandane. The majority of areas highlighted tend to be located in the West of the county.
- Mosaic consumer profiling suggests that the best way to communicate with households that are likely to experience long term mental health issues is to use word of mouth techniques rather than internet communications (due to lack of access).
- Many of the households have good access to local services via walking or local transport as they do not have access to a car. This therefore emphasizes the importance of locally based services.

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The term ‘dual diagnosis’ is used to describe the situation where a person has been diagnosed with both a mental health condition and a problem with drugs and / or alcohol.

Dual diagnosis covers a wide range of problems that have both mental health and substance misuse in common and consequently it can mean different things to different service providers. The Department of Health summarises dual diagnosis within four principal definitions:

A primary mental health problem that provokes the use of substances
Such as a person suffering from schizophrenia who finds that heroin reduces some of his / her symptoms

Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses
Emergence of depression post-detoxification – insomnia and low mood; also the emergence of a psychiatric disorder to which the individual was vulnerable pre-substance misuse

A psychiatric problem that is worsened by substance misuse
For example, a person with heightened anxiety of danger from others who uses cannabis to relax, but finds that the cannabis can increase their paranoia, leading to increased alienation

Substance misuse and mental health problems that do not appear to be related to one another
For example, someone who has an ongoing anxiety problem that is neither lessened nor worsened by drug or alcohol use

Previous research has estimated that up to half of people diagnosed with a mental health condition also misuse substances. People with a dual diagnosis are likely to have problems with their physical health, social functioning, money management, housing and are more likely to be in contact with the criminal justice system. The severity of a person’s mental health condition as well as the extent of their drug misuse will determine how complex their needs are.

To better meet the need of people with drug and alcohol issues and mental disorders (dual diagnosis) is one of the biggest challenges facing frontline mental health services and substance misuse treatment services.

The complexity of these issues makes all aspects from diagnosis to care to treatment all the more important. This is made more so by ongoing challenges and risks which include:

- Two or more potential relapsing conditions
- Readmission rates to hospital high
- Drop out rates high
- Engagement poor
- High suicide rates
- Increased risks of violence.
- A review into homicides committed by people with mental illness identified substance misuse as a factor in over half the cases, and substance misuse is over represented among those who commit suicide.
- Increased rates of substance misuse are found in individuals with mental health problems, affecting around half of people with severe mental health problems
- Alcohol misuse is the most common form of substance misuse and where drug misuse occurs it often co-exists with alcohol misuse

• Community Mental Health Teams (CMHTs) typically report 8-15% of their clients have dual diagnosis problems although higher rates are found in inner city areas.

In 2011/12, substance misuse treatment services and mental health services in Cornwall and the Isles of Scilly were mapped against severity of symptoms and needs to develop a framework for working with dual diagnosis and agreement was achieved regarding joint working and care co-ordination.

Dual diagnosis is captured as a simple yes or no in NDTMS but the completion rate is currently poor. In 2010/11 this field was not completed in almost half of all new service users triaged in year.

• Service users with a dual diagnosis made up 12% of new treatment journeys in 2010/11, which was in line with the regional average and a little lower than the national average.

**Mapping prevalence of mental health issues**

Measuring prevalence of mental health issues at a local level is problematic due to their being no single measure that can identify such issues. We do however have two possible data sources that can be used to indicate the distribution of mental health need throughout Cornwall.

• The rate of adults suffering from mood and anxiety disorders, which makes up part of the Index of Multiple Deprivation 2010.

• Experian's Mosaic lifestyle classification is a measure that draws upon hospital episode data for long term mental health conditions, of which we selected schizophrenia, bi-polar disorder and depression.

The mood and anxiety disorder indicator is a modelled estimate based on prescribing data for 2005, hospital episode data for 2006-08, suicide mortality data for 2004-08 and health benefits data for 2008. None of these datasets are a perfect measure for mood and anxiety disorders but used in combination they provide a good general picture of those suffering mental ill health.

Experian’s Mosaic classification is also modelled and uses hospital admissions captured at a national level for long term mental health disorders and thus represents more complex cases. Mosaic applies the data to their household classification to highlight certain groups that may be more likely to experience these long term conditions. Mosaic allows us to understand the lifestyles of those more likely to be affected by mental health and improve our communications.

For the composite measure the IMD modelled information was chosen as the most representative measure because it is based on figures captured at a local level.
Identification of mental health using the English Indices of Multiple Deprivation (IMD)

The IMD is an important tool for being able to identify disadvantaged areas throughout England. This identification allows policy makers and communities to target areas in the greatest need of service. The Indices of Deprivation draw information from seven key areas, income, employment, education, housing, services, living environment and crime, and health deprivation and disability. This information is then combined to form a measure of deprivation.

The measure on mood and anxiety disorders is one of four indicators that make up the overall score for health deprivation and disability. This measure is provided at LSOA level and allows us to see which areas are indicated as having higher levels of mental health.

Prescription data is based on prescriptions and typical doses of anxioliotics (including Benzodiazepines) and anti-depressants. As prescription data is not held at individual level it needs to go through a method where area rates can be calculated. This methodology works on the assumption that those people with mental ill health take the national daily quantity of a specific drug on every day of the year. Although this assumption may not fit well at individual level it is more likely to hold across the average for the practice population. These practice populations are then distributed to LSOA level through knowledge of practice population level.

For the purpose of this assessment these rates have been ranked, separated into quintiles and then mapped to LSOA level. Those areas highlighted in red are ranked within the top 5% in Cornwall for having issues with mental health. The rest of the areas are broken down into their quintile groups and mapped accordingly.

- The majority of areas that are being highlighted on the map (upper quintile, orange and red) tend to be located in the West of the county. Areas such as Hayle and the Camborne, Pool and Redruth conurbation have been identified that were not shown by Mosaic (discussed below).
- Within the Central and East localities, Truro, St Austell, Falmouth and Newquay have been highlighted. Many of the other towns highlighted by Mosaic do not feature within the upper quartile of the IMD measure.

13 Methodology taken from The English Indices of Deprivation 2010 which can be found at http://www.communities.gov.uk/documents/statistics/pdf/1870718.pdf
St Austell Mount Charles Ward North West, Camborne West Ward East Central and Penzance Lescudjack and Ponsandane are identified as the three areas having the highest indicator score in Cornwall for mood and anxiety disorders.

The majority of coastal communities highlighted by Mosaic also do not feature in the upper quintile of the IMD measure. However there are a few exceptions with Mevagissey and St Ives both appearing in the upper quintile. Other coastal communities such as Porthleven and Padstow, which were not identified by Mosaic, are also in the upper quintile of the IMD measure.

Identification of mental health by Mosaic classification

Mosaic Public Sector is a classification system developed by Experian for use in resource planning, to enable services to be delivered in response to an individuals needs and target resources and communications more effectively. Mosaic uses 440 data elements from public and private sector resources to classify each household in England into ‘groups’ and ‘types’. Each group and type has an associated profile which contains information on the likely characteristics lifestyle and preferences (such as preferred communication method).

Mosaic looks at all the data about a household that is available and uses this information to assign a ‘group’ and ‘type’ to that household. The data is retrospective and therefore will never be 100% accurate as one household could be home to people with very different needs. It does however allow us to draw broad conclusions and extend the data that is held at a local level to include additional information about likely lifestyle characteristics of households and improve our communications.

For this report we have calculated the number of households based on hospital admissions for three specific long term conditions, schizophrenia, bi-polar disorder and depression. This refers to complex cases as information is based on hospital admissions and not lower level instances of these conditions. By using the admission information from these cases, Experian are able to determine which ‘groups’ or ‘types’ are more likely to experience these conditions.

The most numerous type of household in Cornwall which are most likely to have mental health issues are B08s (description can be found below), which has high levels of incidence for all three conditions. Although there are other types of household that are likely to have mental health issues, B08s make up the majority of households in Cornwall identified by Mosaic as being associated with all three of the long term mental health issues.

The B08 type specifically looks at residents from mixed communities with many single people in the centres of small towns.

The residents can be both young or old and typically live in low grade accommodation such as small flats above shops, small terrace houses and quite often in communal accommodation or in hostels. The population is transient, with many living in privately rented accommodation, often shared with others on a temporary basis.

Other types of households include G33, M59 and N61 all of which have been identified as being associated with risk of long term mental health issues.

- Type G33 is described as transient singles, poorly supported by family and neighbours.
- Type M59 is described as people living in social accommodation designed for older residents whereas.
- Type N61 is described as childless tenants in social housing flats with modest social needs.

The map below shows the types of households with mental health issues associated with it mapped at LSOA. Areas that are highlighted in red have twice the number of households indicated as being more likely to have mental health issues than the Cornwall average.
Many LSOAs that Mosaic identifies are located in the urban town centres of Cornwall, with Bodmin, Truro, Penzance, Camborne, Redruth, St Austell, Newquay, Liskeard and Falmouth all being highlighted.

Smaller towns have also been identified as having a higher proportion of households with Wadebridge, Launceston, Callington, Saltash and Helston being identified.

There also appears to be a trend of properties located near the coast being identified with Bude, Perranporth, St Ives, Marazion, Mevagissey and West Looe all being highlighted.

It is important to remember that the households in these areas have been identified from national information on hospital admissions and are not based on local information. Although Mosaic can be used as a good indicator of mental health issues it is unable to give actual numbers of hospital admissions and therefore does not take into account any local differences between Cornwall and other areas in England.

Mosaic however is able to provide a description on how best to communicate and raise awareness with residents of the particular households identified.

Using Mosaic to inform communication with target households

The following information is taken from Experian’s description of each household type. For the purpose of this report only the information regarding access to these residents has been used. There are some common themes that emerge from these descriptions.

- Many of the types have good access to commercial and local services but do not have access to a car.
- Most of the types also have little or no access to the internet meaning that details of services will need to be communicated in a different format.
- The type with the largest resident population in Cornwall (B08) is best engaged with via face to face communications. This is also true with another type (M59) who tend to prefer communication by word of mouth.

A summary of each type is shown on the next page\(^\text{14}\) – for more information about Mosaic please contact Amethyst or Abi Smith in the Community Intelligence Team (Cornwall Council).

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\(^{14}\) Information taken from Experian public sector knowledge base website
Type B08 residents from mixed communities in small town centres

This type refers to residents from mixed communities with many single people in the centres of small towns. This is the largest population that are likely to have mental health issues throughout Cornwall.

“This population has good physical access to commercial and public services. However, because not many people’s names are held on official registers they can be difficult to reach via conventional channels. Many can be engaged only via face to face communications”

Type G33 transient singles

This type refers to households who are described as transient singles, poorly supported by family and neighbours.

“Many residents do not have access to a car. In other respects they tend to have good access to commercial and public services, many being within easy walking distance of the town centres.

Many residents are not connected to the internet. Those that are tend to download entertainment rather than search for information. Few people would use the internet to access information on local services.”

Type M59 older residents in social accommodation

Mosaic describes this type as people living in social accommodation designed for older residents.

“Many residents grew up in an age when car ownership was far from universal and are happy to rely on public transport outside their immediate community. Many welcome weekly lifts from friends or family to help them with local shopping.

Many residents do not have access to the internet and of those who do, large numbers lack the confidence to use it to access information about local authority services. Many still operate in a culture where information is passed by word of mouth”

Type N61 childless tenants in social housing flats

These residents are described as childless tenants in social housing flats with modest social needs.

“Residents tend to have below average levels of car ownership but mostly live within easy access of retail outlets and of bus routes.

Levels of internet access are below average. However, the internet is likely to be more intensively used than in other areas of social housing to access information on public services.”
Chapter 5 – Working with families

Substance misuse is a key risk factor in families with complex multiple problems and vulnerabilities.

A key factor in recovery for adults is involvement, support and interventions for their families.

The impact of someone’s drink or drug problem on their family and friends is often overlooked, but it's estimated that almost one in five of us are likely to have a family member affected in this way.

Coping with a loved one’s problem drug or alcohol use can take a toll on their family’s health, wellbeing, their finances, social lives and relationships with others.

Key findings

- Evidence suggests that effectively supporting and involving family members and carers can lead to improved outcomes for the whole family.
- For the drug user, effective involvement of family members and carers helps increase the chances of:
  - Entering treatment
  - Reducing or stopping their drug misuse
  - Engaging with treatment if they do enter
  - Being retained in treatment
  - Successfully concluding treatment
  - Drug users are also less likely to suffer major relapses. This leads to better quality of service provision overall.
- We have a wide range of interventions in Cornwall that are tailored to the needs of different family types. Interventions are both for the individual (parenting for example) and collective (family group work), moving us towards a comprehensive family work programme;
- We are well placed to meet the needs of families targeted by the Troubled Families programme.
- West Cornwall has the highest concentration of areas identified as having complex needs. Most of the identified LSOAs fall within the Camborne and Redruth network area with other areas highlighted in Penzance, Hayle and Helston.
- Illogan Highway South, Redruth North South West and Penzance Treneere have been identified as areas that have the highest levels of complex needs based on these issues. These areas are ranked within the top 10% for each one of the parental risk factors.
- There is a strong positive correlation between mental health disorders and domestic abuse incidents where the child is resident. This means that LSOAs that experience high rates of domestic abuse are likely to experience higher rates of mental health disorders.
- There is also a significant relationship between substance misusing parents and mental health disorders. There is a moderate relationship between the two variables, meaning that areas with high percentages of substance misusing parents may also have high rates of mental health disorders.
- The relationship between substance misusing parents and domestic abuse incidents is also significant, although it is weaker than between other variables.
There is a good deal of evidence that suggests supporting and involving family members and carers effectively can lead to improved outcomes for family members and carers, as well as drug users themselves.15

Effectively involving family members, kinship carers and other carers helps users increase their chances of:
- Entering treatment
- Reducing or stopping their drug misuse
- Engaging with treatment if they do enter
- Being retained in treatment
- Successfully concluding treatment.
- Drug users are also less likely to suffer major relapses. This leads to better quality of service provision overall.

A wide range of interventions tailored to the needs of different family types – individual and collective, moving us towards a comprehensive family work programme

Well placed to meet troubled families and complex needs strands

Good practice guidance included:
- Commissioning consistent, effective and quality services for family members and carers who are affected by someone else’s drug use, either through generic mainstream carer services or through specialist substance misuse family member and carer services.
- Ensuring services that treat drug users involve family members and carers in their treatment, as far as this is possible and appropriate
- Involving family members and carers effectively in the planning and commissioning of drug treatment, and family and carer services
- Embedding effective monitoring systems and practices relating to work with family members and carers within commissioned services
- Local commissioners tracking delivery of these services via robust delivery assurance systems

National policy and guidance increasingly highlights the benefits of health and social care services involving and supporting carers. In June 2008, the Government published Carers at the Heart of 21st Century Families and Communities (DH, 2008), which set out the vision and framework for developing support for carers as a progressive process of change over the next ten years.

Drug Misuse and Dependence: UK Guidelines on Clinical Management (DH et al., 2007) also states the importance of providing services for families and carers as well as appropriately involving them in drug misusers’ treatment.

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 four broad domains – social, physical, human and cultural.

1 Social capital is defined as the sum of resources that each person has as a result of their relationships, and includes both support from and obligations to groups to which they belong; thus, family membership provides supports but will also entail commitments and obligations to the other family members.

15 Supporting and Involving Families and Carers in Treatment, NTA (2008)
2 **Physical capital** is defined in terms of tangible assets such as property and money that may increase recovery options (e.g. being able to move away from existing friends/networks or to afford an expensive detox service).

3 **Human capital** includes skills, positive health, aspirations and hopes, and personal resources that will enable the individual to prosper. Traditionally, high educational attainment and high intelligence have been regarded as key aspects of human capital, and will help with some of the problem solving that is required on a recovery journey.

4 **Cultural capital** includes the values, beliefs and attitudes that link to social conformity and the ability to fit into dominant social behaviours.

**Best and Gilman (2010)** have argued that the growth of recovery has a ripple effect that confers benefits on families but also serves to generate ‘collective recovery capital’ that provides support and hope for those in recovery and that engages people in a range of activities in the local community.

This process translates into active participation in community life and ‘giving something back’ by creating a collective commitment in recovery groups to community engagement and immersion. In other words, the recovery community acts and is seen as a positive force in the local community and a resource for that community that goes beyond managing substance misuse issues.

### Supporting families in the treatment system

<table>
<thead>
<tr>
<th><strong>Telephone advice, and drop-in information and support</strong></th>
<th>available to people affected by someone else’s drug use through Addaction and Freshfield services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family groups</strong></td>
<td>available in Liskeard, Truro and Penzance on a weekly basis.</td>
</tr>
<tr>
<td><strong>Breaking the Cycle pilot sites</strong></td>
<td>have been jointly funded by Zurich International for 3 years in partnership with Addaction to deliver family support, including:</td>
</tr>
<tr>
<td>• Prioritisation, assessment and care planning</td>
<td>• A range of motivational and solution focused interventions</td>
</tr>
<tr>
<td>• Advice and information</td>
<td>• One-to-one and family support</td>
</tr>
<tr>
<td>• Group work</td>
<td>• Group work</td>
</tr>
<tr>
<td>• Family mediation</td>
<td>• Signposting</td>
</tr>
<tr>
<td>• Advocacy</td>
<td>• Advocacy</td>
</tr>
<tr>
<td>• Home visits</td>
<td>• Home visits</td>
</tr>
<tr>
<td>• Work with children through coordination with partner agencies and schools</td>
<td>• Work with children through coordination with partner agencies and schools</td>
</tr>
<tr>
<td>• Systemic family therapy</td>
<td>• Systemic family therapy</td>
</tr>
</tbody>
</table>

The next chart below shows the referral pathways from Children and Family Services into treatment.
Breaking the Cycle seeks to achieve three key outcomes:
- Reduction in the number of parents and children at risk of the significant harm associated with problematic substance use.
- Improvement in family functioning.
- Improvement in the health and wellbeing of parents and their children.

**Accredited Parenting programmes** for drug users in treatment who wish to improve their confidence and competence in parenting are delivered through Gwellheans, for recovery service users and through Addaction for people currently in treatment.

**Family Conferencing** has been introduced into Chy Colom to improve outcomes for those leaving residential rehabilitation, by involving families prior to completion, to facilitate resolution of outstanding or pertaining issues.
The **MPACT programme** - Moving Parents and Children Together - was developed by Families Plus and is licensed for delivery in Cornwall.

M-PACT is designed to address:
- Chaotic and unpredictable lifestyles
- Unsafe environments
- Difficult family circumstance for children and young people

M-PACT aims to:
- Increase opportunities for all children and young people living with substance misuse in the home
- Ensure safe, effective help and support is available
- Provide information that addiction is a long term complicated problem
- Provide an arena of ‘non blame’
- Strengthen families and address difficult relationships

The Programme offers a whole family approach to meeting the needs of children, young people and their parents where a parent has a substance misuse problem. Children aged 10 to 17 years old, and parents from a number of families are invited to meet together, where a professional team work together with them.

The programme consists of an assessment meeting, followed by eight weekly sessions, lasting two and a half hours. Children, young people and parents meet in separate groups for some of the time and then together for the final part of the session. There is a review meeting with each family and finally a reunion session which brings all of the families together again, several weeks after the end of the programme.

Help is provided to understand the impact of substance misuse, to identify family strengths, and to explore practical ways to improve communication, well being, safety, the home environment, and relationships between family members. Children, young people and parents contribute to the content of each meeting.

M-PACT Programme will:
- Improve communication within the family
- Provide education for young people and parents around addiction
- Enable children, young people and parents to access appropriate support
- To promote self esteem in children and young people
- To strengthen ability to cope

**What Changes for Families?**
- Greater understanding of addiction and its impact
- Understanding by children that the problem is not their fault
- Families learn how to cope with the addiction and the associated problems at home - and break negative behaviour patterns

**New initiatives for families**

In December 2011, the government announced a new, determined, cross-government drive intended to turn around the lives of 120,000 of some of the country’s most “troubled” families by the end of this Parliament.

A troubled family is one that has serious problems and causes serious problems. Typically in these families, there will be a range of factors including parents out of work, mental health problems, truanting and exclusion from school, family involvement in crime and anti-social behaviour and high demand placed on local services in routinely responding to these problems. New figures from national research indicate that troubled families cost an estimated £75,000 per family per year.
A new Troubled Families Team based within the Department for Communities and Local Government (DCLG) and headed by Louise Casey, has been established to join up efforts across Whitehall, provide expert help to local areas and drive forward the strategy.

This programme will run primarily on a payment-by-results basis to incentivise local authorities and other partners to take action to turn around the lives of troubled families in their area by 2015. The Government will offer to pay up to 40% of local authorities' costs of dealing with these families (Payment by Results Model) payable only when they and their partners achieve success with families.

The Government will also fund a national network of troubled family 'trouble-shooters' in each (upper-tier) local council. The trouble-shooters will operate at a senior level to oversee the programme of action in their area.

The headline goals and the areas in which success will be measured are:

- Children back into school
- Parents on the road back to work
- Reduced crime and anti-social behaviour
- Reduced costs to the taxpayer and local authorities.

DCLG have provided local authorities with the estimated number of troubled families based on indicative numbers from the Indices of Multiple Deprivation and Child Deprivation Index.

In Cornwall it is estimated that our cohort size is 1,270 families. We are in the process of confirming this figure with our local data across the three key themes (out of school, out of work and involved in crime / anti-social behaviour) with a view to identifying the actual cohort that the programme will work with by the end of March. This will form part of the business case to DCLG that is required to commence the programme.

Prior to this announcement, the Department of Work and Pensions announced that some European Social Fund funding will be used to help some of the country's most disadvantaged families get back on their feet and into jobs. This programme, which locally is called Cornwall Works With Families, provides targeted and personal support to families where the parents are out of work. There are four lead providers who provide the keyworker role and co-ordinate the family action plan, working alongside the local authority and a range of other organisations to deliver programmes designed to overcome barriers to employment.

These include:

- Better parenting and improving family relationships
- Mentoring
- Tackling addiction
- Money management
- Work tasters, work placements and internships
- Healthy living and life skills
- Tackling social exclusion
- Building confidence and motivation

The DWP Programme has subsequently been brought in under the overall umbrella of the Troubled Families Programme.

To ensure that these work streams are integrated, both with each other and with other key programmes, the criteria for prioritising families will include mapping against the locally developed Complex Families Index (discussed in detail in the next section) and cross-referencing with the TurnAround cohort and the Neighbourhood Harm Register.16

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16 The Neighbourhood Harm Register is held by the Police and identifies households where certain triggers have been reached in terms of repeat calls for service (police, ambulance, hospitals) or severe risk has been identified (high risk mental health cases, severe unexplained emergency attendance at hospital, safeguarding alerts raised).
Mapping families with complex needs

In 2011, Amethyst undertook a separate piece of research into families with complex needs to inform the needs assessment processes (themed around substance use and young people) and to inform and support the commissioning of services. The entire report is reproduced here.

For the purposes of this research, the term complex needs refers to parents who experience mental health, domestic abuse and substance use issues which can all have a negative impact on children within these families. The NSPCC has researched the relationship between these three factors and babies born into these families. Brandon et al. (200817) looked into 47 serious case reviews and found that families shared many characteristics with domestic abuse, mental health difficulties and substance misuse issues being most prevalent among parents and carers.

These parental risk factors have been highlighted as a key area of focus for the Young People’s Specialist Substance Use Treatment Needs Assessment (which can be found at https://www.amethyst.gov.uk/strataudit.htm). By looking into the relationships between domestic abuse incidents, parental substance misuse and mental health issues we aim to identify areas where these risk factors may be most prevalent throughout Cornwall.

It is important to note that this document does not assume that all families with domestic abuse issues will also suffer with substance use issues and mental health difficulties. Although there is likely to be a relationship between the factors the main aim is to identify areas where all three parental risk factors are prevalent indicating where specialist resources may be best targeted in order to have the greatest effect.

Measuring combined risk

By looking at LSOAs where domestic abuse incidents, substance misusing parents and mental health issues are most prevalent we will be able to identify those areas where resources may best be targeted. The three data sets that are being used for this composite measure are police crime data on domestic abuse incidents where a child is recorded as resident, the Health Visitor Audit in relation to parental drug disclosures and the Indices of Multiple Deprivation 2010 (IMD) measure on mood and anxiety disorders.

In order to compare and combine the IMD measure with that of the Health Visitor Audit and rates of domestic abuse incidents, the rates of the latter variables are ranked in order to create a standardised measure. Although this means that some data granularity is lost as intervals between scores (difference in rates between areas) become equal we will still be able to see which areas have the highest rates (through ranks) and therefore the highest comparative need. By taking an average of the combined ranks we can identify those areas that have the highest prevalence of complex needs.

The table below illustrates each of the areas identified in the top 5% (16 out of 327 LSOAs) in Cornwall with the highest combined index score. The colours within the index identifies where an LSOA is ranked within each variable (i.e. if an area is red it is in a top 5% for that variable).

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• From this index we can see Illogan Highway South, Redruth North South West and Penzance Treneere are ranked within the top 10% for each one of these indicators. These areas should be highlighted as a priority as they have high ranks in all three areas.
• Other areas of high risk include Camborne West Central (both east and west LSOAs), Bodmin St Mary’s South East and Redruth North Close Hill.
• 7 of the areas within the top 16 are located within the Camborne, Pool and Redruth conurbation.
• There are a further four areas that are located in West Cornwall, highlighting that complex families are more likely to be found in the West.

The map below shows the mapped by composite measure at LSOA level.

- The West has the highest concentration of areas identified as having complex needs. Most of the identified areas fall within the Redruth and Camborne network area with other areas highlighted in Penzance, Hayle and Helston.
• Within the central locality there are fewer areas that are in the top 20% (highlighted in orange or red in the map). These tend to be situated around the larger towns of Truro, Newquay, Falmouth and St Austell. There are also complex needs situated in the China Clay community network area. This area is highlighted due to high prevalence of parental substance misuse and domestic abuse incidents.

• In the East, areas of highest complex need tend to be located around the towns of Bodmin and Liskeard. There are also some areas that have been identified around Looe, Saltash, Launceston and Bude.

Prevalence of domestic abuse

The ACPO\(^{18}\) definition of domestic abuse is defined as patterns and incidents of threatening behaviour, violence or abuse (psychological, physical, sexual, financial and emotional) between adults who are or have been intimate partners or are family members,\(^{19}\) regardless of gender.

- The ACPO definition excludes incidents or crimes where the offender or victim is less than 18 years of age. In July 2008 Devon and Cornwall amended the definition in use in crime recording locally to include victims aged 16 and 17 years.
- Domestic abuse is not always criminal and hence we record and complete risk assessments for incidents that may be precursors to or indicators of criminal behaviour (referred to as non-crime incidents).

It is acknowledged that domestic abuse is significantly under-reported. Unlike the approach to tackling other types of crime, one of the key objectives in tackling domestic abuse is to drive up reporting, and hence the interpretation of patterns and trends using police data is limited.

The negative impact of domestic abuse on children can be devastating and long lasting. National figures show that around 750,000 children witness domestic abuse every year and nearly three quarters of the children on the ‘at risk’ register live in households where domestic abuse occurs.\(^{20}\)

The impact of domestic abuse can start before birth. Research has shown that about a third of domestic abuse starts or escalates during pregnancy.\(^{21}\) Domestic abuse is associated with increased incidence of miscarriage, low birth weight, prematurity, foetal injury and death. Children experiencing domestic abuse are at increased risk of behavioural problems, emotional trauma and mental health issues that may continue into adult life. They may also be at increased risk of violence themselves.

Results from the British Crime Survey self-completion module showed that in 2010/11 7% of women and 5% of men had been victims of abuse in the last 12 months. In Cornwall this would equate to around 17,000 victims of abuse in one year – 7069 incidents were reported to the police in 2010/11, a large proportion of which will have related to repeat cases. The British Crime Survey showed that 75% of all incidents were repeat victims. This therefore clearly indicates that only a minority of incidents are reported.

- In September 2008 the police began to record when a child was resident in domestic abuse incidents (both crimmed and non-crimed).
- In 2010/11 there were a total of 2694 incidents where a child has been recorded as resident, equating to a rate of 8.1 incidents per 1000 population aged 18 to 64 (please note that rates are calculated by adult population in order to compare with other parental risk factors throughout the report).
- A child or children were recorded as resident in the household in 38% of domestic abuse incidents recorded in 2010/11 and the number of incidents reduced by 14% compared

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18 Association of Chief Police Officers
19 Including parents, grandparents, sons, daughters, siblings, any direct relatives or in-laws or step families.
20 Department of Health (2003)
21 Women’s Aid website www.womensaid.org.uk (Lewis and Drife, 2001, 2005; McWilliams and McKeirnan, 1993)
with 2009/10. This trend is contrary to the general trend for domestic abuse incidents, which shows a 4% rise over the same period.

Trends in domestic abuse are discussed in more detail in the Community Safety Strategic Assessment 2010/11 (which can be found at [http://www.amethyst.gov.uk/strataudit.htm](http://www.amethyst.gov.uk/strataudit.htm)).

The next maps show the rate of incidents per 1000 population (aged 18 to 64) mapped to Lower Super Output Area. Areas shown in red have a rate twice the Cornwall average or greater.

There is strong correlation between recorded incidence of domestic abuse and deprivation, as measured by the Index of Multiple Deprivation 2010, and particularly with the health, employment and income domains. This means that as these deprivation factors increase, so does recorded incidence of domestic abuse. Note that the reported level of incidence will also be influenced by the accessibility of support services in an area and the level of confidence in the services offered.

- Areas with the highest rates of domestic abuse where the child is resident tend to fall in the urban centres of Cornwall. Towns of Penzance, Hayle, Camborne, Redruth, Truro and St Austell all have high rates of domestic abuse.
- The main hotspots are Redruth North Close Hill, Hayle South and High Lanes Penzance Town Centre North, Liskeard South Ward North West and Camborne South Pengegon. All these areas have a higher than average proportion of incidents where children are resident in the household.
- Other hotspots at small area level include Hayle North West and Phillack, Liskeard South Ward North West, Bodmin St Mary's Ward East and Camborne West Ward West Central.

The following chart shows the rate per 1000 18-64 population of domestic abuse incidents where a child is recorded as resident by Community Network Area.

- The Camborne and Redruth area has the highest rate of domestic abuse incidents at 12.5 per 1000 18-64 population. This area accounts for 16% of the total number of domestic abuse incidents in Cornwall.
In line with the pattern for all violence, approximately half of all domestic abuse incidents where children are resident in the household are recorded by the police as linked to alcohol. Incidents that are not recorded as occurring in households with children are slightly more likely to be alcohol-related.

Prevalence of parental substance use

In order to estimate the distribution of substance misusing parents we have two possible data sources; a Health Visitor Audit from 2010 and the National Drug Treatment Monitoring System (NDTMS) which records figures on people in drug treatment who are parents. Both data sets can give a good indicator on substance misusing parents throughout Cornwall.

NDTMS holds information on service users engaged with specialist drug treatment services and thus captures high level need. The information includes the number of parents in treatment and whether or not their child currently resides with them.

The Health Visitor Audit reached a larger sample of the population than the treatment population and also captures parents with lower level substance use issues that would not necessarily meet the treatment threshold.

Health Visitor Audit 2010

The Cornwall and Isles of Scilly family health needs profile required health visitors to record if there were substance misuse issues amongst the parents of the families visited with a child under 2 years of age. This would have been either, reported by the parent or disclosed to the Health Visitor on a ‘need to know’ basis.

- The Health Visitor Audit found that out of the 10,000 families in Cornwall, 4% had parents who disclosed issues with alcohol and 3% issues with drugs.

The table below shows the number of parental alcohol and drug users at network area level. The values highlighted in red indicate that the percentage of parents with alcohol or drug use is greater than the Cornwall average.
The table shows that the China Clay, Liskeard and Looe, Penzance, Callington and Camelford areas all have higher than average parental substance use for both drugs and alcohol.

Network areas of Camborne and Redruth, Liskeard, Penzance, Truro all have above average numbers of parents disclosing drug issues. Smaller towns of Launceston, Callington, Camelford, and Bude also have above average number of disclosures.

The China Clay area has the highest proportion of parents who have been identified by the audit as using alcohol. The area also has a higher than average incidence of parents disclosing drug issues.

Camelford has also been identified as having above average numbers of parents disclosing drug and alcohol issues.

The following maps show the percentages of families in each LSOA area that have disclosed either alcohol or drug issues. Those areas that are highlighted in red are those that have a percentage of parents disclosing alcohol or drug issues that are twice the Cornwall average or greater.
The higher proportions of parental drug and alcohol misuse can be found in the urban centres of Cornwall, with Penzance, Camborne, Redruth, Truro, Falmouth, Bodmin and Liskeard all having higher than average number of parents disclosing Alcohol or drug issues.

The maps also show large areas in the Centre and East of the county where proportions of parental drug issues with areas around Callington, Launceston, Liskeard, Looe, Veryan and Portloe all being identified as having twice the Cornwall average.

We can also see that there are areas in the East of the county (Bodmin, Camelford, Callington and Liskeard) that have twice the Cornish average for parents disclosing alcohol issues.

Correlating the parental drug and alcohol disclosures with domestic abuse incidents where a child is recorded as resident indicates a significant relationship between the two variables, meaning that as one increases so does the other.
Parents engaged with treatment services

NDTMS also provides a means of estimating the distribution of parental substance use. The NTA requires adult substance misuse agencies to record parental status and whether or not a client has any children, living with them or otherwise. The following information is gathered from NDTMS and illustrates how many of these clients have children either living with them, in care or living with a partner/relative.

There is a significant relationship between substance misusing parents and domestic abuse incidents where a child is recorded as resident in the home. This therefore means that those postcode sectors with high rates of domestic abuse where a child is recorded as resident are likely to have high rates of substance misusing parents.

During 2010/11 there were 974 service users in treatment who are recorded as parents of which 45% (440 clients) have children living with them. The remaining children are recorded as either living with the clients’ partner/relative, in care or living somewhere else. These parents are in treatment for both alcohol and drugs as primary substances. The split equates to 60% for primary drug use and 40% for alcohol use. Nearly two thirds of these service users have heroin identified as a primary substance.

The map below shows the number of parents in treatment per 1000 adult population (aged 18 to 64 years) at postcode sector. This is done using postcodes which have been submitted to NDTMS (National Drug Treatment Monitoring System) and matching them to postcode sector. This is the smallest geography available for this information, which means that some of the mapping detail is lost due to the large size of the sectors used.

- Postcode sectors with the highest rates of parents in treatment are situated around the towns of Bodmin, Penzance, Newquay and Liskeard.
- There are also fairly high rates of substance misusing parents located around Marazion, Hayle, Truro, Falmouth and St Austell.
- Camelford has again been identified as having above average substance use issues. It is worth noting that this refers to 17 service users but due to the low base population in the area, the rate per 1000 18-64 population is comparatively high.

The chart below shows the rate per 1000 population calculated at network area level (best fit based on postcode sectors). There are 8 network areas where the rate is above the Cornwall average, with Bodmin, Penzance (which includes Marazion and St Just), Newquay and Liskeard network areas showing the highest rates. Although the mapping at postcode sector
highlights the sectors covering the towns of Falmouth and Truro as above average, the rate across the whole network area is lower than average in both cases, indicating that the population is highly concentrated in the town centre and not the surrounding areas.

**Prevalence of mental health**

Measuring prevalence of mental health issues at a local level is problematic due to their being no single measure that can identify such issues. We do however have two possible data sources that can be used to indicate the distribution of mental health need throughout Cornwall.

- The rate of adults suffering from mood and anxiety disorders, which makes up part of the Index of Multiple Deprivation 2010.
- Experian’s Mosaic lifestyle classification is a measure that draws upon hospital episode data for long term mental health conditions, of which we selected schizophrenia, bi-polar disorder and depression.

The mood and anxiety disorder indicator is a modelled estimate based on prescribing data for 2005, hospital episode data for 2006-08, suicide mortality data for 2004-08 and health benefits data for 2008. None of these datasets are a perfect measure for mood and anxiety disorders but used in combination they provide a good general picture of those suffering mental ill health.

Experian’s Mosaic classification is also modelled and uses hospital admissions captured at a national level for long term mental health disorders and thus represents more complex cases. Mosaic applies the data to their household classification to highlight certain groups that may be more likely to experience these long term conditions. Mosaic allows us to understand the lifestyles of those more likely to be affected by mental health and improve our communications.

For the composite measure the IMD modelled information was chosen as the most representative measure because it is based on figures captured at a local level.

The summary of mental health mapping is shown in Chapter 4 on Drugs and Mental Health.

There is a fairly strong positive correlation between mood and anxiety disorders with domestic abuse. This therefore means that it is probable that LSOAs that experience high rates of domestic abuse where a child is recorded are also more likely to have higher rates of mental health issues.

There is also a significant relationship between substance misusing parents (identified by the Health Visitor Audit) and mood and anxiety disorders.
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.

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.

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 enables drug using offenders to access a range of additional 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 will be embedded within the Integrated Offender Management framework, TurnAround, from April 2012.

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.

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.

Key findings

- There are pockets of good evidence relating to the overall offender health picture, but they are not well connected and there are some clear gaps in our knowledge;
- Crime and drugs are well documented, as are the impacts of drug use on offenders’ health and outcomes. We know very little about mental and physical health and the impact of family and relationships on outcomes;
- Analysis of offender needs to support the commissioning of wraparound services for TurnAround highlighted a significant number of higher risk offenders with drug and alcohol problems that were not engaged with community treatment services (the majority);
- Offenders who have not engaged with community treatment services are mostly cannabis users (no class A drugs) and tend to be younger (under 30 years of age). They are also slightly more likely to be living in the West of Cornwall.
- NDTMS data also indicate that offenders are not coming into community treatment services. Despite a small rise in referrals through criminal justice routes, at 14% the proportion remains considerably below the national average of 31%.
• It is vital to the success of TurnAround that the selection criteria identifies offenders based on risk and incorporates a range of risk factors (such as substance use and mental health) that align the methodology to the priorities for IOM highlighted in the offender needs assessment.

• The recent DIP review found that there is much enviable good practice in Cornwall; particularly excellent communication amongst partners, a general ‘can-do’ attitude and a high level of commitment to the objectives of the programmes. Co-location has been a key factor in this.

• Broadening the DIP context to consider the wider interface between substance misuse and offending required by TurnAround, there are a number of areas where need is either not being met or being met in a limited way, including:
  o Substance misusers (both in treatment and not) prior to their CJS involvement
  o Alcohol misusing offenders not otherwise in programmes (e.g. not under ATR, PPO, DRR, DIP, etc)
  o Offenders misusing drugs other than opiates and stimulants (e.g. solvents, alcohol)
  o Ex-prisoners released on licence and case managed by Probation
  o Ex-prisoners who are not opiate or crack/cocaine users
  o Substance misusing offenders no longer under any kind of licence, e.g. some ex-prisoners, ex-DRRs, etc

• Assertive outreach and engagement with people with drug problems who come to the attention of neighbourhood policing teams (but not currently in the criminal justice system) has been highlighted as a gap that would assist in reaching some of these groups.

• Contrary to the national trend, in 2010/11 drug offences increased by 4% compared with 2009/10, further to a rise of 21% in the previous year. Previous rises have been attributed to changes in police powers with regard to possession of cannabis, the impact of which appears to have now ceased. Rises this year were noted in possession of heroin, cocaine and mephedrone (which was made illegal in April 2010) and trafficking cannabis.

• In 2010/11 police recorded drug trafficking offences increased, contrary to the trend elsewhere in the country, and the rate of crime climbed fractionally above the average for our ‘most similar family’ group.

• Police intelligence on drug markets locally indicates that the purities of heroin and cocaine remain very low. There are signs of increased use of benzodiazepines, believed to be influenced by easy access via the internet. The use of Tramadol has also been notable with pockets of illegal use becoming apparent. Tramadol and Diazepam are common features in drug related deaths and the drug combinations coupled with alcohol and other depressants is causing some concern.

• The emergence and continual dynamic emergence of new psychoactive substances (NPS, sometimes referred to as ‘legal highs’) is becoming problematic. The NPS world is new and evolving with little or no historic evidence to support health and rehabilitation schemes.

• Trends in acquisitive crime show that, following a sustained period of reduction, dwelling burglary started to rise in October 2008 and has followed a gradual declining path since then. The rate of dwelling burglary remains lower than the national average but the gap has shrunk significantly over the last two years. Other types of acquisitive crime, such as thefts and shoplifting, have also started to rise in the last 6 months. Wider evidence for Cornwall highlights that the impact of the economic climate, public sector cuts and changes to benefits are now becoming apparent, with disadvantaged households potentially at greater risk.

• Although nationally the latest crime statistics show no consistent evidence of upward pressure across the range of acquisitive crime, it is reasonable to assume that these factors may have a stronger influence on crime trends where the underlying rate of crime is low.
Chapter 6 – Drug use and crime

Understanding the needs of offenders

Adults and young people convicted of offences are 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 often debt and financial problems.

They are often socially excluded with limited or no support networks of friends and family and generally have a poor record of voluntary engagement with services. Tackling these issues in an holistic way is important for addressing the offender’s problems, providing ‘pathways out of offending’ and breaking the inter-generational cycle of offending and associated family breakdown.

Offenders are also a key group in considering local approaches to address health inequalities, and engagement of health services with the criminal justice system presents opportunities to improve health and prevent, or intervene early in, ill-health.

There are currently three separate strands of work related to the health of offenders:

1. The transfer of responsibility from the police to the NHS for commissioning all aspects of police custody healthcare provision. This requires the completion of health needs assessments for offenders in custody, in prison and also in the community;
2. Work to assess the overlap between young offenders, children and young people in care, and those who misuse drugs or alcohol;
3. Integrated Offender Management (IOM), which is a framework that provides all agencies engaged in local criminal justice partnerships with a single coherent structure for the management of repeat offenders. The aim is to provide an holistic approach to offender management that encompasses mental and physical health, problem substance use, housing, employment and work with families.

Currently these three strands of work are being developed independently but it is recognised that they should complement and inform each other.

NHS commissioning of police custody healthcare provision

The Shared Operating Model for PCT Clusters published by the Department of Health in July 2011 has specific requirements for offender health. Offender healthcare should be planned around the needs of the individual.

Police custody healthcare is currently commissioned by the police, and is provided by SERCO under a three-year contract, which began on 1st April 2011. There are seven custody suites across the Devon and Cornwall Constabulary area. The main functions of police custody healthcare are to:

- Ensure those in custody are fit to be detained
- Ensure those in custody are fit to be interviewed
- Identify any impairment, particularly those under the influence of drugs and alcohol
- To undertake initial mental health assessments
- To take blood samples from individuals who are attending hospital whilst in custody
- Provide forensic medical examination to Sexual Assault Referral Centre.

The current service is nurse-led for those in custody, with one doctor on duty for the whole of Devon and Cornwall Constabulary. For victims, the service is doctor-led.

In 2014/15, the law will change so that the NHS becomes responsible for commissioning all aspects of police custody healthcare provision. Devon and Cornwall Constabulary is one of ten early adopter forces. Funding of £70K is available for each of the two years 2011/12 and 2012/13 to support the transfer of commissioning responsibility to the NHS. A partnership board has been established to oversee the transfer, and take responsibility for the transfer budget.
By April 2013, it is expected that police custody healthcare will be an NHS commissioned or endorsed service. There is however, an option to withdraw from the project in April 2012 if it is felt not to be in the best interests of the police or NHS.

The Cornwall and Isles of Scilly Executive team has agreed that the work to take forward this project should be carried out at a peninsula level, led by NHS Devon on behalf of NHS Cornwall and Isles of Scilly. NHS Devon has experience of and governance arrangements for the commissioning of prison and substance misuse services in a partnership forum. NHS Devon has a senior commissioning lead, who will take the lead commissioning responsibility. NHS Devon have appointed a project manager and an analyst to take this work forward.

The project requires that a health needs and equality impact assessment is carried out to look at the health needs of offenders to ensure that healthcare is built around the needs of the individual. Specific groups have been identified, and include:

- People with mental health problems
- People with learning disabilities
- Women
- Young offenders
- Older offenders

An initial assessment focusing on offenders in prisons and custody suites will be completed by the commissioning project manager and the analyst in early 2012.

**Work with young offenders**

Children and young people who offend have greater health needs than the non-offending population. They are more likely to have mental health needs, misuse alcohol or drugs, have a learning disability, have spent some of their childhood in care, been subject to poor parenting, witnessed violence in the home, been abused or have been the victim of crime. In response to this, youth offending teams were established in 1998. The teams have the dual role of preventing further offending, whilst also helping to meet the needs of children and young people who offend.

A national Healthcare Commission report in 2006, and a second one in 2009 highlighted that the healthcare needs of young offenders are not always adequately provided for. A third report in 2011 showed that some progress has been made, but improvements still need to be made.

In particular, there is an overlap between young offenders, children in care, and young people who misuse drugs and alcohol. It is likely that this is a small group of young people, but that they consume a large amount of resources. Initial work is underway to map the extent of the overlap between the groups and to establish what the health needs of this group are.

**Integrated Offender Management**

Integrated Offender Management is a system that provides all agencies engaged in local criminal justice partnerships with a single coherent structure for the management of repeat offenders, incorporating the existing provisions for the Drugs Intervention Programme (DIP) and Prolific and Other Priority Offender (PPO) scheme.

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

Guidance to support IOM implementation puts a strong focus on using a robust evidence base to direct the activities of the IOM, commission services and to inform the decisions about which offenders will be prioritised for interventions.

The Community Safety Strategic Assessment provides clear direction regarding the priority issues for tackling crime and disorder in Cornwall. A supplementary assessment was developed in Autumn 2011 to provide an initial evidence base around the criminogenic needs for
of the offenders considered to be at higher risk of reoffending to inform the prioritisation of resources and the selection criteria for offenders.

Guidance from the Home Office / Ministry of Justice suggests that the following could be considered for IOM as priority groups:

- PPOs;
- Targeted offenders (adult and youth) on statutory supervision requiring additional support to hold them in compliance;
- Targeted groups of offenders not being supervised, especially those released from short-term prison sentences;
- Drug-misusing offenders managed through DIP and on community sentences with a Drug Rehabilitation Requirement

It also suggests that local partners will want to take into account the needs of particularly vulnerable offenders, especially women offenders and offenders who have mental health needs.

As far as possible within the constraints of resources and availability of reliable data, the supplementary assessment aims to build a picture across these priority groups.

The Offender Assessment System (OASys) is used in prisons and by Probation to measure the risks and needs of criminal offenders under their supervision. It is designed to assess the likelihood of reoffending, identify and classify offending-related needs, including basic personality characteristics and cognitive behavioural problems, assess risk of serious harm, risks to the individual and other risks to assist with management of risk of harm and links the assessment to the supervision or sentence plan. Risk of reconviction was assessed along a scale of low to very high using key indicators drawn from OASys assessment.

For the purposes of the offender needs assessment, analysis was undertaken with a data ‘snapshot' drawn from OASys on 1 April 2011 – a total of 916 offenders.

This assessment of offender needs does not, however, include non-statutory offenders (who have no statutory obligation to Probation or the courts), such as those who serve short prison sentences of less than 12 months duration. At the time of preparing this assessment, no data source had been identified that would provide information on the needs of non-statutory offenders or assist with estimating demand on IOM from this group. This is a significant knowledge gap.

Debate is ongoing about whether young offenders are in scope for IOM in Cornwall. The benefits of managing issues around transition through IOM and the value of joining up the Deter strand of the PPO Scheme (which has been handled separately by the Youth Offending Service until now) with the adult strands are specific issues for consideration.

The needs of young offenders are covered separately in the assessment.

The Health and Wellbeing section and the overall key findings are reproduced here. The full report can be viewed and downloaded on the Amethyst website.
Tumaround – Integrated Offender Management

It is estimated that around 50% of crime may be committed by a repeat offender. Prison is not a cost effective solution and does not deliver sustainable benefits in terms of reduced harm to the community. Research by the Government's Social Exclusion Unit found that nearly 3 in every 5 ex-prisoners are reconvicted within two years of release.

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.

In recognition of the importance of tackling reoffending, as of April 2010 it became a statutory responsibility\textsuperscript{22} of local community safety partnerships, Probation have been added to the responsible authorities within those partnerships and in addition, Section 17 of the Crime and Disorder Act, which places a duty on certain defined authorities\textsuperscript{23} has been extended to include reducing reoffending.

IOM 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 concept of IOM has been developed across England and Wales over the last two years and there is an expectation that all Partnership areas will introduce an IOM.

IOM in Cornwall is being delivered within a peninsula-wide framework under the name TurnAround. Local governance and accountability for TurnAround sits with our Community Safety Partnership, Safer Cornwall, and an official launch is planned for May 2012.

There are five key principles of IOM:

- All partners tackling offenders together
- Delivering a local response to local problems
- Offenders facing their responsibility or facing the consequences
- Making better use of existing programmes and governance
- All offenders at high risk of causing serious harm and/or re-offending are ‘in scope’

Offenders are selected for TurnAround, which has a proposed initial capacity of around 180 to 200 offenders, based on risk and local need. Offenders are selected using a risk assessment matrix that factors in a range of elements including criminal history and perceived risk to the community.

Building on existing work with PPOs and drug-using offenders, intervention programmes delivered through TurnAround are tailored to addressing the needs of the offender in an holistic and integrated way and may include, for example, assistance with housing and access to employment, referral into treatment for problem substance use, referral into programmes to address thinking and attitudes (such as domestic abuse or anger control) and support for their children and families.

\textsuperscript{22} Section 108 of the Policing and Crime Act 2009
\textsuperscript{23} The bodies currently listed under Section 17 are: local authorities, police authorities, fire and rescue authorities; joint authorities; national parks authorities; the Broads Authority; the Greater London Authority; Transport for London; and the London Development Agency
TurnAround and the Drugs Intervention Programme

In 2011 the DAAT commissioned a review of the Drugs Intervention Programme (DIP) provision in Cornwall and the Isles of Scilly with particular reference to upcoming re-commissioning, and the development of Integrated Offender Management (TurnAround).

The report focused on offenders where there is a higher risk of offending combined with a problem drugs and/or alcohol use as a significant factor in their offending. Currently there is a patchwork of provision covering substance-misusing offenders. Provision varies widely depending on a range of factors. Pathways and programmes are often dependent on substance used or status in the criminal justice system rather than on actual level of risk or need. As such, there are a number of significant gaps and inconsistencies in provision. IOM is an opportunity to bring a coherent approach and resolve most of the current contradictions.

The DIP will be firmly embedded within TurnAround and its future defined as ‘specialist’ substance misuse care coordinators within the TurnAround structure and serving the TurnAround caseload. The exact role should be defined within the TurnAround intervention matrix, but should be tiered and targeted, i.e. the most resources are targeted at those who are highest risk. This will apply to the DIP Team’s interventions as well as the rest of TurnAround provision. Re-commissioning of the DIP Service will be informed by the details of this revised role and the main change will be a broadening in criteria for who DIP work with.

The review found that there is much enviable good practice in Cornwall; particularly excellent communication amongst partners, a general ‘can-do’ attitude and a high level of commitment to the objectives of the programmes. It is important that this is maintained within any new structures. Co-location has been a key factor in this.

Broadening the DIP context to consider the wider interface between substance misuse and offending, there are a number of areas where need is either not being met or being met in a limited way, including:

- Substance misusers (both in treatment and not) prior to their CJS involvement
- Alcohol misusing offenders not otherwise in programmes (e.g. not under ATR, PPO, DRR, DIP, etc)
- Offenders misusing drugs other than opiates and stimulants (e.g. solvents, alcohol)
- Ex-prisoners released on licence and case managed by Probation
- Ex-prisoners who are not opiate or crack/cocaine users
- Substance misusing offenders no longer under any kind of licence, e.g. some ex-prisoners, ex-DRRs, etc

TurnAround’s wider strategic perspective should allow for all these groups to be considered within its current planning, and provision targeted towards risk and need within the available resources. Whilst this may not change interventions for many offenders, it can at least remove inconsistencies and gaps and allow more effective and impactful use of resources.

Key recommendations are:

- Strategic partners to agree a framework for IOM that reflects the strategic priorities, is realistic about the resources available, aims to match intervention to risk and need, is clear about pathways and responsibilities, and can respond to changes in circumstances
- Ensure TurnAround criteria includes a hierarchy of priorities matching interventions to risk and is flexible enough to adapt to developments in the strategic context and local provision
- TurnAround criteria to be based on risk and need, not substance or criminal justice status
- Ensure TurnAround strategic planning considers pathways for all substance-misusing offenders, whether in TurnAround or not
- Ensure mental health pathways and provision are integrated into TurnAround planning
- Ensure safeguarding for children of substance users is integrated into TurnAround planning
- Further work at the strategic level on housing, particularly tiered supported housing options
Who will receive TurnAround intervention?

The next diagram shows the offender population arranged into four tiers by intensity of management. The two highlighted tiers are anticipated to come under the management of an 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 and 3 (serious sexual and violent 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 reoffending Significant substance use</td>
<td>Intensive joint supervision</td>
</tr>
<tr>
<td>Persistent and / or non-compliant offenders</td>
<td>High persistence High / medium risk of reoffending Serious anti-social behaviour / current ASBO</td>
<td>Enhanced joint supervision</td>
</tr>
<tr>
<td>Compliant offenders</td>
<td>First time entrants Low risk of reoffending Limited breach history</td>
<td>Agency management</td>
</tr>
</tbody>
</table>

Offenders are selected for TurnAround, which has a proposed initial capacity of around 180 to 200 offenders, based on risk and local need. Offenders are selected using a risk assessment matrix that factors in a range of elements including criminal history and perceived risk to the community.

To reflect our local priorities for tackling crime, disorder and substance use in Cornwall, additional weighting is also given to the following issues: problem alcohol use, problem drug use, domestic abuse, homelessness / housing problems and parental responsibility.

The current Prolific and Other Priority Offenders (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 TurnAround along with delivery of the Drugs Intervention Programme (currently around 60 individuals).

The matrix approach provides a transparent and consistent means of identifying offenders who should be selected for intervention and could also be used to de-select offenders after a period of engagement.

The “Day One” cohort for TurnAround in Cornwall was selected from the current Probation caseload using the risk of reconviction score (a score of 75% or above) and the weighting factors identified as priorities for Cornwall. Ongoing selection for TurnAround will utilise the matrix to identify offenders from any point within the criminal justice system.
Chapter 6 – Drug use and crime

Higher risk offenders – summary of needs

Drugs and alcohol
Just over half of higher risk offenders with drug problems are current or previous opiate users.
Problem drug use was much more likely amongst PPOs.
Criminal justice referrals into community treatment services have increased but remain substantially below average.
30% of adult offenders with alcohol problems and 45% with drug problems engaged with community treatment services (last 17 months); the majority therefore are not engaged.

Mental and physical health
27% of higher risk offenders have a history of self harm and/or suicide attempts and 15% had been assessed as having some or significant psychiatric problems.
Emotional and mental health issues are more prevalent amongst young people at 44%.
The data includes scant information about offender physical health, apart from linked to substance use.
National research indicates higher prevalence of long term illness or disability, smoking and blood borne viruses (that has clear links to drug use and injecting behaviour).

Risk factors associated with reoffending
Locally, the most prevalent issues amongst adult offenders are alcohol problems (69%), domestic abuse (51%) and drug problems (46%).
The most prevalent issues amongst young offenders are thinking and behaviour (81%), family and personal relationships (68%) and lifestyle (58%). Domestic abuse is a common contributor to young offender risk relating to family and relationships.
35% of higher risk offenders (165 offenders) were identified as requiring support in five or more areas. Complexity increases as the risk of reconviction increases.
Although female offenders are much lower in number they have more complex needs, particularly in relation to mental/emotional health issues.

Housing, employment & finances
Just over a third of adult offenders have problems with their finances that are linked to their offending behaviour.
Prevalence of accommodation and education, training and employability issues were similar (to each other) across both the adult and youth cohorts, falling between 27% and 30%.
Lack of suitable accommodation is a severe risk to an offender’s ability to engage with any other kind of programme or service and should thus be viewed as of utmost priority.

Family and relationships
40% of higher risk adult offenders have parental responsibility, the majority of which are living with or have regular contact with (their) children.
On 1 April 2011, there were 369 children linked to offenders. National research indicates that offenders are significantly less likely to reoffend if they maintain family contact.
Consideration also needs to be given, however, to safeguarding and parenting issues and the known intergenerational link from parent to child in offending behaviour.
Chapter 6 – Drug use and crime

Health and wellbeing needs of offenders

Problem drug use

Drug use, particularly of class A drugs, is strongly associated with crime and offending. Measuring the extent of drug-related crime is problematic because, unlike alcohol-related crime, the link to drugs is not routinely recorded by the police.

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

Current trends in acquisitive crime are on the rise in Cornwall, the latest community safety strategic assessment reports a 4% rise in dwelling burglary in the 12 months to 30 September 2011 (compared to the same period the previous year) and a 9% rise in thefts (shoplifting and other thefts). This has seen further deterioration as the year has progressed. The impact of recession is believed to be a key influencing factor and a continued rising trend is anticipated.

The Public Health Outcomes Framework (2012) includes the identification of people entering prison with substance dependence issues who are not previously known to treatment as a key outcome described within the domain of health improvement.

Comparison of NDTMS and local Probation data has identified a cohort of 138 offenders who come into this category (27 drugs and alcohol, 92 alcohol only and 19 drugs only).

- Drugs are the 3rd most common risk factor for higher risk offenders (after alcohol and domestic abuse). 46% of higher risk offenders (218 offenders) have a drug problem that either presents a risk of serious harm, is linked to their offending or both (compared with 35% for all offenders). Just over half are current or previous opiate users.
- PPOs are far more likely to have drug problems; with almost the entire cohort reviewed (26 out of 32) affected.
- Where drug use is identified as a risk factor, just over half are currently using drugs, with cannabis and heroin the most common in current use (64% and 40% respectively). 39% of this group have a history of injecting (half currently and half previously).
- The majority also have concurrent risks associated with problem alcohol use.

<table>
<thead>
<tr>
<th>Higher risk offenders : drugs a risk factor</th>
<th>Number</th>
<th>Total higher risk offenders in area</th>
<th>% of total offenders</th>
<th>Current / previous opiate user</th>
</tr>
</thead>
<tbody>
<tr>
<td>East</td>
<td>83</td>
<td>209</td>
<td>40%</td>
<td>40</td>
</tr>
<tr>
<td>West</td>
<td>83</td>
<td>184</td>
<td>45%</td>
<td>37</td>
</tr>
<tr>
<td>Out of county inc secure estate</td>
<td>52</td>
<td>85</td>
<td>61%</td>
<td>34</td>
</tr>
<tr>
<td>Total offenders</td>
<td>218</td>
<td>478</td>
<td>46%</td>
<td>111</td>
</tr>
</tbody>
</table>

Where drug use is identified as a risk factor and the person is currently using, we would expect offenders to be engaged with treatment services. Previous drugs needs assessments have consistently highlighted a significant shortfall in numbers and this continues to be the case.

- Of the 86 higher risk offenders living in the community (and hence able to access community drug treatment services), 39 (45%) were engaged with treatment services on or after 01 April 2010. This means that the majority, however, are not engaged with treatment.
- Offenders who have not engaged with community treatment services

[Graphs showing the proportion of offenders in and not in treatment, with categories such as OCU, Cannabis, Cocaine / ecstasy / amphet, and Other]
are mostly cannabis users (no class A drugs, see charts) and tend to be younger (under 30 years of age).

- Male offenders are less to engage than females; the majority of female offenders identified with current drug problems were engaged with treatment.
- Offenders living in the West of Cornwall are slightly less likely to be engaged with treatment and this is also true of offenders with alcohol problems.
- A list of offenders has been provided to Devon and Cornwall Probation to further investigate, on an individual case basis, the extent and nature of drugs intervention that the offender received or is receiving on an ongoing basis outside of the community treatment system as part of their programme.
- NDTMS referrals also indicate that offenders are not coming into community treatment services. 14% of referrals into community treatment services for primary drug use in 2010/11 came via a Criminal Justice route; a total of 101 referrals.
- The proportion of Criminal Justice referrals locally remains considerably below the national average of 31%.
- The number of referrals reduced by 11% compared with last year, but all referrals into primary drug treatment are down.

Although some of the shortfall may be explained by a gap in NDTMS recording (recorded in the DIP database but with no parallel record in NDTMS) performance indicators for the CJIT / DIP in 2010/11 also indicate that we do not compare favourably with the national average for getting offenders into treatment, although there has been notable improvement over the last 12 months.

DIP performance reports are provided on a quarterly basis by NDTMS and reports covering four quarters have been aggregated to make up the 12 months of 2010/11 (hence if an offender was referred in more than one quarter they will be counted twice).

- Over the 12 month period, 134 offenders had care plans agreed by the DIP, of which 28% were referred by the CJIT into specialist treatment. There was a significant drop in number (there were 168 offenders with care plans in 2009/10) but the proportion referred has remained about the same. The proportion referred is close to the South West average (which has dropped to 31%) but considerably below the national average of 51%.
- 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 data and, as we have already established, there is a gap between the two systems.
- Compared with 2009/10 the number of referrals via DIP has seen a small increase and the proportion engaging with treatment following referral has substantially improved – from 18% to 44%. Performance is now in line with the South West average and only just below the national average.

<table>
<thead>
<tr>
<th>Referrals (12 months)</th>
<th>Cornwall &amp; Isles of Scilly</th>
<th>South West</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Total clients referred</td>
<td>63</td>
<td>44%</td>
<td>1809</td>
</tr>
<tr>
<td>Enter treatment system via DIP</td>
<td>28</td>
<td>44%</td>
<td>852</td>
</tr>
<tr>
<td>In treatment already</td>
<td>14</td>
<td>42%</td>
<td>487</td>
</tr>
<tr>
<td>No treatment take up</td>
<td>21</td>
<td>33%</td>
<td>470</td>
</tr>
</tbody>
</table>

- There were 44 CARAT referrals, of which a third were picked up the CJIT, slightly higher than the regional and national averages.

In relation to performance, the DIP review highlighted that overall, the DIP Team do not achieve their referral targets but they do largely meet their outcome diagnostic indicators.

- DIP referrals:
  - 2008/09: Referral Target 240, achieved 212
  - 2009/10: Referral Target 240, achieved 227
  - 2010/11: Referral Target 180, achieved 135
**Promoting recovery**

**Chapter 6 – Drug use and crime**

- DIP diagnostics:
  - DI 1 60% of initial contacts to be assessed
  - DI 2 85% of assessments taken onto caseload
  - DI 3 95% taken onto the caseload to engage in treatment

- Of the 24 referrals in Quarter 2 of 2010/11 by DIP into treatment, a third made (or already were) in contact with services within 6 weeks. This is half the national average of two-thirds, but a considerable improvement on the previous quarter’s figures. There is insufficient data to verify reasons for this, though it is safe to assume that at least some will be because the person does not feel the need for treatment (rightly or otherwise).

- Services appear to be able to engage and retain appropriately, the problem appears to be at earlier stages. For example, there are many offenders being supervised by Probation who could be referred to treatment but haven’t been and there are arrestees who are not being identified and engaged when they could be.

**Problem alcohol use**

Problem use of alcohol is generally linked to violent crime – both in the community in the form of assaults and disorder associated with the night-time economy and in the home, as a contributory factor to domestic abuse. In 2010/11 just under half of all violent crime reported to the police was recorded as linked to alcohol, primarily involving an offender in drink.

Evidence on the impact of the recession and changes to public sector spending are beginning to unfold (Understanding Cornwall 2011). There has been a rise locally in unemployment and personal insolvency, and the number of households in financial difficulty has started to increase, due to the combination of unemployment, higher bills and benefit reassessments. In terms of crime and substance use, anticipated impacts of the recession include a rise in acquisitive crime, increased domestic abuse and problem substance use, particularly alcohol.

Problem alcohol use is the principal reason for contact with offenders by the Arrest Referral team. 65% of contacts (744 contacts) were for suspected problem alcohol use, usually following a violent offence or incidents specifically linked to alcohol use, such as being drunk and disorderly or drink driving. Problem alcohol use was the only substance implicated in the vast majority of cases. This is consistent with previous years.

- OASys data confirms that problem alcohol use is by far the most prevalent factor affecting the offender population, affecting 58% of all offenders.
- Alcohol problems are more prevalent amongst higher risk offenders than the general offender population. 69% of higher risk offenders (329 offenders) have an alcohol problem that either presents a risk of serious harm, is linked to their offending or both.
- This rises to 83% amongst violent offenders.
- 48% (229 offenders) are assessed as having some or significant problems with their current drinking, suggesting a level of either higher risk drinking or dependence.
- Alcohol is slightly more likely to be a risk factor for offenders resident in West Cornwall, particularly Truro (78%) and Falmouth (77%). Higher prevalence was also noted for Newquay (78%).

<table>
<thead>
<tr>
<th>Higher risk offenders : alcohol a risk factor</th>
<th>Number</th>
<th>Total higher risk offenders in area</th>
<th>% of total offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>East</td>
<td>143</td>
<td>209</td>
<td>68%</td>
</tr>
<tr>
<td>West</td>
<td>131</td>
<td>184</td>
<td>71%</td>
</tr>
<tr>
<td>Out of county inc secure estate</td>
<td>55</td>
<td>85</td>
<td>65%</td>
</tr>
<tr>
<td>Total offenders</td>
<td>329</td>
<td>478</td>
<td>69%</td>
</tr>
</tbody>
</table>

Note that assessment of risk takes into account violent behaviour exacerbated by binge drinking as well as problems linked to higher risk drinking or dependence. Offenders for whom alcohol treatment, which addresses dependency, is not appropriate would benefit instead from less intensive interventions, with the aim of reducing the harms associated with their
promblematic relationship with alcohol and preventing the escalation into more serious harm later in life.

We would expect offenders assessed as having some or significant problems with alcohol to have received some kind of structured intervention to address this issue. The last alcohol needs assessment found that the majority of offenders with alcohol problems were not engaged with community treatment services and this remains the case.

- Of the 169 higher risk offenders living in the community (and hence able to access community alcohol treatment services), who had been identified through OASys assessment as having some or significant problems with alcohol, only 50 (30%) were engaged with treatment services on or after 01 April 2010.
- This means that there is a cohort of 119 offenders (the majority, 70%) for whom alcohol is a contributory factor in their offending but are not engaged with treatment services. Just under half of this number are assessed as having significant problems with alcohol.
- Offenders who have not engaged with community treatment services tend to be younger (under 30 years of age) and there is a slightly higher engagement rate for females than males (although the cohort of females is much smaller). Offenders who have significant problems with alcohol and have concurrent drug problems are slightly more likely to be engaged with treatment than those that do not.
- A list of offenders has been provided to Devon and Cornwall Probation to further investigate, on an individual case basis, the extent and nature of alcohol intervention that the offender received or is receiving on an ongoing basis outside of the community treatment system as part of their programme.
- NDTMS referrals also indicate below average numbers of offenders coming into community treatment services, although the gap is not as significant as for drugs. 7% of referrals into community treatment services for primary alcohol use in 2010/11 came via a Criminal Justice route.
- There were 48 referrals in 2010/11, three times the number of referrals in 2009/10, with the majority of additional referrals coming via Probation. The proportion of Criminal Justice referrals locally is now closer to the national average of 9%.
- Higher risk offenders with alcohol problems living in the community in the West of Cornwall are least likely to be engaged with treatment services.

Mental and physical health

The original comprehensive report by the Government’s Social Exclusion Unit ‘Reducing Reoffending by Ex-Prisoners’ (2002) identified mental and physical health as key drivers that contribute to the committing of crimes. This research found that prisoners suffer from much poorer mental health than the general population. Rates of mental health disorders, such as multiple mental disorders, neurotic and psychotic disorders and personality disorders, are around 14 times higher in prisoners than in the general population.

Mental health problems may be made worse by imprisonment unless dealt with effectively. Inadequately treated, they will make it more difficult for prisoners to make the best use of opportunities such as education and training which can reduce re-offending. Offenders with mental health problems are at particularly high risk of suicide on release from prison.

Two mental health indicators were extracted from OASys assessments for the purposes of this analysis – history of self-harm / suicide attempts and current psychiatric problems (recorded as none, some or significant).

- In total a third of higher risk offenders have mental health issues, as determined by one or both of these indicators.
- Just over a quarter of higher risk offenders (130 higher offenders) had a history of self-harm or suicide attempts.
- Higher risk offenders are not significantly more likely to have a history of self-harm or suicide attempts than the offender population average of 26%. This issue is more prevalent, however, amongst high risk violent offenders at 35%.
• Out of the 10 factors reviewed for this assessment, some or significant psychiatric problems was the least apparent factor in the offender profile.
• 74 higher risk offenders were assessed as currently having some or significant psychiatric problems on the 01 April 2011, accounting for 15% of the higher risk group and in line with the offender population as a whole (14%). This includes illnesses or symptoms diagnosed by a GP or a psychiatrist, such as schizophrenia, manic depression and obsessive compulsive behaviours.
• Female offenders are more likely than male offenders to have a history of self-harm or suicide attempts at 40%.
• Although there are no significant differences by locality at a more local level, higher prevalence of a history of self-harm / suicide attempts was noted in offenders from both Penzance and St Austell.

<table>
<thead>
<tr>
<th>Higher risk offenders</th>
<th>Self-harm or suicide attempts</th>
<th>Some or significant psychiatric problems</th>
<th>Total higher risk offenders in area</th>
<th>% with mental health issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>East</td>
<td>58</td>
<td>36</td>
<td>209</td>
<td>35%</td>
</tr>
<tr>
<td>West</td>
<td>50</td>
<td>27</td>
<td>184</td>
<td>32%</td>
</tr>
<tr>
<td>Out of county inc secure estate</td>
<td>22</td>
<td>11</td>
<td>85</td>
<td>31%</td>
</tr>
<tr>
<td>Total offenders</td>
<td>130</td>
<td>74</td>
<td>478</td>
<td>33%</td>
</tr>
</tbody>
</table>

Indicators of physical health were not available for this assessment. National research indicates that although prisoners’ physical health problems are not as pronounced as their mental health problems, there are some areas where they are much poorer than the general population.

• These include long-standing illness or disability, smoking, HIV and Hepatitis B and C infections.

Limited information on interventions relating to blood-borne viruses can be obtained from NDTMS data where offenders have engaged with community treatment services.

263 offenders under supervision with Probation on 1 April 2011 had a history of engagement with community treatment services (either currently or previously).

• 54% had been tested for Hepatitis C, of which a third were recorded as tested within the last two years.
• Of those who were not recorded as having been tested, a third were offered testing but refused and for a third testing was not considered to be appropriate.
• 87% had completed a course of Hepatitis B vaccinations, with the majority of the remainder part way through a vaccination programme. Vaccination status was missing for 25 offenders (10%) but these were mostly excluded because vaccination was not considered appropriate.

How do we know that IOM is working?

There are currently 4 nationally prescribed indicators that measure reoffending in various cohorts of the offender population. These indicators are expected to cease in their current form on 31 March 2012, after which a new ‘single measure of reoffending’ will be introduced.

These broad measures of reoffending are not sufficient to performance manage IOM effectively, however, and the IOM Implementation Board will consider proposals from all the partner agencies involved for development of a basket of indicators specifically to measure ‘what success looks like’ in Cornwall. This has sat on the agenda of the Board for some time and needs to be progressed as a matter of some urgency, with some kind of skeleton framework in place preferably prior to the commencement of the new performance year.

The existing four national indicators are:

• NI 18 Reoffending rate for adult offenders under probation supervision
In previous years Cornwall CJIT and the treatment system have been successful in diverting drug users from crime with offending rates for PPOs and class A drug using offenders at around half the targeted rate.

- Over the course of 2010/11 performance significantly declined. The latest published figures (March 2011) showed that a reduction of 5% in local PPO offending, compared with 13% in national cohort. It should be noted that this indicator relates to a small cohort of offenders (41) and hence is vulnerable to skew by the behaviour of a few individuals.
- Reoffending in class A drug users locally was around 65% the level predicted by the national model.
- Reoffending in young offenders has consistently reduced and at a better rate than the target of 3% reduction year on year. In 2010/11 the proven rate of reoffending reduced by 10% compared with the previous year.
- The adult reoffending measure, however, has consistently tracked above (worse than) both the predicted rate and the locally agreed Partnership target. In 2010/11 the reoffending rate for adult offenders under supervision by Probation was 8.1% compared with a predicted rate of 7.4%, a difference of 10.1%. Although the difference is not statistically significant, we did not meet the partnership target to achieve an 11% improvement compared with the rate predicted. Performance has declined compared with 2009/10 (when the actual rate was directly in line with the predicted rate).

Statistics produced according to the new methodology for measuring proven re-offending in England and Wales were released by the Ministry of Justice in October 2011. The statistics relate to proven re-offending figures for offenders who were released from custody, received a non-custodial conviction at court, received a caution, reprimand, warning or tested positive for opiates or cocaine between January and December 2009. Proven re-offending is defined as any offence committed in a one year follow-up period and receiving a court conviction, caution, reprimand or warning in the one year follow up. Following this one year period, a further 6 months is allowed for cases to progress through the courts.

Between January and December 2009, there were just over 5,000 offenders who were cautioned, convicted (excluding immediate custodial sentences) or released from custody. Just over 1,100 of these offenders committed a proven re-offence within a year. This gives a one-year proven re-offending rate of 22%, which is below the national average of 26%.

These re-offenders committed an average of 2.5 offences each - around 2,800 offences in total – 80% were committed by adults (5% accounted for by known drug using offenders) and 20% were committed by young offenders.

Local reoffending rates are lower than the national average across all cohorts (see left).

Latest figures for 2009 are provided with comparisons in the last 12 month and previous years to highlight long term trends. Looking at performance over the last 4 years, we have had better than average success (adults and young people combined) in the last year of the measurement (2009 compared with 2008) but less than average over the whole 4 year period.

Performance is best in relation to PPOs and drug using offenders.

The youth offending measure (which is different from the old NI19) shows that the proportion of young offenders who reoffend has gone up over the last 4 years (from 28% in 2005 to 31% in 2009), but their level of reoffending (number of re-offences per offender) has reduced.

**Drug specific crime**

Analysis of long term trends show that crime has reduced significantly in Cornwall over the last five years.

- All recorded crime has reduced by 35% since 2004/05; 13,000 fewer crimes were recorded in 2010/11 than five years previously.
- Acquisitive crime (all thefts and burglary) and criminal damage have seen the greatest reduction over this period; dropping by 40% and 39% respectively.
- Within the acquisitive crime group, vehicle-related thefts have more than halved and dwelling burglary has reduced by a third. This is in line with national trends and largely attributed to improvements in both vehicle and household security. Negative trends in dwelling burglary over the last two years (discussed in more detail later) relate to low numbers and currently have little impact on the long term picture.
- Violent crime, which includes homicide, all assaults, sexual offences and robbery, has dropped by 26%. Sexual offences and robbery, both of which are very low volume crimes, have remained relatively stable over the whole period. Assaults with injury have dropped by a third, indicating that around 1,400 less people sustained physical injury as a result of violent crime in 2010/11 than in 2004/05.
- The only type of crime to see a notable rise over the longer term is drug-specific crime (possession of or trafficking illegal drugs). Drug offences have increased by 26%, predominantly reflecting a rise in offences relating to cannabis (particularly possession and production of cannabis plants) and cocaine.
- National trends show a rise of around 40% in drug crime over the same period, citing changes in police powers with respect to cannabis possession as the main determinant. Locally we have seen a similar pattern in cannabis-related offences, but in percentage terms offences relating to class A drugs have seen a stronger upwards trend.
- Trends will inevitably reflect increased police activity in response to local drug problems so do not necessarily signal an increase in drug-related offending. Based on referrals into community drug treatment services, however, there is some indication of increased prevalence of both cocaine and cannabis as a primary problem substance.

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.

- Crime specifically related to production, possession and trafficking of illegal drugs accounted for 6% of all recorded crime in the 12 month period to 30 September 2011.
- There were 1,410 drug crimes recorded during this period, of which three quarters relate to possession of cannabis. Offences relating to class A drugs make up 16% of all recorded drug offences and the most common drugs are cocaine (8%) and heroin (5%).
- Contrary to the national trend, in 2010/11 drug offences increased by 4% compared with 2009/10, further to a rise of 21% in the previous year. Previous rises have been attributed to changes in police powers with regard to possession of cannabis, the impact of which appears to have now ceased. Rises this year were noted in possession of heroin, cocaine and mephedrone (which was made illegal in April 2010) and trafficking cannabis.
- Generally crime rates in Cornwall are significantly lower than the national average. Drug crime is one of the few areas where we are more closely aligned to our ‘most similar
family and in 2010/11 the rate was 3% below the average for this group. Historically we have tended to see slightly higher rates of possession offences locally but lower rates for trafficking, but in 2010/11 police recorded drug trafficking offences increased, contrary to the trend elsewhere in the country, and the rate of crime climbed fractionally above the average for our ‘most similar family’ group.

- The main hotspots for drug offences in the 12 months to 30 September 2011 are Newquay (cannabis and cocaine), Liskeard (cannabis and heroin), Penzance (cannabis), Bodmin (cannabis) and Falmouth (cannabis and cocaine). Drug crime notably increased in Newquay, attributed to more proactive policing, and Liskeard. There was also a substantial rise in Bude compared with last year, with many of the offences relating to repeat locations (again indicating proactive policing).

- Unique offence codes were created for mephedrone and other cathinone derivatives in April 2010. Since then the police have recorded 35 crimes, predominantly possession.

- There were 1,512 seizures of drugs in the 12 month period to 30 September 2011, a fall of 12% compared with previous 12 month period. Some of the drop is explained by the withdrawal of the requirement to report the contents of drug boxes to the Home Office as drug seizures, implemented in April 2011 (previously accounting for around 10% of all seizures). The number of seizures has, however, dropped year on year since 2008/09.

- As reported last year, the quantities of drugs seized were also significantly less, partly due to a greater proportion of small seizures amongst cannabis and cocaine seizures.

- Large seizures of note in this period, all linked to trafficking offences, include heroin (500g, Hayle), MDMA powder (750g, Liskeard), amphetamine powder (850g, Callington), and herbal cannabis (2kg in St Austell, 1.25kg in Saltash and 500g in Bude).

- 30g of mephedrone and 3g of ketamine were seized in the last 12 months, all small seizures. Within this group of seizures, however, there are 29 believed to be mephedrone (15 seizures) or ketamine (14) for which quantities had not been recorded by the end of December 2011. In terms of number mephedrone seizures are significantly down compared with last year but ketamine seizures are up.

- Newquay police sector has historically continuously seen the highest number of seizures, with just under half of them accounted for by small seizures (less than 1g in weight or 5 items in number) taken from drugs boxes in pubs, night clubs and campsites.

- Excluding the drug box seizures, Camborne and Penzance saw the highest numbers of seizures in the 12 month period to 30 September 2011. After cannabis, amphetamines were the most common drug seized.

Drug markets in Cornwall

There are similarities in the illegal drugs market throughout Cornwall and several dealers whose ‘patch’ overlaps West and East Cornwall. This means that prices and purities therefore remain fairly constant. These include police seizures of heroin and cocaine being forensically tested and now routinely returning low purity levels.

Heroin and cocaine

- The purity of cocaine in some instances has been so low that it mirrors the consistently low purities that have been seen in amphetamine seizures for a long time.

- There has been one instance of a ½ kilogram block of heroin being intercepted with purity as low as 6%. There is every likelihood that this heroin would have been further reduced in purity as it made its way down to street level sized deals.

- In the East of Cornwall street prices for cocaine and heroin have remained the same. In West Cornwall, however, during the heroin ‘drought’ purity levels fell and conversely prices increased, (purities as low as 2% and prices of £15.00 for a 0.1gram deal being quoted in the Penzance and Hayle areas).

25 The police performance website iQuanta allows us to compare levels of crime and general trends with the average for community safety partnerships (CSPs) with similar characteristics nationally, known as our ‘most similar family’ or peer group.
Chapter 6 – Drug use and crime

The natural assumption to be made here is that drug users will increase their consumption as purity decreases. Whilst this may be true in some cases, there is a possibility that users will seek out other drugs instead.

Benzodiazepines

- There has been an increase in the use of Diazepam (based on the number of occasions Police Drug Liaison Officers are getting involved in live cases and intelligence reports etc) across the peninsular helped by the ease of access to the drug via the internet.

The use of Tramadol (synthetic opiate analgesic and not a controlled drug) has also been notable with pockets of illegal use becoming apparent

In the West of Cornwall, there are also increased seizures of illicit internet benzodiazepines (Temazepam, Diazepam, Lorazepam, Clonazepam and Alprazolam). These drugs are readily available from internet web sites and these sites act as facilitator to ‘connect’ users, dealers and suppliers from all over the world. The most prevalent exporters are India and China. This type of transaction is very attractive to a user because it appears to bear none of the risks associated with purchasing from a street dealer.

Tramadol has also featured in some drug related deaths - although these deaths have mainly been suicides, Tramadol is appearing sporadically in some other toxicology reports where the underlying cause of the death is consumption of drugs. Likewise, diazepam is a common feature in drug related deaths and the drug combinations coupled with alcohol and other depressants is worrying.

MDMA, ketamine and other stimulants

- The emergence and continual dynamic emergence of new psychoactive substances (NPS, sometimes referred to as ‘legal highs’) is becoming problematic.
  - Bodmin has seen 5 young adults being hospitalised in the last quarter of 2011/12 having consumed locally sourced NPS.
  - An instance of a person with dual diagnosis issues injecting a NPS.
  - An instance of a registered sex offender self-medicating with NPS.

The police are seizing an increasing amount of NPS and finding that these new substances are now the drugs of choice for many. It may be that the low purities of cocaine and previous drop in ecstasy production have added to the impetus in growth of the NPS market. It is of concern generally that NPS users tend to be on the younger end of the scale.

The police are looking at both internet sales of these NPS and also the local source potentially from ‘head shops’ or ‘new age’ shops where paraphernalia and alternative ‘highs’ can be purchased. A local police and Trading Standards initiative aimed at NPS outlets in the West of Cornwall has been launched.

Ketamine still remains popular in the West of Cornwall with regular seizures by club door staff and police. Purities remain high, as Ketamine has not ‘yet’ had a history of being cut with adulterants. Again, the majority of this is coming in via internet from India/China, and not from local medicinal / veterinary diversion.

Information from the PCT indicates an increase in patients presenting with Ketamine related health issues, this does not seem to be abating and we have already seen one patient locally who has had a bladder removal.

Due to the popularity of ketamine, it has become the latest ‘in vogue’ controlled drug to be copied and synthesised by the NPS labs in China. The legal high version is methoxetamine (not yet controlled) and the effects are said to mimic ketamine. Methoxetamine has been referred to the ACMD for advice re possible classification in line with mephedrone, naphyrone etc. A decision is expected in March / April 2012.
Seizures of crystal MDMA continue, which in turn reflects the poor quality of ecstasy tablets we are seeing (true ecstasy tablets are quite rare, mostly BZP and Mephedrone). The crystal form is better quality, harder to adulterate and therefore more popular. Falmouth seems to be a focus point for most of the ‘personal’ use seizures (similar with ketamine). The local student population and active door staff could account for this.

**Cannabis**

Resin seems to be dropping in popularity, the higher strength of locally grown skunk could account for this.

The norm now seems to be that the street price of ‘skunk’ cannabis has effectively doubled. Whilst there are pockets of street deals being the old imperial ‘teenths’ (sixteenth of an ounce) and ‘eighths’, we are finding a lot more metric gram deals where there is this inflated price. This is also the case in the West of Cornwall and it is normally the younger, newer dealers who are quoting gram deals. Ounce deals and above remain significantly cheaper.

The price at wholesale middle market of cannabis is such that profits can only be made by selling for increased prices at street level.

The closer these cannabis prices get to some of the NPS drugs, the more there is the possibility of overlap and people moving into the NPS world. This NPS world is new and evolving with little or no historic evidence to support health and rehabilitation schemes.

**Acquisitive crime**

We know that offenders with drug problems are more likely to commit acquisitive crime, where property is stolen for the purposes of selling on, to provide funds for their addiction. A review of the offending profile of known drug using offenders in Cornwall confirms that crimes such as burglary and shoplifting are the crimes of choice.

As previously discussed, acquisitive crime (all thefts and burglary) and criminal damage have seen the greatest improvement over the last five years, with vehicle-related thefts dropping by more than a half and dwelling burglary by a third. This is in line with national trends and largely attributed to improvements in both vehicle and household security.

- There were 949 dwelling burglaries in 2010/11, a rise of 3% compared with 2009/10. There has been a further rise of 13% in the year to date.
- Following a sustained period of reduction, dwelling burglary started to rise in October 2008 and has followed a gradual declining path since then. The rate of dwelling burglary remains lower than the national average but the gap has shrunk significantly over the last two years.
- Starting from a very low baseline, however, means that even small changes in criminal behaviour can affect what looks like a startling change – the increase over the last 3 years amounts to 90 burglaries across Cornwall and, despite the rise, levels of burglary in 2010/11 were still lower than those recorded in 2006/07 and before.

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 as a potential threats in previous assessments. This has proved thus far not to be the case at a national level: the latest British Crime Survey notes that “despite difficult economic conditions these latest statistics show no consistent evidence of upward pressure across the range of acquisitive crime.”

- Local trends to date show that other types of acquisitive crime, such as thefts and shoplifting, have also started to rise in the last 6 months. Wider evidence for Cornwall highlights that the impact of the economic climate, public sector cuts and changes to benefits are now becoming apparent, with disadvantaged households potentially at greater risk.
- Although nationally the latest crime statistics show no consistent evidence of upward pressure across the range of acquisitive crime, it is reasonable to assume that these
factors may have a stronger influence on crime trends where the underlying rate of crime is low.

- Persistent hotspots in West Cornwall (Camborne / Pool / Redruth, Penzance), Falmouth and Newquay. Highest rises in the last 12 months noted in Hayle / St Ives and Liskeard and surrounding area.
- National research emphasises the importance of adequate home security measures to reduce the household risk of burglary.
- A recent geo-demographic profile\(^{26}\) of burglary risk in Cornwall highlights two broad groups of higher risk – students/transient singles and low income households (areas of social housing) – and a potentially emerging increased risk for the group described as “Wealthy people living in the most sought after neighbourhoods” (includes areas such as Rock in North Cornwall). Each of these groups requires different strategies for communication of crime prevention advice.

The Community Safety Strategic Assessment highlights that the wider Community Safety Partnership has important roles to play both through working with communities to help them reduce their risk of victimisation and through supporting positive intervention work with offenders who are identified as presenting a particular risk, such as Prolific and Other Priority Offenders (PPOs) and drug using offenders.

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\(^{26}\) Using Mosaic Public Sector, which classifies all consumers in the United Kingdom by allocating them to one of 7 Supergroups, 15 Groups and 69 Types. These paint a rich picture of UK citizens in terms of their socio-economic and socio-cultural behaviour.
Chapter 7 – Housing and employment

Following, the publication of the Employment and Housing resource pack27, a DAAT housing and an employment working group have been set up to deliver the recommendations suggested by the NTA.

Key findings

- Supported housing provision has yet to be re-commissioned so there continues to be significant gaps in provision for clients at an earlier stage of their recovery journey, particularly for those who may still be using drugs. This remains the single most significant gap in our ability to deliver recovery locally.
- There is an increase of people presenting to treatment services with housing needs from 19% to 24%.
- 9% of people in treatment in 2010/11 had been at risk of eviction at some point since 01 April 2010 and 16% were recorded as having an acute housing problem. This is consistent with findings the previous year.
- Addaction staff engaged with and supported approximately 30 services users who accessed St Petrocs Cold Weather Provision between December 2011 and February 2012.
- There is an increase from 12% to 14% of people presenting to treatment services in employment despite fewer clients being triaged.
- 22% of people in treatment in 2010/11 undertook one or more days of paid work in the 28 days prior to a TOP being completed, with a mean number of days worked of 18 days. This is a 3% rise on last year
- 9% were recorded as having attended school or college on one or more days in the 28 days prior to a TOP being completed. The mean number of days is 9 days, although the most common is 4 days. Again this is up 3% on last year
- For both housing and employment, the information recorded in NDTMS has been more complete this year than in previous years so we believe it depicts a more accurate picture.

Housing

The priorities that were identified by the needs assessment last year regarded the need for staged provision that better meets the needs of our service users, with reduced evictions and through accommodation providers who are highly trained to recognise the nature of addiction remains a DAAT priority as Adult Care and Support prepare to commission future services.

In addition there have been pieces of work undertaken in the following areas:

Understanding the range of/access to housing related support services

Clearer pathways have been developed for care co-ordinators and key workers to access housing provision for clients who are homeless or at risk of homelessness. The accommodation related support services have been mapped across each locality and this mapping information can be found on the DAAT website.28

Integrated pathways and partnership working

This year a closer working relationship was developed between the Cold Weather Provision and Addaction, who were available at St Petroc’s for three days a week throughout the winter

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27 NTA (2011) Employment and Housing: Resource pack for needs assessment
period. A report will be submitted about this in March, with recommendations for the required support in future years.

The protocol for Prolific and other Priority Offenders (PPO) has been refreshed and agreed between the Local Authority and the partners working within the Criminal Justice Integrated Team.

- Many housing staff have attended the Identification and Brief Advice (IBA) training for those with alcohol issues.

Work has been and continues to be undertaken between the FreshStart project, the Probation Service and the DAAT to ensure joint working between organisations that best meets the needs of substance using offenders. Processes are being developed to more closely monitor progress of clients living at the project. In addition closer partnerships are being developed with Stonham to more effectively care co-ordinate the various strands of accommodation and treatment support being delivered.

Some issues have been identified when clients are, or at risk of becoming homeless on leaving Chy Colom residential rehabilitation project. A solution to this is being considered in partnership with the Local Authority (Cornwall Housing Limited, from 1st April 2012). Stronger links are being developed between Chy Colom and Housing Options services as well as transition support to clients in the community provided by Chy Colom.

Support implementation of the service delivery model evolving from the Supporting People sector reviews

One of the key themes highlighted by the service analysis within the SP Substance misuse sector review was the level of unplanned moves from services due to either eviction or abandoned tenancies; this averaged at 35% with roughly half of these due to evictions. Anecdotal evidence also indicated that there is a high level of clients representing at one or more services highlighting the “revolving door” syndrome.

- Staff reported that referrals were increasingly received for individuals with more chaotic or complex needs than services were resourced or designed to support effectively, and that people had to be turned away or later evicted for the very issue for which they were seeking support (SP Substance Misuse sector Review, 2011).

In order to reduce evictions and increase successful outcomes in supported housing a range of commissioning recommendations were made following the SP Substance misuse sector review, such as:

- Strategically implemented staged approach with clear pathways towards independent living;
- Services that are tolerant within the limits of the law, with clear eligibility criteria and eviction policies, and staff who are trained in how to minimise evictions in respect of clients’ presenting needs;
- Increased provision generally countywide, with particular need in the North and East of the county and to increase Stage 1 and Stage 2 service provision;
- Harm reduction approaches at a strategic level (e.g. wet houses) and at appropriate service/individual level (e.g. Naloxone initiatives, safer injecting training etc.) that recognise that not all clients will be clean and dry;
- Services that can support those with complex needs (particularly those with a dual diagnosis) or for whom a substance misuse specific accommodation based service may not be appropriate or currently widely available (e.g. people with dependent children, 16-17 year olds, older people with other needs, people with pets etc);
- Services that can support older people with substance misuse needs, who may also have mental health needs (dual diagnosis). This client group is increasing client group; service design of substance misuse and older people services needs to be flexible and responsive to ensure these needs can be met regardless of age;
• Services that address clients’ holistic needs (practical, emotional, physical), supplemented by specialist staff based at one or more services where appropriate, to help clients build recovery capital to achieve and sustain recovery.
• Work is needed with partners in Health to help us understand and address the barriers, perceived or real, that some providers have reported in working effectively with local mental health and drug and alcohol teams, particularly where a client has complex needs;
• Where possible and/or appropriate to jointly commission specialist posts/functions that may serve one or more services, including pre and post tenancy;
• Alternative service delivery model options should be considered when commissioning substance misuse services to help in embedding personalisation. For this sector, a “core and flex” funding model is likely to be the most appropriate solution at this point, offering clients choice and control while ensuring services are able to provide value for money. Feasibly one or two pilots could be trialled to test such an approach.
• Further work is required to explore what more can be done to support individuals to obtain qualifications to improve their employment prospects and, ultimately, their ability to better support themselves financially.

In order to prepare strategic services and their managers to work with current drug users, training sessions were organised by the DAAT on the ‘eyes wide open’ approach to supported housing. This was positively received by all statutory services and many provider organisations and addressed some of the myths and bad practice that prevail about Section 8 of the Misuse of Drugs Act.

• This training was delivered by Kevin Flemen from Drugs and Housing, which is the main online resource in the UK for drugs workers and housing agencies. It provides a comprehensive and indispensable set of resources for professionals addressing the dual issues of housing need and substance use.
• Sample drugs policies have been developed including those for high tolerance environments where housing providers are working with ongoing drug users.
• Medium and low tolerance policies are also in development.
• Additional training around implementation of high, medium and low tolerance models will be arranged following the agreement of the future supported accommodation commissioning model.

Answers to some of the most common questions related to drugs and housing can be found at http://www.drugsandhousing.co.uk/faqs.htm

Assessing level of accommodation need

Accommodation need at presentation to treatment is captured in NDTMS and this provides a useful snapshot of individuals being triaged for treatment in year. It can be used to highlight emerging trends but it is not updated as the episode of treatment progresses so thus does not capture need across the whole treatment population. Additional questions around critical housing need are asked on a regular basis as part of the Treatment Outcome Profile (TOP), however, which add to the overall picture.

Reports taken from HALO do not currently provide updated information on housing needs and this is to be further investigated for data collation next year.

The next table shows the number of triages in year (taken from the latest cut of raw data from NDTMS) by recorded accommodation need. Immediate need means presenting to treatment as homeless or with “problem” accommodation (temporary arrangements such as short term bed and breakfast or sofa surfing).
In the last needs assessment we reported that the level of need appeared to have diminished over the years, although previous trends may have been clouded by poor data completion.

The figures below show an increase in the number of people presenting to treatment with accommodation problems. We can also see the steadily improving completion rate, which reflects greater awareness amongst service providers of the importance of capturing information on accommodation need and means that we can have more confidence in what the data is telling us. This rise in need could be attributed to the removal of the Stonham floating support services and the 40% cut in funding that was applied locally to what was the Supporting People budget.

There have been 58 people presenting to treatment in immediate need between April and August 2011. Extrapolating these figures to year end for 2011/12 for people indicates that we will see around 140 people in immediate housing need, of which a third will be homeless.

This does not take into account people who are in supported housing. Whilst locally we believe that there is a housing-related support need to consider when a person is in supported housing, the guidance for NDTMS categorises supported housing as “no problem”.

We should be able to use TOP to get an updated picture of critical risk around housing. The TOP records whether the service user has an acute housing problem or is at risk of eviction.

TOP data indicates that:
- 9% of people in treatment in 2010/11 (134 people) had been at risk of eviction at some point since 01 April 2010 and
- 16% (246 people) were recorded as having an acute housing problem.
- These figures are consistent with TOP findings relating to housing need for people in treatment in 2009/10.

Historically there have been some issues identified in recording on TOP where the records are incomplete with clients/workers reporting questions on housing as NA (not answered). A review of all the TOPs completed since 01 April 2010 show, however, that this has reduced to an acceptable level of only 2% NA responses overall.

There were a small number of occasions (around 1% of all TOPs completed) where a worker has reported that the service user was at risk of eviction but not that they had an acute housing problem. Additional understanding is required to understand why this is happening and to ensure consistent reporting in future years.

One worker said that her client responded in this way because, although they did not have a problem with accommodation at the time, they will be at risk of eviction if they drink or use drugs so wanted to record it in that way.

Thus, the information provided from NDTMS does not provide a very full picture of housing need.

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<tr>
<td>Urgent (NFA)</td>
<td>27</td>
<td>26</td>
<td>26</td>
<td>33</td>
<td>19</td>
</tr>
<tr>
<td>Problem</td>
<td>94</td>
<td>100</td>
<td>57</td>
<td>63</td>
<td>39</td>
</tr>
<tr>
<td>No problem</td>
<td>361</td>
<td>339</td>
<td>435</td>
<td>408</td>
<td>180</td>
</tr>
<tr>
<td>Not completed</td>
<td>214</td>
<td>232</td>
<td>245</td>
<td>125</td>
<td>23</td>
</tr>
<tr>
<td>Triages in year</td>
<td>688</td>
<td>685</td>
<td>756</td>
<td>618</td>
<td>260</td>
</tr>
<tr>
<td>Immediate need n</td>
<td>120</td>
<td>126</td>
<td>83</td>
<td>93</td>
<td>58</td>
</tr>
<tr>
<td>Immediate need %</td>
<td>25%</td>
<td>28%</td>
<td>16%</td>
<td>19%</td>
<td>24%</td>
</tr>
<tr>
<td>Completion rates</td>
<td>69%</td>
<td>66%</td>
<td>67%</td>
<td>80%</td>
<td>91%</td>
</tr>
</tbody>
</table>
However, the psychosocial section of the comprehensive assessment gives a clearer picture of need and the type of provision that would best meet the needs of the client. Tier 3 treatment providers are being requested to complete this section of the comprehensive assessment so this information can be gathered more efficiently through HALO in future years. In addition to this work with other partnerships is being undertaken to ensure we are recording housing needs in the most effective way.

**St Petrocs/Addaction Winter Provision Report**

Addaction Penzance provided extra support during the winter provision through December to February at St Petroc’s which was regarded as being a valuable part of service provision over and above sessional work being done by Nicola Hunter. The added service provision was available on 3 mornings a week for 3 hours each morning on a Monday, Wednesday and Thursday.

**Client Group**

The service users targeted within St Petroc’s are generally drug and alcohol users who have come from in and around Truro as well as from other areas of the UK and who are transient throughout Cornwall. The age group that were worked with ranged from 18 upwards with both male and female clients being given support on a range of issues not solely substance misuse.

**Support and Statistics**

- 30 service users were engaged within St Petroc’s on City Road, Truro over this period on a number of levels from discussing what Addaction services were to the greater number of those that had been identified as requiring support to address their substance misuse.
- The majority of the service users were currently street homeless with 4 living in supported accommodation provided by St Petroc's and 2 living in private lets.

Some had already been seen by an Addaction worker and therefore needed brief interventions on an ongoing basis to manage their behaviour and to ensure that the support and actions required to reduce their using safely including harm reduction was being carried through and maintained by the service users.

Some were new referrals and new to the area but this accounted for a minimal amount.
- There were approximately 30 users engaged within the period requiring more than one intervention session.

A number of the service users would regularly miss appointments due to the nature of their lifestyle even with St Petroc's reminding them of appointments. 7 of the clients had moved on to other supported accommodation and were at times easily followed through by being picked up by Addaction at satellite clinics. Some requested to be seen at GP surgeries as they had moved areas and wanted to be seen out-with St Petroc’s in a bid to move away from the social group that frequented there. Some left Cornwall returning to their home towns and 1 died after moving from Truro into supported accommodation and subsequently losing the accommodation and going back to rough sleeping and dying within a couple of days before re-Engagement of services and further contact could be put in place. The service users are still accessing Addaction services at St Petroc's.

**Barriers**

- The main barrier identified to engaging service users was lack of access to stable housing.

This made it hard to maintain a reduction in their drug or alcohol use and to establish any routine and stability in their lives. This led to many of the service users missing initial or follow on appointments. The service users would often arrive at St Petroc’s stating that they believed they had missed an arranged appointment and having to make another. This meant prioritising looking at the amount and what they were drinking and to ensure that harm reduction information was given, as little else could be achieved. However due to their
lifestyle, peer pressure within the group could easily over-ride any knowledge of individual
empowerment to reduce their using.

- Another barrier identified was that evidence points to detoxification and residential
  rehabilitation having very low success rates/being unviable for people who are homeless.

Service users cannot benefit from these interventions unless they have housing to return to.

- Service users were also reluctant to go to Trevint (treatment service base) to access
  services as this would mean going out of their comfort zone and would rather access
  services at St Petroc’s or at the GP.

There was also a feeling from the service users that they were unable to attend groups within
Addaction at Trevint due to them being homeless as they feared other service users would
judge them and not want them at the groups. They did state that the workers were inclusive
of them at group and did not see their housing situation as a barrier.

Positive Outcomes

- The client group started to engage better on an ad-hoc drop-in basis where they could
  establish trust.
- The service users started to request the service as they were getting to know that
  someone from Addaction would generally be around most mornings and would be able to
  see them even if they had to wait to be seen.
- Clients also got to understand that if they were to move into accommodation they could
  still be seen in the 3 localities team bases around Cornwall.
- Partnership working has been very successful with both service providers having a better
  understanding of what each other do and how the services can link in to make services
  more accessible. St Petroc’s were also able to identify people that were currently in
  supported accommodation or private lets that required support so that relapse prevention
  could be provided to reduce the risk of losing their accommodation.

Conclusion

- The winter provision was beneficial for all concerned and showed that with partnership
  working a lot of support can be put in place to enhance the provision of both services
  concerned.
- The clients were able to build up a level of trust that Addaction could understand the
  nature of the issues the service users face and were flexible in their style of working and
  that they would not be penalised for struggling to make positive changes in a short period
  of time as a result of their lifestyle. The work of Addaction has been highlighted within the
  homeless community.

Employment

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 (OCUs) 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 10 people have entered treatment in Cornwall via Job Centre Plus referral
between 01 April 2010 and the 31 March 2011. None of these referrals confirmed with Job
Centre Plus that these clients had been assessed. Additional work is required between Job
Centre Plus and treatment providers to ensure staff across services are kept aware of the
progress being made by clients.

From the employment work group pieces of work have been undertaken in the following areas:
Integrated pathways and partnership working

A plethora of new services have been developed in recent months, including structured treatment programmes with Addaction, the pre-work programme and the work programme at Job Centre Plus and Cornwall Works for Families through European Social Fund (ESF) funding allocated to Cornwall. Subsequently it has been possible to develop clearer pathways for care co-ordinators and key workers to access and progress clients through this provision. These pathways will be published on the DAAT website once they have been finalised.

Job Centre Plus staff have been targeted for Identification and Brief Advice training around alcohol and several training sessions have been held in Job Centre Plus offices throughout Cornwall with many of their staff now trained in this area.

There are still few referrals from Job Centre Plus into treatment and even fewer referrals from treatment into Job Centre Plus and more joint working is required to ensure clients make progress towards work that most supports their recovery journey.

Completion of TPR2 forms that enable treatment providers and Job Centre Plus staff to come together with clients and discuss their long term goals and support needs have been highlighted as requiring completion at a very early stage in the client’s recovery journey, particularly if the client is claiming Job Seeker’s Allowance.

Assessing the level of employment need

In order to ensure that services delivered are most equipped to meet the needs of substance misusers a needs audit is being planned by Addaction Life Skills workers to assess the skills gaps in communication, finance, daily living, learning, housing and employment, of their service users. It is the intention that this survey will be extended to other providers so that we get a broader picture of need.

Employment status at presentation to treatment is captured in NDTMS. This information is useful as a snapshot of individuals being triaged for treatment in year. It can be used to highlight emerging trends but it is not updated as the episode of treatment progresses so thus does not capture need across the whole treatment population. As for housing need, additional questions around employment and education are asked as part of the TOP which helps to inform the overall picture.

The next table shows the number of triages in year (taken from the latest cut of raw data from NDTMS) by the employment status recorded.

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<tbody>
<tr>
<td>Unemployed</td>
<td>212</td>
<td>391</td>
<td>489</td>
<td>350</td>
<td>129</td>
</tr>
<tr>
<td>Economically inactive</td>
<td>15</td>
<td>14</td>
<td>19</td>
<td>105</td>
<td>73</td>
</tr>
<tr>
<td>Regular employment</td>
<td>63</td>
<td>68</td>
<td>72</td>
<td>74</td>
<td>36</td>
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<tr>
<td>Pupil / student</td>
<td>6</td>
<td>5</td>
<td>15</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>22</td>
<td>28</td>
<td>25</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Unknown</td>
<td>370</td>
<td>185</td>
<td>145</td>
<td>91</td>
<td>16</td>
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<tr>
<td>Triages in year</td>
<td>688</td>
<td>685</td>
<td>756</td>
<td>618</td>
<td>260</td>
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<tr>
<td>Completion rates</td>
<td>46%</td>
<td>73%</td>
<td>81%</td>
<td>85%</td>
<td>94%</td>
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This indicates that, despite a drop in the overall number of people triaged, the number of people presenting to treatment in regular employment has remained fairly constant and in percentage terms has increased from 9% to 12% between 2007/08 and 2010/11. Figures for the year to date (five months) show a further rise to 14%.

As for accommodation need, we can also see a similar steady improvement in the completion rate, which reflects greater awareness amongst service providers of the importance of capturing this information and means that we can have more confidence in what the data is
telling us. Improved awareness is also likely to be the underlying reason for the increase in the number of people recorded as economically inactive.

The TOP should be used to capture information on an ongoing basis relating to days engaged in either paid employment or education. Historically completion of TOP has been patchy but the latest data indicates that only 1% of TOPs undertaken since 01 April 2010 include NA responses for these elements.

- 22% of people in treatment in 2010/11 (334 people) undertook one or more days of paid work in the 28 days prior to a TOP being completed, with a mean number of days worked of 18 days.
- 9% (130 people) were recorded as having attended school or college on one or more days in the 28 days prior to a TOP being completed. The mean number of days is 9 days, although the most common is 4 days.
- Compared with 2009/10, there has been a small improvement in service users undertaking paid work (+3%) and the number attending school or college is similar.

In addition more detailed information can be gathered using the psychosocial section of the comprehensive assessment to ensure we gather a clearer picture of aspirations and needs. Additional work is also required with other partnerships to ensure we are recording this information in the most effective way.

**Employment support services and numbers accessing them**

The work programme, pre-work programme and the ESF contracts have only been awarded this year and as yet few of our clients appear to have accessed them. It is hoped that through the HALO system we will be able to track which of our clients are at stage 1, an induction into treatment where there is therapeutic interventions and the development of soft skills; stage 2, a structured day programme with a focus on life skills and learning and moving towards employment type activity or stage 3, where they are making specific progress towards employment or indeed stage 4 where they have accessed employment.

This pathway is shown in the next diagram.

**Pathway to assist drug and/or alcohol users to work towards employment**

![Pathway Diagram](image-url)
The impact of employment and housing on successful completion

Suitable housing is recognised as a critical component of recovery – lack of suitable accommodation presents a severe risk to a person’s ability to engage with any kind of programme or service and should thus be viewed as of utmost priority.

- Analysis of treatment outcomes by a range of factors (see Chapter 3 Mapping the Treatment System) indicates that people who were NFA on presentation to treatment are less likely to achieve a successful completion. Unfortunately we cannot find out from the data whether the person was still NFA when they dropped out.
- Higher levels of unplanned exits from treatment were also noted for service users that were missing information relating to accommodation need and employment status on presentation to treatment. This may be indicative of poor engagement with the service user at the start of treatment.
- A review of TOP for service users who dropped out of treatment in the last 15 months indicates higher prevalence of accommodation problems for this group (13% at risk of eviction at some point in the period and 26% with acute housing problems).

Conversely, being in regular employment on presentation appears to have a positive impact on whether a person leaves treatment successfully drug free. The successful completion rate for people who presented to treatment in regular employment is 61%, 13 percentage points above the average for all people leaving treatment.

This is the reverse of the finding for last year and, combined with a rise in the number of employed people engaging with treatment, indicates that the increase in open access and out of hours provision through Addaction may be having a positive impact.

A significantly higher rate of successful completion was also noted for people who presented to treatment as students (79%), although the numbers involved are comparatively small and may be skewed by the drive over the last year or so to move young adults on and out of Yz-Up (most of which were planned exits).
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

Key findings

Needle exchange

- Trends in usage of pharmacy-based services have not been updated this year due to data not having been provided in time for this assessment.
- Numbers accessing Freshfield needle exchange services has remained stable compared with last year, although the number of client visits has dropped. This discrepancy may be explained by an increasing number of steroid users in the client base, who visit less frequently.
- Freshfield issued 232,400 syringes over the course of the year, 98% of which were known to be disposed of safely (96% at Freshfield services).
- New presentations continue to be predominantly male and heroin users. The age profile for new clients is younger than for Tier 3 treatment services, particularly in terms of young adults (under 25 years of age).

Infections amongst injecting drug users

- People who inject drugs (PWID) are vulnerable to a wide range of viral and bacterial infections. These infections can result in high levels of illness and in death.
- Around one-third report having a symptom of a bacterial infection (such as a sore or abscess) at an injecting site in the past year. Staphylococcus aureus and Group A Streptococcal infections continue to cause severe illnesses among people who inject drugs in the UK.
- Since 2000 there have been 163 cases of wound botulism, 93 of Clostridium novyi infection, 52 confirmed cases of anthrax and 35 of tetanus associated with injecting drug use in the UK.
- Combined data from across the UK suggest that around one in six PWID have been infected with hepatitis B and about half with hepatitis C. They also indicate that at around one in 100 has HIV. Interventions that aim to prevent infections among PWID therefore need to be sustained and the levels of provision reviewed to ensure adequate coverage.
- The HPA estimates that there are approximately 410 current (and 643 former) PWID infected with HCV in Cornwall. Between 62 and 92 new cases are diagnosed per year. In total, approximately 600 cases have been diagnosed over the last 12 years. In Cornwall and Isles of Scilly, 70% per annum of the PWID in treatment have been tested for HCV infection using the current method of venepuncture. This is comparable with the national rate of testing at 75% but significantly below the national target of 90% (National Treatment Agency).
- 89% of service users starting new treatment journeys in the year to date (April to December 2011) were recorded as being offered Hepatitis B vaccination (compared with 69% in 2009/10) – an increase of 20%.
- There is good Needle and Syringe Exchange scheme coverage in Cornwall and the Isles of Scilly, which include infection control advice. However, we do not have local data pertaining to bacterial infections in PWID.
- Services to prevent and treat blood borne viruses (BBV) are well developed, and access to HBV immunisation and HCV testing have improved significantly in the past year, to above the national average, but have yet to meet our target of 90%.
- The priority for 2012/13 is to ensure 90% of people accessing our treatment services that have a history of injecting have been immunised and tested.
Drug-related deaths

- The number of recorded drug related deaths has reduced by 7 deaths (38%) compared with 2010. Included within the currently recorded drug related deaths are three suspected heroin/morphine deaths.
- Of the 11 recorded drug related deaths 5 were in treatment for drug dependency at the time of their death and one other had been discharged from treatment following residential de-toxification. The other 5 had no previous involvement with any known treatment provider nor were they awaiting appointments for assessment for any such treatment.

Hospital admissions

- The overall number of hospital admissions related to substance misuse has increased over the last three years.
- Between 2008/09 and 2010/11, ‘opioids’ have formed the most common drug group leading to drug-related hospital admissions. ‘Cannabinoids’ was the second most common group of substances linked to drug related hospital admissions, followed by ‘other stimulants’, and ‘Multiple drug use and other Psychoactive substances’
- Admissions associated with the use of ‘other stimulants’ rose sharply in 2009/10 and 2010/11.
- The most common type of drug-related admissions are emergency admissions.
- The local strategy should acknowledge the high (and rising) numbers of emergency admissions related to drug use, the higher proportional need in males and the changing trends of substance types associated with hospital admissions.
- Nearly half of all hospital admissions are related to the use of opioids. Cannabinoids and MDU/other psychoactive substances each accounted for 15% of drug related admissions over the last three years but whereas those related to cannabinoid use have been rising, those related to MDU/other psychoactive substances have been falling.

Drug misuse and the risk of suicide and self harm

- People who misuse drugs are at increased risk of mental health problems, self harm and suicide.
- Hospital admissions in the South West due to self harm (overdose) by drugs of abuse have been rising for males and females.
- Opportunities for ASIST training should be promoted for staff working with people who misuse drugs and suffer from depression.
Needle exchange

Needle and syringe exchange services are available in Cornwall through 20 pharmacies (Cornwall and Isles of Scilly PCT), 4 static sites and a domiciliary services provided by Freshfield and in the three custody suites (Camborne, Newquay and Launceston). Needle exchange services are also available through all clinics and specialist services where other treatment interventions are delivered.

Pharmacy-based services

In the last assessment we reported that pharmacy-based services saw on average around 800 clients per quarter, picking up an average of 8 packs per visit. The number of visits slightly reduced overall in 2009/10, following a period of growth in the preceding two years.

Up-to-date trend data for usage of the pharmacy-based services has not been provided for this assessment but the DAAT are not aware of any significant changes in client behaviour.

Freshfield

- 580 clients accessed needle exchange services through Freshfield in 2010/11, accruing a total of 2,554 visits over the course of the year (90% at static sites and 10% home visits and / or postal service). Almost 232,400 syringes were issued, of which 98% were known to be disposed of safely.
- Client numbers remained stable compared with last year although client visits saw a fall of 10% (further to a similar fall noted in 2009/10).
- Client numbers increased in East and Central Cornwall but this was balanced by the drop in West Cornwall.
- The highest volume of usage consistently remains in the West, where more than 50% of clients reside.
- 31% of clients using the services presented for the first time in 2010/11 – the vast majority are male and under 40 years of age. Needle exchange services attract a younger client profile than treatment – around 30% of new needle exchange clients were young adults compared with 15% in new presentations to treatment recorded in NDTMS in 2010/11.
- The majority of new clients are heroin users and only other significant group are steroid users.
- Freshfield have reported that steroid users are the fastest growing group of clients using needle exchange services. Due to the nature if steroid use, these clients visit far less frequently than heroin users. The influence of this on the statistics is further reinforced by the fact that the greatest variation between clients and visits continues to be Central Cornwall, which is where the majority of steroid users using Freshfield services are.

<table>
<thead>
<tr>
<th>Area</th>
<th>Clients 2010/11</th>
<th>Number</th>
<th>%</th>
<th>Contacts 2010/11</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>East</td>
<td>94</td>
<td>11</td>
<td>13%</td>
<td>441</td>
<td>46</td>
<td>12%</td>
</tr>
<tr>
<td>Central</td>
<td>149</td>
<td>16</td>
<td>12%</td>
<td>435</td>
<td>-63</td>
<td>-13%</td>
</tr>
<tr>
<td>West</td>
<td>337</td>
<td>-32</td>
<td>-9%</td>
<td>1,678</td>
<td>-277</td>
<td>-14%</td>
</tr>
<tr>
<td>Cornwall &amp; Isles of Scilly</td>
<td>580</td>
<td>-5</td>
<td>-1%</td>
<td>2,554</td>
<td>-294</td>
<td>-10%</td>
</tr>
</tbody>
</table>
Infections amongst injecting drug users

- The latest figures from national research estimate that there are between 398 and 1,312 injecting opiate and / or crack users (OCUs) in Cornwall and the Isles of Scilly, with a mid-point estimate of 858. Contrary to the national picture, injecting prevalence is estimated to have increased locally since 2006/07 (when the last estimates for injecting were calculated).

- NDTMS data provided for needs assessment indicates a figure of around 860 injecting (either currently or previously) OCUs in treatment in 2010/11. This is very close to the mid-point figure for estimated prevalence, suggesting that actual prevalence is more likely to be in the upper range.

- Around three quarters of OCUs in treatment in 2010/11 had a history of injecting behaviour which is in line with the regional average. Compared with the previous year, there was a small uplift of 2% in injecting behaviour in the OCU population and this trend was also apparent at a regional level. Looking at new presentations to treatment, however, within this group there is a higher proportion of current injectors locally.

- Looking across all types of substance use, the level of injecting behaviour locally is fairly similar to the regional average, with OCUs the most likely to inject and cannabis users and users of “other drugs” the least likely (at 28% and 29% respectively). Amphetamine users are the exception – although we have more of them locally, they less likely to inject.

People who inject drugs (PWID) are vulnerable to a wide range of viral and bacterial infections. These infections can result in high levels of illness and in death.

Around one-third report having a symptom of a bacterial infection (such as a sore or abscess) at an injecting site in the past year. Staphylococcus aureus and Group A streptococcal infections continue to cause severe illnesses among people who inject drugs in the UK.

Since 2000 there have been 163 cases of wound botulism, 93 of Clostridium novyi infection, 52 confirmed cases of anthrax and 35 of tetanus associated with injecting drug use in the UK. Cases from the UK make up the vast majority of the reported cases of these four infections associated with injecting drug use in Europe. To date we do not have data specific to CIOS.

Around one-half of people who inject drugs in the UK have been infected with Hepatitis C and one-sixth with Hepatitis B.

The prevalence of HIV among those who have injected drugs remains comparatively low in the UK. It is estimated that around one in every 100 has HIV.

Needle and syringe sharing is lower than a decade ago, although one-fifth of people who inject drugs continue to share needles and syringes.

Reported symptoms of injecting-site infections

Symptoms of a possible injecting-site infection are common among PWID. In 2010, about a third (35%, 528 of 1,524) of PWID participating in the Unlinked Anonymous Monitoring (UAM) survey in England, Wales and Northern Ireland reported that they had experienced an abscess, sore or open wound, all possible symptoms of an injecting-site infection, during the preceding year. This level has not changed since the UAM Survey first reported on this in 2006, with women more likely to report a symptom than men.

Overall, 37% (459 of 1,242) of the participants in the UAM Survey who had injected during the last four weeks reported having had these symptoms during the preceding year. Those who had injected into the fragile veins of their hands, legs and feet during the last four weeks more frequently reported these symptoms.
More frequent injecting among cocaine injectors, due to the relatively short duration of the drug’s effects may result in more tissue damage at injecting sites and so an increased risk of infection. However, those who had injected amphetamines reported symptoms less often.

**Hepatitis C**

The main route of transmission of BBVs in PWID is through the sharing of contaminated injecting equipment, a practice that is common in one in five PWID. Once infected with HCV one in three PWID will clear the virus, the rest will develop progressive liver disease.

Current levels of Hepatitis C transmission amongst PWID appear to be higher than a decade ago, as 23% of the recent initiates to injecting participating in the UAM Survey were infected in 2010 compared with 12% in 2000.

Uptake of voluntary confidential testing for Hepatitis C has increased among those who have injected drugs, with the proportion reporting ever having been tested in England, Wales and Northern Ireland rising from 49% in 2000 to 82% in 2010.

Untreated chronic HCV typically leads to cirrhosis after 20-30 years of infection with subsequent development of liver failure or primary liver cancer (hepatoma). Co-infection of either HCV or HBV with HIV can lead to rapidly progressive liver disease as compared to mono-infection. However, chronic HCV and HBV infection can be treated successfully with a combination of (some or all of) Interferon, Ribavirin and oral antivirals in the majority of PWID. Treatment of HCV and HBV has been shown to be cost-effective in prevention of disease progression,

As patients with chronic HCV and HBV infection are predominantly asymptomatic, most infected PWID will be unaware of their infection status unless they have been screened. In these individuals their infection will continue to pose a threat to their future health as well as others. The prevalence of infection in PWID will also continue to remain high, acting as a source of future infection. Failure to identify and treat current and former PWID 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 (see Figure 3).

**Figure 1: UK deaths from end stage liver disease (ESLD) or hepatocellular carcinoma (HCC) in those with HCV on the death certificate.**

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Figure 2: Annual number of individuals in England, Scotland and Wales hospitalised with HCV-related end-stage liver disease (ESLD) and HCV-related hepatocellular carcinoma (HCC)

Figure 3: Overall number of transplants that list first registration with a code of post-Hepatitis C cirrhosis in the UK

Early detection of infection provides a means of reducing the pool of infection, improving long-term prognosis, reducing inequalities in health in this marginalised population and limiting the financial burden on the NHS for caring for patients with advanced liver disease. Nevertheless, studies show around half of PWID with HCV remain unaware of their infection, a proportion that has not changed in recent years, despite national policy and campaigns supporting testing.

**Epidemiology of HCV infection in Cornwall**

- Using survey and study data from 2004/5, the HPA estimates that there are approximately 410 current (and 643 former) PWID infected with HCV in Cornwall. Between 62 and 92 new cases are diagnosed per year.

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In total, approximately 600 cases have been diagnosed over the last 12 years. However, based on the known increases in admissions for liver disease, hepatic cancer, deaths associated with the viruses and liver transplants, as shown in the figures above, this is not an area that will decrease in activity without some action and preventative measures being put into place.

**Current position of testing for HCV for Cornwall and Isles of Scilly**

- In Cornwall and Isles of Scilly, 70% per annum of the PWID in treatment have been tested for HCV infection using the current method of venepuncture. This is up from around 50% last year.
- This is comparable with the national rate of testing at 75% but significantly below the national target of 90% (National Treatment Agency).

The main factor in this low testing rate is the difficulty of venous access in this client group, and often PWID may agree to being tested but do not proceed to the stage of having blood taken because either a further appointment has to be scheduled purely for the venepuncture, or they are required to attend elsewhere (e.g. a GUM clinic) if an attempt to take blood at the initial appointment was unsuccessful.

This does suggest that HCV infection remains under diagnosed in Cornwall and that screening of PWID is, at best, ad hoc, which Dry Blood Spot testing should assist in improving by using an easier method of testing which is performed during the initial consultation.

**Hepatitis B**

With HBV infection, about one in twenty will develop chronic infection of a variable course with some spontaneously developing immunity to HBV.

The transmission of hepatitis B continues among PWID, but may have declined in recent years as the proportion of participants in the UAM Survey who had ever been infected has fallen from 28% in 2000 to 16% in 2010 (Table 1). Among those attending NSP in Scotland during 2010, 68% reported uptake of the hepatitis B vaccine.

**Human Immunovirus (HIV)**

All untreated HIV patients will typically lead to Acquired Immune Deficiency Syndrome (AIDS) after 10 years and death 3-5 years later.

There were 141 new HIV diagnoses associated with IDU in 2010 in the UK. This is similar to the number seen in previous years. In CIOS, the HIV prevalence among PWID appears to be stable.

In England, Wales and Northern Ireland 1.1% of the participants in the UAM Survey in 2010 were found to be infected.

The number of people seen for HIV treatment and care in the UK who had acquired their infection through IDU has increased over the past decade, with 1,565 seen in 2010 compared with 1,298 in 2000. In 2010, anti-retroviral therapy uptake among PWID diagnosed with HIV was 83% overall, and 86% among those who had CD4 counts of 350 or less (the level at which it is recommended to start anti-retroviral therapy).

**Risk Behaviours**

The level of needle and syringe sharing reported in England, Wales and Northern Ireland has declined from 31% in 2000 to 21% in 2010.
Performance Data

Information about blood borne virus interventions with drug users in treatment should be recorded in NDTMS. In previous years we have highlighted a significant shortfall in recording, particularly with respect to Hepatitis C testing and interventions. The latest reports from NDTMS indicate that this issue has now been resolved and recording rates are much closer to the regional average.

Rates of immunisation for hepatitis and testing for hepatitis C improved significantly in 2010/11 and 2011/12, and above the national average, but still fall short of the target for 90%. Immunisation against Hepatitis B and testing for Hepatitis C form part of the treatment plan for drug users with a history of injecting behaviour.

Hepatitis B

- 89% of service users starting new treatment journeys in the year to date (April to December 2011) were recorded as being offered Hepatitis B vaccination (compared with 69% in 2009/10).

- Levels of acceptance are higher locally than regionally (44% compared with 35%) but this may be partly explained by the fact that the level of previous immunisation / immunity is currently lower in Cornwall.

Hepatitis C

- 70% of injecting drug users in treatment are recorded as having received a Hepatitis C test. Although this is exactly in line with the regional average, the target remains to achieve a test rate of 90%.

- As for Hepatitis B vaccination, take up of Hepatitis C intervention is higher locally but the difference is more significant (+14%).
What is being done locally?

- 2 specialist nurses are employed within CDAT to promote immunisation, testing and access to treatment.
- CDAT have pathways and protocols for access to immunisation
- DSBT has been implemented throughout the drug & alcohol treatment community.
- Close working relationships have been developed between RCHT Hospital based consultant led viral hepatitis treatment services and community treatment.
- One GPwSI for drug misuse is able to offer a Hepatitis C treatment service in an area of high need and low access.
- Community pharmacies run needle exchange schemes, three month Public Health campaigns on safer injecting and are about to embark on a project to offer DSBT in needle exchange locations.
- The new electronic case management system used in treatment services is able to collect data on assessment of injecting status, BBV interventions and other health concerns.

Conclusions and recommendations

Even though the level of injecting-related equipment sharing has declined, large numbers of PWID continue to report injecting practices that put them at risk of acquiring infections. Bacterial infections remain a problem among PWID.

HIV, hepatitis B and C infections are also continuing to occur among PWID.

Combined data from across the UK suggest that around one in six PWID have been infected with hepatitis B and about half with hepatitis C. They also indicate that at around one in 100 has HIV. Interventions that aim to prevent infections among PWID therefore need to be sustained and the levels of provision reviewed to ensure adequate coverage.

Priorities

4 Immunisation for hepatitis A/B should as widely available as possible to the PWID population and their families that do not access CDAT (e.g.: through Needle exchanges, Pharmacies, Drug & Alcohol Treatment services, GP practices).
5 All PWID should be able to access needle exchange facilities and be given high quality advice and information on safer injecting techniques.
6 All clients of drug & alcohol treatment services should have access to DSBT.
7 Treatment services for viral hepatitis must be accessible and available to all, including those groups that may find it hard to engage in existing services.
8 Local data specific to CIOS is collected and collated to inform future commissioning decisions regarding provision of specific treatment services.
9 Ensure that adjunctive provision for infections associated with injecting behaviour are in place e.g.: tissue viability and specialist wound care nursing, training in detection and treatment for GP practice staff and pharmacists.
Overdose Call-outs

In previous years we have been able to obtain details of call-outs to suspected incidents of drug and alcohol overdose by South West Ambulance Service Trust. We have been advised that information for 2011 will not be available until April 2012.

These were the key findings from the 2010 data:

- 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-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

From 2004 all Drug and Alcohol Action Teams are required by the Department of Health and Home Office to have in place a system of monitoring and surveillance of all drug related deaths within their area of responsibility.

All Drug and Alcohol Action Teams, Police and Department of Health work to the standard definition of a drug related death ‘deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971, as amended, were involved’.

In 2009 a new database was set up to routinely record all drug related deaths throughout Devon and Cornwall. This database is maintained by Devon and Cornwall Police with researchers appointed to trawl daily occurrence logs and input suspected drug related deaths. Cornwall & IOS DAAT has access to this database and has also back recorded onto the database all Cornwall & IOS drug related deaths since 2004. The database was updated during 2011 to ease search facilities and continues to be an effective monitoring tool.

The system of monitoring and surveillance of drug related deaths introduced by Cornwall & IOS DAAT and known as ‘The Cornwall Model’ continues to be effective and is acknowledged and recommended by the National Treatment Agency (NTA) as good practice. This model was subject of a national review by the NTA in July 2009 and a report on its findings is included at Appendix B. A further review conducted by the NTA in 2011 has declared the Cornwall DAAT process as ‘gold standard’.

32 Based on provisional diagnosis by SWAST clinicians
33 An opiate antagonist that reverses the effects of opiate based drugs
Chapter 8 – Harm reduction

This report is prepared in draft for consideration by the Cornwall Drug Related Deaths Review Panel on 20th December 2011 and to be included in the planning process for the 2012-2013 DAAT annual plan.

The following table shows all deaths reported in 2011:

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total suspected drug</td>
<td>20</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>related deaths reported</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmed / suspected</td>
<td>9</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>non drug related deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin / and methadone</td>
<td>7</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Methadone only</td>
<td>2</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Other controlled drug</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>MDMA + other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTA/Suicide + CD</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Phenobarbitone</td>
<td></td>
<td></td>
<td>(traces cannabis)</td>
</tr>
<tr>
<td>Heroin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total drug related</td>
<td>11</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

% Increase or Reduction

<table>
<thead>
<tr>
<th>Reduction 38% from 2010</th>
<th>Increase 38% from 2009</th>
<th>Reduction 27% from 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The new Devon and Cornwall database assists in screening out most non-relevant deaths that do not involve controlled drugs. Of those reported throughout 2011 as suspected to be drug related 8 are confirmed as not drug related deaths and one awaits confirmation but is strongly thought to be a non-drug related medical episode and this is included in the above table taking the total non-drug related deaths to 9.

- The number of recorded drug related deaths shows an overall reduction of 38% from 2010 (11 compared with 18 in 2010). Included within the currently recorded drug related deaths are three suspected heroin/morphine deaths.

Preliminary enquiries suggest these three to be drug related and have been included to identify the most current drug related deaths and what may be considered the ‘worst case scenario’. However it is possible some of these may transpire not to be drug related and the figures presented within this report may be even more favourable.

- Deaths from heroin have decreased by 2 to a total of 7 which represents a reduction of 22%.
- Deaths from methadone overdose also decreased by 5 to a new total of 2 which represents a 71% reduction and is the lowest number of methadone deaths since 2006.

It is not possible to identify reasons for the above decreases however it is considered that increasing numbers into treatment, improving care co-ordination and planning whilst in treatment, together with overdose awareness campaigns and specific projects have a bearing.

- Of the 11 recorded drug related deaths 5 were in treatment for drug dependency at the time of their death and one other had been discharged from treatment following residential de-toxification.
- 5 had no previous involvement with any known treatment provider nor were they awaiting appointments for assessment for any such treatment.
The following tables offer a brief synopsis of the recorded 2011 deaths:

### Males

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Drug Related Deaths</td>
<td>11</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age</td>
<td>35.8</td>
<td>40.3</td>
<td>27.09</td>
</tr>
<tr>
<td>Oldest</td>
<td>47 (4x40+ yrs)</td>
<td>64 (5x40+yrs)</td>
<td>39</td>
</tr>
<tr>
<td>Youngest</td>
<td>24</td>
<td>29</td>
<td>27</td>
</tr>
<tr>
<td>Males – heroin/alcohol/benzos</td>
<td>7</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Males – methadone</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Males – other controlled drug</td>
<td>2</td>
<td>2 (cocaine)</td>
<td>2 (traces cannabis)</td>
</tr>
<tr>
<td>Males in Treatment</td>
<td>5</td>
<td>5 (inc 1 ref/assessed)</td>
<td>4 + 1 referred not seen</td>
</tr>
</tbody>
</table>

### Females

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Drug Related Deaths</td>
<td>11</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age</td>
<td>24</td>
<td>27.5</td>
<td>29.75</td>
</tr>
<tr>
<td>Oldest</td>
<td>24</td>
<td>31</td>
<td>49</td>
</tr>
<tr>
<td>Youngest</td>
<td>24</td>
<td>24</td>
<td>17</td>
</tr>
<tr>
<td>Females – heroin/alcohol/benzos</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Females – methadone</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Females – other controlled drug</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Females in Treatment</td>
<td>0</td>
<td>2</td>
<td>3 + 1 referred not seen</td>
</tr>
</tbody>
</table>

### England & Wales


<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Drug Related Deaths</td>
<td>1784</td>
<td>1876</td>
<td>1939</td>
</tr>
<tr>
<td>Male</td>
<td>1382</td>
<td>1512</td>
<td>1506</td>
</tr>
<tr>
<td>Female</td>
<td>402</td>
<td>364</td>
<td>433</td>
</tr>
</tbody>
</table>

DAAT has introduced or been involved in a number of new initiatives throughout 2011 aimed at preventing and reducing drug related deaths these are outlined within section 6 of the main report.

All DAAT areas are required to prepare an annual report identifying the process of recording and inquiry into drug related deaths together with any preventative measures introduced. This is the report prepared by the Cornwall and IOS Drug and Alcohol Action Team.
Hospital admissions

Drug-related 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.

Data extraction criteria

The data extraction criteria for drug related hospital admissions used for this report are the same as were used for the 2011 report.

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: In this report the number hospital ‘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 than ‘episodes’ would.

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 (table 1). Admissions to Cornwall Partnership Foundation Trust have fallen. The greatest rise (27%) has occurred between 2009/10 and 2010/11.

<table>
<thead>
<tr>
<th></th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospitals NHS Trust</td>
<td>190</td>
<td>225</td>
<td>286</td>
</tr>
<tr>
<td>Cornwall Partnership NHS Foundation Trust</td>
<td>39</td>
<td>23</td>
<td>19</td>
</tr>
<tr>
<td>Plymouth Hospitals NHS Trust</td>
<td>39</td>
<td>56</td>
<td>75</td>
</tr>
<tr>
<td>Other providers</td>
<td>9</td>
<td>&lt;5</td>
<td>10</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>277</td>
<td>308</td>
<td>390</td>
</tr>
</tbody>
</table>

Drug-related admissions by type of substance

- Between 2008/09 and 2010/11, ‘opioids’ have formed the most common drug group leading to drug-related hospital admissions, accounting for 47% of total drug-related admissions in the three year period (table 2).
In 2010/11, ‘Cannabinoids’ was the second most common group of substances linked to drug related hospital admissions, followed by ‘other stimulants’, and ‘Multiple drug use and other Psychoactive substances’.

The proportion of total drug-related admissions attributed to ‘multiple drug use and other psychoactive substances’ has fallen over the last three years, from 23% to 11% (and from 34% four years ago, as reported in last year’s health needs assessment), whereas the proportion attributed to Cannabinoids has risen from 9% to 19% (from 85 four years ago).

Admissions associated with the use of ‘other stimulants’ rose sharply in 2009/10 and 2010/11.

### Table 2. Drug related admissions by substance and year of admission

<table>
<thead>
<tr>
<th>Substance</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids</td>
<td>127</td>
<td>157</td>
<td>174</td>
<td>458</td>
<td>47</td>
</tr>
<tr>
<td>Cannabinoids</td>
<td>26</td>
<td>47</td>
<td>74</td>
<td>147</td>
<td>15</td>
</tr>
<tr>
<td>Sedatives or hypnotics</td>
<td>23</td>
<td>17</td>
<td>15</td>
<td>55</td>
<td>6</td>
</tr>
<tr>
<td>Cocaine</td>
<td>19</td>
<td>&lt;5</td>
<td>14</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other Stimulants</td>
<td>14</td>
<td>38</td>
<td>57</td>
<td>109</td>
<td>11</td>
</tr>
<tr>
<td>Hallucinogens*</td>
<td>-</td>
<td>-</td>
<td>12</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Volatile Solvents*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>MDU/other Psychoactive Substances</td>
<td>63</td>
<td>45</td>
<td>43</td>
<td>151</td>
<td>15</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>277</td>
<td>308</td>
<td>390</td>
<td>975</td>
<td>100</td>
</tr>
</tbody>
</table>

NB Some data have been suppressed for reasons of data confidentiality, to avoid identifying small numbers. Percentages may not add up to 100% due to rounding.

### 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).
- There have been more admissions of males than females for all substance groups except ‘sedatives or hypnotics’ which resulted in more female admissions and ‘hallucinogens’ and ‘volatile solvents’ which account for small numbers and are equally distributed between males and females (chart 1).

### Table 3. Drug related admissions by sex

<table>
<thead>
<tr>
<th></th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>178</td>
<td>194</td>
<td>264</td>
<td>636</td>
<td>65</td>
</tr>
<tr>
<td>Female</td>
<td>99</td>
<td>114</td>
<td>126</td>
<td>339</td>
<td>35</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>277</td>
<td>308</td>
<td>390</td>
<td>975</td>
<td>100</td>
</tr>
</tbody>
</table>

Chart 1. Drug related admissions by substance and sex, years 2008/9–2010/11 pooled.
Types of admission

Admission types are defined as follows:

1 **Elective admissions**, where the decision to admit is separated in time from the actual admission. These could be
   - ‘Waiting list’
   - ‘Booked’, or
   - ‘Planned’.

2 **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

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

4 Admissions by other means

Admissions have been grouped under the four headings described above and plotted in chart 2.

- The most common type of drug-related admissions are emergency admissions
- Within the group ‘emergency admissions’ 75% are admitted via A&E (or dental casualty department). Nearly half (47%) of all drug-related hospital admissions over the three years were admitted as emergencies via A&E. Clarify which % is correct with Sara Roberts
- Numbers of admissions through all routes (except the small numbers classified as ‘other means’) have increased between 2008/09 and 2010/11.

Chart 2. Types of drug-related admissions

![Chart showing types of drug-related admissions from 2008/09 to 2010/11](image)
Drugs misuse and the risk of suicide and self harm

Suicide

The national suicide prevention strategy consultation paper in July 2011 stated that at a local level ‘measures that reduce alcohol and drug dependence are critical to reducing suicide’.

Drug use can increase suicide risk in three ways:
- Many people with drug and alcohol dependence problems also have some form of mental health problem;
- Drug use can increase impulsive and risk taking behaviour so people may be more likely to take their own life while under the influence of drugs;
- Drugs themselves can be used as a method of suicide.

People suffering from depression combined with substance abuse should be monitored closely for signs of suicide. Training is available through the ASIST programme in Cornwall and Isles of Scilly for people to develop the skills and confidence to recognise the signs and to respond appropriately.

Drug-related poisoning is the second most common method of suicide (after hanging) in England, the South West and Cornwall and Isles of Scilly. The drugs most commonly used as a means of suicide are prescribed drugs, followed by drugs of abuse and then over the counter drugs (see next chart).

- In the South West between 2001 and 2009 there were 136 male deaths and 85 female deaths by suicide or undetermined intent due to poisoning by drugs of abuse.
- Over that nine year period suicides due to poisoning by drugs of abuse declined slightly in men but increased slightly in women.

Trends in numbers of suicides and undetermined deaths from poisoning, gases, fire and smoke in persons aged 15 and over, by sex, in the South West, 2001–09

![Graph showing trends in numbers of suicides and undetermined deaths from poisoning, gases, fire and smoke in persons aged 15 and over, by sex, in the South West, 2001–09.](chart.png)

Source: Data: ONS Public Health Mortality File; Calculations: South West Public Health Observatory
Self harm

There is a complex relationship between self harm and suicide. Some people harm themselves as a way of dealing with distress but with no intention to die; others harm themselves as a failed suicide attempt. Statistics about self harm cannot distinguish between the two.

Self harm methods leading to hospital admissions are dominated by poisoning. From 2006/07 to 2008/09, poisoning accounted for 88% of male admissions and 93% of female hospital admissions for self harm in the South West. While there might be some accidental poisonings, over 90% of hospital admissions for self poisoning were coded as intentional.

- Most admissions for self harm by drug poisoning are by prescribed or over the counter drugs (unlike completed suicides, where over the counter drugs are the least likely to have been used), and admissions for both have been rising (see chart below).
- Although lower in number, admissions for poisoning by drugs of abuse have also been rising for males and females.

Trends in numbers of admissions for self-harm from poisoning, gases, fire and smoke in patients aged 15 and over, by sex, in the South West, 2001/02 to 2008/09

Note: Several causes have numbers too small to be seen on the graph.
Source: Data: Hospital Episode Statistics; Calculations: South West Public Health Observatory
Appendices
Appendix A – 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 ‘snapshot’ used for this assessment was drawn on 1 April 2011.

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 (provided quarterly).

National comparisons of crime rate per 1000 population are made using the Home Office ‘iQuanta’ family groupings\(^34\), 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.

---

\(^{34}\) 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 CSPs to compare their crime performance with other Police forces, BCU and CSPs with similar characteristics, by grouping them into ‘families’.
## Appendix B

### Population features by locality

<table>
<thead>
<tr>
<th>Factor</th>
<th>North &amp; East</th>
<th>Central</th>
<th>West</th>
<th>CIOS</th>
<th>North &amp; East</th>
<th>Central</th>
<th>West</th>
<th>CIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young adults (18 to 24)</td>
<td>15%</td>
<td>13%</td>
<td>10%</td>
<td>13%</td>
<td>64</td>
<td>95</td>
<td>57</td>
<td>215</td>
</tr>
<tr>
<td>Females</td>
<td>32%</td>
<td>28%</td>
<td>31%</td>
<td>30%</td>
<td>137</td>
<td>200</td>
<td>176</td>
<td>515</td>
</tr>
<tr>
<td>OCU</td>
<td>72%</td>
<td>67%</td>
<td>76%</td>
<td>73%</td>
<td>334</td>
<td>484</td>
<td>428</td>
<td>1245</td>
</tr>
<tr>
<td>Stimulants (non-OCU)</td>
<td>13%</td>
<td>12%</td>
<td>15%</td>
<td>16%</td>
<td>54</td>
<td>144</td>
<td>82</td>
<td>281</td>
</tr>
<tr>
<td>Primary cannabis</td>
<td>10%</td>
<td>14%</td>
<td>10%</td>
<td>12%</td>
<td>43</td>
<td>99</td>
<td>58</td>
<td>291</td>
</tr>
<tr>
<td>Adjuvant alcohol</td>
<td>22%</td>
<td>32%</td>
<td>31%</td>
<td>30%</td>
<td>95</td>
<td>228</td>
<td>177</td>
<td>514</td>
</tr>
<tr>
<td>Injecting</td>
<td>57%</td>
<td>53%</td>
<td>62%</td>
<td>57%</td>
<td>243</td>
<td>380</td>
<td>351</td>
<td>979</td>
</tr>
<tr>
<td>In treatment 4+ years</td>
<td>23%</td>
<td>22%</td>
<td>33%</td>
<td>27%</td>
<td>98</td>
<td>162</td>
<td>189</td>
<td>456</td>
</tr>
<tr>
<td>Dual diagnosis (Yes)</td>
<td>16%</td>
<td>12%</td>
<td>10%</td>
<td>12%</td>
<td>69</td>
<td>87</td>
<td>55</td>
<td>209</td>
</tr>
<tr>
<td>Parents / live with children</td>
<td>30%</td>
<td>23%</td>
<td>26%</td>
<td>26%</td>
<td>127</td>
<td>164</td>
<td>146</td>
<td>441</td>
</tr>
<tr>
<td>Parents but not living with children</td>
<td>8%</td>
<td>10%</td>
<td>7%</td>
<td>8%</td>
<td>32</td>
<td>73</td>
<td>38</td>
<td>141</td>
</tr>
<tr>
<td>Not parents</td>
<td>19%</td>
<td>32%</td>
<td>22%</td>
<td>26%</td>
<td>81</td>
<td>232</td>
<td>125</td>
<td>443</td>
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<tr>
<td>TOPs in year</td>
<td>76%</td>
<td>82%</td>
<td>78%</td>
<td>80%</td>
<td>320</td>
<td>590</td>
<td>443</td>
<td>1370</td>
</tr>
<tr>
<td>Physical health rating 10+</td>
<td>80%</td>
<td>77%</td>
<td>74%</td>
<td>77%</td>
<td>257</td>
<td>453</td>
<td>329</td>
<td>1053</td>
</tr>
<tr>
<td>Physical health average rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.6</td>
<td>11.9</td>
<td>11.9</td>
<td>12.1</td>
</tr>
<tr>
<td>Emotional health rating 10+</td>
<td>83%</td>
<td>75%</td>
<td>75%</td>
<td>77%</td>
<td>267</td>
<td>440</td>
<td>332</td>
<td>1052</td>
</tr>
<tr>
<td>Emotional health average rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.7</td>
<td>11.8</td>
<td>11.6</td>
<td>12.0</td>
</tr>
<tr>
<td>Discharged</td>
<td>47%</td>
<td>44%</td>
<td>43%</td>
<td>45%</td>
<td>198</td>
<td>320</td>
<td>243</td>
<td>777</td>
</tr>
<tr>
<td>Successful completions</td>
<td>47%</td>
<td>58%</td>
<td>44%</td>
<td>52%</td>
<td>93</td>
<td>186</td>
<td>108</td>
<td>405</td>
</tr>
<tr>
<td>Unsuccessful completions</td>
<td>45%</td>
<td>39%</td>
<td>47%</td>
<td>44%</td>
<td>89</td>
<td>125</td>
<td>114</td>
<td>342</td>
</tr>
<tr>
<td>Referred on</td>
<td>11%</td>
<td>10%</td>
<td>14%</td>
<td>11%</td>
<td>22</td>
<td>32</td>
<td>34</td>
<td>89</td>
</tr>
<tr>
<td>Drop-outs</td>
<td>41%</td>
<td>32%</td>
<td>40%</td>
<td>37%</td>
<td>82</td>
<td>101</td>
<td>96</td>
<td>291</td>
</tr>
<tr>
<td>Triaged</td>
<td>36%</td>
<td>34%</td>
<td>35%</td>
<td>36%</td>
<td>151</td>
<td>248</td>
<td>195</td>
<td>618</td>
</tr>
<tr>
<td>Regular employment</td>
<td>11%</td>
<td>10%</td>
<td>8%</td>
<td>12%</td>
<td>17</td>
<td>39</td>
<td>16</td>
<td>74</td>
</tr>
<tr>
<td>Unemployed</td>
<td>54%</td>
<td>54%</td>
<td>57%</td>
<td>57%</td>
<td>81</td>
<td>133</td>
<td>111</td>
<td>350</td>
</tr>
<tr>
<td>Economically inactive</td>
<td>24%</td>
<td>24%</td>
<td>13%</td>
<td>17%</td>
<td>31</td>
<td>51</td>
<td>25</td>
<td>105</td>
</tr>
<tr>
<td>Homeless</td>
<td>1%</td>
<td>4%</td>
<td>7%</td>
<td>5%</td>
<td>2</td>
<td>11</td>
<td>13</td>
<td>33</td>
</tr>
<tr>
<td>Accommodation problem</td>
<td>9%</td>
<td>10%</td>
<td>12%</td>
<td>10%</td>
<td>13</td>
<td>25</td>
<td>24</td>
<td>63</td>
</tr>
<tr>
<td>Currently injecting</td>
<td>24%</td>
<td>13%</td>
<td>23%</td>
<td>21%</td>
<td>36</td>
<td>31</td>
<td>45</td>
<td>127</td>
</tr>
<tr>
<td>Self</td>
<td>25%</td>
<td>35%</td>
<td>26%</td>
<td>28%</td>
<td>38</td>
<td>86</td>
<td>50</td>
<td>174</td>
</tr>
<tr>
<td>GP</td>
<td>32%</td>
<td>22%</td>
<td>30%</td>
<td>27%</td>
<td>48</td>
<td>55</td>
<td>58</td>
<td>166</td>
</tr>
<tr>
<td>Criminal Justice</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>13%</td>
<td>21</td>
<td>35</td>
<td>28</td>
<td>81</td>
</tr>
</tbody>
</table>
Appendix C
Further reading

Evidence papers from the Community Safety Strategic Assessment can be viewed and downloaded from the Amethyst website [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.

Kernow Matters 2011, the needs assessment that underpins the Children and Young People’s Plan can be downloaded from the Children’s Trust website [www.cornwallchildrenstrust.org.uk](http://www.cornwallchildrenstrust.org.uk).

The current Young People’s Specialist Substance Misuse Needs Assessment can also be downloaded from the Children’s Trust pages.

The Supporting People Sector Review Report can be downloaded from [www.cornwall.gov.uk/default.aspx?page=24872](http://www.cornwall.gov.uk/default.aspx?page=24872). Of particular interest are Appendix 10 (Substance Misuse) and also Appendix 4 (Homelessness), Appendix 6 (Mental Health) and Appendix 7 (Offenders).

Appendix D – Treatment Outcomes Profile (TOP) form

### Treatment Outcomes Profile

<table>
<thead>
<tr>
<th>Client ID</th>
<th>D.O.B. (dd/mm/yyyy)</th>
<th>Name of keyworker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td></td>
</tr>
</tbody>
</table>

**TOP interview date (dd/mm/yyyy):**
- [ ] Treatment start
- [ ] Review
- [ ] Treatment exit
- [ ] Post-treatment exit

#### Section 1: Substance use

(Use NA only if information is not disclosed or not answered.)

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

<table>
<thead>
<tr>
<th>Substance</th>
<th>Average</th>
<th>Week 4</th>
<th>Week 3</th>
<th>Week 2</th>
<th>Week 1</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

(Use NA only if information is not disclosed or not answered.)

Record number of days client injected non-prescribed drugs in past four weeks (If no, enter zero and ‘N’, and go to section 3)

<table>
<thead>
<tr>
<th>Injected</th>
<th>Week 4</th>
<th>Week 3</th>
<th>Week 2</th>
<th>Week 1</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-28</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inject with needle or syringe used by someone else?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inject using a spoon, water or filter used by someone else?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Section 3: Crime

(Use NA only if information is not disclosed or not answered.)

Record days of shoplifting, drug selling and other categories committed in past four weeks

<table>
<thead>
<tr>
<th>Crime</th>
<th>Week 4</th>
<th>Week 3</th>
<th>Week 2</th>
<th>Week 1</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoplifting</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-28</td>
</tr>
<tr>
<td>Drug selling</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-28</td>
</tr>
<tr>
<td>Theft from or of a vehicle</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other property theft or burglary</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fraud, forgery and handling stolen goods</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Committing assault or violence</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Section 4: Health and social functioning

(Use NA only if information is not disclosed or not answered.)

<table>
<thead>
<tr>
<th>Category</th>
<th>Poor</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients' rating of psychological health status (anxiety, depression and problem emotions and feelings)</td>
<td>0-20</td>
<td>0-20</td>
</tr>
</tbody>
</table>

Record days worked and at college or school for the past four weeks

<table>
<thead>
<tr>
<th>Work</th>
<th>Week 4</th>
<th>Week 3</th>
<th>Week 2</th>
<th>Week 1</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days paid work</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-7</td>
<td>0-28</td>
</tr>
<tr>
<td>Days attended college or school</td>
<td>0-7</td>
<td>0-7</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client's rating of physical health status (extent of physical symptoms and bothered by illness)</th>
<th>Poor</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Record accommodation items for the past four weeks

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute housing problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At risk of eviction</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner)</th>
<th>Poor</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix D – Treatment Outcomes Profile (TOP) form

# Treatment Outcomes Profile (TOP)

## National Treatment Agency for Substance Misuse

### 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 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-returns 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: when 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.nta.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, bear or cider</td>
<td>3.5</td>
<td>2</td>
</tr>
<tr>
<td>Pint strong lager, bear 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, bear 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>0</td>
<td>0</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
## Appendix E – Summary of progress against 2010/11 priorities

### Improving access to treatment

<table>
<thead>
<tr>
<th>Action</th>
<th>2011-12 update</th>
<th>Comment and future developments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater frequency and flexibility of contact and appointments</td>
<td>Services have redesigned to enable them to deliver more frequent and flexible treatment.</td>
<td>The re-design process in two services has delivered increased availability and flexibility for PDUs. However, in a third it has not delivered the required results and Service users describe the appointment system ‘a nightmare’. Continues to require greater improvements.</td>
</tr>
<tr>
<td>Daily activities in support of recovery plans, including education, training, skills, psychosocial interventions and group</td>
<td>Daily activity programmes available in Liskeard, Truro and Penzance for people in treatment and in Redruth for people in recovery.</td>
<td>Evaluate degree to which these meet needs for Criminal Justice clients and other localities. In development for Newquay.</td>
</tr>
<tr>
<td>Taster sessions of treatment and recovery interventions open to all</td>
<td>Available in Liskeard, Truro and Penzance for people in treatment and in Redruth for people in recovery</td>
<td>Increasing the range and improving information about what is available.</td>
</tr>
<tr>
<td>Recovery maps for all to describe the system, how it works and routes of progression through it</td>
<td>First edition drafted.</td>
<td>Making available on websites.</td>
</tr>
<tr>
<td>Individually tailored packages of treatment and care drawn from a menu of service provision</td>
<td>All service users have a Recovery Care Plan. Majority know what one is. Quality varies enormously. Very few specialist services are involving others in care plans. Hampered by delays in loading onto electronic case management system (ECMS)</td>
<td>Improving the quality of Recovery Care Plans. Making available on the ECMS.</td>
</tr>
<tr>
<td>Volunteers and peer mentors to support people in accessing the services they require and engaging with help</td>
<td>Volunteers trained and operating. Peer mentoring in development.</td>
<td></td>
</tr>
<tr>
<td>Preparation for change groups and individual interventions</td>
<td>Preparation for change leaflet and manual produced.</td>
<td>More groups required, particularly preparing for detox. Commissioned for 2012-13</td>
</tr>
<tr>
<td>Post-Detox Support Groups and individual support to maximise the gains from treatment interventions</td>
<td>PODS review due to report.</td>
<td>Insufficient post detox support available. Commissioned for 2012-13 as a priority.</td>
</tr>
<tr>
<td>Aftercare support groups and individual interventions to maintain recovery</td>
<td>Not developed sufficiently. Cited again in this year’s needs assessment.</td>
<td>Commissioned for 2012-13 as a priority.</td>
</tr>
</tbody>
</table>
### Attract and proactively engage earlier/increase self referrals for people using illicit drugs

**Overarching aim:** to 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, as detailed below:

<table>
<thead>
<tr>
<th>Action</th>
<th>2011-12 update</th>
<th>Comment and future developments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of overall progress</strong></td>
<td>Self referral has increased significantly, but still lower than regional and national average.</td>
<td>Continues to be a priority. Need to aim at engaging younger adults and specify better what is on offer.</td>
</tr>
<tr>
<td><strong>Free, confidential telephone helpline</strong></td>
<td>Addaction, the Freshfield Service and Coastline operate helplines. Coastline 24hr.</td>
<td>Confusion regarding which service to use and entry points into system. One point of contact required with out of hours support for people in treatment and in aftercare/recovery.</td>
</tr>
<tr>
<td><strong>Drop in access</strong></td>
<td>Available in Liskeard, Bodmin, Truro, Redruth, Penzance, St Austell</td>
<td>Daily availability to be developed in Newquay and investigation of needs in North Cornwall.</td>
</tr>
<tr>
<td><strong>Outreach;</strong></td>
<td>Services were commissioned to re-engage people at risk of dropping out of treatment or who had recently dropped out. Peer mentoring introduced by Addaction.</td>
<td>Drop out rates still high and plans now being put in place to reduce drop outs and support early re-engagement.</td>
</tr>
<tr>
<td><strong>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</strong></td>
<td>Recovery map drafted to describe the local system with clearer routes. Pathways drafted for families, tier 4, dual diagnosis and employment.</td>
<td>Pathways now in development for people requiring more intensive and flexible treatment and for stimulant users and housing.</td>
</tr>
<tr>
<td><strong>Peer mentors and mutual aid</strong></td>
<td>Peer mentors and Mutual Aid Programme (MAP) now delivered through Addaction.</td>
<td>Increased availability of NA still required in localities.</td>
</tr>
</tbody>
</table>

### Delivering recovery and progress within treatment

#### Recovery programmes

**Overarching aim:** To provide choice of recovery programmes in each locality to enable the delivery of individualised packages of care

<table>
<thead>
<tr>
<th>Action</th>
<th>2011-12 update</th>
<th>Comment and future developments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To provide a choice of recovery programmes in each locality, to include:</strong></td>
<td>Chose MAP instead of SMART, on advice of service users who tested both. Mindfulness available. More NA groups required. Recovery Cafes now available.</td>
<td>Ensure NA are aware of premises available for groups.</td>
</tr>
<tr>
<td>• SMART Recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mindfulness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 12 step programmes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Achieving positive outcomes and successful completions

Overarching 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 (detailed below).

<table>
<thead>
<tr>
<th>Action</th>
<th>2011-12 update</th>
<th>Comment and future developments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of overall progress</td>
<td>Successful completions increasing, but not much above national average rate of</td>
<td>Increased priority. Services required to review outcomes performance.</td>
</tr>
<tr>
<td></td>
<td>improvement. First outcomes report just received and shows deterioration in outcomes in injecting and drug use.</td>
<td></td>
</tr>
<tr>
<td>Skills development</td>
<td>This has been a huge priority and development in 2012-13. Life skills co-ordinators</td>
<td>Continues to develop. Housing largest element to focus upon improving.</td>
</tr>
<tr>
<td>Meaningful activities</td>
<td>Joint JC+/treatment initiative All addressing pathways to work and ETE.</td>
<td></td>
</tr>
<tr>
<td>Education and training initiatives</td>
<td>Supported Accommodation initiatives still to be re-commissioned.</td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation – tiered levels of support to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>secure and sustain accommodation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevent the spread of blood borne viruses</td>
<td>Immunisation programme commenced. Dry blood spot testing commenced. Numbers</td>
<td>All services can deliver in-house in 20-12-13.</td>
</tr>
<tr>
<td></td>
<td>immunised and tested improved above national average, but still much room to improve.</td>
<td>Task Group to continuie to focus.</td>
</tr>
<tr>
<td>Reduce drug related deaths</td>
<td>Numbers reduced OD DVD produced</td>
<td>Mobile scheme commissioned (HCV).</td>
</tr>
</tbody>
</table>

Improving outcomes for children and families

Overarching 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.

<table>
<thead>
<tr>
<th>Training staff in services for children and families in screening and identification for substance use</th>
<th>Alcohol screening tool approved for adults. IBA e-learning started. Improved recording system for CFS in development. No SM tools found yet. Training for CFS started.</th>
<th>Select the drug screening tool. Systematic training programme.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish a single point of contact into treatment</td>
<td>Established.</td>
<td></td>
</tr>
</tbody>
</table>
### Delivering parenting and family interventions for families affected by substance misuse

- Parenting programme
- Family Interventions
- Breaking the Cycle
- MPACT Family programme
- Family Conferencing available for Chy residents

- Demand for services far exceeds supply. Additional capacity commissioned for 2012-13.

---

### Improving outcomes for communities and reducing reoffending

<table>
<thead>
<tr>
<th>Action</th>
<th>2011-12 update</th>
<th>Comment and future developments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Offender Management (IOM) is a system that provides all</td>
<td>Project Board agreed a plan with leads.</td>
<td>Official peninsula launch of TurnAround in May 2012. This is discussed in detail within the</td>
</tr>
<tr>
<td>agencies engaged in local criminal justice partnerships with a single</td>
<td>Task group formed.</td>
<td>assessment.</td>
</tr>
<tr>
<td>coherent structure for the management of repeat offenders</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>