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

SAFER CORNWALL
Gwrians rag Kernow moy salow

CORNWALL & ISLES OF SCILLY ALCOHOL NEEDS ASSESSMENT 2012/13

one and all · onen hag oll
CORNWALL COUNCIL

Cornwall and Isles of Scilly NHS
Primary Care Trust

AMETHYST

Acknowledgements

Needs Assessment prepared by the Drug and Alcohol Action Team Needs Assessment Expert Group (alphabetically by organisation):

Anna Whitton	Addaction	Regional Manager
Jeremy Booker	Bosence / Boswyns	Manager
Alex Arthur	Cornwall Council	Analyst, Community Safety Team
Penni Barker	Cornwall Council	13-19 Commissioning Manager, Children, Schools and Families
Erika Sorensen	Cornwall Council	Analyst Manager, Community Safety Team
Angela Andrews	DAAT	Primary Care Development Manager
Jez Bayes	DAAT	Alcohol Strategy Co-ordinator
Kim Hager	DAAT	Commissioning Manager
Howard Stevens	DAAT	Drug-related Deaths Co-ordinator
Robert Daws	Freshfield Service	
Richard Chidwick	National Treatment Agency	Regional Manager (South West)
Sara Roberts	NHS Cornwall & Isles of Scilly	Associate Director of Public Health

Contents

Introduction 4
Strategic and legislative context 5
Commissioning priorities and objectives 7
The delivery landscape 11
Local context 13
Local Alcohol Profile 14
1: Advice and Information 16
2: Anti-social behaviour 20
3: Children, young people, parents and families 22
4: Community safety schemes 29
5: Criminal justice interventions 33
6: Domestic abuse and sexual violence 37
7: Employment and deprivation 40
8: Health, treatment, aftercare and recovery 42
9: Homelessness and housing 53
10: Licensing, alcohol retail and the night time economy 54
Cornwall profile – facts and figures 59
Further reading 63
Appendix A - Alcohol Diversions for offenders 64
Appendix B Report to HASCOSC 66

Introduction

How to use this assessment

This needs assessment has been **structured around the ten themes** in the Alcohol Strategy. It aids understanding about the wide-reaching impacts of alcohol, considers the range and effectiveness (where possible) of the services in place to address them and explores future threats and opportunities.

Under each thematic area, you will find **key findings** brought together from a wide range of research and analysis relevant to the topic. These have been designed to be used as standalone reference papers and there is no separate Executive Summary.

The priorities drawn from the evidence are presented under Commissioning Priorities.

What is needs assessment?

Needs assessment is the cornerstone of evidence-informed commissioning.

It is based on:

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

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 needs assessment is to examine, as systematically as possible, what the relative needs and harms are within different groups and settings, and make

evidence-based and ethical decisions on how needs might be most effectively met within available resources.

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

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

- What works well, and for whom in the current system, and what the unmet needs are across the system, in both community and prison settings
- Where there are gaps for alcohol clients in the wider reintegration and treatment system
- Where the system is failing to engage and / or retain people
- Who are the hidden populations and what are their risk profiles
- What are the enablers and blocks to treatment, reintegration and recovery pathways
- What is the relationship between treatment engagement and harm profiles (LAPE)

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

Strategic and legislative context

Reducing the harms of alcohol has been a priority in Cornwall for many years and our first Alcohol Harm Reduction Strategy was published in 2006. Our current alcohol strategy "Taking Responsibility for Alcohol[1]" draws on evidence compiled for the Alcohol Needs Assessment and has three overarching objectives:

- Enable people to make informed choices about alcohol
- Improve services to reduce the harm caused by alcohol
- Promote partnerships to reduce alcohol's impact on the community

The Alcohol Needs Assessment is one of the evidence sources within the Joint Strategic Needs Assessment[2] and **alcohol has also been identified as a priority area in the Health and Wellbeing Strategy** (that the JSNA supports) under the outcome "Helping People to Live Longer, Happier and Healthier Lives."

Arranged around ten themes, the Cornwall Alcohol Strategy addresses preventative and early intervention issues such as education and advice; covers responsible retail, licensing and enforcement; incorporates treatment and housing; and includes reducing the impacts of alcohol-related harm on families and communities. This assessment is arranged around the same ten themes.

Our local alcohol strategy is set within the context of the national response to alcohol issues, with the recent publication of the Government's 2012 Alcohol

[1] The strategy and the needs assessment will be available to view and download from the alcohol pages of the Safer Cornwall website
[2] The Cornwall Council website provides more information on the Joint Strategic Needs Assessment and an online resource library of assessments and focus papers

Strategy. This is the Coalition's new approach to reducing the number of people drinking above health guidelines or to excess. They intend to **reduce alcohol-fuelled violent crime, binge drinking, alcohol-related deaths and underage drinking**.

Measures introduced include a consultation on **minimum alcohol unit pricing**, and **greater control on alcohol retail offers** and advertising.

Local alcohol policies will be given greater strategic importance through Health and Wellbeing Boards and Joint Strategic Needs Assessments, embedded within the Public Health Grant and Outcomes. **Health will have more input in licensing decisions**, and Criminal Justice commitment and funding will be led by the new Police and Crime Commissioners to be elected in November 2012.

The recently passed Police Reform and Social Responsibility Act 2011 introduces new measures to tackle alcohol problems and these will be in place in the autumn for areas to consider using; they include introducing a **late night levy** to help cover the cost of policing the late night economy, **increasing the flexibility of early morning alcohol restriction orders** and **doubling of fines for persistent underage sales**. Local areas will need to consider how to best use the tools available to reduce alcohol problems.

New measures will also be introduced to **increase the range of responses to anti-social behaviour**, and to enable hospital emergency departments to better address on-site alcohol related offences. **Various new sentencing options for alcohol-related offences** will be piloted, and family and youth policies will be introduced.

Education about alcohol will be reviewed along with all other PSHE areas, and responsible drinking messages are now delivered within the 'Change4Life' campaign. **Earlier identification will be promoted through Health Checks** and in key areas such as pregnancy, domestic abuse, and mental health services. Other health issues will be addressed in a Liver Disease Strategy and recovery based 'payment by results' schemes.

Much of this national strategy will develop as we deliver our local strategy. Our challenge will be to incorporate the new national policies and initiatives alongside our commitment to addressing local needs, and the continued development of our own good practice.

Commissioning priorities and objectives

1. Dependent drinkers engaging in treatment (PH Outcome 2.15 and 2.18)

Aim:

Sustain the level of dependent drinkers engaging with treatment services at above the national average.

Objectives:

- To proactively attract and engage dependent drinkers earlier in treatment and thereby reduce the length of time their problems have developed and the length of time required in treatment.
- Sustain referrals and access through GP referral and hospital liaison services.
- Monitor and ensure equality of access across all localities.
- Increase referrals from criminal justice routes, including by court and custody suite activity

2. Delivering sustainable recovery: increasing the numbers of dependent drinkers completing treatment and not re-presenting (PH Outcome 2.15)

Aim:

Sustain the level of dependent drinkers successfully completing treatment at above the national average and reducing the numbers who represent to treatment subsequently.

Objectives:

- Reduce waiting times for detoxification to a maximum of 3 weeks from assessment.
- To ensure all dependent drinkers have access to the full range of detoxification options
- Increase the numbers who detoxify having an recovery aftercare programme in place to 100%
- Increase the numbers engaging in recovery support post detoxification to 80%
- Improve completion rates for those aged 25-44, for those who are unemployed and particularly those who present to treatment as NFA (PH 1.15), as these people have had the poorest completion rates.
- Improve access to residential service provision (both In-Patient and Residential Rehabilitation) **for particular vulnerable groups identified** (those with co-morbid mental health problems, clients with dependent children, young dependent alcohol and drug users, and clients with physical and learning disabilities)

3. Reducing Hospital Admissions (PH Outcome 2.18)

Aim:

3.1 Reduce the number of alcohol-related frequent attendees

Objectives:

This is a targeted approach to address the needs of the highest risk group. Actions include:

- Identification of the most frequently presenting patients;
- Providing an **effective referral pathway** from hospitals to community alcohol treatment in Primary Care and in the community
- Delivering **effective alcohol treatment** in line with the latest evidence-based NICE guidance.[3]
- Promoting the use of Identification and Brief Advice, including a version of the validated toolkit adapted for Royal Cornwall Hospitals Trust.
- Co-ordinated multi-agency case review process;
- Agreed multi-agency care plans to be stored on Royal Cornwall Hospitals Trust IT systems and flagged on the reception system, so that patients are referred back to community treatment and support wherever possible rather than admitted;
- Incorporate this approach into the Emergency Dept Psychiatric Liaison RAID (Rapid Assessment Interface and Discharge) model processes.

Aim:

3.2 Provide advice and information

Objectives:

- Promoting the use of Identification and Brief Advice **in medical settings**, using a version of the validated toolkit adapted for Royal Cornwall Hospitals Trust.
- NICE[4] guidance recommends that screening should target people who are at **increased risk of harm** from alcohol and those with an **alcohol-related condition**.
- The toolkit will be used for agreed evidence-based, **alcohol-related priority health conditions**, such as hypertension and mental and behavioural problems caused by alcohol. This will be used in these settings:
  - Royal Cornwall Hospitals Trust wards;
  - Royal Cornwall Hospitals Trust Emergency Department
  - Minor Injury Units
  - Primary Care
- This is in addition to the continued promotion of IBA in non-health sector community settings targeting vulnerable people, for example people in deprived areas.

4. Children, young people, parents and families

Aim:

Reduce the number of parents and children at risk of the significant harm associated with problematic substance use.

---

[3] All NICE alcohol intervention guidance can be found on the NICE website. A full recommended patient pathway outline can be found here: http://pathways.nice.org.uk/pathways/alcohol-use-disorders

[4] Alcohol-use disorders: preventing the development of hazardous and harmful drinking (NICE, 2010)

To include:

- Improvement in family functioning.
- Improvement in the health and wellbeing of parents and their children.

Objectives:

Provide specialist support for families

- Breaking the Cycle programme, delivered by Addaction. Family support that includes:
  - Prioritisation, assessment and care planning
  - A range of motivational and solution focused interventions
  - Advice and information
  - One-to-one and family support
  - Group work
  - Family mediation
  - Signposting
  - Advocacy
  - Home visits
  - Work with children through coordination with partner agencies and schools
  - Systemic family therapy

- Together for Families in Cornwall (local delivery of the government's Troubled Families programme). 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.

- Other priority areas identified within the needs assessment.

5. Reducing Anti-social behaviour

Aim:

Address alcohol-related anti-social behaviour at the **earliest opportunity** before any criminal line is crossed

Objectives:

Make effective use of enforcement powers and legislation

- Use of the Inebriation Act is being explored to tackle persistent, nuisance drunks for whom other forms of intervention have been ineffective or inappropriate and links them directly into appropriate support.

Take positive action in the community

- **Community safety bulletins** distributed in local communities advising them of what action has been taken in their area to tackle anti-social behaviour
- There are two key over-arching community safety schemes that aim to address anti-social behaviour as part of an overall programme to tackle crime and disorder in persistent problem places in Cornwall: Community Safety Schemes - the "What Will Your Drink Cost?" summer campaign and the multi-agency Safer Towns programmes.

- The three stage escalation process[5] has proven effective in managing anti-social behaviour issues, especially for young people.
- **An alcohol-related anti-social behaviour diversion scheme for young people** is being piloted in the Safer Town areas. The scheme gives an individual receiving a warning for behaviour linked to alcohol the opportunity to attend an information, education and assessment session aimed at getting them to look at their alcohol use and the consequences of their behaviour.

6. Wider health promotion / social marketing initiatives

Aim:

Reduce alcohol misuse and promoting safer drinking

Objectives:

- Collaboration in and support of Safer Towns programmes and What Will Your Drink Cost?
- Launch of the Health Promotion Service Young Peoples' Alcohol, Sex & Drugs initiative for 2013/14
- Sustain the level of dependent drinkers engaging with treatment services at above the national average.

[5] Method of phased engagement with perpetrators designed around early intervention and prevention

The delivery landscape

There are many factors that will impact on delivery in the coming years:

- Introduction of Police and Crime Commissioner
- A challenging economic climate driving up demand for services against a backdrop of cuts to budgets and resources
- Changes to and development of Government policy in key areas
- Widespread restructuring and change across the public sector
- Effectiveness and value for money of services under increasing scrutiny
- Devolution of accountability to local councils, empowerment of communities to influence and change service delivery with a strong drive for local solutions to local problems
- More integrated working across agencies and across borders (Peninsula and regional); increased reliance on strong and effective partnerships

A challenging economic climate

The economic decline from the recession has been worse in Cornwall than the national average; the impacts of this will be severe and far reaching and present significant challenges in delivering against our priorities effectively.

- **Rises in acquisitive crime, violence, problem drug and alcohol use, domestic abuse and family breakdown** are predicted as individuals and families struggle to cope with the financial and emotional pressures of poverty, unemployment and indebtedness.
- In light of current trends in youth unemployment (the rate of unemployed 16 to 24 year olds in Cornwall has risen by 40% over the last two years[6], one of the highest rises in the South West) **young people may be especially vulnerable to problematic alcohol use**. A significant increase in problematic alcohol use amongst young people will leave a disproportionate legacy of future health, social and criminal problems for our communities.
- **Pressure on public sector funding** with further considerable cuts required (potentially up to 30%), a reduction in grant funding to Councils and **potential prioritisation of frontline services over preventative work**, such as early intervention and diversion schemes
- **Welfare Reform** will place additional pressure on families and is predicted to increase the number of children in poverty. Incapacity benefit reassessments may result in people being declared fit for work at a time when unemployment is comparatively high. Changes to housing benefit will create particular challenges for housing vulnerable people and high risk offenders.

Widespread restructure and change

Extensive restructuring across the public sector presents opportunities for positive change but also presents potential threats to service delivery, agencies and employment locally as well as impacting on inter-partner support and working relationships.

[6] Annual Population Survey, October 2010 to September 2011 compared with October 2009 to September 2010 www.nomisweb.co.uk

- **Changes to national structures** including the National Treatment Agency, Public Health England and the National Commissioning Board, as well as changes of accountabilities at a regional level due to the disbanding of Government Office for the South West and the South West Strategic Health Authority.
- The **transition of public health into the Council** from April 2013 will change the way in which alcohol treatment services are governed and delivered and require new working relationships to be established (such as with the new Health and Wellbeing Board). This combined with the implementation of **local NHS clinician-led commissioning**, currently presents uncertainty around future commissioning arrangements.
- **Restructuring of the Police, Probation and Council services** to make efficiency savings and meet challenging reductions in budgets.
- Over the past two years the Council has been exploring alternative service delivery options and is now **moving towards becoming a "commissioning Council**". As a result all Directorates will be expected to explore commissioning of key services outside of the Council. This will have a significant impact on service provision, delivery and relationships between partner agencies.
- **Some key services are being recommissioned locally** this year – drug and alcohol treatment, domestic abuse and supported housing.

New ways of working

- Introduction of **Police and Crime Commissioner** in 2012, taking a pan-Peninsula view of need across all areas of community safety. Opportunities for best practice to be recognised and implemented across the Peninsula but also potential loss of funding and initiatives locally. In the future community safety partnerships may have to compete with other sectors in society for the Commissioner's funding.
- **Changes to and development of Government policy** in a variety of key areas such as health, National Framework for Fire and Rescue, sentencing, safeguarding, alcohol and anti-social behaviour, providing new tools and powers to tackle community safety issues.
- **Devolution of accountability to local councils**, demands for a reduction of bureaucracy, more transparency, increased efficiency savings and a drive for service delivery with a strong local focus. Effectiveness and value for money will be under increasing scrutiny.
- **Empowerment of local communities through the Localism Bill**, particularly in relation to community rights, neighbourhood planning, housing and general power of competence. Critical issues for the future include the "Right to Challenge" and the potential impact on where and how we deliver services, their continuity and consistency.
- **Intensive multi-agency case management**, such as through Integrated Offender Management and Together for Families in Cornwall, will provide opportunities for partners to work together, sharing intelligence and processes and pooling resources to tackle the most problematic families and individuals.

Other opportunities and challenges

- Technological developments provide opportunities for **more efficient and greener working arrangements** across the public sector, including sharing of work space and the creation of virtual teams.
- Social media and smart phone technology offer **alternative routes for positive engagement**, but **also pose increased risks** through cyber-stalking, harassment, unchecked hate campaigns and on-line sexual exploitation.

Local context

Cornwall is the second largest local authority area in the South West region and is an area of many contrasts; with remote rural, coastal and environmentally sensitive areas, interspersed with villages and historic market towns; where affluence sits alongside some of the most disadvantaged areas in England. Issues around alcohol in Cornwall can be understood by a number of contextual factors:

Population

- Dispersed and sparsely populated settlement pattern combined with Cornwall's coastline present **issues of accessibility** and challenges for equal provision of services.
- Concentrations of population in the larger towns and these exhibit the **same crime and disorder issues as urban areas elsewhere** in the UK.
- **Low representation of minority ethnic groups**; more acute feelings of isolation and vulnerability and may lack access to support networks and a strong voice locally.
- Cornwall's MOSAIC profile indicates that the most common household types are residents of **isolated rural communities** (23%) and residents of **small and mid-sized towns** with strong local roots (21%).

Housing

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

Health and wellbeing

- Higher prevalence of life-limiting health problems, including **mental health.**
- Significantly higher proportion of working age people claiming health-related benefits due to **alcoholism**.

Labour market and economy

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

Deprivation

- **Pockets of high deprivation** where communities experience multiple issues such as lower incomes, higher unemployment rates, ill health, child poverty, low qualifications, poorer housing conditions and higher crime rates. **Hidden rural poor**.

Geography

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

For all the facts and figures, please refer to the more detailed Cornwall Profile at the end of this document.

Local Alcohol Profile

Difference from England average

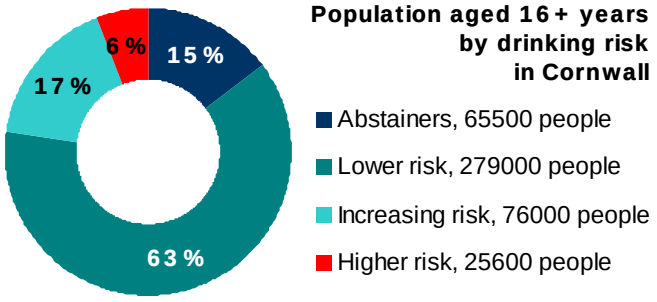
Significantly higher | Above average | No significant difference | Significantly lower

Ranked from 1 to 151 (PCT areas) or 1 to 326 (local authority areas) and presented as deciles, where 1 means ranked in the 10% lowest areas and 10 means ranked in the 10% highest areas

Indicator	Measure	Regional average	National average	National rank (decile)
Drinking behaviour				
Abstainers (% of population 16+)	14.7	14.3	16.5	5
Lower Risk drinking (% of population 16+, ex. abstainers)	73.3	72.7	73.3	7
Increasing Risk drinking (% of population 16+, ex. abstainers)	20.0	20.4	20.0	4
Higher Risk drinking (% of population 16+, ex. abstainers)	6.7	6.9	6.7	6
Binge drinking	18.8	20.7	20.1	4
Employees in bars - % of all employees	3.7	2.7	2.0	10
Crime				
Alcohol-related recorded crimes	5.2	6.2	7.0	3
Alcohol-related violent crimes	4.3	4.8	5.0	4
Alcohol-related sexual offences	0.1	0.1	0.1	6
Health				
Alcohol-specific hospital admission - under 18s	61.0	62.0	55.8	6
Alcohol-specific hospital admission - males	454.8	411.3	450.9	5
Alcohol-specific hospital admission - females	245.9	216.4	225.0	7
Alcohol-attributable hospital admission - males	1439.7	1361.1	1485.3	4
Alcohol-attributable hospital admission - females	818.7	779.2	845.6	5
Admission episodes for alcohol-attributable conditions (prev. NI39)	1756.3	1753.7	1895.2	4
Alcohol treatment - prevalence per 1,000 population	4.0	2.8	3.0	8
Claimants of incapacity benefits (alcoholism) - working age	111.1	102.0	91.5	7
Mortality				
Alcohol-specific mortality - males	11.2	12.0	13.2	4
Alcohol-specific mortality - females	5.8	5.3	6.0	5
Mortality from chronic liver disease - males	9.9	11.8	13.7	2
Mortality from chronic liver disease - females	6.3	5.9	7.0	4
Alcohol-attributable mortality - males	32.3	33.0	35.5	3
Alcohol-attributable mortality - females	12.2	13.2	14.7	2
Mortality from land transport accidents	2.3	1.6	1.3	10

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

- Just under a quarter of people, however, are estimated to drink at above the recommended levels.
- 6% or **25,600 people are drinking at higher risk levels**, double the recommended safe levels or above.
- In addition, an estimated 84,000 people (19%) are binge drinkers.



Modelling work based on results from the Adult Psychiatric Morbidity Survey (2007)[7] has estimated that there are 770,000 dependent drinkers in England who may benefit from some form of alcohol treatment, including Extended Brief Interventions or Brief Treatment. This will include those people who are severely dependent on alcohol and likely to require intensive specialist interventions.

- Using the same methodology, there are an estimated **4,900 dependent drinkers** in Cornwall and Isles of Scilly. This is a significantly lower number than estimates provided by previous models.
- Based on these estimates, we are **more successful locally in attracting dependent drinkers into specialist treatment**. In 2011/12, 21% of dependent drinkers received specialist alcohol treatment in Cornwall and Isles of Scilly, compared with an average of 13% nationally. The national target is 15%.

Indicators regularly monitored for the Local Alcohol Profiles for England (LAPE)[8] indicate that, compared with other local authorities nationally, alcohol is having the **greatest adverse effect on health** and **the economy** in Cornwall.

- We are significantly higher in relation to the proportion of the working age population claiming **health related benefits due to alcoholism,** prevalence of people in **treatment for alcohol problems, alcohol-related road deaths** and **employment in bars** (due to employment serving the tourist industry).
- Whilst health-related indicators[9] for males are higher than for females, the majority of **health-related indicators for females** are above the regional average and some are also above the national average.
- Alcohol-specific **hospital admissions for under-18s** remain slightly above the England average but have **fallen below the regional average** for the first time in five years.
- LAPE crime measures[10] indicate that incidence of **alcohol-attributable crime is significantly lower** in Cornwall and Isles of Scilly than the England average.

---

[7] Joint Strategic Needs Assessment Support Pack for Strategic Partners (NTA, 2012)
[8] Local Alcohol Profiles for England, North West Public Health Observatory
[9] Alcohol-specific conditions are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose); alcohol-attributable conditions also include conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-attributable conditions with their ICD-10 codes can be found on the North West Public Health Observatory website.
[10] Attributable fractions applied to Home Office crime data 2011/12, based on survey data on arrestees who tested positive for alcohol by the Strategy Unit

1: Advice and Information

What the evidence says

Excessive drinking is a major cause of disease and injury, both short term due to alcohol poisoning and the consequences of risk taking behaviour, and longer term due to the effects of regular alcohol misuse on mental and physical health. Health inequalities are evident; alcohol-related **death rates are 45% higher in areas of high deprivation**.[11]

Identifying problems with alcohol **at an early stage** and providing information and advice to help reduce drinking risk will potentially have the greatest long term impact on reducing alcohol-related harm.

- National estimates indicate that there are **25,600 higher risk drinkers** in Cornwall and Isles of Scilly, including **4,900 dependent drinkers** who may benefit from some form of specialist alcohol intervention.
- We appear to be **more successful** than the national average in attracting dependent drinkers into treatment, with 21% of the estimated total engaged with treatment providers, compared with the national average of 13%.
- These two factors combined suggest that our resources may be better directed to **prevention and early intervention** activities rather than increasing numbers into treatment.

There is extensive and consistent evidence that brief advice in health care settings reduces alcohol-related harm[12] and that brief interventions are cost–effective.

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

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

Evidence shows that[13] **for every eight at-risk drinkers who receive advice, one will reduce their drinking to within low-risk levels**, leading to improved health and reduced demand on hospital services.

---

[11] Roberts S., Report to Health and Adult Social Care Overview and Scrutiny Committee on Alcohol-Related Hospital Admissions, January 2013. See Appendix B.

[12] Changing Health Choices: A review of the cost-effectiveness of individual-level behaviour change interventions (NWPHO, 2011); Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm (WHO, 2009)

[13] The Government's Alcohol Strategy, Home Office 2012, taken from (Moyer et al, 2002) Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment - seeking and non-treatment seeking populations, Addiction, 97, 279-292.

- NICE[14] guidance recommends that screening should target people who are at **increased risk of harm** from alcohol and those with an **alcohol-related condition**.
- Local research into health burden of alcohol misuse in terms of hospital admissions reiterates the national guidance and has highlighted a number of other areas where we need to focus our efforts.
- Both local and national evidence also make clear **links between alcohol use and social problems**, such as deprivation, crime and anti-social behaviour, financial worries and debt.

In Health & Primary Care settings

- With relevant physical conditions, such as **hypertension** and **gastrointestinal** or **liver** disorders
- With relevant **mental health problems**, such as anxiety, depression or other mood disorders
- Have been **assaulted**
- At risk of or known to be **self-harming**
- Regularly experience **falls**, other accidents or minor traumas
- Have been injured as a result of a **road traffic collision**
- Present to Emergency Departments with **acute alcohol intoxication / poisoning**
- Regularly attend GUM clinics or **repeatedly seek emergency contraception**

In wider community settings

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

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

What are we doing about it?

Identification and Brief Advice (IBA)

The drive to improve access to early **Identification and Brief Advice** (IBA) is a strong and consistent thread throughout our local alcohol strategy.

Cornwall DAAT has established an Alcohol Awareness (IBA) Toolkit in line with national guidelines, which forms the basis of training in Primary Care and other settings in the community. This includes the WHO identification tools AUDIT-C and AUDIT (The Alcohol Use Disorders Identification Test) well as the Department of Health Brief Intervention advice guidance and handout.

[14] Alcohol-use disorders: preventing the development of hazardous and harmful drinking (NICE, 2010)

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

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

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

Alcohol screening in medical settings:

- The Local Enhanced Service (LES – GP Identification and Brief Advice for uncontrolled increased blood pressure) was offered in 38 GP practices across Cornwall. The LES allows GP practices to provide a funded service, identifying alcohol use disorders among defined patients with uncontrolled hypertension, i.e. raised blood pressure.
- Alcohol Directed Enhanced Service (DES) was offered in 47 GP practices across Cornwall. This required GP practices to screen new registrants for alcohol misuse. This service is not administered or commissioned by the DAAT, and is only available on a yearly rolling basis.
- The NHS Healthcheck programme in Cornwall includes the alcohol-screening tool, AUDIT-C.
- In Treliske Hospital Emergency Department YZUP provide alcohol interventions for young people whilst Psychiatric Liaison service delivers the service for Adults.

A recent public health report[15] to the Health and Adult Social Care Overview and Scrutiny Committee recommends further **promoting the use of IBA in medical settings**, using a version of the validated toolkit adapted for Royal Cornwall Hospitals Trust.

This will be used in these settings:

- Royal Cornwall Hospitals Trust wards;
- Royal Cornwall Hospitals Trust Emergency Department
- Minor Injury Units
- Primary Care

The toolkit will be used for agreed evidence-based, **alcohol-related priority health conditions**, such as hypertension and mental and behavioural problems caused by alcohol. This is in addition to the continued promotion of IBA in non-health sector community settings targeting vulnerable people, for example people in deprived areas.

[15] Roberts S., Report to Health and Adult Social Care Overview and Scrutiny Committee on Alcohol-Related Hospital Admissions, January 2013. See Appendix B.

IBA in criminal justice settings is discussed in section 5: Criminal Justice Interventions.

Wider health promotion/social marketing initiatives aimed at reducing alcohol misuse

A range of actions are being taken by the Safer Cornwall partnership, and the Health Promotion Service to promote safer drinking in Cornwall. These include the Safer Towns programmes and What Will Your Drink Cost? These are guided by evidence of effectiveness and evidence of local needs. They aim to reduce alcohol consumption and to keep people safe and will contribute to reducing admission rates to hospital as a result of alcohol-related harm. The introduction of a national policy to set a minimum price per unit of alcohol is also predicted to reduce alcohol-related harm – particularly among the highest risk drinkers.

The Health Promotion Service provides a Young People's Alcohol Worker, as well as a Young People's Sexual Health Promotion Worker. It is anticipated that valid delivery information will be available next year when the service has been re-promoted from 1//04/13.

2: Anti-social behaviour

What the evidence says

Research into anti-social behaviour in Cornwall and the Isles of Scilly indicates two key areas where alcohol consumption and anti-social behaviour are closely linked – anti-social behaviour linked to the night time economy and street drinking. These issues are quite separate in terms of the risks posed to the community, the individuals involved and the types of approaches employed to tackle them.

- There were just under 19,000 incidents reported to the police in 2011/12, reflecting a drop of 27% compared with the previous year.
- Drinking and / or the night time economy are recorded as a factor in around a **quarter of anti-social behaviour incidents** reported to the police. The Anti-social Behaviour Team report that the majority of anti social behaviour referrals in Cornwall result from incidents where alcohol is a factor, however, indicating a degree of discrepancy in how the link to alcohol is recorded.
- Although low in volume, making up only 4% of all incidents reported, street drinking and begging / vagrancy significantly increased (up by 16% and 92% respectively) – **in both cases predominantly driven by a rise in Truro town centre**. Growing public concerns about street drinking, particularly in Camborne, have resulted in specific actions within the Safer Cornwall "Safer Town" plans to try and tackle this, such as the withdrawal of high strength alcohol products by local retailers.
- Anti-social behaviour in Cornwall and the Isles of Scilly shows a **strong reducing trend** which has been in evidence for the last five years. Despite the drop in reports, **anti-social behaviour remains the number one public priority**; three-quarters of all neighbourhoods in Cornwall say that some form of anti-social behaviour is an issue in their local area, although this is not necessarily alcohol-related.
- A fifth of neighbourhood in Cornwall specifically cite an alcohol-related issue as a problem in their local area through Have Your Say[16] consultations.
- In the majority of cases **issues of concern are specifically associated with the night time economy** and include violence, anti-social or intimidating behaviour, public drunkenness, under-age drinking or associated environmental nuisance such as noise, vandalism and spoiling public spaces. 4 neighbourhoods said that day-time street drinking was an issue – Camborne North and West, Penzance and the Moresk/Tregolls area of Truro.
- Our larger town centres generally experience the highest levels of anti-social behaviour and there is strong correlation between incidence of anti-social behaviour with all types of crime, but particularly violent crime, criminal damage and thefts. The main hotspots are town centre neighbourhoods in **St Austell, Newquay, Penzance** (East), **Truro, Camborne** and **Redruth**.
- Rowdy / nuisance behaviour tends to peak mid-evening (between 8pm and 9pm), whereas street drinking is more likely to be reported in the afternoon.
- Anti-social behaviour follows **a strong seasonal pattern** with higher levels of incidents reported particularly in the summer months (July and August), influenced by the influx of tourists into popular holiday spots, the school summer holidays and lighter nights.

[16] See page Notes on the data for more information about Have Your Say

What are we doing about it?

The three stage escalation process[17] has proven effective in managing anti-social behaviour issues, especially for young people.

- In 2011/12 80% of young people and 68% of adults who received a warning / intervention from the Anti-Social Behaviour Team did not come to the attention of the team for the following three months

An alcohol-related anti-social behaviour diversion scheme for young people is being piloted in the Safer Town areas. The scheme gives an individual receiving a warning for behaviour linked to alcohol the opportunity to attend an information, education and assessment session aimed at getting them to look at their alcohol use and the consequences of their behaviour.

The warning received, which normally lasts three months and is monitored at a multi agency level, will be terminated following successful completion of the course.

The aim is to address alcohol-related anti-social behaviour at the **earliest opportunity** before any criminal line is crossed. This scheme works at the earliest stages of anti-social behaviour, well in advance of similar schemes such as Penalty Notice for Disorder (PND) referral.

Effective use of enforcement powers and legislation

- First successful use of the **Inebriates Act 1898** (in Camborne, March 2012) that makes it an offence for an habitual drunkard to purchase or attempt to purchase alcohol. Use of the Act is being explored to tackle persistent, nuisance drunks for whom other forms of intervention have been ineffective or inappropriate and links them directly into appropriate support.
- 7 **premises closures** and 1 crack house closure
- 10 **Anti Social Behaviour Orders**, including the first on a nuisance 999 caller
- 28 **Drink Banning Orders**

Positive action in the community

- 2 **deployable wireless CCTV** cameras purchased, to be mounted in rural areas showing greatest need. First wireless CCTV permanent mounting point in Torpoint to assist in reducing late night disorder and anti-social behaviour.
- Over 2500 **community safety bulletins** were distributed in local communities advising them of what action has been taken in their area to tackle anti-social behaviour

There are two key over-arching community safety schemes that aim to address anti-social behaviour as part of an overall programme to tackle crime and disorder in persistent problem places in Cornwall and more information on these is included in Section 4: Community Safety Schemes - the "What Will Your Drink Cost?" summer campaign and the multi-agency Safer Towns programmes.

[17] Method of phased engagement with perpetrators designed around early intervention and prevention

3: Children, young people, parents and families

What the evidence says

The risks of alcohol-related harm to young people come from their own problem use of alcohol and the associated risks of involvement in crime, injury and other health problems, as well as safeguarding risks around parental problem use of alcohol.

Alcohol and parents

A separate piece of analysis has been undertaken to assist with identifying needs relating to drug and alcohol treatment for families, particularly substance using parents with dependent children, and aims to **uncover any possible service gaps or unidentified treatment** need in areas throughout Cornwall.

Information on parental substance use has also been used in conjunction with police recorded domestic abuse and mental health prevalence data to identify geographical areas in Cornwall where there may be concentrations of "**complex families**" – families with multiple, inter-related issues that require a **multi-agency approach**.

- There is a **proven statistical link** between prevalence of mental health, domestic abuse and parental substance use in Cornwall. **West Cornwall** contains the most areas estimated to be at highest risk of these combined factors, with particular clusters around Camborne and Redruth.
- This analysis suggests that there may be unmet need for substance use interventions for families around **Hayle and in the China Clay area** (drugs and alcohol), **St Blazey and Launceston** (predominantly drugs) and **Liskeard and St Just** (predominantly alcohol).
- Furthermore, **Hayle, St Blazey and Liskeard** are also highlighted as areas where families may be more likely to have **complex needs**, specifically in relation to domestic abuse and mental health.

To examine parental problem alcohol use, two datasets were compared – adults in treatment for alcohol as their primary substance who are living with a child (taken from NDTMS) and parental disclosures of alcohol problems to the 2011 Health Visitor Audit[18] (HVA). It should be noted that the HVA surveyed only families with children aged 3 years and under.

Prevalence of parental alcohol problems

- The Health Visitor Audit (HVA) in 2011 found that in **4% of families, one or both parents disclosed a problem with alcohol**. This is based on around 500 families out of 14,000 disclosing a problem with alcohol. There are pockets around Penzance, Liskeard and China Clay where this proportion rises to nearer 20%. This audit does not collect information on the severity of problem or whether the parent/s is engaged in any kind of treatment.

[18] 14,000 families with a child under the age of 3 years surveyed, Health Visitor Audit 2011

- Applying the HVA results to the latest figures from the Census 2011 provides an estimate of around **800 families with young children**[19] where there may be a recognised problem with **parental alcohol use**. This figure indicates the **prevalence of risk** to children in regard to alcohol use, where a parent may benefit from specialist alcohol interventions (although not necessary require structured treatment for dependency).
- The highest proportions of disclosed parental problem alcohol use are found in Newlyn East and Liskeard Town. Other areas that have been identified include St Just, Hayle South and High Lanes and St Dennis North.

Parents in treatment

- Approximately **one in four of Cornwall's alcohol treatment population has a child living with them** at least some of the time (333 service users in 2011/12), compared with one in three nationally. A further quarter is a parent but not living with their child.
- The data identifies the following areas as having high rates of adults in alcohol treatment living with a child; **Penzance, Camborne, Redruth, Truro** and **St Blazey**. Areas in the Roseland and Tintagel are also highlighted, which are typically more rural than the other areas highlighted.
- Comparing the geographical spread of the two data sets, the following are identified as areas where there may be a requirement for better access to specialist alcohol interventions for parents: **St Just, Hayle, China Clay and Liskeard.**

In this assessment a "complex family" means a family that experiences mental health, domestic abuse and substance use issues, all of which 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, (2008[20]) 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**.

By using the Complex Families Index[21] methodology and substituting parental drug misuse with parental alcohol use the following areas have been identified as having the highest overall rank of these combined issues. It is a combined small area measure that identifies geographical areas that are most likely to experience co-morbidity of domestic abuse[22] with parental alcohol use[23] and mental health issues[24]. The index has been updated with the latest information for 2012.

- There is a **strong positive relationship** between **parental alcohol use** and both **domestic abuse** (where a child is resident in the household where the abuse took place) and **mood and anxiety disorders** in mental health. This

[19] This figure uses as the denominator the total number of families in Cornwall where there is one child or more aged under 4 years (21,300 families), the closest population group for which there are currently published results from the 2011 Census
[20] Brandon, M. et al. (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005, DCSF RR023.
[21] The Complex Families Index was developed in 2011 to inform the drug treatment needs assessment process
[22] Measured by police recorded incidents
[23] Measured by the HVA
[24] Measured by the "mood and anxiety disorders" indicator drawn from the Health domain of the Indices for Multiple Deprivation 2010

means that areas that experience higher proportions of parental alcohol abuse are **more likely** to experience mental health issues and higher rates of domestic abuse where a child is resident.

- The majority of the areas identified are located in the **West of Cornwall**, with 5 being in the **Camborne and Redruth** network area.
- Many of these areas have also been identified in regard to parental drug use. Camborne town centre and Hayle South and High Lanes are identified as top priorities in both indices. St Blazey and Illogan are also ranked highly in both indices.
- Of particular note is that areas in **Hayle** and **Liskeard** are ranked highly in this index, already highlighted as areas where there may be unmet need for alcohol interventions for parents.

Town	Area	Mental health	Domestic abuse	Parental alcohol use
Camborne	West East Central			
Hayle	South and High Lanes			
Illogen	Highway South			
St Austell	Mount Charles North			
Camborne	South Pengegon			
Redruth	North Close Hill			
St Blazey	West			
Penzance	Newlyn East			
Liskeard	South East			
Redruth	North South West			
	Key	Top 5%	Top 10%	Top 20%

Alcohol and risks to health and wellbeing

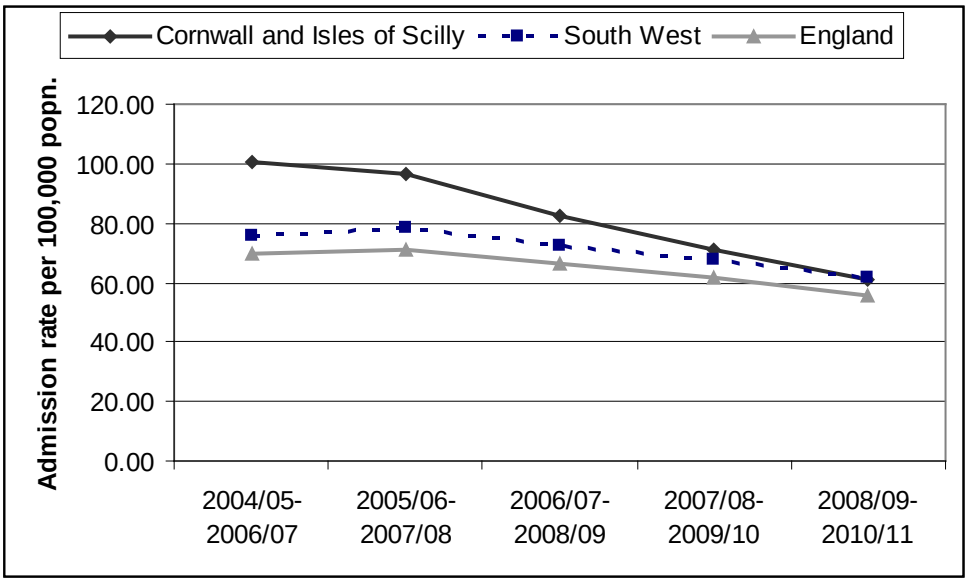
Many of the risks for young males and females are shared, such as those related to adverse affects on health and wellbeing, but there are different risks in terms of involvement in crime – young males are much more likely to be involved in public violence, both as victims and offenders, and young females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

- National research[25] shows that there has been a **fall in recent years** in the proportion of pupils **who think that drinking is acceptable** for someone of their age. In 2010, 32% thought it was ok for someone of their age to drink once a week compared with 46% in 2003. Similarly 11% of pupils thought that it was ok for someone of their age to get drunk once a week, compared with 20% in 2003.
- It also found that there is a strong relationship between **pupils' drinking behaviour** and their **parents' attitudes** to their drinking. 85% of pupils whose parents did not like them to drink had never drunk alcohol, compared with 27% who thought their parents wouldn't mind as long as they didn't drink too much.
- Other research[26] showed that pupils were **more likely to drink if they live with other people who drink alcohol**. 83% who lived with no one else who drank alcohol had themselves never drunk, compared with 26% of pupils who lived with three or more drinkers.
- Alcohol Concern (2002) **links alcohol consumption to risk taking behaviour** in regard to **sexual behaviour**. The study found that 75% of young people (aged 16 to 20 years) surveyed used contraception when sober compared with 59% using contraception when mildly intoxicated and 13% when strongly intoxicated. The study also found that 61% of females and 48% of males cited

25 Health Survey 2007, cited in Statistics on Alcohol: England, 2012, NHS
26 Smoking, drinking and drug use among young people in England 2010. Health and Social Care Information Centre.

drugs and alcohol as the reason behind having had sex with someone that they had known less than a day.

- Alcohol is recorded as linked to around a fifth of violence involving a young victim under the age of 18 in Cornwall. **Under the age of 18, young females are equally likely to be involved in alcohol-related assaults** (particularly day time violence and off-street crime) and much more likely than males to be victims of domestic or sexual offences.
- Historically alcohol-related hospital admissions for under 18 year olds have been significantly higher than regional and national averages. The latest data[27] indicates, however, that alcohol-specific **hospital admissions for under-18s** have **fallen below the regional average** for the first time in five years, although the rate remains slightly above the England average. Note that this does not include attendance at Emergency Departments.
- Young people admitted to hospital for alcohol-related causes are more likely to have acute needs, such as for **alcohol poisoning, mental and behavioural disorders due to use of alcohol** (under 18s) **or assault-related injuries** (young adults).



Alcohol specific hospital admissions, aged <18 years.

- 160 young people under the age of 18 accessed specialist treatment services for substance use in 2011/12, **an increase of 16%** compared with the previous year.
- Along with cannabis, alcohol is the main substance for which young people access specialist services. Just over a **third of young people were in treatment for cannabis and alcohol problems together** and a further 16% were in treatment for alcohol only, which is in line with the national profile for young people in treatment. 42% of under 18s accessing specialist substance use treatment are female.
- A review of NDTMS data shows that alcohol is actually involved as either a primary, secondary or tertiary substance in 99 cases (62% of the YZUP cohort) where the young person was aged under 18. This figure is significantly lower than in the previous two years, where 78% of young people had an identified alcohol treatment need.

[27] Local Alcohol Profiles for England (NWPHO, August 2012), from Hospital Episodes Statistics 2008/09 - 2010/11 and Office for National Statistics mid-year population estimates 2008-2010

The NDTMS risk-harm profile[28] identifies 10 key items to gauge the vulnerability of young people entering specialist substance misuse services, such as involvement in self harm or offending, or homelessness. The higher the score, the higher the risk.

- Young people accessing specialist treatment services in Cornwall in 2011/12 were more likely to be at the **lowest end of the complexity range** with 40% scoring 1 or less, compared with the national average of 24%.
- There was a similar proportion in the upper range of 5 to 7, however, but the numbers are very small (5% or 6 people).
- Young people in Cornwall are slightly **more likely than average to be alcohol users**, however, and to have started using their problem substance at a younger age (a figure likely to be influenced by a higher proportion of alcohol users). They are **significantly less likely to be involved in offending** than the national average (26% locally compared with 47% nationally).

Young people and offending behaviour linked to alcohol is discussed in the Criminal Justice section.

What are we doing about it?

Specialist support for families

A recent research study into the Social Return On Investment (SROI) of drug and alcohol family support services[29] examined the work and outcomes of one dedicated family and friends support service over the course of one year. The study calculated the cost benefits in relation to the individuals receiving the service, their family and friends and to the NHS and Criminal Justice system, in terms of reduced costs as a result of positive outcomes for both of the above groups.

- The research concluded that the total return on investment ratio was 4.7:1, meaning that every pound invested in the service leads to the creation of £4.70 of social value.

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

Breaking the Cycle seeks to achieve three key outcomes:
- Reduction in the number of parents and children at risk of the significant harm associated with problematic substance use.
- Improvement in family functioning.
- Improvement in the health and wellbeing of parents and their children.

The Breaking the Cycle programme, delivered by Addaction, provides wraparound family support that includes:
- Prioritisation, assessment and care planning
- A range of motivational and solution focused interventions

[28] Joint Strategic Needs Assessment Support Pack for Strategic Partners, The Data for Young People (NTA, 2012)
[29] The Social Return on Investment of Drug and Alcohol Family Support Services: Assessing Adfam's contribution; Emma Rattenbury Associates, working with Envoy Partnership, March 2012. The full report is available on the Adfam website

- Advice and information
- One-to-one and family support
- Group work
- Family mediation
- Signposting
- Advocacy
- Home visits
- Work with children through coordination with partner agencies and schools
- Systemic family therapy

Addaction, in partnership with the University of Warwick, has recently been funded by the Big Lottery Fund to develop a new funding model for Breaking the Cycle, using **social investment** and **payment by results** methods. Cornwall has been selected as one of the six Local Authority areas nationally to be included in this research, which will commence in April 2014.

Together for Families in Cornwall

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

The "Troubled Families" programme, locally delivered under the name **Together for Families in Cornwall**, focuses on reducing the demands on local services in responding to families who have multiple issues, such as parents out of work, mental health problems, truanting and exclusion from school, family involvement in crime and anti-social behaviour. Figures from the Government estimate that each "troubled" family costs around £75,000 per year.

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.

This programme will run primarily on a **payment-by-results basis** with 40% paid up front and the remaining 60% payable only when they and their partners achieve success with families. The amount of funding available depends on the estimated size of the cohort of "troubled families" in each local area. DCLG estimate[30] that the cohort in Cornwall is **1,270 families**.

In addition to the three areas identified by the Government, locally we recognise that the families identified will have **complex needs** and have prioritised **domestic abuse**, **any offending** in the family (not just the child), **substance use** and **mental health** as critical issues to address.

Services for young people

Schools
Cornwall Healthy Schools working with the Schools Health Education Unit (SHEU) are conducting a **schools based survey** with year 8 and 10 pupils in order to try and capture the behaviour and attitudes of young people linked to the Every Child

[30] Based on indicative numbers from the Indices of Multiple Deprivation and Child Deprivation Index.

Matters outcomes. This survey will be made available to all secondary schools and is proposed to start in October 2013.

This survey has been sent out to partners for input in order to ask the right questions. Representatives from both YZUP and Safer Cornwall have had an input in this survey which will hopefully provide valuable information regarding young people's thoughts and attitudes regarding alcohol, substance use and crime.

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

From this assessment the service is able to offer the most appropriate interventions in order to help in the young person's recovery plan. These psycho-social interventions include a weekly drink diary, unit calculator and motivational interviewing to provide support. YZUP also work with young people around confidence, self esteem, peer pressure, personal safety and relationship skills.

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

Health Promotion

Health Promotion are currently assessing their delivery of drugs and alcohol education, along with Cornwall Public Health, in line with the latest NICE Guidance.

4: Community safety schemes

Alcohol, violence and the night time economy is a community safety priority in Cornwall and the Isles of Scilly and for the wider Peninsula group of community safety partnerships covering Devon and Cornwall.

The community safety partnership, Safer Cornwall, has implemented a range of schemes to tackle alcohol-related violence and anti-social behaviour, targeting persistent problem places and supporting a safe and vibrant night time economy.

Schemes directly involving the licensed trade, such as Best Bar None, are discussed in section 10: Licensing, alcohol retail and the night time economy.

What the evidence says

Alcohol is associated with a range of crime but plays a particular factor in violent crime. Previously we have measured trends in alcohol-related violence using information recorded in police data. There are gaps in this information over the last 18 months which means that we do not have a continuous time period to replicate this analysis. The Community Safety Strategic Assessment instead focuses on trends in all violent crime and in violent crime linked to the night time economy.

It is also a significant factor in anti-social behaviour and increases the risk of involvement in road safety collisions, both as a driver and as a pedestrian, and accidental dwelling fires.

- Alcohol-attributable crime[31] is estimated to be **significantly lower** than the England average in Cornwall and the Isles of Scilly, despite an overall rise in violent crime compared with last year.
- Based on the periods where the link to alcohol was recorded we can estimate that alcohol continues to be linked to violent crime in 45-50% of cases. Domestic violence and violence associated with the night time economy are more likely than day time violence to be linked to alcohol.
- Violent crime saw a **significant rise** in Cornwall in 2011/12, but the upwards trend is being driven by rises in day time crime and domestic abuse, rather than night time economy violence.
- Violence directly associated with the night-time economy **remained stable overall** compared with last year, but contrary to the overall trend there are **more crimes recorded as resulting in injury and fewer without injury**.
- Night time economy violence continues to be important. It **accounts for around a third** of all recorded non-domestic violence and it is **significantly more likely to be linked to alcohol** (estimated at around 73%).
- This is further emphasised in the attendance data for assault-related injuries at Treliske Emergency Department, with the related incident occurring between 9pm and 4am in just over three quarters of cases and the vast majority linked to alcohol.
- In 2011/12 **70% of violence linked to the night time economy occurred in Cornwall's larger towns**, resident to only 39% of the population. These problems peak at weekends and in the summer months and can **negatively**

[31] Local Alcohol Profiles for England (NWPHO, August 2012) - attributable fractions applied to Home Office crime data 2011/12, based on survey data on arrestees who tested positive for alcohol by the Strategy Unit

affect local businesses and the way in which residents and visitors use and enjoy our town centres.

- Incidence of alcohol-related road deaths in Cornwall is significantly above the England average. Over the last five years, there have been **12 fatal road traffic collisions where alcohol and/or drugs was a factor** (driver/rider/pedestrian impaired) and 89 serious injury collisions. 6 out of the 7 pedestrians who died on Cornish roads in the last of two years had been drinking. The majority of collisions involving alcohol and/or drugs occur at the weekend.
- People who have drunk to excess are also at **increased risk of accidental fire whilst under the influence** and their ability to escape may be impeded.

National evidence from the DCLG ("The effect of alcohol or drugs on casualty rates in accidental dwelling fires, England, 2011-12") links alcohol to the risk of death and injury from domestic fires:

- In 2011-12, there were 30,709 accidental dwelling fires in England. In 8% (2,483) of these fires where impairment due to suspected drug or alcohol use was recorded as a contributory factor.
- Impairment due to alcohol or drug use resulted in 41 deaths and 1,208 injuries from 2,483 dwelling fires.
- Fatalities and non-fatal casualties
- Average fatality rate where alcohol or drug impairment suspected to be an influencing factor is three times more compared to where alcohol or drug impairment was not an influencing factor.
- The rate of serious injuries is four times higher where drug or alcohol impairment was a contributory factor than where alcohol or drug impairment was not a factor.
- Male casualties outnumbered females by two to one in dwelling fires where impairment due to suspected alcohol or drug use was an influencing factor.
- Circumstances of the victims
- More than half (56%) of casualties in accidental dwelling fires where impairment due to alcohol or drugs was a contributory factor were themselves not suspected to be under the influence of alcohol or drugs.

This is **a local data gap**, which we may discuss with Cornwall Fire and Rescue, to see if we can gather local evidence.

What are we doing about it?

In 2012, a Cornwall-wide multi-agency **alcohol-related violence task group** was established and a pooled **town centre "toolkit"** is in the process being developed, with the aim of promoting best practice approaches from a range of interventions and initiatives that have been successfully implemented to date.

Through the **Assault Related Injuries Database** (ARID) we are now gathering better information about assaults, so that we can address the causes through the Licensing teams, and reduce the burden on health and other services. ARID is currently at Treliske Emergency Department but we would like to see its use expanded to other hospitals. Problem premises are being encouraged to look to the best practice standards in Best Bar None to help them to improve safety for their customers and local communities.

The **Safer Towns** initiatives are multi-agency action groups directly addressing problems in the six priority towns identified in last year's assessment and full details (agencies involved, action plans, objectives etc) of these are published on the Safer Cornwall website – Camborne, Redruth, Penzance, St Austell, Newquay and Bodmin. All action plans have a **common objective to reduce alcohol related crime and anti-social behaviour**, as well as to improve the local environment, reduce fear of crime and increase the satisfaction of residents with their area as a place to live.

Safer Cornwall has been successful in securing £90,000 over two years from the one million pound **Alcohol Prospectus fund** set up by Baroness Newlove, the Government Champion for Active Safer Communities, to support the Safer Towns initiatives. The Safer Towns bid is the **only successful bid in the South West** and one of only ten nationally to the fund that was oversubscribed ten-fold.

Projects in the Safer Towns include **an alcohol-related** anti-social behaviour diversion scheme **pilot for young people**, the removal of high strength alcohol from the shelves of local retailers, positive engagement work with street drinkers, diversionary activities for young people and multi-agency patrols.

Newquay already has an existing local partnership Newquay Safe that has gained national recognition for its response to alcohol-related fatalities and anti-social behaviour in the town. Several Safer Cornwall projects are delivered under this umbrella, such as the StreetSafe cabin and the anti-social behaviour scheme, **Follow You Home,** that follows up incidents caused by young visitors to Cornwall by contacting the relevant authorities in their home area, and their parents.

Newquay StreetSafe runs during the peak summer season and provides a place of safety for vulnerable and intoxicated people, treats minor injuries and provides safe travel home or onward referral as required. A similar scheme is being considered for other towns (a pilot in Falmouth commenced in November 2012) particularly with respect to safeguarding those who may be particularly vulnerable due to pre-loading.

The **"What Will Your Drink Cost?"** campaign has been run successfully in July and August over the last two years in 7 towns (all priority towns except Newquay, plus Truro and Falmouth). The 2012 campaign focussed on **publicity and education**. Changes in Policing neighbourhood teams, and the requirements placed upon the Devon and Cornwall Police by the Olympics, meant that the Police capacity to support the enforcement activities carried out in the 2011 campaign was not available in 2012.

Of particular note was the pilot Facebook campaign which **targeted prevention and education messages** to a very specific cohort of young people in Cornwall who explicitly expressed an interest in getting drunk in their Facebook profiles.

Of the 13,720 target cohort, 642 (5%) young people clicked through during the 2 month campaign period, spending an average of **2 minutes on the Safer Cornwall website** advice page. Total costs were similar to those for printed material used previously but with **more clearly evidenced**

benefits, as it is not known what proportion of leaflets or flyers are discarded without being read.

There is now the intention of widening the Cornwall 'What Will Your Drink Cost?' branding as a Social Marketing approach, so that the message becomes part of the culture, implying messages about health, community safety and enforcement, and reaches out beyond a few locations in a brief period of the year.

As such the campaign names, as well as the tag line 'Enjoy Cornwall, Drink Sensibly' will gradually gain wider use.

There have been a number of road safety initiatives directly targeting night time pedestrians, including **Safe Travel 4 Every Pedestrian** (STEPS) initiative for students at Combined Universities in Cornwall (promoting road safety messages for night time pedestrians) and a pilot scheme in Truro, were street pastors distributed high visibility wristbands ('**glow bands**') to pedestrians at night.

5: Criminal justice interventions

What the evidence says

Problem alcohol use is the most prevalent issue linked to risk of reoffending amongst adult offenders[32] and is particularly identified as a risk factor for violent offenders. A problem with alcohol does not necessarily mean dependence and **offenders with alcohol problems are less likely to be engaged with treatment services** than drug-using offenders.

The Alcohol Strategy identifies the need for increased use of accredited tools for identification of alcohol problems and brief interventions with offenders.

- Of the 1,500 people contacted by **Arrest Referral** staff in Police custody in 2011/12, **62% said that they had a problem with alcohol** and for the majority, alcohol was their only problem substance. **Four out of five were not receiving any help** with their problem from any specialist treatment service at the time – just over half were given advice about their drinking and / or referred for treatment as a result of their contact with the Arrest Referral worker. We do not know how many of these referrals resulted in engagement with treatment.
- **4% of new presentations** to alcohol treatment in 2011/12 came via a criminal justice route and this is **low compared with the national average** of 10%.
- Alcohol problems are most common in offenders serving sentences for violent offences and drink driving. Overall just under half the offenders[33] on community sentences under supervision by Probation have some or significant problems with alcohol and **the majority (81%) are not receiving any kind of care planned alcohol interventions.**
- This suggests an **unmet need of around 220 adult offenders**, of which around a third have **significant alcohol problems**. Offenders are more likely to be engaged with community services if they are also problematic drug users.
- In 2011/12, substance misuse was identified as a risk factor in a **higher proportion** of young offenders being worked with by the Youth Offending Service than in previous years, and this reflects a general shift towards a smaller number of more complex young people on the caseload.
- A dip sample of those assessed as at increased risk from their substance use indicated that **alcohol was considered a factor**, either as a primary or secondary substance **in 83% of start assessments**. This represents a significant increase compared with last year when approximately half of all cases identified alcohol as being a risk factor. It should be noted that the assessment identifies alcohol as a risk in regard to reoffending and does not necessarily require structured treatment.
- 58 young people known to the Youth Offending Service in 2011/12 were also engaged with the YZUP service. This accounts for just over half of the young people who have had substance misused flagged as a risk in their initial assessment. This presents a **more positive picture of engagement** than for adult offenders.

Violent crime saw a significant rise in Cornwall over the latter part of 2011/12. Of particular concern was a rise in violence with injury, which was a Peninsula-wide

[32] 61% of adult offenders under supervision with Probation on community sentences
[33] Caseload snapshot 30th September 2012 – 1033 offenders, of which 650 have open or initial assessments provided for analysis

trend, and this led to a specific Police research report examining repeat offending / offenders for violence with injury.

- This research found that **rolling trends indicated an overall increase in repeat offending**, both in the volume of offences of violence with injury committed by repeat offenders and also in the number of individuals engaged in repeat offending.
- The research also considered current approaches to violent offender management which has led to the **introduction of a risk assessment matrix based on a model used by Dorset Police**. This seeks to identify both the highest risk and increasing risk offenders that do not meet the criteria for dangerous offender management schemes (such as MAPPA[34] and DASSP) for proactive prevention, intelligence and enforcement activity. Referral into the range of alcohol interventions **should be embedded** into this process.
- The **key target group** for intervention in violent offending are **young males** (18 to 24 age group), particularly in violence associated with the night time economy. Probation data indicates that alcohol problems are above average in adult offenders from 18 years up to the age of 29 years.
- Recent trends show that the violence with injury trend has levelled out this year, although the trend for violence without injury continues to climb.
- The majority of violence linked to the **night time economy**, however, involves **young adult males, as both victims and offenders**. The key age group are 18 to 24 years, not under 18s, with those aged 18 at highest risk. This is further evidenced in the data collected in Treliske Emergency Department for assault-related injuries – 44% of all presentations in 2011/12 were aged 18 to 24 years, 4 out of 5 were male and the vast majority of the assaults were recorded as linked to alcohol.

In December 2012 **Truro** was named as the **fifth worst city in the UK for drink driving offences** by an analysis of insurance applications. The information below is drawn from Police data to help highlight who is most likely to drink and drive and what time of day they are most likely to be drinking and driving.

- In 2012, there were 734 arrests for drink driving in Cornwall. The vast majority were **male** (82%, 603 drivers).
- Younger people, in their **early twenties and thirties**, make up a large proportion of those arrested for drink driving. The most common age of those arrested is 22. Just over half of those arrested are between the ages of 17 and 34.
- The highest numbers of drink drive arrests occur in the evening and early hours of the morning. The most common time for arrest is between **midnight and 1am**.
- Causing death or serious injury by driving whilst under the influence is a notifiable offence (arrest for drink driving is not) and included in recorded crime figures for violent crime but the numbers are very few – on average there are 2 crimes recorded per year.

[34] Multi Agency Public Protection Arrangements (potentially dangerous violent and sexual offenders) and Domestic Abuse Serious and Serial Perpetrator

What are we doing about it?

The **Identification and Brief Advice Toolkit** is being rolled out to all Probation and Arrest Referral staff and all services within the TurnAround Integrated Offender Management programme.

There are **11 different interventions** in Cornwall that can be used to tackle problem drinking in offenders, dependent on the scale and seriousness of both the offending and alcohol as a factor in their behaviour. Some of these, such as the use of the **Inebriates Act** and the **Alcohol Diversion Scheme** have already been discussed in this assessment but a full summary is provided at Appendix A.

- Follow-you Home Scheme
- Drink Banning Order (DBO)
- Anti-social Behaviour Order (ASBO)
- Inebriates Act
- Alcohol Arrest Referral
- Alcohol Conditional Caution
- Penalty Notice for Disorder Alcohol Diversion Scheme
- Anti-social behaviour Alcohol Diversion Scheme (pilot)

There are two court ordered interventions tackling alcohol-related offending:

- The **Low Intensity Alcohol Programme (LIAP)**, delivered by Probation, is aimed at low level violent offenders to help them to understand the consequences of their actions on themselves and other people. This has resulted in a proven track record of reduced violent and other offences.[35]
- The **Alcohol Treatment Requirement** targets offenders who are dependent drinkers, taking individuals who have not previously voluntarily engaged with help on offer, and providing increased support as they enter alcohol treatment. This scheme will fall under the remit of the new Police and Crime Commissioner, and should create ongoing resources for all such schemes in the Devon and Cornwall Constabulary area.

Offenders that present the **most risk to their communities** are identified for intensive management in the Integrated Offender Management programme, delivered under the name **TurnAround** in Devon and Cornwall. TurnAround builds on previous multi-agency work with prolific and drug-using offenders through the Drugs Intervention Programme (DIP). Both programmes have been brought into TurnAround.

Offenders are selected for TurnAround intervention based on a risk assessment matrix that factors in a range of elements including criminal history, perceived risk to the community and local crime reduction priorities. In Cornwall, **additional weighting is also given problem alcohol use**, problem drug use, domestic abuse, homelessness / housing problems and parental responsibility.

- TurnAround started working with an initial cohort of **180 offenders in Cornwall** in May 2012. This cohort included existing prolific offenders and drug using offenders engaged with the DIP that had relevant convictions (or intelligence suggesting that they are prolific offenders).

[35] A recent evaluation shows that in the following two year period, 37% of offenders completing LIAP reoffended, compared to 68% in the control group. Of those who did offend the offences were less serious.

- Each offender is managed by a **single lead professional** who works as part of a multi-agency team and co-ordinates access to advice and support across all the pathways, including accommodation, family support and physical and mental health. The offender is **managed according to the level of risk** and length of time for the offences and / or sentence.
- Recognising the importance of taking **a "whole family" approach** to tackling reoffending, in addressing both its causes and its impacts, integrated working opportunities are actively being sought within the delivery framework of the new **Together for Families in Cornwall** programme.

Historically the DIP programme has focused on working with offenders with opiate problems, in line with previous national priorities. A comprehensive review of Cornwall DIP was undertaken in 2011 and this identified a number of **areas where need was not being met** or being met in a limited way, and this included **alcohol misusing offenders** (with the exception of those under Alcohol Treatment Requirements or known prolific offenders already working with the DIP).

All drug and alcohol services, including DIP, have been recommissioned this year and new contracts will be in place from April 2013. In recognition of the prevalence of alcohol problems amongst the offender cohort and to align the DIP service to the predicted needs of TurnAround, the DIP service will **broaden its criteria to include alcohol** and other substances other than opiates and provide a **tiered and targeted approach based on risk and need** (i.e. the most resources are targeted at those who are highest risk), rather than substance or criminal justice status.

The Youth Offending Service (YOS) provides a co-ordinated response to the needs of young offenders (aged 10 to 17 years) who come to the attention of the police. Children aged 18 years can also be on the YOS caseload if they committed an offence before their 18th birthday.

- In 2011/12 there were 579 young people on the Youth Offending Service caseload who were charged with offences during that year, and this shows a **significant drop of 27%** compared with last year.
- Local research indicates that, with a rising number of low level cases being dealt with through the Youth Restorative Disposal, **the service are now working with a larger proportion of young people with higher complex needs**, including specifically in relation to substance misuse.

Issues around transition from youth to adult services (where the degree of support may be less intensive and the perceived 'safety net' removed) are highlighted as presenting a particular risk for young offenders and also for young people in treatment for substance use.

Young offenders aged 17 years who have been identified as having the potential to become prolific offenders will be jointly managed by TurnAround, with the aim of a more seamless and supported transfer from youth to adult services.

6: Domestic abuse and sexual violence

What the evidence says

The ACPO[36] 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,[37] regardless of gender.

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

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

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

Alcohol use is associated with a fourfold increase in risk of violence from a partner[38] and is more common when sexual violence is involved, but should not be seen as the ***cause*** of the abusive behaviour, as the relationship is complex. Alcohol is **consistently feature in breakdown in families,** however, and inhibits effective engagement and intervention.

- There were 7,438 domestic abuse incidents reported to police in 2011/12, a rise of 5% compared with last year and **the current trend is rising**.
- It is acknowledged that domestic abuse is significantly under-reported. Based on the number of reports, we can estimate that there were **19,100 incidents in 2011/12 with 9,200 victims, of which 4,000 were repeat victims**. This may still be an under-estimate, however.
- **38% of high risk cases are repeat victims**, which is at the upper end of the national benchmark range of 28% to 40%. The proportion of repeats rose significantly in 2011/12, which is believed to reflect improved identification further to the implementation of "flag and tag" on agencies' databases.
- Rates of police recorded domestic abuse in **deprived areas** are almost **two and a half times higher than the Cornwall average**.
- The link to alcohol is recorded only for violent assaults, sexual offences and robbery. Based on these crime types, domestic violence is **more likely to be**

[36] Association of Chief Police Officers. The ACPO definition excludes incidents or crimes where the offender or victim is less than 18 years of age. In July 2008 Devon and Cornwall amended the definition in use in crime recording locally to include victims aged 16 and 17 years
[37] Including parents, grandparents, sons, daughters, siblings, any direct relatives or in-laws or step families
[38] Cornwall & the Isles of Scilly Domestic Abuse & Sexual Violence Strategy 2011-2015

alcohol-related than non-domestic violence (an estimated 53% compared with 49%).

- Previous research has highlighted a relationship between prevalence of police reported domestic abuse and estimated prevalence of mental health problems and parental alcohol use. Using the Complex Families Index, a number of areas were identified as likely to contain **clusters of families** experiencing all three problems, these are **Camborne** town centre, **Hayle** South and High lanes and **Illogan** Highway South.
- This analysis further suggests that there may be a particular requirement for better access to specialist drug and alcohol interventions for parents around **Hayle** and in the **China Clay area** (drugs and alcohol), **St Blazey and Launceston** (predominantly drugs) and **Liskeard and St Just** (predominantly alcohol
- Recorded incidence of sexual violence is comparatively low but **the current trend is rising**; there were 548 crimes reported to police in 2011/12, a rise of 20% compared with last year. The Sexual Assault Referral Centre and improved services to victims is understood to be having a **positive impact on the reporting rate** and Police data confirms that a higher proportion of victims are reporting their assault **within 7 days**.
- National prevalence estimates indicate 1,000 victims of rape and sexual assault (aged 16 years and over) annually in Cornwall. **Again, significant under-reporting**.
- Police reported incidence of domestic abuse and sexual violence in Cornwall is **higher than the average for similar areas elsewhere in the country**.
- Women, particularly young women, and children are most likely to be victims of domestic abuse and sexual violence but men are also victims and are less likely to seek help. National research also indicates higher risks of domestic abuse victimisation for vulnerable adults.
- Sexual violence is less likely to be linked to alcohol (an estimated 21% of offences) but **alcohol is more likely to be a factor in offences linked to the night time economy** (occurring at night and in a public place, 50%).

What are we doing about it?

Improving the safety of victims of domestic abuse and their families thus focuses on reducing repeat victimisation – by increasing the opportunities for early intervention, breaking the cycle of abuse and supporting victims through the criminal justice system and helping them to move forward in their lives free of abuse.

Cornwall's Domestic Abuse and Sexual Violence Strategy "The Right Response[39]" was first published in 2011, building on the previous Domestic Violence Strategy.

The response is structured around **four key principles**:

- **Prevent** domestic abuse and sexual violence from happening in the first place by challenging attitudes and behaviours which foster it and intervening where possible prevent it;
- **Provide** high quality levels of service of support where domestic abuse and sexual violence occurs;
- Work in **Partnership** to obtain the best outcomes for victims and families;

[39] Available to view and download from the Safer Cornwall website – Cornwall and Isles of Scilly Domestic Abuse and Sexual Violence Strategy 2011-2015 "The Right Response"

- **Risk Reduction and Justice Outcomes**. Take action to reduce the risk to men, women and children who are victims of these crimes and ensure that perpetrators are brought to justice.

These echo the principles underpinning the Government's Strategy 'Call to End Violence Against Women and Girls' (Prevent, Provide, Partnership Working and Risk Management and Justice Outcomes), but **widens their application** to include the call to end domestic abuse and sexual violence against **men, women, boys and girls of all ages**.

The strategy acknowledges that that **alcohol appears to be a major contributing factor** to domestic abuse and sexual violence and stresses the importance of joint working between services to ensure that substance use is effectively addressed alongside other issues for victims and families.

All domestic abuse services in Cornwall have been recommissioned this year with new contracts in place in the latter part of this year.

There are four key components of the services provided:

- The **Independent Domestic Violence Advocacy Service** provides risk assessment, safety planning and intensive support to victims and families. New commissioning arrangements have expanded the remit of the service to provide support to both high and medium risk victims and their families.
- The **Healthy Relationships programme** aims to increase awareness of abusive relationships to Year 8 to 11 (12 to 16 years of age) pupils and provide the attendees with the skills to identify warning signs and make informed decisions on their relationships.
- The **Domestic Abuse Prevention Programme** provides education to perpetrators as to the affects of their abusive behaviour and / or supports behavioural change, and complements existing programmes delivered by Probation for convicted perpetrators (**Building Better Relationships** and the **Voluntary Perpetrator Programme**, delivered in partnership with Children's Social Work).
- **Specialist therapeutic services for children** affected by domestic abuse.

Domestic abuse and substance use are key factors for families identified for the Together for Families in Cornwall programme (discussed in more detail under theme 3: Children, young people, parents and families). It is likely that packages of intervention will work around the multi-agency Family Intervention Programme (FIP) model, with all key services engaged. We are unable to say at this point how the programme will impact on existing service provision in terms of resources and targeting.

Further to the shared learning workshops between domestic abuse and substance use services ("Used and Abused" in 2011), in 2012 domestic violence advocates also undertook IBA training. Substance use workers have started to identify victims of domestic abuse using the "flag and tag" system to improve monitoring of domestic abuse cases and contribute to the information that is shared and response provided for the Multi Agency Risk Assessment Conference (MARAC).

7: Employment and deprivation

What the evidence says

Employment in treatment

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

- People in alcohol treatment are more likely than drug users to present to treatment **in regular employment** – 22% compared with 15% of drug users.
- The majority who start treatment in regular employment **continue to work**[40] whilst in treatment and are **more likely to complete their treatment successfully**.

29% of people in alcohol treatment are economically inactive (not working predominantly due to long term sickness or disability) and this is slightly higher than for drug users. Overall rates of **incapacity claimants due to alcoholism** in Cornwall are significantly above the England average.

The NDTMS risk profile[41] provides an overview of the complexity of adults entering the treatment system and unemployment at start of treatment is one of 11 factors examined.

- **55% of adults** starting alcohol treatment in Cornwall in 2011/12 were **unemployed** at the start of treatment, **above the national average** of 47%.

Migrant workers

In a survey of Migrant Workers in Cornwall it was found that **29% were not registered with a GP**. As Primary Care is the main starting point for a range of treatment options and pathways, this must act as a **barrier to alcohol treatment** pathways.

Over a third of respondents stated that they **drank more in Cornwall** than they had in their country of origin, with 6% of those asked admitting to drinking daily. As 40% declined to answer how often they drank in a week the real figure will be much higher. **Very few migrant workers are accessing treatment services**, with huge issues such as translation to overcome.

Deprivation

Around **10% of the population** of Cornwall live in areas that are described as deprived, according to national measures of deprivation.[42] These are predominantly found in town centres with the most deprived areas located in **Penzance, Camborne** and **Redruth**; we know, however, that there are **pockets of**

[40] Based on a subset of 311 Treatment Outcome Profiles (TOP) – this is primarily a (mandatory) tool designed to measure progress of drug users through treatment but just over a quarter of alcohol service users also have TOP.
[41] Joint Strategic Needs Assessment Support Pack for Strategic Partners, The Data for Alcohol (NTA, 2012)
[42] Defined as the 20% most deprived areas in England, English Indices of Deprivation 2010

deprivation in rural areas that are not identified by national measures due to the dispersed nature of our rural population.

- Many people living in these areas are **disadvantaged** by lower incomes, higher unemployment rates, ill health, child poverty, low qualifications, poorer housing conditions and higher crime rates.
- The Citizens Advice Bureau recorded a 56% increase in clients presenting with debt issues between 2007 and 2010, as well as a related 86% increase in problems with benefits. Of these, 15% of single people and carers also reported **turning to alcohol or drugs as a means of escape**, thereby adding to their financial pressure.
- **Welfare Reform** will place additional pressure on families and is predicted to increase the number of children in poverty. Incapacity benefit reassessments may result in people being declared fit for work at a time when unemployment is comparatively high. Changes to housing benefit will create particular challenges for housing vulnerable people and high risk offenders.
- Findings from the first round of Health Checks in Cornwall found that the health risk factor most commonly identified alongside higher risk drinking levels was **raised blood pressure**, and that this was **most evident in patients from deprived areas**.

What are we doing about it?

Identification and Brief Advice training (IBA) was undertaken by Job Centre Plus staff in the first round of the programme in 2011 so has been embedded for one year. There have been **5 referrals into specialist alcohol treatment services** in the last 12 months (to August 2012).

- We do not know what degree of **monitoring of IBA** delivery is taking place within Job Centre Plus and **this is now an important issue to** address, not only to evaluate the training given but for planning further training in the year ahead.

People living in **deprived areas** have been identified as a key target group for delivery of IBA. Deprivation is strongly associated with poor health in a wide range of areas, including higher levels of obesity, physical inactivity, unhealthy diet, smoking and poor blood pressure control, so this approach could offer **wider benefits for tackling health inequalities**.

8: Health, treatment, aftercare and recovery

What the evidence says

Alcohol and health

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

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

Health inequalities are clearly evident as a result of alcohol-related harm; alcohol-related **death rates are about 45% higher in areas of high deprivation**.

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

Evidence presented in this section has been drawn from national indicators and local research[43] into the health burden of alcohol misuse in terms of hospital admissions.

- Of the total 444,000 population aged 16 and over in Cornwall, just under a quarter (102,000) are drinking above the recommended safe levels, according to public health estimates; in addition, an estimated 84,000 are 'binge drinkers'.
- There are an estimated **4,900 dependent drinkers** in Cornwall and Isles of Scilly that may benefit from some form of alcohol treatment, including Extended Brief Interventions or Brief Treatment. This is a significantly lower number than estimates provided by previous models and this may have implications for service planning.
- National benchmarking data shows that compared with the England average Cornwall has a significantly higher rate of working age people claiming **health related benefits due to alcoholism,** a higher prevalence of people in **treatment for alcohol problems** and a higher rate of **alcohol-related road deaths**. Whilst health-related indicators[44] such as alcohol-related hospital admissions and deaths (see Local Alcohol Profile) for males are higher than for females, the majority of **health-related indicators for females** are above the regional average and some are also above the national average.

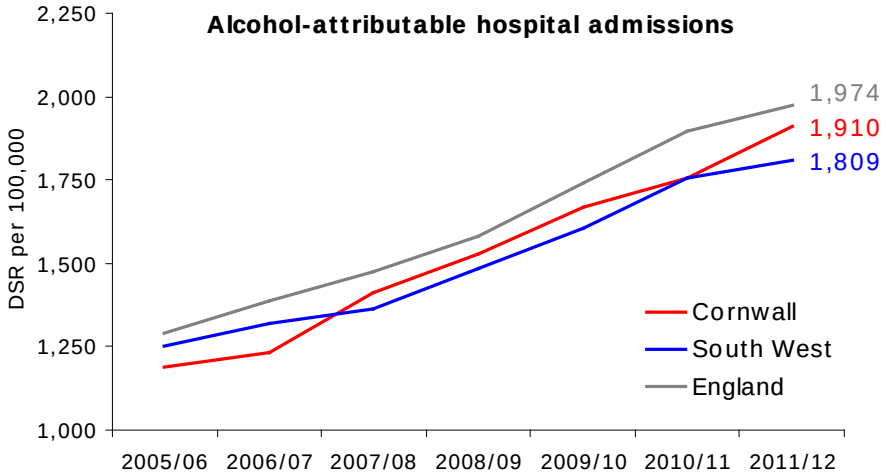
[43] Roberts S., Report to Health and Adult Social Care Overview and Scrutiny Committee on Alcohol-Related Hospital Admissions, January 2013.

[44] Alcohol-specific conditions are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose); alcohol-attributable conditions also include conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-attributable conditions with their ICD-10 codes can be found on the North West Public Health Observatory website.

- Cornwall has seen higher than average admission rates for alcohol-specific conditions among **young people** (under the age of 18 years) but **admissions in this group have been falling**. The latest rate is similar to that of the South West region and just slightly higher than the national average. Despite a falling trend, the fact that patients as young as **early 20s** are being admitted to hospital with **alcoholic liver disease** is of great concern.
- Admission rates for all ages pooled have been **increasing, locally and nationally**. The alcohol-related conditions with the biggest impact on admissions are **hypertension** and **mental/behavioural disorders**. Analysis of local data also highlights a significant impact on **injuries** from falls, self harm, assault and road traffic collisions.
- It is known that people living in deprived areas are more likely to be admitted for alcohol specific conditions than those living in the least deprived areas and alcohol-related **death rates are about 45% higher in areas of high deprivation**.
- Both long and short term misuse of alcohol **increase the risk of suicide**. Over time, alcohol misuse can disrupt relationships, and lead to alienation and depression. The immediate effects of alcohol can be to increase impulsive behaviour, with a loss of regard for the consequences. It is estimated that over a quarter of people in Cornwall and Isles of Scilly who have died by suicide in recent years have taken alcohol at the time of death.
- South West Ambulance Service Trust attended 730 incidents of alcohol overdose in 2011 (the latest data available), a reduction of 11% compared with 2010. **Two thirds of attendances** were accounted for by pick-ups from 7 towns – Newquay (21%), Truro (11%), Falmouth (10%), St Austell (8%), Redruth (7%), Penzance (6%) and Camborne (5%).

The number of hospital admissions for **alcohol-attributable conditions** is a key indicator used across the country to measure progress in reducing alcohol-related harm. It is one of two outcomes relevant to alcohol set out in the **public health outcomes framework** (the other relates to mortality from liver disease in people under the age of 75). The public health outcomes framework forms the new strategic direction for the new public health system, in which local authorities will have increased responsibility for health and wellbeing.

- Alcohol attributable hospital admissions have almost **doubled over a ten year period**. Age standardised rates are similar across Cornwall and Isles of Scilly, the South West and England.



- The local trend has tracked a middle path between the regional and national average for the last 4 years but the latest data[45] for 2011/12 suggest that the regional and national trends have slowed (+3% and +4% respectively) whilst Cornwall's hasn't (+9%). No further information is available at this time.

A consultation on alternative methodologies for calculating this indicator was undertaken in summer 2012 and we are awaiting the publication of the findings. One of the possible outcomes is a simplification of the way in which the estimates are calculated and thus more timely and meaningful data that is easy to interpret.

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

Activity recording shows that in the calendar year 2012, there were 35 alcohol related presentations of Cornish Young People at Derriford ED. Of these, 8 also involved drugs. 17 were male, 18 female, with a relatively even spread of 15 to 18 year olds: 15:7; 16:9; 17:11; 18:8.

In Treliske ED, in the year from 01/11/11 there were 40 presentations of young people related to alcohol, of which 8 also involved drugs. 18 were male, and 22 female.

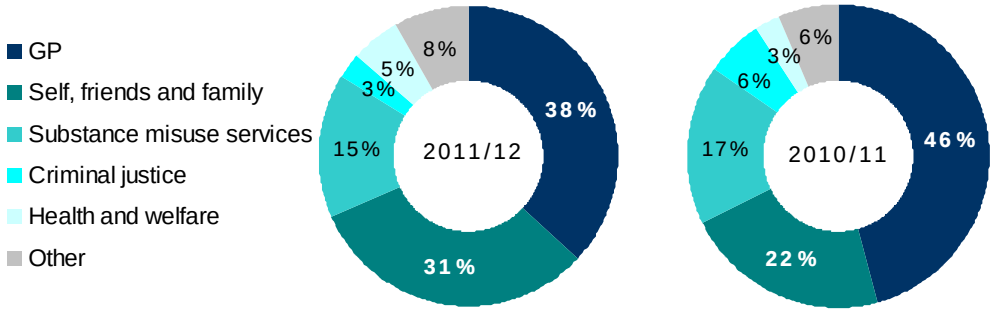
These spanned a wider age range than in Derriford: 11:1; 12:1; 13:4; 14:7; 15:10; 16:8; 17:6; 18:2, with 1 age unrecorded. These resulted in 4 child protection referrals.

- Our local data for attendances for assault-related injuries at Treliske Emergency Department, shows that in 81% of cases the related incident was recorded as linked to alcohol and the day and time profile shows a strong bias towards the night time economy (late night and weekends).
- 47% of attendees were aged 18 to 24 years and a further 11% were under 18.

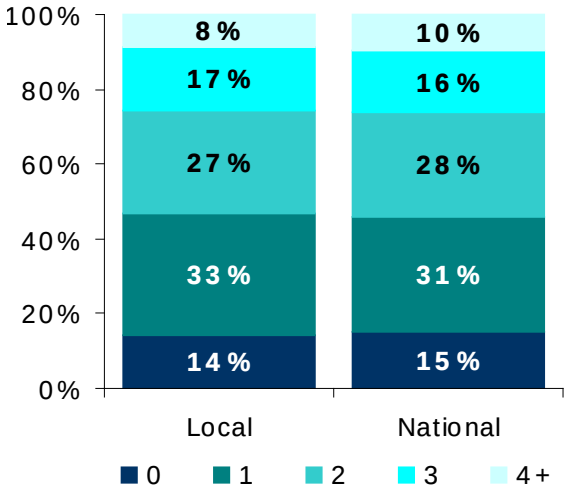
Alcohol treatment, aftercare and recovery

- Based on prevalence estimates, we are **more successful locally in attracting dependent drinkers into specialist treatment**. In 2011/12, 21% of dependent drinkers received specialist alcohol treatment in Cornwall and Isles of Scilly (1,295 people), compared with an average of 13% nationally. The national target is 15%.
- 877 new people started alcohol treatment in 2011/12 and this represents a **substantial increase** of 39% (around 240 people) compared with 2010/11. This equates to an extra 350 individual referrals as some people were referred in more than once. A higher percentage of referrals came through **non-GP routes**, **particularly self, friend and family referral** (accounting for 31% compared with 22% the previous year).
- There were small increases in referrals from wider community services (such as hospitals, mental health services, social services and Job Centres) and in referrals from "other" sources.

[45] Local Alcohol Profiles for England, North West Public Health Observatory



- The number of people referred twice or more within the year increased to 15% from 7% the year before and this raises a **question about the suitability** of referral.
- The **total number of people accessing specialist treatment in Cornwall appears to be dropping**, however, compared with previous years.[46] Despite the substantial rise in new presentations in 2011/12, this was largely balanced by the number of people leaving treatment, indicating a faster turnover than seen previously. Since April 2012, new presentations have fallen behind the number of people discharged.
- Although the impacts of excessive alcohol use are evident in the younger population, **recognition of a problem with alcohol frequently does not come until later life** when dependency is well established and has taken a considerable toll, particularly on health, but also on families and the wider community. The average age of first contact with specialist treatment is 40 years (for both men and women).
- Locally, people accessing alcohol treatment are **more likely than the national average to cite additional problematic cannabis use** (15% compared with 10%); additional opiate use and other drug use are fairly similar to the national profile.
- Many adults in alcohol treatment experience complex and wide-ranging problems and these can impact on an individual's ability to sustain treatment and complete successfully.
- The level of complexity in local service users coming into alcohol treatment is very **similar to the national profile** with the majority of people having one or two factors. The chart (right) shows the local complexity profile compared with the national.



- A review of individual factors, however, highlights that locally service users are much **more likely to be unemployed** at the start of treatment and to be using another drug (which we have already established largely means cannabis).
- Local service users are **less likely** to have been in treatment **three or more times previously** or to have been referred in **via the criminal justice system**.

[46] Published figures on ndtms.net indicates a drop of 15% in 2011/12 compared with 2010/11 but the latest data shows that that the number in treatment in 2010/11 was significantly revised downwards following the end of the year. The net result suggests a rise rather than a drop in numbers in 2011/12. Since the beginning of the 2012/13, however, the numbers have started to drop and the latest position suggests that there are 8% fewer people in treatment in the last 12 months (to August 2012) than there was in 2011/12.

Complexity item	Local		National %
	Number	%	
Unemployed at start of treatment	854	**66%**	57%
Lives with children	333	26%	30%
Received/is receiving treatment for drug use	286	22%	20%
Using another drug (not opiates or crack)	235	18%	14%
Receiving care from mental health services*	216	17%	19%
Housing issue at the start of treatment	175	14%	13%
Also using opiates / crack	76	6%	5%
3 or more courses of treatment	56	4%	11%
Pregnant	21	2%	1%
Referred from criminal justice system	20	2%	7%
Referred from A&E	<5		1%

* for reasons others than substance use

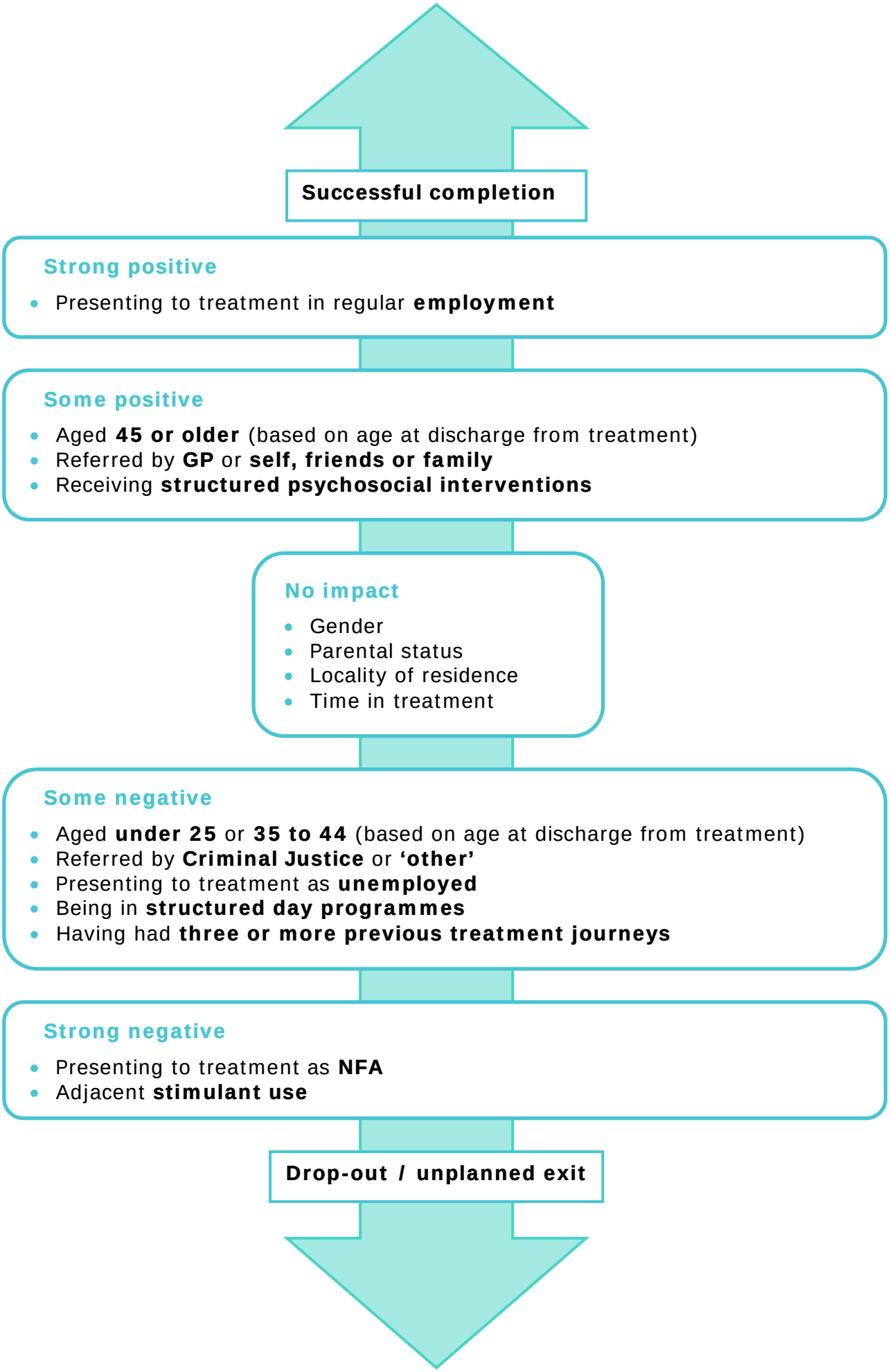
- People in alcohol treatment in Cornwall **stay in for longer** than the national average (272 days average compared with 175 nationally) and are more likely to be receiving **more than one type of treatment**.
- Psychosocial interventions are used much more widely locally (73% compared with 52% nationally) but day programmes and tier 4 treatment (inpatient or residential rehabilitation) are also above average. Community prescribing and "other" structured interventions, on the other hand, saw less use locally than the national average.

Who is leaving treatment successfully and what can we learn from them?

- People in alcohol treatment locally are **more likely to complete successfully** than the national average (68% compared with 57%) and **less likely to represent** in the 6 months following successful completion.
- They leave less quickly, however, which means that the number completing successfully as a proportion of everyone in treatment is similar to the national average at 36%.
- **In-patient treatment** and **structured psychosocial interventions** have the highest success rate in Cornwall.

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

- Several factors **do not notably impact** in either a positive or negative way – these are **gender, parental status, area of residence** and **length of time in treatment** before discharge.
- The **impact of ethnicity / nationality is difficult to assess** due to the low numbers of people in non-white / non-UK national groups. There appears to be a slightly higher rate of successful completions amongst non-UK nationals leaving treatment but the difference may not be significant.


Successful completion
Strong positive
Presenting to treatment in regular employment
Some positive
Aged 45 or older (based on age at discharge from treatment)
Referred by GP or self, friends or family
Receiving structured psychosocial interventions
No impact
Gender
Parental status
Locality of residence
Time in treatment
Some negative
Aged under 25 or 35 to 44 (based on age at discharge from treatment)
Referred by Criminal Justice or 'other'
Presenting to treatment as unemployed
Being in structured day programmes
Having had three or more previous treatment journeys
Strong negative
Presenting to treatment as NFA
Adjacent stimulant use
Drop-out / unplanned exit

What are we doing about it?

A recent public health report to the Health and Wellbeing Board[47] identified the following actions, to reduce hospital admissions addresses need at different levels:

- Focussing on **repeat attendees** (more detail below)
- Providing an **effective referral pathway** from hospitals to community alcohol treatment in Primary Care and in the community
- Delivering **effective alcohol treatment** in line with the latest evidence-based NICE guidance.[48]
- Promoting the use of Identification and Brief Advice, including a version of the validated toolkit adapted for Royal Cornwall Hospitals Trust.
- Wider health promotion initiatives

A focus on alcohol-related frequent attendees in hospital

This is a targeted approach to address the needs of the highest risk group. Actions include:

- Identification of the most frequently presenting patients;
- Co-ordinated multi-agency case review process;
- Agreed multi-agency care plans to be stored on Royal Cornwall Hospitals Trust IT systems and flagged on the reception system, so that patients are referred back to community treatment and support wherever possible rather than admitted;
- Incorporate this approach into the Emergency Dept Psychiatric Liaison RAID (Rapid Assessment Interface and Discharge) model processes.

In-patient treatment and residential rehabilitation (Tier 4 Interventions)

Severely dependent drinkers usually have **serious and long-standing problems**. Typically, they have experienced significant alcohol withdrawal and may have formed the habit of drinking to stop withdrawal symptoms. They may have progressed to habitual significant daily alcohol use or heavy use over prolonged periods or bouts of drinking.

Given adequate risk assessment and a comprehensive and intensive care plan, medically assisted alcohol withdrawal can be provided safely to many severely dependent drinkers in the **home** or in **community settings**. However, more drinkers in this category may be in need of **inpatient assisted alcohol withdrawal** and **residential rehabilitation**. Some may have **special needs**, such as treatment for co-existing psychiatric problems, polydrug dependence or complicated assisted alcohol withdrawal; others may need **rehabilitation** and strategies to address the level of their dependence, or to address other issues, such as **homelessness** or **social dislocation**. Some may have had multiple previous episodes of treatment.

Those with **additional and co-existing problems**, including people with mental health problems, people with learning disabilities, some older people, and some with social and housing problems, **may be particularly vulnerable**. They may have complex needs that require more intensive or prolonged interventions, even at

[47] Roberts S., Report to Health and Adult Social Care Overview and Scrutiny Committee on Alcohol-Related Hospital Admissions, January 2013.
[48] All NICE alcohol intervention guidance can be found on the NICE website. A full recommended patient pathway outline can be found here: http://pathways.nice.org.uk/pathways/alcohol-use-disorders

lower levels of alcohol use and dependence. Complex problems may also include **difficulties that have significant impact on others**, such as domestic abuse, whether as victim or perpetrator, impact upon children become young carers or experiencing harm.

Tier 4 interventions are residential, specialist alcohol treatments which are care-planned and co-ordinated to ensure continuity of care.

Provision Tier 4 treatment for both alcohol and drugs are key elements of the Government's National Drugs Strategy (2010) and in the increased focus upon **improving recovery from dependent drinking**.

These include:

- **Medically assisted alcohol withdrawal** (detoxification), stabilisation and assessment of complex cases in inpatient or residential care, including a range of structured evidence-based psychosocial therapies and support to address alcohol misuse
- **Residential rehabilitation** services

They are provided in offered in specialised statutory, independent or voluntary sector inpatient facilities and residential rehabilitation units for alcohol misuse.

For residents in Cornwall, access to residential detoxification facilities form part of a comprehensive framework of provision, the 'CIOS Stepped Approach to Alcohol Detoxification' ranging from supported detox at home ('**Home and Dry**') to detoxification in local community hospitals **(Community Hospital Alcohol Detox – CHAD**), as well as our purpose built unit in West Cornwall, **Boswyns** and through out of County referrals, where required.

Demand for in-patient assisted withdrawal considerably outstrips provision.

Waiting times for in-patient interventions / residential rehabilitation are **considerably longer than the national average** – in 2011/12 51% of people waited more than three weeks to start their first intervention, compared with 22% nationally.[49]

There is **poor provision** of residential service provision (both In-Patient and Residential Rehabilitation) **for particular vulnerable groups**, such as those with co-morbid mental health problems, clients with dependent children, young dependent alcohol and drug users, and clients with disabilities and learning difficulties.

Each client's circumstances should be judged individually as to what package of care would best suit their needs and circumstances.

The Stepped Approach to Alcohol Detoxification

CHAD is delivered by a partnership between Addaction, 5 GP practices and 3 Hospitals: Edward Hain in St Ives, Helston Hospital, Bodmin Hospital.

[49] Joint Strategic Needs Assessment Support Pack for Strategic Partners (NTA, 2012)

In 2011/12 102 detoxes were carried out in these settings, compared with 116 in 2010/11. This is a developing service, which has potential to increase capacity and delivery to St Mary's, Liskeard and Newquay in future.

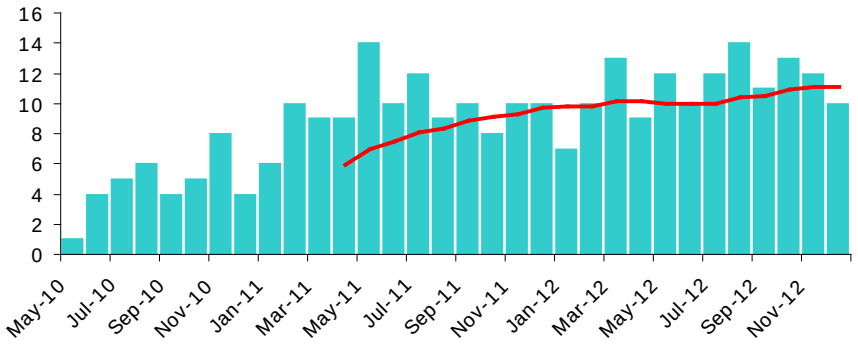
The National Tier 4 Needs Assessment guidance estimates that 10% of the treatment population require in-patient interventions and 5% require residential interventions. This would equate to 129 detoxes and 64 residential rehabilitation placements in 2011/12. Whilst take up of both in-patient and residential rehabilitation placements increased significantly, only residential rehabilitation placements matched the required level of capacity, albeit for the first time.

Treatment / year	2011/12	2010/11	Change n	%
In-patient	46	11	35	318%
Residential rehab	62	33	29	88%
Total tier 4	101	42	59	140%

Boswyns opened in May 2010 and this was the first time that residents of Cornwall and Isles of Scilly had access to a local dedicated specialist unit for assessment and detoxification. Two thirds of people accessing treatment through Boswyns receive alcohol treatment.

Since opening, 258 severe and dependent drinkers have been supported to withdraw from alcohol in this residential setting, with just over a third receiving treatment for drug dependency at the same time.

The number of people admitted has steadily increased to an average of 11 per month (see chart, right).



Successful completions for alcohol detoxification are well above the national average at over 80%, although adjacent drug problems reduce the success rate significantly.

After detoxification, 22% went on to residential rehabilitation settings (Bosence, Chy, Trevi House), which is half the rate estimated as required. The vast majority were discharged to their home (69%, with aftercare support).

37 people have undertaken more than one episode of detoxification for alcohol (or alcohol and drugs together) at Boswyns, meaning a **re-presentation rate of 14% or around 1 in 7**. For most (24 out of 37), a second episode of treatment has followed previous successful completion and this happens on average 44 weeks later (with a range of 2.6 to 104 weeks).

The DAAT commissioned an evaluation of the service from the start, including the evaluation of the user experience, that of referrers in the community and follow up residents on completion.

Service user experience

I have been here before (walked out previously) and have also been to Clouds. I have taken drugs since I was 14 years old (opiate user for 10 years). I was in prison at 17 years old for 3 years. I am detoxing from drugs and alcohol now and have been here a week

I have been in community services for between 2-4 years. I have tried many different treatments but I couldn't make them work for me. Service x offered counselling which didn't work but the farm is a miracle. I was told about the farm and looked it up on the internet.

I have been in treatment 3 times: 13 years ago for family. 2-3 years ago I was in Broadreach, I was dishonest there and left. I had trouble with violence and engaged with Freshfield and Addaction. I have been here for 6 weeks and on the farm for 7 months, I will be leaving in 4 months. I will make use of the support and my friends when I leave. I have a deposit on a cottage, it was the best thing I did coming to the farm

I have been in community services for under 2 years. I went to Addaction meetings and my employment came to and end which was hard. I contacted Addaction and was then placed here. I have been here for 4-5 months and leave in 6 weeks. I will continue to see Addaction, visit my GP, go to the gym, yoga and generally keep busy and maintain structures and close communications with people on the farm and AA.

I have been in community services for under 2 years. Probation helped to get me in here and the farm because I asked for their help. I was very unwell, had attempted suicides. It wasn't easy coming here but I felt safe and am so glad to be here.

I have been in community services for under 2 years. I was here over a year ago and also in Chy Colom where I relapsed, I have attempted suicide which triggered me to see my key worker and I was then referred here

I was homeless and dying on the street. St Petroc's referred me and it was a very very good process. I have been on the farm for 2 weeks

I was told I was dying, this time is different for me as I'm doing it for myself

If you have been in rehab more than once, what is different this time?

Last time I came because my family wanted me to, this time I'm doing it for me

Good / positive feedback about Tier 4 services

- Accessible through NHS.
- Residential is fantastic as this is being stopped in some other counties.
- Previously there were only a proportion of care workers who knew the system/funding. There are now lots of care managers who have knowledge/experience of the system.
- If you have a good care manager you know that funding, aftercare etc will all be sorted.
- Work between Bosence and Boswyns is 'warm and delighting'.
- Steve Slade is very good – beginning stuff could be improved!
- Sharon Nesbit and Rachel Hawley are very good.
- Night shelter and St Petroc's relationships are very good.
- Flexible workers – e.g. funding was agreed for a client, they were in the next day for a look around and then in the week after.
- Links with Chy Colom have really improved.
- Ability to respond is getting better.
- Cosgarne, Freshstart and Coastline are very open, want to build relationships.

Bad / negative feedback about Tier 4 services

- Some peoples' care workers visit them regularly, others don't at all
- Only half of the referrals received can be actioned straight away because of the quality of the referral information. It can take weeks and can be difficult to get the missing information.
- A care worker brought in a client to look around. They were keen to get things moving so spoke to the clients care manager who wasn't happy to refer on.
- Funding is a problem. People know they want to go to rehab, and knew this on their first day in detox, but their funding hasn't been sorted. Chasing these wastes a lot of time.
- Funding for extensions is getting harder and harder.
- Some care workers have 70 people on their case loads and are leaving because of this. Some are not aware of who their clients are.
- Clients don't always know who their care workers are; some have only met them once.
- Care managers in some cases have already decided clients won't be going to rehab without having open discussions.

What could we do to improve the service?

- Option of going to all types of tier 4 service needs to be put on the table for clients
- Fully explore information of T4.
- Streamline funding.
- Not have a 'lottery effect'.
- Clearly defined roles, who should be doing what and what the care co-ordinators responsibilities are. Staff shouldn't be taking clients to GP/dental/hospital appointments, picking clients up, taking clients to Chy Colom/home etc.
- Access to community physio would be good.
- Travel expenses for criminal justice clients to attend appointments
- Primary care needs in house.
- Audit what primary care medical needs to be done.
- The ability to look/shadow other workers to gain an insight in what they do and help understand their jobs.

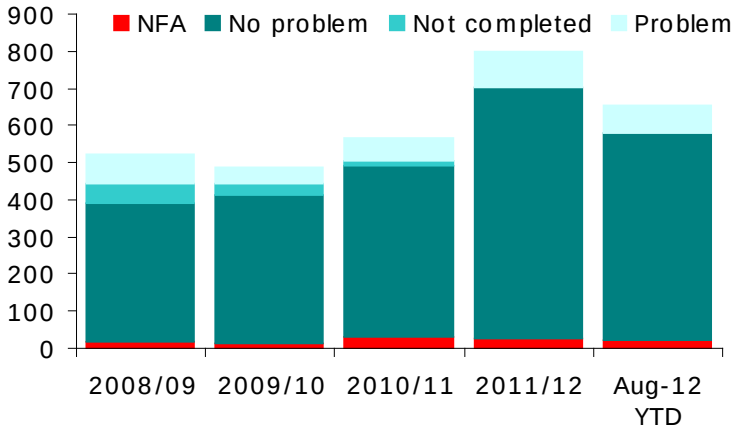
9: Homelessness and housing

What the evidence says

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

In order to successfully support people through alcohol treatment it is vital that they obtain and remain in suitable housing. Relapse can often lead to the loss of housing, causing problems in maintaining contact with treatment and support.
In the last 12 months, 15% of people starting alcohol treatment presented to treatment with problems with their accommodation (99 people); 4% were homeless.

The proportion of people in accommodation need on presentation to treatment has remained fairly constant over the last three years, although the numbers requiring support saw a spike last year, reflecting the rise in new presentations.



- People in alcohol treatment are **less likely than drug users** to present to treatment with accommodation problems.
- Prevalence of housing issues for people presenting to alcohol treatment is **in line with the national average**. It is one of the 11 key complexity factors.
- Although many people are helped to improve their housing situation whilst in treatment, homelessness at treatment start is the **strongest negative factor in successful completion**.

Pressures on the housing market, combined with the current economic climate and changes to benefits under Welfare Reform, places an **increasing number of people at risk of homelessness**, including those who would not have previously been considered vulnerable.[50] Changes to housing benefit will create particular challenges for housing vulnerable people and high risk offenders.

What are we doing about it?
Housing agencies and services both independent and within Cornwall Council have:

- Signed up to the Alcohol Strategy
- Agreed that a tiered approach is the correct approach although hard to deliver,
- Have engaged with the community IBA training, and
- Continue to undertake ACS commissioned outreach services.

[50] Homelessness Strategy 2010, Cornwall Council

10: Licensing, alcohol retail and the night time economy

What the evidence says

Evidence shows that the best results are gained when there is a constructive relationship between the Licensed Trade and local enforcement authorities. When well run schemes are located in affected areas, both the number of violent incidents and the burden on hospital Emergency Departments are reduced, and schemes work at their best when all the Licensed Trade in an area commit to supporting them, so that there is no commercial disadvantage created[51].

The term 'evening and night time economy' refers to leisure-related businesses that are open after normal shopping hours, such as bars, pubs, nightclubs and takeaway food outlets.

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

In this assessment, when we refer to crime linked to the night time economy (or NTE) we mean **the late night period that this relates to** (from 9pm to 5am).

There is no standardised data routinely available on alcohol-related violence linked to the night time economy. Monitoring and analysis in trends in violent crime in Cornwall has focused on violence with injury as the key indicator – although this includes domestic abuse so has limitations when specifically applied to the night time economy. Previous analysis has been undertaken using crimes recorded as linked to alcohol consumption or licensed premises but there is a gap in the data between October 2011 and March 2012.

For the purposes of establishing a fairly robust link with the night time economy for this assessment, non-domestic crimes occurring within the time period 9pm and 5am and in a public place (street/highway/road, licensed premises or takeaway food outlet) were examined.

- 1 licensed premise per 104 people in Cornwall – believed to be the highest ratio in the country.
- 1,469 recorded violent crimes linked to the night time economy in 2011/12, no change compared with last year.
- 38% of night-time economy violence in 2011/12 was recorded as taking place on licensed premises.

- Although overall violent crime saw a significant rise in Cornwall in 2011/12 compared with the previous year, violence directly associated with the night-time economy **remained relatively**

[51] Department of Health http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104854.pdf

stable. There were, however, **more crimes recorded as resulting in injury and fewer without injury**.

- Night time economy violence continues to be an important issue for community safety. It **accounts for around a third** of all recorded non-domestic violence and it is **significantly more likely to be linked to alcohol.**
- In 2011/12 **70% of violence linked to the night time economy occurred in Cornwall's larger towns**, resident to only 39% of the population. The top 5 hotspots are **Newquay Gannel** North East, **Truro Boscawen** City Centre, **Penzance Town** Centre**, Falmouth Arwenack** North and **Redruth North** Ward South. These problems peak at weekends and in the summer months and can **negatively affect local businesses and the way in which residents and visitors use and enjoy our town centres**.
- Victims of violence linked to the night time economy are most likely to be **young males** – 38% of crimes involved a male victim under the age of 25 years. The highest risk of victimisation is at 18 years. Under 18s make up 10% of victims. Assault-related injury data shows a similar profile with young males being most likely to attend the Emergency Department due to being assaulted (50% of attendances are male and under 25 years of age).
- **20% of neighbourhoods in Cornwall cite an alcohol-related issue as a problem** in their local area through Have Your Say consultations. In the majority of cases issues of concern are specifically linked to the night time economy.
- Cornwall is ranked **2nd highest in our 'most similar family' group for the number of noise nuisance complaints** made to the authority which require an investigation.
- Local test purchase operations indicate that **under-age alcohol sales continue to be a problem** in Cornwall.
- Although a third of licensed premises have no crime recorded in the immediate vicinity, there are **clusters of licensed premises in crime hotspots** (such as in Newquay, Truro and Falmouth).
- Improving safety in licensed premises provides benefits for the workforce; **the licensed trade is a key element of our local economy** and a significantly higher proportion of employees work in bars than regional and national averages.

The issue of "**pre-loading**", drinking at home prior to going out, has been subject to significant media attention and is seen as symptomatic of the current economic climate, with drinkers opting for cheaper shop-bought alcohol to reduce the cost of a night out.

Research in Plymouth[52] found that **66% of those arrested for violence/public order offences had pre-loaded** and they self assessed as more intoxicated than those that hadn't. **Major supermarket chains were the main source** of alcohol. The main reasons for offending were arguments with friends and flash points over 'control' by door/bar staff etc.

The research highlights that **a lack of controls in the home environment** (such as standardised measures, door staff, inability to judge the degree of intoxication in the context of others) is a key issue and concludes that **more thought needs to be given to controlling early evening drinking**.

[52] The impact of 'pre-loading' on Plymouth's night time economy, Barton A. and Husk K., Plymouth University, 2012

What are we doing about it?

In 2012, a Cornwall-wide multi-agency **alcohol-related violence task group** was established and a pooled **town centre "toolkit"** is in the process being developed, with the aim of promoting best practice approaches from a range of interventions and initiatives that have been successfully implemented to date.

A range of community safety initiatives that impact specifically on the night time economy have been implemented by Safer Cornwall and are discussed in more detail in Section 4: Community Safety Schemes. These include:

- Assault Related Injuries Database in Treliske Emergency Department, used to identify potential problem premises to support proactive targeting by police and licensing
- Safer Towns programmes, supported by £90,000 funding from the national Alcohol Prospectus Fund
- StreetSafe service and Follow You Home initiative in Newquay
- What Will Your Drink Cost? Campaign

In addition, we have just completed year two of the Cornwall **Best Bar None** award scheme. This is believed to be the only countywide scheme of its type in the country, and will be expanded to incorporate more categories of premises in the next few years.

Best Bar None is a UK-wide scheme which is backed by the Home Office and the BII. In just nine years it has been adopted in over one hundred towns and cities. Its aim is to promote the responsible management and operation of alcohol-licensed premises. More details can be found on the Cornwall Best Bar None Facebook page and the new Cornwall Best Bar None site (http://www.cornwallbestbarnone.co.uk/).

In Cornwall the members of the Cornwall Licensing Strategy Group, including Cornwall Council, the Fire and Rescue Service, Devon and Cornwall Police and licensed trade representatives lead and manage delivery of the scheme.

The scheme **rewards licensees** who demonstrate excellent management practice, provide a **safe and enjoyable environment** for customers, encourage **responsible drinking** and **reduce the potential for alcohol related crime**. It provides a positive communication channel between the licensed trade and statutory authorities.

Premises that meet the criteria are awarded Best Bar None accreditation and those that demonstrate exceptional management practice have the chance to achieve the ultimate and become overall Cornwall winners.

The overall winner and the Cornwall Best Bar None premises for 2013 was Sound Nightclub, Penzance

The Awards Evening for the 2013 Cornwall Best Bar None Scheme took place at Heartlands, Pool on Tuesday 26th March 2013.

Des Tidbury, Chief Fire Officer for Cornwall, presented accreditation awards to the following premises:

- Sound, Penzance – also winner of Best Nightclub
- Vanilla, Truro
- The Eclipse, Bodmin
- The Central Inn, Newquay
- Zafiros, Truro – also winner of Best Bar
- Walkabout, Newquay
- The Office, Truro
- The Western Inn, St Austell
- The John Francis Bassett, Camborne – also winner of Best Large Pub
- The Hain Line, St Ives
- The Tremenheere, Penzance
- The Hop and Vine, St Austell – also winner of Best Small Pub
- The Cribbar, Newquay
- The Try Dowr, Truro
- The Chapel An Gansblydhen
- The Rann Wartha, St Austell

The award for the premises showing the most commitment to staff training sponsored by the British Institute Of Innkeeping was won by Sound and The Hop and Vine.

Some areas in Cornwall are running or investigating other best practice trade schemes, such as Business Improvement Districts or Purple Flag status areas, and towns with **Cumulative Impact Zones (Newquay, Penzance and Truro)** are reviewing the lessons learned in order to improve practice.

Licensing and Trading Standards have also undertaken the following additional activities in 2011/12.

- Challenge21 and Challenge25 schemes

- Operation Viking (targeting under-age drinking) and test purchase operations
- Publishing and circulating newsletters to the licensed trade, including the taxi and private hire trade
- Safety Health Awareness Days (SHADs) and licensing forums
- Training council members about administration of new licensing legislation and requirements

The Community Safety Intelligence Team, working jointly with Public Health and Protection and other partners as appropriate, has recently undertaken the development of a comprehensive evidence base to support a complete refresh of the Cornwall Licensing Strategy and this is planned for delivery in summer 2013.

This will support local decision making for the application of new measures introduced in the Police Reform and Social Responsibility Act 2011, including a **late night levy** to help cover the cost of policing the late night economy, **increasing the flexibility of early morning alcohol restriction orders** and **doubling of fines for persistent underage sales**.

Cornwall profile – facts and figures

All the information in this profile was drawn from the Cornwall 2012: Bitesize guide[53] produced by Community Intelligence, Chief Executive's Department, Cornwall Council.

Population

- 2011 Census estimates suggest that Cornwall's population stands at around **532,300**[54] and is estimated to reach 633,200 by 2030[55], an increase of 100,900 (18.9%).
- Cornwall's population has been growing steadily since the 1960s. The highest numbers of **inward migrants are persons of working age**, contrary to common perceptions that most people who move to Cornwall are retired or elderly.
- In line with national trends **Cornwall's population is getting older** as average life expectancy continues to rise; it is estimated that by 2033, one in four people will be aged 65 and over.
- Cornwall has **fewer younger people** than the UK average but this is changing.
- Black and minority ethnic groups are estimated to make up around 4% of the population; this is in contrast to only 1% in the 2001 Census. This does not include migrant workers (estimated at between 8,200 and 13,900[56]) and Gypsy, Roma and Traveller communities (estimated at around 1,000).
- Cornwall's resident population is **significantly swelled by tourists each year**. In 2010 there were 10.2 million day trips and 3.9 million staying trips, bringing in a total visitor spend of £1.6 billion and supporting 22% of employment.

Households and housing

- Cornwall has just over **230,400**[57] **households**. Around 53% are couples living together and 34% are households with only one person. The rest are single-parent families (7%) or people living in shared accommodation (4%).
- **Housing affordability is a major issue in Cornwall** – particularly for new households. Despite the recent economic downturn house prices have remained strong as demand for housing has remained high.
- Cornwall suffers from the **worst fuel poverty in the South West** and furthermore the rate of **excess winter deaths is significantly higher** than in England and Wales.
- As at the 31st March 2012 there were just under 25,000 households in need of housing.
- Pressures on the housing market combined with the current economic climate places an **increasing number of people at risk of homelessness**, including those who would not have previously been considered vulnerable.[58]

---

[53] This is published on the Data and Research pages of the Cornwall Council website
[54] Note that this is from the first release from the 2011 Census. All rates elsewhere in this document are based on mid-2010 estimates which were the latest available at the time the analysis was undertaken.
[55] 2008-based subnational population projections and mid year population estimates, Population Estimates Unit, ONS: Crown Copyright 2010
[56] LINC (Local Intelligence Network Cornwall) derived this 'best estimate' of Migrant Worker numbers in 2006, which is well beyond the official Worker Registration Scheme (WRS, around 3,000) figures for Cornwall and could, in itself, be an underestimate.
[57] 2011 Census, ONS: Crown Copyright 2012
[58] Homelessness Strategy 2010, Cornwall Council

Education and skills

- Enhanced participation in education and educational attainment at all levels are vital to the future competitiveness and flexibility of Cornwall's businesses and labour market. **Skills levels** of local residents of working age **are slightly lower than the regional average**.
- GCSE attainment and the percentage of residents qualified to degree level and above, however, are **improving**.
- Six universities and colleges make up the Combined University for Cornwall and we are one of the UK's fastest growing study destinations. The **number of students has more than doubled in the last eight years** and this presents both risks and opportunities.

Labour market and economy

- Earnings in Cornwall are approximately **19% below the national average**.[59] This can be attributed to an over-dependence on low paid jobs, a higher proportion of seasonal and part time jobs and lower earnings across many sectors of the economy.
- **Levels of unemployment have risen** both nationally and locally in the wake of the recession. Unemployment levels in Cornwall have been getting worse since 2007 (4.1%), and are now in-line with national rates at 7.5% of the working age population.
- The rate of unemployed 16 to 24 year olds in Cornwall has risen by 40% over the last two years; this is **one of the highest rises in the South West**.
- Levels of unemployment differ across Cornwall and there are areas with **high concentrations of people who are not in work**, which is a severe and persistent problem.
- Growth rates for the local economy have been high over the last decade. It remains the **second weakest economy in the country**, however, and the latest data for 2009 shows local **economic decline from the recession has been worse than the national average**.[60]

Deprivation

Cornwall as a whole is not particularly deprived, ranking 110 out of 326 local authorities. There are, however, wide geographic variations between areas; Pengegon in Camborne is within the 2% most deprived areas in England and Latchbrook South is at the other end of the spectrum at 94%.

- Around **52,000 people (10% of the population of Cornwall) live in 'deprived' communities** according to the national measure of deprivation.[61] These are predominantly found in town centres; we know however that there are **pockets of deprivation in more rural areas** that are not identified by national measures due to the dispersed nature of our rural population.
- Many people living in these areas will experience issues associated with **lower incomes, higher unemployment rates, ill health, child poverty, low qualifications, poorer housing conditions and higher crime rates**.

59 ONS annual survey of hours and earnings - resident analysis, 2011, NOMIS
60 Cornwall's Economy at a glance, Community Intelligence, March 2012
61 Defined as the 20% most deprived areas in England, English Indices of Multiple Deprivation

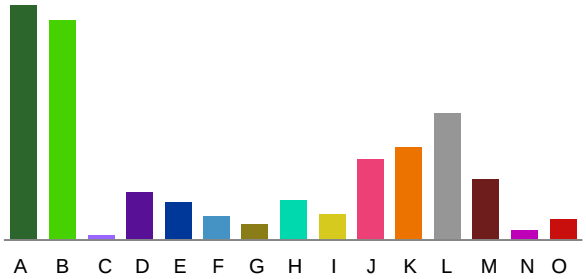
- The effects of deprivation are often **cumulative** and **intergenerational**. Those who are in persistent poverty i.e. poor for a long time, are most at risk of social exclusion.
- The Department for Work and Pensions estimate that 19% or **17,040 children aged under 16 live in poverty** in Cornwall. This is a rise of 420 children since 2008 and is **likely to rise further** given the welfare reforms and reductions to benefits.

Health and Wellbeing

- 66% of Cornwall residents described themselves as being in good health.[62]
- Cornwall has a **higher than average rate of chronic disease or limiting long term illness**, however, even when the numbers of elderly people are considered.
- Compared to the England average, Cornwall has a **high percentage of people with a mental health diagnosis**.63 Dementia prevalence and the percentage of people with depression in Cornwall are higher than the South West and England.
- A significantly higher proportion of the working age population in Cornwall is claiming **health related benefits due to alcoholism** and the majority of alcohol-related **health indicators for women are worse than the regional average**.[64]
- Road deaths due to alcohol are also significantly higher than average.

Household Types in Cornwall

Experian's Mosaic UK™ is a classification system provides an understanding of the demographics, lifestyles and behaviour of all individuals and households in the UK. The data can be used to better understand our communities and make sure that services are designed around their needs.[65]



Households in Cornwall are most commonly residents of isolated rural communities (23%) and small and mid-sized towns with strong local roots (21%).

Group A

Residents of isolated rural communities

55,700 households,

- Small villages and isolated farmhouses
- Traditional way of life and long established local families
- Strong community spirit and sense of responsibility towards neighbours
- Farming, small businesses, low and middle income jobs in local market towns; high self employment
- Modest disposable income but quite high levels of capital; high motor costs
- Low crime but residents often complain that they get little support from police
- A legacy of poor quality housing among privately rented stock
- Physical access to public and commercial services is a serious issue
- Residents prefer face-to-face contact but increasingly rely on the internet and the telephone

62 2001 Census, NOMIS
63 Community Mental Health Profile 2012, North East Public Health Observatory
64 Local Alcohol Profiles for England, North West Public Health Observatory
65 If you would like further information on Mosaic please contact the Cornwall Council Community Intelligence Team; telephone: 01872 324126, email: intelligence@cornwall.gov.uk

- Medium sized and smaller towns
- Mixed communities in terms of ages and types of household
- Traditional attitudes and strong local roots; support of extended family networks and friends
- Wide range of jobs in service occupations and public sector; mixed income levels but few at either extreme of the income distribution
- Mixed housing; often older properties, poor condition private rents above shops
- Lack of variety of entertainment for young people
- Moderate crime levels; relatively good relationship with local police
- Good access to public and commercial services, often within walking distance
- Prefer face-to-face contact and establishing a personal relationship; internet and telephone less favoured channels of communication

Group B
Residents of small and mid-sized towns with strong local roots
52,300 households,

Breakdown by all types

Group A Residents of isolated rural communities *55,700 households, 23%*	**Group B** Residents of small and mid-sized towns with strong local roots *52,300 households, 21%*	**Group C** Wealthy people living in the most sought after neighbourhoods *1,200 households, 0.5%*
Group D Successful professionals living in suburban or semi-rural homes *11,300 households, 5%*	**Group E** Middle income families living in moderate suburban semis *9,100 households, 4%*	**Group F** Couples with young children in comfortable modern housing *5,600 households, 2%*
Group G Students and transient singles *3,600 households, 1%*	**Group H** Couples and young singles in small modern starter homes *9,500 households, 4%*	**Group I** Lower income workers in urban terrace *6,200 households, 3%*
Group J Owner occupiers in older-style housing in ex-industrial areas *19,200 households, 8%*	**Group K** Residents with sufficient incomes in right-to-buy social housing *21,900 households, 9%*	**Group L** Active elderly people living in pleasant retirement locations *30,000 households, 12%*
Group M Elderly people reliant on state support *14,500 households, 6%*	**Group N** Young people renting flats in high density social housing *2,200 households, 1%*	**Group O** Families in low-rise social housing with high levels of benefit need *4,900 households, 2%*

Further reading

Key assessments, strategies and information sources are shown below with links to their current locations.

Community Safety

All assessments relating to community safety issues can be found on the Safer Cornwall website http://safercornwall.co.uk/crime-in-your-area/documents-publications/
These include:

- Safer Cornwall Strategic Assessment
- Adult Drug Treatment Needs Assessment
- Young People's Specialist Substance Use Treatment Needs Assessment
- The Peninsula Strategic Assessment, which brings together the key messages from the community safety partnerships across the Devon and Cornwall Peninsula.

In addition, the following may be of interest:

- **Cornwall and Isles of Scilly Domestic Abuse and Sexual Violence Strategy** "The Right Response" http://safercornwall.co.uk/what-we-do/domestic-abuse-sexual-violence/
- **Risk Based Evidence Profile** currently published internally only; a copy is available on request from the Business and Intelligence Unit, Community Safety and Protection (contact Sophie Coles scoles@cornwall.gov.uk)

Overarching assessments for Cornwall

- **Understanding Cornwall** http://www.cornwall.gov.uk/default.aspx?page=24160
- **Joint Strategic Needs Assessment** – information and online resource library of assessments and focus papers http://www.cornwall.gov.uk/default.aspx?page=29567

Cornwall in context

- **Cornwall People Profile** http://www.cornwall.gov.uk/default.aspx?page=26491
- **Cornwall 2012: Bitesize guide** – will be published Data and Research pages
- **2011 Census at a glance** http://www.cornwall.gov.uk/default.aspx?page=26945
- **Cornwall's Economy at a glance** and the **Local Economic Assessment** http://www.cornwall.gov.uk/default.aspx?page=22135
- Local Alcohol Profiles for England, North West Public Health Observatory

Appendix A - Alcohol Diversions for offenders

Enforcement and Intervention

Preventative interventions alongside enforcement are being actively promoted to police officers and staff, to increase the chances of reducing offending. A leaflet detailing the 11 options available are being distributed widely – a summary of which is shown here.

1: (Alcohol) Arrest Referral

The NHS Arrest Referral team can contact offenders in custody, in court (esp. CJSSS) or after Exit Risk Assessment Referral. They can work within the legal process or alongside it.

2: Alcohol Conditional Caution

This can be offered to offenders who are aged 18 and over and who:

- Have been arrested for D&D, D&I, S5POA;
- Have been arrested for Criminal Damage up to £500;
- Have a limited criminal record.

If a Conditional Caution is agreed by the CPS, the offender must then make contact with the treatment agency within four days to organise the alcohol session. The session has to be attended within the next four months from the date of the offence.

The Custody Sergeant sends the 341(j) form to the treatment provider to notify them of the offender's contact details, risk assessment etc, with a copy going to the Conditional Cautioning Co-ordinator.

3: PND Alcohol Diversion Scheme

Offenders eligible for an £80 PND for D&D or S5POA, can instead be referred to an Alcohol Awareness Course. This costs them £40, and eliminates the PND if they attend. There is also a course for juveniles, and a Cannabis Diversion Scheme.

4: ASB Alcohol Diversion Scheme

From November onwards, this will at least initially be based on the Druglink PND ADS Course, with an emphasis on the juvenile version, as most ASB interventions are for under 18 year olds. Attending the course may result in the removal of a Warning, or may be an early intervention for Stop and Search contacts.

This scheme will be launched in November 2012.

5: Court Requirement: Low Intensity Alcohol Programme

Offenders can be sentenced to a 14 session group programme, run by Probation, which helps them to face up to the impact and consequences of their actions. This is targeted at offences of low level violence and disorder, and has an excellent proven track record locally of reducing reoffending.

6: Court Order: Alcohol Treatment Requirement

Highly dependent drinkers can be sentenced into treatment, to be monitored by Probation and reviewed by the Court.

This is not a group activity, it is care planned treatment within the Cornwall alcohol treatment system.

7: ASB Drinks Banning Order (DBO)

A DBO imposes restrictions on an offender, to protect other people from alcohol-related crime or disorder.

The prohibitions must include whatever the court thinks is necessary with regard to that person entering premises that sell alcohol. This could include exclusions from:

- Purchasing alcohol;
- Consuming alcohol or being in possession of alcohol in public;
- Specified individual or sets of licensed premises;
- All licensed premises in a geographically defined area.

A DBO can last from 2 months to 2 years.

8: Inebriates Act

Under this legislation premises can be fined up to £500 for knowingly serving a declared 'habitual drunkard', while the offender can also be fined up to £200.

Once sentenced it becomes an offence for the 'habitual drunkard', who has caused repeated problems in the same place, to purchase or attempt to purchase alcohol again after the police have distributed identifiable information about them.

The police also have the responsibility to distribute identifiable information about the offender.

9: ASBO

We have a countywide ASB team, addressing all stages of the ASB process, with the emphasis on early intervention where possible.

This has resulted in reduced rates of ASB over the last few years.

10: Follow You Home

If someone visiting the area commits an ASB or Disorder offence, we would like the implications and follow up to be addressed in their home area. We have developed a system for making sure this takes place.

11: PPO / IOM scheme

The Prolific Offender Team work in a multi-agency setting, addressing the background issues in the lives of those committing the most crime.

This will lead to targeted enforcement where necessary, but will also lead to referrals for help in addressing such issues as drugs, alcohol, mental health, housing, benefits, and training.

Appendix B Report to HASCOSC

Full report to the Health and Adult Social Care Overview and Scrutiny Committee

Report From: Felicity Owen, Director of Public Health
Authors: Sara Roberts, Associate Director of Public Health,
Jez Bayes, DAAT Alcohol lead.
Date: 8th January 2013
Subject: Alcohol-related hospital admissions

1.0 Purpose

HASCOSC has requested a paper describing the health burden of alcohol misuse in terms of hospital admissions.

2.0 Executive summary

Just under a quarter of the adult population of Cornwall & Isles of Scilly (102,000 people) regularly drink above recommended safe levels of alcohol. In addition, 66,500 people are 'binge drinkers'.

Excessive drinking is a major cause of disease and injury, both short term due to alcohol poisoning and the consequences of risk taking behaviour, and longer term due to the effects of regular alcohol misuse on mental and physical health. Health inequalities are evident; alcohol-related death rates are 45% higher in areas of high deprivation.

Hospital admissions provide a useful indicator of alcohol-related harm. A distinction is made between alcohol-specific rates (due solely to alcohol misuse) and alcohol attributable rates (calculated as the sum of the influence of alcohol on admissions for conditions that are sometimes due to alcohol).

Cornwall has seen higher than average admission rates for alcohol-specific conditions among young people (<18 years) but admissions in this group have been falling. Admission rates for all ages pooled have been increasing, locally and nationally. The alcohol-related conditions with the biggest impact on admissions are hypertension and mental/behavioural disorders.

Action to reduce hospital admissions addresses need at different levels:

- focussing on repeat attenders,
- providing an effective referral pathway
- delivering effective alcohol treatment
- promoting the use of Identification & brief advice
- wider health promotion initiatives

Risks identified:
Failure to acknowledge and respond to alcohol misuse as a cross cutting issue would risk harming population health and well being and community safety.

3.0 Recommendation:

The health and Adult Social Care Overview and Scrutiny Committee is recommended to resolve to: **note the findings of this report and support the alcohol strategy for Cornwall.**

4.0. Alcohol-related hospital admissions.

4.1. Introduction. Alcohol related harm.

The majority of people who use alcohol do so without negative consequences. However, for some, their drinking causes problems for themselves, their families and the communities within which they live.

Official government guidelines recommend that men should not regularly drink more than 3-4 units of alcohol daily and that women should not drink more than 2-3 units.

It is estimated that just under a quarter (102,000 people) of the population aged 16 and over in Cornwall and Isles of Scilly are regularly drinking above the recommended safe levels. 16,200 of these are estimated to be alcohol dependent. In addition, an estimated 66,500 people are 'binge drinkers' (drinking more than double the daily unit guidelines in one session).
Alcohol-related harm is a major public health problem. Excessive drinking is a major cause of disease and injury, with only tobacco smoking and high blood pressure as higher risk factors. In the short term, alcohol misuse can result in injury or alcohol poisoning. In the long term, it can lead to a range of alcohol related conditions, including cancer, liver cirrhosis and high blood pressure, and even to death.
There is a complex relationship between alcohol and mental health, Many people drink to cope with stress, anxiety and depression. Individuals with high levels of consumption may be more susceptible to mental health problems.
Health inequalities are clearly evident as a result of alcohol-related harm; alcohol-related death rates are about 45% higher in areas of high deprivation.

Alcohol misuse leads to people being admitted to hospital for a range of conditions and causes. These include acute intoxication, alcoholic liver disease, fall injuries, hypertensive disorders and a number of cancers related to alcohol harm. Hospital admissions can be used as an indicator of alcohol-related harm.

4.2. Public Health Outcomes Framework

The strategic direction for the new public health system, in which local authorities will have increased responsibility for health and wellbeing, is set out in the public health outcomes framework. The outcomes that are relevant to discussion about alcohol-related harm are:

- 2.18. Alcohol-related admissions to hospital
- 4.16i Under 75 mortality from liver disease

This report provides an analysis of alcohol-related hospital admissions and alcohol related mortality for residents of Cornwall and Isles of Scilly. A distinction is made between alcohol specific harm and alcohol attributable harm and this is explained in the text.

4.2. Alcohol specific hospital admissions

Alcohol specific harm refers to harm that is wholly attributable to the use of alcohol.

4.2.1. Young people.

Hospital admission rates as a result of alcohol have been relatively high in recent years for young people in Cornwall & IoS.. Three year average rates for alcohol specific admissions of young people under the age of 18 years are plotted in figure 1. Although local rates were considerably higher than the national average at the beginning of the period examined, the latest rate is similar to that of the South West region and just slightly higher than the national average. Rates have been falling locally and nationally.

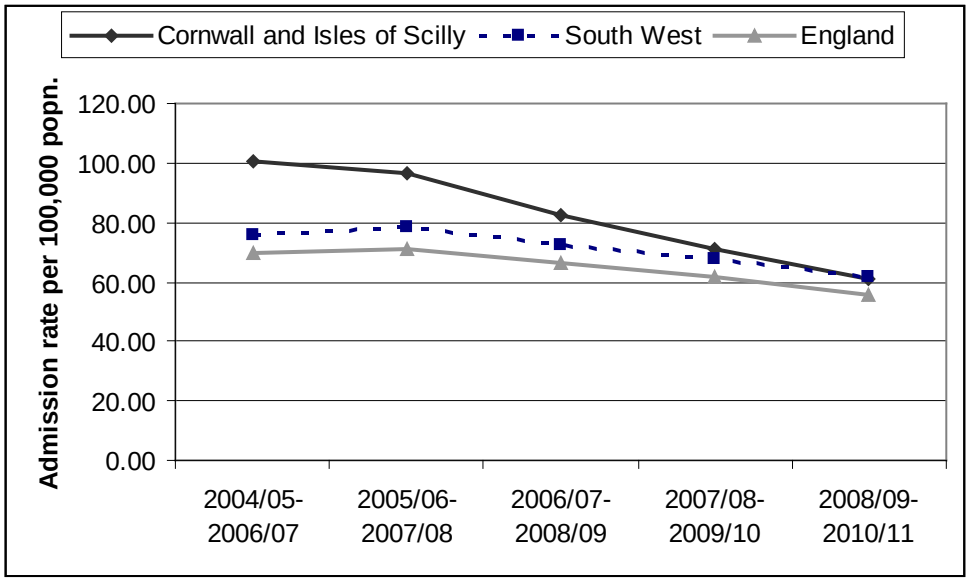


Figure 1. Alcohol specific hospital admissions, aged <18 years.

A local data set over the most recent three year period (2009/10 to 2011/12) revealed that forty-eight 16 year olds and fifty-seven 17 year olds had been admitted to hospital for alcohol specific causes. The main causes were found to be:

- Mental and behavioural disorders due to use of alcohol (71%)
- Ethanol poisoning (29%)

4.2.2. All ages

Over the period 2006/07 to 2010/11 alcohol specific admissions of both male and females have been rising (figure 2). Males have been more likely to be admitted than females. Local rates are similar to regional and national rates (although slightly higher for females in the last three years). It is known that people living in deprived areas are more likely to be admitted for alcohol specific conditions than those living in the least deprived areas.

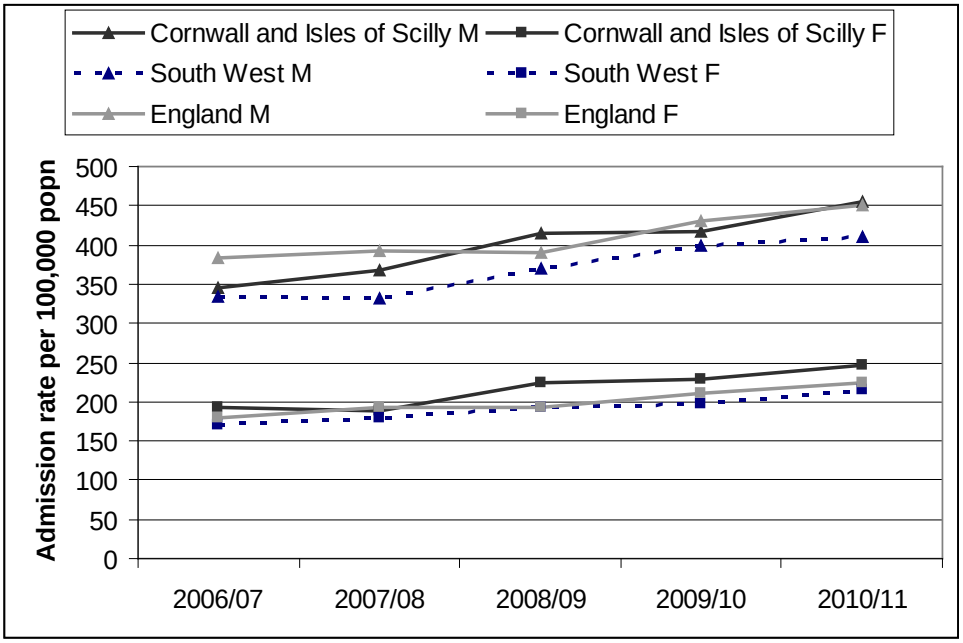


Figure 2. Alcohol specific hospital admissions. All ages.

The main causes of alcohol specific admissions were:

- Mental and behavioural disorders due to use of alcohol (64%)
- Alcoholic liver disease (18%)
- Ethanol poisoning (15%)

The distribution of these causes by age is shown in figure 3. The age band with the highest frequency of admissions for mental and behavioural disorders due to alcohol is 40- 49 years but the range covered 16 to 96 years.

The age band with the highest frequency of admissions due to ethanol poisoning is also 40-49 years, with a secondary peak at age 20-29 years and a range of 16-89 years. The age band with the highest frequency of admissions due to alcoholic liver disease is 60-69 years, with a range of 20-89 years.

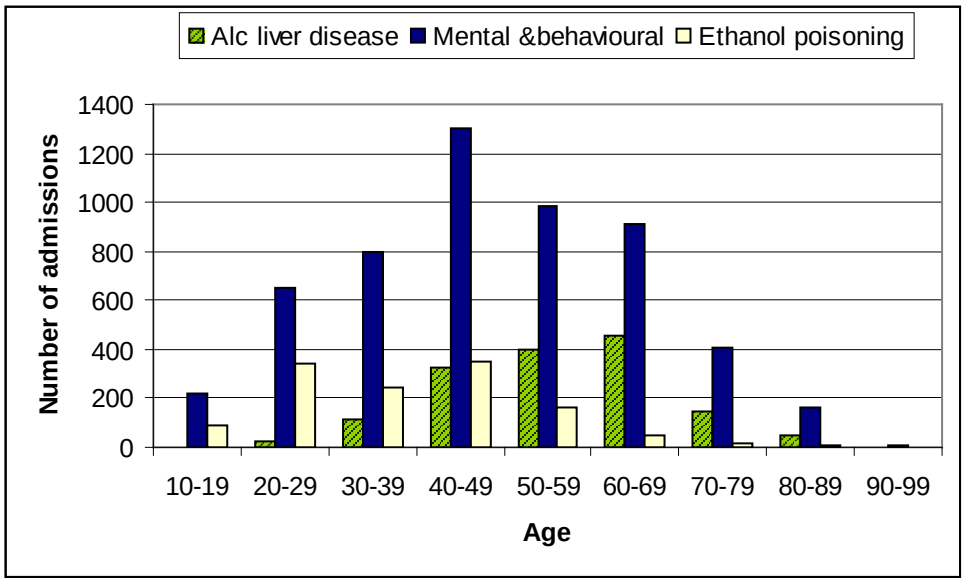


Figure 3. main causes of alcohol specific hospital admissions by age. 2009/10–2011/12.

4.3. Alcohol attributable admissions

The alcohol-specific conditions described above are conditions that are wholly attributable to alcohol. There are also health conditions where alcohol is causally implicated in some but not all cases, so looking at alcohol specific admissions alone will underestimate the impact of alcohol. Alcohol attributable admissions are calculated, based on the estimated contribution of alcohol. Conditions wholly caused by alcohol are given an attributable fraction of 1. An attributable fraction of less than 1 indicates that the harm is only partially attributable to alcohol and will count for part of a whole admission. The lower the fraction, the smaller the contribution of alcohol.

When alcohol attributable fractions are added together the total will be less than the number of people admitted but will provide a useful indicator of alcohol attributable harm.

Alcohol attributable fractions have been used to calculate the 'NI39' indicator that has been used to compare different populations by standardising the results to a single population profile. Figure 3 shows that alcohol attributable hospital admissions have almost doubled over a ten year period, and that age standardised rates are similar across Cornwall & Isles of Scilly, the South West and England.

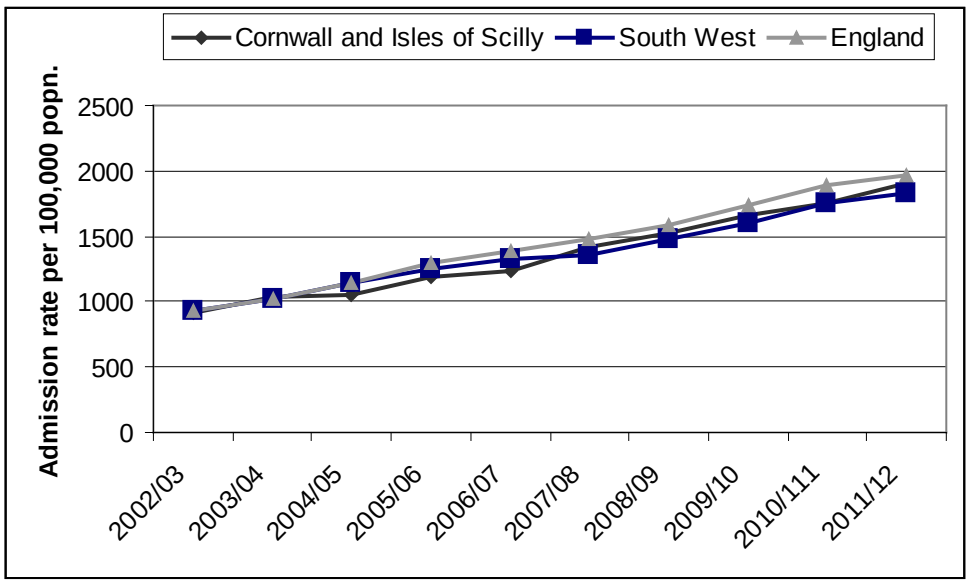


Figure 4. Age standardised alcohol attributable hospital admissions (NI39 indicator). All ages.

Local data has been examined to determine the relative contribution of different conditions leading to hospital admissions. The most common cause of admission is hypertensive disease, accounting for nearly 16,000 admissions, four times as many as the most common alcohol specific disease (mental and behavioural disorders due to alcohol). The other category that stands out is 'injuries', reflecting the influence of alcohol on risk taking behaviour. This table reveals the health burden of alcohol in a way that looking at alcohol specific conditions alone cannot.

Health conditions attributed to alcohol (ranked by AAF sum)	Sum of alcohol attributable fractions (AAF)	Notes
circulatory system	23,390.26	Of which: 15,706.63 due to hypertensive disease
mental and behavioural disorders	6,082	
nervous system	2,645.7	
injuries	1,895.84	Of which: 802.56 due to falls, 604.24 to self harm, 257.35 to transport accidents and 188.19 to assault
digestive system	1,585.72	Of which: 1186.17 due to liver disease
cancers	1,503.22	
poisoning	1,281	Of which: 1265 due to ethanol poisoning
skin diseases	256.75	
pregnancy/childbirth: Spontaneous abortion	196.99	

Figure 4. Hospital admissions attributable to alcohol. 2009/10–2011/12.

4.4. Alcohol specific mortality

Mortality rates for alcohol specific conditions have risen slightly in Cornwall & IoS over recent years for both males and females. Both have been below national rates although the rate of female mortality is now close to the England rate. In 2008-10, 159 deaths in C&IoS were from conditions wholly due to alcohol.

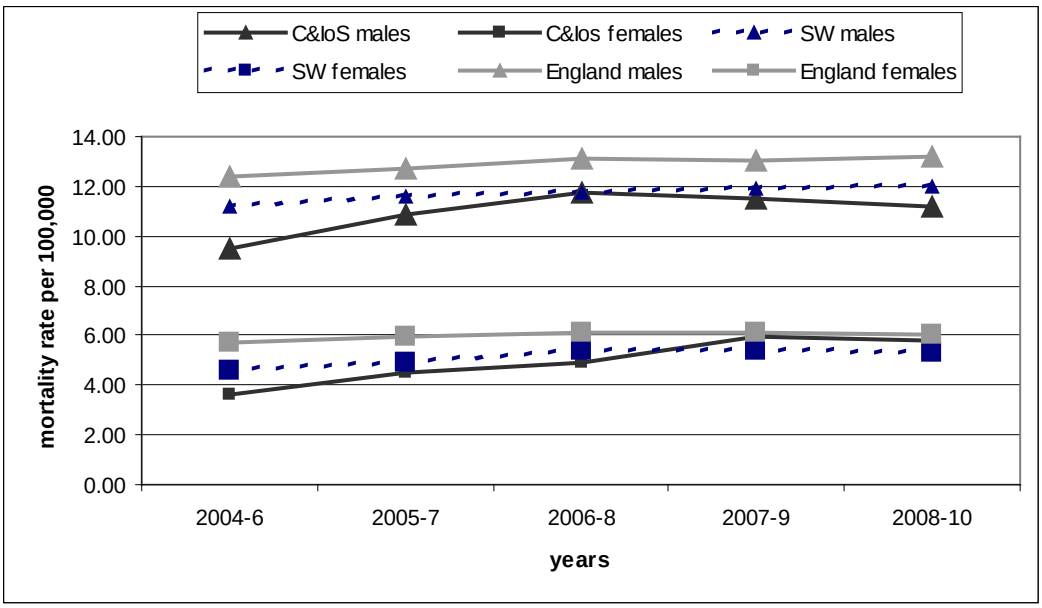


Figure 5. Alcohol specific mortality rates. 2004-06 to 2008-20

4.5. Mortality from chronic liver disease

Over a three year period (2001-2010) there were 166 deaths in Cornwall & Isles of Scilly from chronic liver disease. Males were more likely than females to die from chronic liver disease. The male mortality rate was lower than the England average.

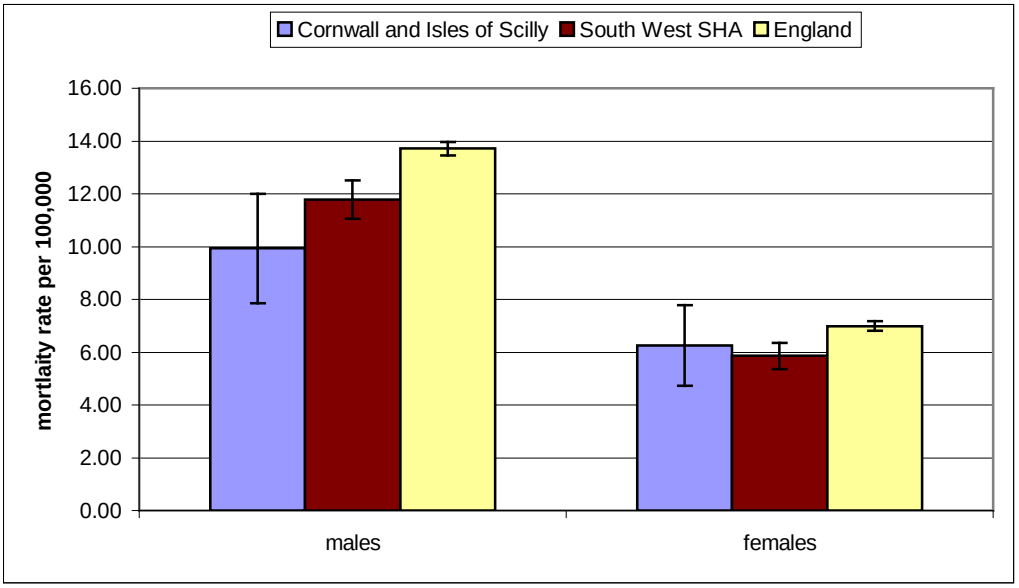


Figure 6. Mortality from chronic liver disease

4.6. Alcohol attributable mortality

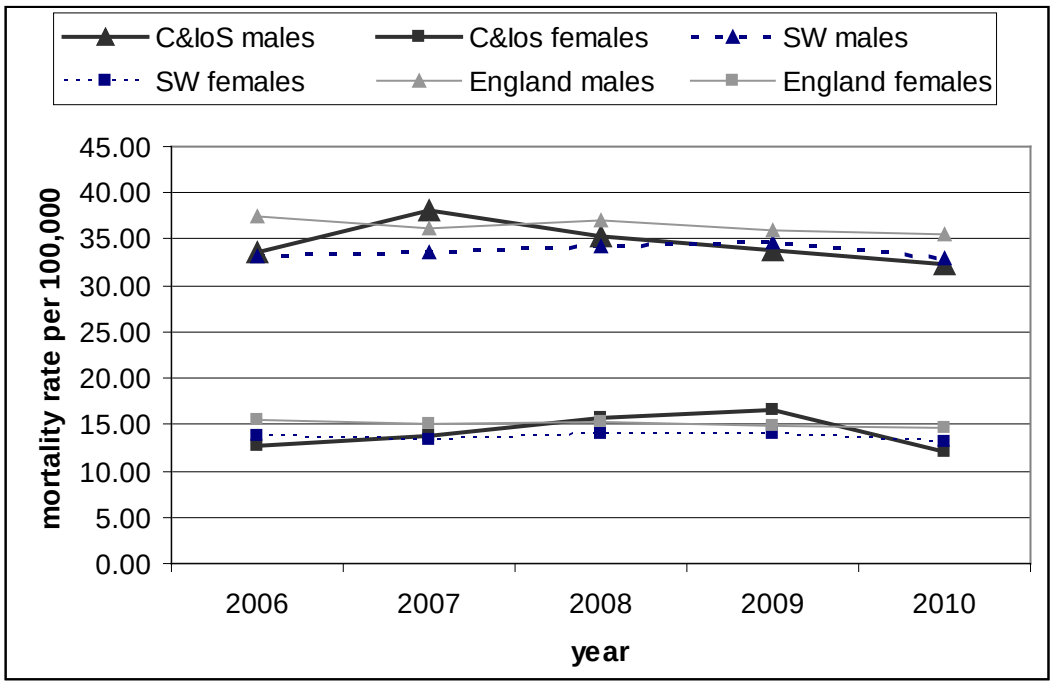


Figure 5. Alcohol attributable mortality

Although hospital admission rates have been increasing, and alcohol specific mortality rates have risen slightly, alcohol attributable mortality rates have remained fairly static, and similar to regional and national rates. Males are more likely than females to die from alcohol attributable conditions. In 2010, 166 deaths in C&IoS were attributable to alcohol.

4.7. Action to reduce alcohol attributable hospital admissions

The following actions, identified in Cornwall's alcohol strategy, will help to reduce the number of alcohol attributable hospital admissions:

4.7.1. A focus on alcohol-related frequent attenders in hospital

This is a targeted approach to address the needs of the highest risk group. Actions include:
a) identification of the most frequently presenting patients;
b) co-ordinated multi-agency case review process;
c) agreed multi-agency care plans to be stored on RCHT IT and flagged on the reception system, so that patients are referred back to community treatment and support wherever possible rather than admitted;
d) incorporate this approach into the Emergency Dept Psychiatric Liaison RAID (Rapid Assessment Interface and Discharge) model processes.

4.7.2. Continue to develop and monitor referral pathways from RCHT to community alcohol treatment in Primary Care and in the community

(NB: At the time of preparing this paper, the Cornwall Drug and Alcohol services were undergoing a service tender process with a view to transitioning to a single provider for adult services, and a single provider for young people's services, with new contracts commencing on 01/04/13. Pathways will need to factor in both the existing and the new systems.)

4.7.3. Continue to deliver alcohol treatment in line with the latest evidence-based NICE guidance

Treatment services will incorporate new treatment and medication options as they become available.

A full recommended patient pathway outline can be found here:
http://pathways.nice.org.uk/pathways/alcohol-use-disorders

All NICE alcohol intervention guidance can be found on the NICE website.

4.7.4. Promote the use of Identification and Brief Advice (IBA) using an RCHT-adapted version of a validated tool

This will be used in these settings:
a) RCHT wards;
b) RCHT Emergency department;
c) Minor Injury Units;
d) Primary Care.

And it will be used for agreed evidence-based, alcohol-related priority health conditions, such as hypertension and mental and behavioural problems caused by alcohol, as identified by this report. This is in addition to the continued promotion of IBA in non-health sector community settings targeting vulnerable people.

4.7.5. Wider health promotion/social marketing initiatives aimed at reducing alcohol misuse

A range of actions are being taken by the Safer Cornwall partnership, Safer Towns partnerships, and the Health Promotion Service to promote safer drinking in Cornwall. These are guided by evidence of effectiveness and evidence of local needs. They aim to reduce alcohol consumption and to keep people safe and will contribute to reducing admission rates to hospital as a result of alcohol-related harm. The introduction of a national policy to set a minimum price per unit of alcohol is also predicted to reduce alcohol-related harm – particularly among the highest risk drinkers.

4.8. Conclusions

Alcohol-related hospital admissions have been increasing for a number of years. Although mortality rates attributed to alcohol have remained fairly static, hospital admissions for conditions solely caused by alcohol under-estimate the impact of alcohol misuse, so other conditions that are partly attributable to alcohol should also be examined, as they have in this report. This allows the full impact of alcohol on a range of conditions to be considered, including hypertension (a risk factor for cardiovascular disease) and injuries from falls, self harm, assault and road accidents.

Although admissions of young people aged under 18 years have been falling, the fact that patients as young as early 20s are being admitted to hospital with alcoholic liver disease is of great concern. Interventions must target those who are already suffering the consequences of alcohol misuse and who have the greatest immediate needs, but we must also act to influence the culture around drinking and to support young people to make healthier choices.

The alcohol strategy for Cornwall has been refreshed during 2012. Its main aims are to:

1) enable people to make informed choices about alcohol
2) increase services to reduce harm caused by alcohol
3) create partnerships to reduce alcohol's impact on the community

Reducing alcohol-related harm has been identified as a priority by Cornwall's Health and Well Being Board. Action will continue to be taken within a partnership approach to address the needs of individuals, families and communities, and to improve population health and well being and community safety.

Page intentionally left blank

SAFER CORNWALL

Gwrians rag Kernow moy salow

If you would like this information in another format please contact:

Community Safety Team, Cornwall Council, Old County Hall, Station Road, Truro TR1 3HA.
Telephone: 0300 1234 100 email:
mail@safercornwall.co.uk

www.safercornwall.co.uk