

Building for recovery

A DrugScope report for the
Drug Sector Partnership



FOREWORD

In 2010 the Drug Sector Partnership produced a 'drug treatment consensus' statement, with more than 70 signatories, including over 30 chief executives of Britain's leading independent drug treatment services in the voluntary and community sector (see appendix 1). Its key message was that a great deal has been achieved by services, but there is much left to do.

The Consensus Statement highlighted the evidence that drug treatment delivers benefits for individuals, families, communities and society. But it also called for a greater focus on recovery, quality of outcomes and social re-integration. We welcome and applaud the vision of a balanced, recovery-orientated treatment system set out in the Drug Strategy 2010.

The challenge for our members is to deliver it, and to do so while navigating public service reforms at a time of financial austerity. It has been estimated that as much as £1 billion of current drug and alcohol treatment spend could be transferred to the budget of the new public health service in April 2013, with the expectation that the nominal 'ring fence' around the national 'pooled drug treatment budget' will be removed. This will increase local discretion over how this money is allocated, at a time when Local Authorities are financially stretched.

Other key reforms that will impact on drug and alcohol treatment include the introduction of elected Police and Crime Commissioners, the development of the Work Programme and the Troubled Families initiative. In addition, our sector has a critical contribution to make in the creation of a 'second chance society' as

advocated in the 2012 social justice strategy, with its declaration that 'anybody who needs a second chance in society should be able to access the support and tools they need to transform their lives', and its statement that for people with drug and alcohol problems 'it is not enough simply to ... stabilise their dependency – we need to ensure they have a second chance in life'.

So this is a critical and uncertain time for our sector. Will localism in a period of austerity improve responsiveness to local substance misuse issues and join up local services, or will it spell disinvestment in services for an often stigmatised group? Will the public health service give drug and alcohol treatment the investment and support it needs to deliver on the vision for recovery-orientated services in the 2010 Drug Strategy? Will the support from housing and employment services – for example – be forthcoming? What guidance, training and other support will be available to commissioners, service providers and staff to help them to navigate the transition to localism and to improve outcomes for service users, families and communities?

If we get this wrong the consequences could be devastating for people willing to make the commitment to turn their lives around and begin the work of recovery. This would have serious knock on effects for families and local communities, as well as long term costs for the taxpayer. If we get it right, then we can take another big stride forward in creating recovery-focussed, evidence-based and cost-effective treatment.

We believe that the messages from our membership that have helped to shape this report will enable us to make the most of the opportunities to move forward. We are not starting from scratch but building on solid achievements. We need to protect the ground gained, while recognising how far we still have to go in order successfully to overcome the remaining barriers to recovery. We believe the vision of the 2010 Drug Strategy is achievable, so long as we continue to have sufficient investment in treatment, appropriate support at national and local level, a consensus on the importance of evidence-based approaches and there is a clear voice for our membership in the formation of policy and the design of recovery systems.

Finally, we would emphasise that this report does not attempt to provide a definitive account of the nature of recovery or a complete roadmap for implementation. Its aim is to contribute to what we hope will be an on-going dialogue about the nature of recovery and the creation of recovery-orientated systems, services and pathways. It seems to us that this openness to plurality and dialogue is inherent in the idea of recovery itself – for example, in the emphasis on the active role of service users in mapping their own recovery journeys. In this spirit, we welcome comments and feedback and details of how you can get in touch are provided at the end of this report.

Martin Barnes
Chief Executive
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The drug sector PARTNERSHIP

EXECUTIVE SUMMARY

Recovery is defined in the drug strategy as ‘an individual, person-centred journey, as opposed to an end state, and will mean different things to different people’. This vision is supported within the drug and alcohol sectors as is the Government’s focus on recovery capital, social inclusion and the need for balanced and integrated services.

Building from a position of strength

There have been considerable advances in developing responses to people with drug and alcohol problems, with much that is valuable to build upon:

- There is strong commitment from Government;
- There has been a significant expansion in treatment availability and participation and improved outcomes from treatment, in both the community and criminal justice settings;
- There is a knowledge base about what works and a robust evidence base for the cost effectiveness of treatment;
- There is a high degree of consensus on the way forward;
- There is evidence of a significant level of public support for the availability of high quality drug and alcohol services.

Building recovery in context

The development of recovery orientated services will be shaped and constrained by the policy context. Three factors are of particular significance:

- **Public spending constraints.** For example, local authorities face a 14 per cent ‘cash terms’ reduction in their budgets up to 2014-15 according to the Spending Review 2010;

- **Localism.** In particular the removal of ‘ring fences’, with greater discretion in allocating public health resources for local authorities and other local decision makers, such as Police and Crime Commissioners;
- **Public policy reform.** In particular, the abolition of the National Treatment Agency for Substance Misuse and the absorption of its functions into a new public health body, but also payment by results and reforms - for example - to the welfare system, housing support and criminal justice.

Building recovery: the challenges

A number of challenges for recovery-orientated treatment are identified in this report:

- The risk of disinvestment in drug and alcohol treatment;
- The risk that competition on cost could compromise sustainability and investment in capacity building, research and workforce development;
- The importance of robust clinical and quality standards where treatment services are commissioned by local authorities outside the NHS;
- The importance of workforce development and appropriate support for, and use of, volunteers and peer workers;
- Concerns about access to recovery capital, including, for example, appropriate housing given evidence of local disinvestment in housing support and fears of the potential impact of housing benefit reforms;
- The importance of supporting Health and Wellbeing Boards and other local structures to bring services together and to ‘join up’ local strategies (for example Health and Wellbeing Strategies and Police and Crime Plans);

- The challenge of harnessing the potential benefits of outcome-based commissioning, including Payment by Results, while addressing the risks of 'gaming' and perverse incentives, supporting smaller organisations to participate and ensuring that payments are allocated fairly between services;
 - The need to provide leadership and invest in work to tackle stigma and negative attitudes that can deny people in recovery a second chance, and lock families and communities into cycles of exclusion.
6. To ensure that systems and structures are developed in ways that recognise and support the role of the voluntary and community sector (VCS) in delivering recovery, including VCS representation on Health and Wellbeing Boards and/ or through local advisory structures for public health.
 7. To develop a comprehensive workforce development strategy with the Substance Misuse Skills Consortium.
 8. To develop concerted action to address negative attitudes to people in recovery, their families and communities, with, as a first step, Government departments and local authorities making a public commitment to provide training and employment opportunities, review their information and communications activity to promote positive attitudes to people in recovery and develop active policies for inclusion.

Building the foundations for recovery

The report calls on central government and local authorities to provide the foundations for recovery.

1. To ensure there is sufficient investment in every local area to provide the tools and resources to deliver recovery-orientated drug and alcohol services.
2. To take urgent steps to ensure there is sufficient specialist provision for young people with drug and alcohol problems, and to make this a key theme for public health and in the Department for Education's 'positive for youth' programme.
3. To prepare Directors of Public Health and other local decision-makers for their new responsibilities for drug and alcohol services, producing guidance and with a key role for the Substance Misuse Skills Consortium.
4. To ensure access to the social capital that is critical for recovery, including giving Public Health England a designated responsibility for co-ordinating recovery.
5. To build on work to address 'dual diagnosis' and 'multiple need', exploiting the opportunities created by public health and other reforms to 'join up' substance misuse and mental health services and implementing the recommendations of the Making Every Adult Matter coalition's *Turning the Tide* report.
9. To build on progress on family support, developing the vision of recovery in a way that includes families affected by a family member's drug or alcohol misuse
10. To improve provision in the criminal justice system, developing community sentences, diverting non-violent offenders from the prison system and continuing to improve treatment in prisons.

Our members are committed to working with Government to address these issues, deliver the ambitions of the 2010 Drug Strategy and work with local partners and colleagues to build recovery-based services that respond to local needs and priorities, while providing high quality and evidence based services to manage the harms associated with problem drug use, to individuals, families and communities.

BUILDING FOR RECOVERY

INTRODUCTION

This report is informed by consultation with our membership and many other individuals and organisations with a direct involvement in delivering drug and alcohol treatment. We are aware that this report has a primary focus on changes in England, but many of the changes it discusses will also be relevant elsewhere in the UK, as will the general discussion of the constituents and conditions of a recovery-orientated approach to drug and alcohol treatment.

The Drug Sector Partnership hosted consultation events on the theme of 'Overcoming Barriers to Recovery' in London in December 2010 and Manchester in February 2011. The report has been informed by on-line surveys that have enabled hundreds of local services to have their say - including member engagement work that fed into responses to the National Treatment Agency's 'Building Recovery in Communities' consultation in 2011 and a survey on housing support conducted by the Recovery Partnership for the Inter-ministerial Group on Drug Policy. It has been shaped by the wide range of participation and engagement work that are undertaken on an on-going basis - for example, meetings of DrugScope's Chief Executives Forum and the London Drug and Alcohol Network's Senior Managers Group.

THE VISION – BUILDING BLOCKS FOR RECOVERY

Recovery is 'an individual, person-centred journey, as opposed to an end state, and will mean different things to different people.'
Drug Strategy 2010

'the process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society'. *UK Drug Policy Commission, Recovery Consensus Statement (2008)*

What is recovery and what does a recovery-orientated system look like? It is important to emphasise that there are many routes into drug and alcohol dependency, and many routes out. Recovery means different things and requires different interventions for different people. We would emphasise that it is inherent in the notion of recovery itself that developing recovery-orientated pathways, services and systems should be an inclusive process that provides space for a range of views and experiences to be expressed and is supportive of on-going dialogue and debate.

We believe, however, that some of the principal building blocks for a recovery-oriented approach can be identified, and would be widely recognised and agreed in our sector (for other recent statements of recovery principles see appendices 2, 3 and 4).

1. **Recovery is about hope and aspiration.** It says that people with drug and alcohol problems can rebuild their lives. It is about saying to people with substance misuse problems that if they make a commitment to treatment, then we will give them the chance that they need, providing help, support and opportunity – this is the essence of a genuine 'second chance society'. It is also about recognising the assets, strengths and potential of people who are affected by drug and alcohol problems as well as their problems and needs.
2. **Recovery is a 'journey' and different people take different roads.** There is no single road map or 'silver bullet' for recovery. It is a process that should be shaped by the individual's needs, options, assets, resources, priorities and motivations. This means, for example, that we should work closely with service users to develop and deliver individualised recovery plans that work for them.
3. **Recovery recognises the value of drug-free outcomes, but does not just mean abstinence.** The Drug Strategy says that a 'drug free life' is the 'ultimate goal' of recovery. But, equally, it recognises

that abstinence can take time and that 'medically-assisted recovery can, and does, happen'. Recovery is about creating balanced and integrated treatment systems, that are responsive to service users and remembering that we know a lot already about what works best.

4. Recovery means engaging with the range of an individual's needs.

The Drug Strategy 2010 explains that 'recovery can only be delivered through working with education, training, employment, housing, family support services, wider health services and, where relevant, prison, probation and youth justice services to address the needs of the whole person'. It is difficult to achieve recovery if you have nowhere to go and nothing to do with your time - and these kinds of resources are constituents of recovery too. A recovery approach also helps to focus on dual diagnosis (co-occurring substance misuse and mental health problems) and complex need.

5. Recovery is about social inclusion.

People cannot start to rebuild their lives if the roads to recovery are closed to them and there is no way back into society. Recovery is about working to remove these barriers, including addressing the stigma experienced by people who are trying to tackle their drug or alcohol problems and to sort out their lives.

6. Recovery is about service user networks and mutual support.

Recovery is about empowering people with direct experience of drug and alcohol problems to support each other. It is about integrating peer support and mutual aid options into recovery planning; it is about 'recovery champions' and other people who are able to tell their stories and share their experiences (including those benefiting from medically-assisted approaches); it is about effective mechanisms for service user involvement.

7. Recovery is about families. Families often play a critical role in supporting family members with drug problems – for example, providing emotional support, housing, access to leisure and other forms of meaningful activity and initiating and supporting engagement with treatment services. Families often need to recover from the impact of a family member's substance misuse.

8. Recovery is about communities. The process of recovery takes place in a wider community. The Royal Society of Art's 'Whole Person Recovery' project has built on community work with service users in Sussex to call upon service users themselves, and members of their communities, to foster recovery through collective social effort and innovation – bringing together local services, engaging local people and involving service user led initiatives, including social enterprises.¹ Communities can have a need for 'recovery' too – for example, from their experience of open drug markets, acquisitive crime or alcohol-related disorder.

9. Recovery is about taking responsibility. Many people with drug or alcohol problems have had difficult lives – including abuse, neglect and trauma in childhood - but that does not detract from the fact that their behaviour has often caused harm to others. A relatively small number of problem drug users are responsible for large volumes of acquisitive crime. Some drug-using parents fail to provide a safe and appropriate environment for their children. Some may take advantage of families, partners and friends. Recovery is about taking control and about participation in the rights, roles and responsibilities of society.

¹ Rebecca Daddow and Steve Broome (2010), *Whole person recovery: A user-centred systems approach to problem drug use*, Royal Society of Arts.

10. Recovery should include health and public health interventions. Drug and alcohol services do vital work to keep people alive, prevent the spread of blood borne viruses and other diseases, treat them where they occur, and address other health issues. We have a responsibility to prevent death and disease, which is critical for good public health as well as the wellbeing of the individual. We note that the Drug Strategy 2010 includes ‘prevention of drug-related deaths and blood borne viruses’ among eight ‘best practice outcomes’ for a ‘recovery-orientated system’. There are other issues that do not neatly fit into the ‘recovery vision’ that it is important not to lose sight of too – for example, the effectiveness of child safeguarding arrangements in drug and alcohol services. It is also important that the welcome focus on recovery from substance dependency for adults is matched by a commitment to build on recent progress in developing specialist drug and alcohol services for young people. Nearly 22,000 teenagers were able to access specialist help and support in 2010-11, primarily for cannabis and/or alcohol problems.

Finally, while we recognise the value of drug-free outcomes where these are achievable, and know that a life free of drugs is what many service users and their families want from services, we are concerned that the recent departmental document *Putting Full Recovery First* (March 2012) equates ‘full’ recovery with abstinence, with the implication that service users on substitute prescriptions who are rebuilding their lives (for example, stopping offending, sorting out relationships or moving into volunteering or work) are not properly ‘in recovery’. This is at odds with the statement in the drug strategy that recovery is ‘an individual person-centred journey, *as opposed to an end state*’ (emphasis added). We endorse the conclusion of the interim report produced for the Department of Health by Professor John Strang’s expert group on ‘Recovery Orientated Drug Treatment’. It presents a vision of the future in which ‘the valuable role of prescribing continues to be recognised, though it is not

an end in itself but a component of a phased, integrated package of treatment that minimises risk while being ambitious for each individual patient’s recovery’.

It is helpful to distinguish between recovery in the ‘medical’ sense and alternative notions of recovery which have been critical for other sectors, notably mental health. The Oxford English Dictionary includes two different – but related – ideas of recovery as ‘finding something you’ve lost’ and ‘regaining something that has been taken away’. It is these notions of recovery that have inspired the work within mental health to tackle discrimination and social exclusion. A fundamental principle for the service-user led recovery movement in mental health has been that recovery in this sense should not depend on full recovery in the medical sense. There has been a focus on challenging discrimination based on people’s *engagement with treatment* (including medication) as well as their mental health status as such. For example, the ‘reasonable adjustments’ that employers can be required to make under the Disability Discrimination Act could include – for example – adjustments to working hours to allow for the side effects of psychiatric medications. It is important that this sense of recovery continues to inform the development of recovery-orientated drug and alcohol services. We note that it chimes with the vision of a ‘second chance society’ at the core of the Government’s social justice strategy, *Social Justice: Transforming Lives*.

BUILDING ON ACHIEVEMENT

Considerable advances have been made in providing effective responses to people with drug and alcohol problems. There is widespread awareness of the challenges ahead, a broad consensus on the way forward that is shared by most policy specialists and service deliverers and considerable momentum behind the vision of a recovery-orientated approach as set out in the 2010 Drug Strategy.

1. There is a strong commitment to drug and alcohol treatment from Government.

The Government's support for drug treatment services was demonstrated by the decision to allocate £570 million to the 'pooled treatment budget' for England for 2011-12, despite exceptional pressures on public spending. We are aware that considerable thought has been given in Government to ensuring investment in drug and alcohol treatment is sustained following the transfer to public health, and have welcomed this response to issues and concerns that the Drug Sector Partnership and the Recovery Partnership have been able to raise with officials and ministers.

The Drug Strategy 2010 is in harmony with the drug field's own vision of a balanced and integrated treatment system that 'puts the individual at the heart of any recovery system and commission[s] a range of services at the local level to provide tailored packages of care and support'. It highlights the importance of 'social capital', tackling housing need, enabling reintegration into communities and helping people to find sustained employment. It argues for joint commissioning, holistic responses and partnership approaches. It includes a

commitment to workforce development - to train, support and inspire front line staff to deliver recovery, working through the Substance Misuse Skills Consortium (SMSC).² We welcome the decision by the Department of Health to fund the development of the SMSC over the next three years up to 2014-15 through the Voluntary Sector Investment Programme.

2. There has been an expansion of evidence based drug treatment, with clear evidence of its social impact and cost effectiveness.

The numbers of problem drug users accessing treatment services in England doubled over ten years from 1998-9, with waiting times falling to an average of one week, and three quarters of service users remaining in treatment long enough for it to have a real impact.³ Our drug treatment system has given the UK one of the lowest rates of HIV infection among injecting drug users anywhere in the world. In March 2012, the NTA published systematic research based on NDTMS data and conviction records from the Police National Computer which showed that offenders who were retained in drug treatment for a full two years from 2006-07 showed an average reduction in convictions of 47 per cent, with an almost identical impact on offending discernible among offenders who successfully completed treatment, at 48 per cent.⁴ In 2010-11, nearly 28,000 people completed treatment free of dependency, with over 190,000 engaging in effective treatment (i.e. either staying in treatment for 12 weeks or more or leaving within that period free of dependency). In March 2010 the

2 The Substance Misuse Skills Consortium website is at www.skillsconsortium.org.uk

3 Figures from the National Treatment Agency for Substance Misuse

4 National Treatment Agency (March 2012), '*The impact of drug treatment on reconviction*'. The study was limited to 'trigger offences' (as defined by the Criminal Justice and Court Services Act 2000) and soliciting (i.e. prostitution). It is noted that 'while these figures cannot be interpreted as direct, quantifiable measures of a causal effect of drug treatment, the results suggest that exposure to treatment reduces recorded convictions and therefore offending, as the greater the successful engagement in treatment, the greater the observed reduction. This is most noticeable in opiate and/or crack cocaine users, who make up the majority of the cohort.'

National Audit Office reported that every £1 invested in drug treatment saved £2.50 later on.⁵ There was significant expansion in specialist treatment services for young people, from 2005-06 to 2008-09.⁶ Independent research conducted by Frontier Economics for the Department for Education has concluded that £1 invested in drug and alcohol treatment services for young people saves between £5 and £8.⁷

3. There is a broad consensus on the way forward. For example, the previous Government's 2008 Drug Strategy declared that 'the goal of all treatment is for drug users to achieve abstinence from their drug - or drugs - of dependency', while recognising that although some might achieve this immediately, others will 'need a period of drug-assisted treatment with prescribed medication first'. In 2009, DrugScope's *Drug Treatment at the Crossroads* - based on extensive consultation with the sector - reported that there was a wide consensus that substitute prescribing has a role in treating opiate dependency, but equally that 'warehousing' or 'parking' service users on methadone is unacceptable. In particular, it called for a greater focus on social reintegration – highlighting concerns about access to housing, training, employment and other forms of meaningful activity. These messages informed the Drug Sector Partnership's Treatment Consensus Statement. (Appendix 1)

4. The majority of the public appear to support investment in good quality,

evidence-based drug treatment. A DrugScope/ICM public opinion poll reported in February 2009 that nine out of ten respondents (88 per cent) agreed with the statement that drug treatment should be available to anyone with an addiction to drugs who is prepared to address it. Significantly, one in five respondents (19 per cent) said that they had been personally affected by drug addiction, and a quarter (27 per cent) of 18 to 34 year olds.⁸ A UK Drug Policy Commission survey conducted in 2010 found that over two thirds of the public (68 per cent) think that people with drug dependence 'deserve the best possible care' (while observing that this still contrasts with 93 per cent who think the same about those with a mental health problem).⁹

A 2010 YouGov poll on behalf of the Making Every Adult Matter coalition (Clinks, DrugScope, Homeless Link and Mind) explored public attitudes to people with multiple needs, including drug and alcohol problems, alongside mental health issues, homelessness and histories of offending. Eighty five per cent of respondents said that society should be concerned about people with multiple needs, including over a third (37 per cent) who said society should be 'very concerned'.¹⁰

5. There has been significant progress in working with the high numbers

⁵ National Audit Office (2010), *Tacking Problem Drug Use*, p. 9.

⁶ See National Treatment Agency (2011), *Substance misuse among young people: 2010-11*.

⁷ Frontier Economics (2011), *Specialist drug and alcohol services for young people*, Department for Education.

⁸ See Roberts M (2009), 'What does the public really think about addiction and its treatment – report on the findings of a DrugScope/ICM report' at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/MarcusreportICM.pdf. DrugScope asked about addiction to illegal drugs only. If the question had covered alcohol dependency too it is likely that this figure would be much higher.

⁹ See UK Drug Policy Commission (2010), *Getting serious about stigma: the problem with stigmatising drug users – a summary of findings*, at www.ukdpc.org.uk/resources/serious_about_stigma_summary.pdf

¹⁰ See Peter Kellner (2010), 'Yes, if ...' in *Hardest to reach? The politics of multiple needs and exclusions* at www.meam.org.uk/wp-content/uploads/2010/04/Hardest-to-Reach.pdf

of offenders with drug and alcohol problems and the Government has shown that it has a commitment to build on this work. It has been estimated that between a third and a half of new receptions into prison¹¹ are problem drug users, with one in five prisoners reporting having an alcohol problem on entering prison. A high proportion of offenders on probation have substance misuse problems. Much progress has been made in developing interventions for offenders (including the Drug Interventions Programme and community sentences such as Drug Rehabilitation Requirements), and in expanding treatment in prisons, notably through the Integrated Drug Treatment System. We are in a position to build on the findings of a series of independent reports, notably *The Corston Report (2007)*, *The Bradley Report (2009)* and *The Patel Report (2010)*. These reports have also highlighted the challenges ahead.¹²

The proposals to improve drug treatment provision in the *Breaking the Cycle* Green Paper, the transfer of the Ministry of Justice's drug treatment budget to the Department of Health, the piloting of innovative approaches such as the Social Impact Bond at HMP Peterborough and the continued development of the Government's offender health programme provide opportunities to address these challenges and to take the next step forward in tackling drug and alcohol dependency among offenders, both providing them with support to change their lives and contributing to the reduction of offending and reoffending. The concern is that rising prison numbers and the resulting pressures on the prison

system are impeding the work that is done to address drug and alcohol dependency in prisons, including on drug-recovery wings. A prison sentence should be a last resort, not least because of its negative impact on 'recovery capital', such as relationships, housing and employment and employability.

We also note that there has been significantly less progress to date in developing alcohol treatment in prisons. In 2010, HM Inspector of Prisons concluded that at every stage in prison the needs of prisoners with alcohol problems were less likely to be assessed or met than those with illicit drug problems.¹³

THE CONTEXT

The goal of creating a balanced and integrated, recovery-orientated drug and alcohol treatment system will be supported and constrained by a wider policy and political context.

Three factors are of particular significance and concern for our membership:

- * **Pressures on public spending**
- * **The commitment to localism**
- * **The impact of public policy reforms.**

Public spending

The deficit reduction strategy set out in the 2010 Spending Review will have a profound impact on our members' services and service users. Average cuts across Government departments of 19 per cent by 2014-15 (except for health and overseas aid) will impact on the recovery agenda.¹⁴ The Spending Review announced cuts of 28 per cent in central Government grants to local authorities over four years, with

11. UK Drug Policy Commission (2008), *Reducing drug use, reducing reoffending*, London, UKDPC and HM Chief Inspector of Prisons (2010), *Alcohol services in prison: an unmet need*, London: HMCIP,

12 The reports are *Women in the Criminal Justice System (The Corston Report) (2007)* Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system (2009) and *Reducing drug-related crime and rehabilitating offenders (The Patel Report) (2010)*.

13 HM Inspector of Prisons (2010), *Alcohol services in prisons: an unmet need*, London HMCIP.

14 We note that the period of expected spending cuts was increased by a further two years in the Autumn statement.

an anticipated 14 per cent fall in cash terms in local council budgets over this period.

The commitment to localism

Local authorities are experiencing reductions in their budgets at a time when they are acquiring new powers to determine the priorities for local investment. 'Ring fencing' was removed from 'all revenue grants in 2011-12, except a simplified schools grant and the public health grant'. From April 2013, the nominal 'ring fencing' of the pooled drug treatment budget will be removed, as it is transferred into the new public health budget. These developments could have a profound impact on the development of drug and alcohol services, with the potential for variation in provision in different local areas.

We note also that from April 2013, elected Police and Crime Commissioners will assume responsibility for the Community Safety Fund – which has previously supported some drug and alcohol work, including many young people's services – and the Home Office share of the Drug Intervention Programme budget (which was £35 million in 2011-12). None of this budget will be 'ring-fenced' for investment in drug and alcohol treatment.

It is expected that there will be a cash reduction of around 60 per cent in the Community Safety Fund in 2012-13 compared to 2010-11. The Director General of the Crime and Policing Group at the Home Office wrote to Local Authority Chief Executives and the Mayor of London in February 2011, explaining, against the background of cuts in the Community Safety Fund, that 'ministers intend that other funding streams, including Drug Intervention Programme grants, will be consolidated with Community Safety Funding for PCCs in 2013-14 and 2014-15 and thus provide them with a significantly larger **unringfenced** budget overall' (emphasis added). The implication is that DIP money will be available to plug gaps created elsewhere by the squeeze on community safety investment.

Public policy reform

The Government has embarked on a

programme of ambitious policy reforms which will transform the environment in which drug and alcohol services operate, and within which they will take forward the vision for recovery set out in the 2010 Drug Strategy. These include fundamental changes to the health service, social care, welfare state and criminal justice system.

Three developments will be particularly significant for the recovery agenda.

1. The creation of the public health

service. The expansion of drug treatment in England since 2001 has been overseen by a special health authority, the National Treatment Agency for Substance Misuse (NTA), which has been responsible for the allocation of, and accountability for, the pooled treatment budget. It has been announced that the NTA will be abolished in April 2013, with its principal functions absorbed into a new public health service.

Responsibility for the commissioning of local recovery-orientated treatment services will be assumed by Directors of Public Health, employed by Local Authorities. Local needs assessment and strategic planning will be the responsibility of new Health and Wellbeing Boards, bringing together Directors of Public Health and other key stakeholders, including Clinical Commissioning Groups, Directors of Adult Services and Directors of Children's Services.

2. Payment by results (PbR). This term refers to a variety of approaches to the funding or purchasing of services, which, in different ways, pay providers depending on their actual activity or the outcomes they achieve for clients. It can provide a mechanism to incentivise providers to deliver on the recovery outcomes in the national drug strategy without recourse to central targets or national performance management systems.

PbR was developed by the previous Government and is already being used widely in the NHS, and increasingly in the welfare and criminal justice systems. The Government has recently launched eight Drug Recovery

PbR pilots, which take a significantly different approach to PbR than elsewhere in the health service. The impact of these PbR schemes is not limited to the pilot areas, as our members report that commissioners in other localities are working with providers to develop their own PbR models. Drug treatment service users will also be affected by other PbR schemes, including an NHS led alcohol PbR, mental health PbR, the Work Programme for the long-term unemployed, the 'social impact bond' approach to prisoner resettlement that is being piloted at HMP Peterborough and plans to develop PbR models for the Troubled Families initiative announced by the Prime Minister in December 2011.

3. Access to recovery capital. The successful implementation of the recovery vision is dependent on policies and priorities across Government and throughout local authorities. Is there suitable housing for people in drug treatment? What jobs or training opportunities are available? Are local mental health services set up to work with people with substance misuse problems? What support is offered to recently released prisoners? What about families affected by substance misuse problems?

Three policy initiatives have been of particular relevance and concern:

- Reform of the welfare system, including the Work Programme for the long-term unemployed;
- Access to suitable accommodation, particularly changes to the Supporting People programme and the impact of the Localism Act 2011;
- Reform to the criminal justice system, particularly the approach to integrating treatment and offender management across prisons and the community and the options for robust and innovative community sentences.

Finally, an issue which is consistently raised by our members in discussion of potential barriers

to recovery for people in drug and alcohol treatment is the impact of negative attitudes and stigma directed at people who are in treatment and committed to recovery. For example, two thirds of employers told the UK Drug Policy Commission they would not consider employing someone in recovery from a serious drug problem even if satisfied that they were otherwise suitable and qualified for the role.

BARRIERS TO RECOVERY

We believe that by seizing on the opportunities presented by the 2010 Drug Strategy and the Government's plans for public service reform we could take the next step forward in developing world beating services that can help to transform the lives of people affected by drug and alcohol problems who make the commitment to change, while benefiting families, neighbourhoods, communities and society as a whole. But to realise these opportunities, we need to avoid potential pitfalls that could be barriers to achieving the vision of recovery in the 2010 Drug Strategy.

Eight key issues have emerged as concerns in our consultation work on barriers to recovery.

1. Disinvestment and deprioritisation. Our members recognise their responsibilities to respond constructively and creatively to a more challenging financial environment. Many provider organisations have already been pro-active and innovative in identifying ways in which they can deliver more effective services more efficiently – for example, opportunities for economies of scale. But the ability of our members to support recovery depends on ensuring adequate levels of investment.

Local funding

The NTA's Chief Executive, Paul Hayes, expressed his concerns about local disinvestment in a letter announcing the central allocations for drug treatment spending for 2011-12 (11 February 2011): 'The biggest threat to those ambitions [i.e. for a recovery-orientated drug and alcohol treatment system] is the potential for local disinvestment. With the impending abolition of PCTs and severe

budgetary pressures on local authorities, there is legitimate concern across the treatment field that the vital funding provided from local sources will be squeezed'. Indeed, local funding for drug treatment has been falling for some time – from £226 million in 2005-06 to £208 million in 2008-09.

Young people's drug and alcohol treatment is particularly dependent on local investment. Our members have reported substantial disinvestment in young people's services since the 2010 Spending Review.

An investigation for the July/August 2011 edition of DrugScope's *Druglink* magazine found that a number of young people's treatment services had closed or been severely scaled back in London. Speaking in July 2011, staff at The Lifeline Project and Addaction, treatment providers who support young people, said that cuts to their specialist services would mean the number of young people they can support would be reduced in future. Similar findings have emerged from research conducted by the UK Drug Policy Commission in 2011-12 as part of its 'localism in an age of austerity' project.

Drug education and prevention has also been hard hit with financial pressures on Local Authorities intensifying after the loss of the Healthy Schools funding from central government. In a survey of staff in 79 local education authorities (LEAs) carried out by the National Health Education Group, 28 per cent reported that there had been no specialist drug education support in their LEA's secondary schools since April 2011.

Central funding

In 2011-12, drug treatment services in England were supported by over £570 million of Government investment, including £407 million through the ring-fenced 'pooled treatment

budget', and it was recently announced that the £570 million for community and prison treatment will be sustained in 2012-13.¹⁵ The pooled treatment budget will end in April 2013. As much as £1 billion of drug and alcohol spending could be absorbed into the public health budget when responsibility for treatment transfers to the public health service. This would account for around one quarter of the total, and a third to a half of the money available to Directors of Public Health locally. There will be a 'ring fence' around the public health budget as a whole. However, there has been real concern about the potential for disinvestment given that drug and alcohol treatment is one of 17 responsibilities for the public health service.¹⁶

We understand that careful consideration has been given in Government to how a combination of public health outcome indicators, grant conditions and requirements around reporting and transparency might be combined to secure local spend on drug and alcohol treatment. We welcome the recognition from Government of both the need to secure this investment and its vulnerability during a period of austerity. We note, however, that even if there is transitional protection for the budget that is currently invested through the pooled drug treatment budget, this would not preclude the potential for substantial disinvestment from local budgets. In 2008-09, according to analysis from the National Audit Office, over 35 per cent of the spend on drug treatment was from local funding¹⁷ – in addition, of course, to most of the spend on alcohol services.

2. Austerity, capacity building and sustainability. We are aware of growing concerns that the transfer of responsibility for specialist treatment services to local authorities at a time of financial austerity may result in compromises on service quality and sustainability. One trend appears to be a

¹⁵ National Treatment Agency (2012), 'Funding for drug treatment and recovery services 2012-13' at www.nta.nhs.uk/news-2012-ptb.aspx

¹⁶ As identified in Department of Health (2011), *Healthy lives, healthy people – update and way forward*, Annex A, pp. 27-28.

¹⁷ National Audit Office (2010), 'Figure 5: Drug treatment budgets, activity and outcome data 2004-05 to 2008-09' in *Tackling problem drug use*, p. 24.

movement away from NHS to voluntary and community sector (VCS) providers (for example, a third of respondents to a UK Drug Policy Commission survey of Drug Action Teams said that this had occurred when services were recommissioned in their local area).¹⁸

While we welcome the growing recognition of the role and performance of VCS organisations and the critical contribution they make to delivering recovery, we are concerned that NHS Trusts are reporting to us that they are unable to compete on price, given, for example, national agreements on pay and conditions and requirements around clinical governance arrangements. This also suggests that VCS organisations may be responding to a highly competitive environment by reducing their costs to a level that may be challenging to sustain in the longer term, and could make it difficult to invest in capacity building, including workforce development. The National Council for Voluntary Organisations (NCVO) released figures in March 2012 which suggest that the VCS is facing increased demand for services at a time of rising costs and unprecedented falls in income. It estimates that the VCS lost around 70,000 staff in 2011-12 and says that the voluntary sector is forecast to lose up to £1.2 billion in government income every year over the spending review period, to a cumulative total of 3.3 billion.¹⁹

3. Responsibility for clinical governance and the NHS Constitution. We have raised concerns about how standards of clinical governance and other patient (and staff) rights that are established within the NHS will apply to public health commissioning by Local Authorities. In particular, the NHS Constitution sets out the rights of all patients to access drugs and treatment recommended by the National Institute for Clinical Excellence (NICE) and to receive a professional standard of care, by appropriately qualified and experienced staff, in an approved and registered organisation, that meets the required levels of safety and quality. Currently, many local services which will move

to public health are commissioned by Primary Care Trusts (PCTs) and protected by the NHS Constitution. Under the new arrangements, the commissioning responsibility will transfer to public health bodies within local authorities.

The *Healthy lives, healthy people* White Paper says that the NHS Constitution would 'continue to apply to the whole health service, whether the NHS or Public Health England', but does not discuss Directors of Public Health in Local Authorities. There is a concern that delivery of some clinically focussed services may not be protected by the NHS Constitution. The NHS Constitution also includes other relevant rights, such as the right to 'expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary', and to access services within minimum waiting times.

4. Supporting staff and volunteers. At a consultation event hosted by DrugScope on behalf of Clinks and the Home Office in March 2011, it was argued that while the focus on workforce development in the drug strategy was welcome, it was coming at a time of low staff morale in many drug and alcohol services, which are issuing redundancy notices and losing staff. This is increasing the pressures on remaining staff, who will often be anxious about their own jobs, and are under pressure to manage increasing workloads and to develop more intensive, individualised and recovery-orientated approaches to working with their clients.

A particular issue is the use of volunteers. No one doubts the enormous contribution that volunteers make to treatment services, including peer mentors, recovery champions and people actively involved in other forms of service user work. Participation in this kind of activity can be a key part of the recovery journey for service users. But where services are experiencing economic pressures there is also a risk that volunteers will be used

¹⁸ As discussed in the UK Drug Policy Commission (2012), *Localism in an age of austerity* report (forthcoming).

¹⁹ NCVO (2012), *The UK Civil Society Almanac 2012*. See also NCVO press release 'Charities hit by triple whammy of financial pressures during the recession' (5 March 2012).

inappropriately, as an alternative to paid staff, in roles they may be inadequately trained to fill, and with a lack of support, training and supervision. It was commented that peer support and mutual aid are components of a balanced and integrated treatment system, but should never be seen as a low cost alternative to other forms of service.

5. Accessing recovery capital. Our ability to deliver recovery depends not only on the approach to treatment, but also on 'recovery capital', which the 2010 Drug Strategy identifies as critical to good treatment outcomes – such as housing and employment.

Housing

In August 2011, the Recovery Partnership (DrugScope, the Recovery Group UK and the Substance Misuse Skills Consortium) prepared a report for the Inter-Ministerial Group on drug policy expressing concerns about access to housing – and particularly the impact of removal of the 'ring fence' from Supporting People funding.

It reported on the findings of a survey of nearly 90 frontline providers, which suggests that most struggle to access suitable housing support for their clients, and many are fearful that the situation is worsening. Eighty nine per cent of respondents said that 'safe, secure and appropriate accommodation' was 'difficult' (47%) or 'very difficult' (42%) to access in their local area, with 62% expecting it to become 'less accessible' in the next 12 months.

We are also concerned about the potential impact of reforms to housing benefits on access to suitable housing. For example, the raising of the age threshold for the Shared Accommodation Rate from 25 to 35 means that a single adult under 35 with no dependents will only qualify for housing benefit to cover a room in shared accommodation and not for a self-contained property. We believe that this will significantly increase the risks of relapse where someone in recovery is placed in shared accommodation with people who are still misusing drugs and/or alcohol. We applaud the Government's decision to include an exemption for people who have been resident in homeless

hostels for at least three months (while noting this does not apply to the under 25 group), but this will not exempt the majority of people in recovery from drug or alcohol problems. We also have concerns about the abolition of community care grants and budgeting and crisis loans, which can offer vital financial support for recovery (such as essential items to furnish a new room or flat).

Employment

The Department of Work and Pensions has shown a welcome interest in improving support and opportunities for people with drug and alcohol problems – and has taken a key role in developing the Government's vision of recovery. We welcome the commitment to ensure that 'work pays' that is at the heart of the Welfare Reform Act 2012, and the proposals for universal credit. Many service users have opportunities to work part-time, but the current benefit rules mean there is often little or no financial incentive to do so. We also support the focus on individualised support in the 'Work Programme', which picks up on the previous Government's commitment that nobody should be 'written off' in the benefit system. We were pleased that the Government was able to change benefit regulations to enable clients of residential rehabilitation services to qualify automatically for Employment and Support Allowance.

However, there are real concerns about the potential impact of benefit reforms on people in recovery from drug and alcohol problems. Some of our members report that Work Programme 'prime providers' are not actively sub-contracting with drug and alcohol treatment providers in line with undertakings in their original tenders. There is anxiety that our clients – who experience significant barriers in employment markets - will be 'parked' with little active encouragement and support to find work or to access other forms of meaningful activity. There are also concerns about the impact of conditionality regimes and benefit sanctions on people in drug and alcohol treatment. We look forward to working with Government on flexible conditionality for benefit claimants engaged with drug or alcohol services, as promised in the 2010 Drug Strategy. We welcome

the opportunities that our sector has had to influence Professor Harrington's on-going review of the Work Capability Assessment (WCA), while noting that there are significant issues about its application to people with substance misuse problems. We have had opportunities to comment on a draft of the training materials for WCA assessors produced by Atos, about which we raised concerns.²⁰

6. Making the right connections. Recovery requires a range of services to work together to address the particular needs of individual service users, as well as families and communities. While progress has been made, building the necessary partnerships between sectors and services with their own priorities, languages, approaches and cultures has been a challenge – which helps to explain why progress in addressing dual diagnosis and multiple need has been uneven.

Localism creates opportunities for more integrated approaches that bring different budgets and services together to address local concerns and priorities. But there are also risks. Where budgets are under pressure, there is a tendency for commissioners and providers to concentrate on 'core business' for their own sector's services. In addition, while new local structures such as Health and Wellbeing Boards will facilitate joint strategic planning and commissioning, it is not yet clear how effectively they will address issues such as provision for people with co-occurring substance misuse and mental health problems.²¹

The Joint Strategic Needs Assessments (JSNA) and joint Health and Wellbeing Strategies (HWS) produced by Health and Wellbeing Boards will provide an important vehicle for collaborative work on recovery informed by a shared local strategy. It is not, however, clear

whether Health and Wellbeing Boards will be required to ensure that their JSNA includes a full and detailed assessment of drug and alcohol problems, or what the opportunities will be for influencing the JSNA and HWS around specific issues, such as support for recovery.

There is also a question of how the JSNA and HWS will be joined up with other local strategies, such as the Police and Crime Plans that will be produced by Police and Crime Commissioners (PCCs) from April 2013, which may well address drug and alcohol issues. PCCs are not statutorily required members of Health and Wellbeing Boards and there are practical barriers to their participation.²² In addition, we note that drug and alcohol services in prisons will be commissioned by 'offender health' sitting under the NHS Commissioning Board, and further thought will need to be given to ensuring effective 'join up' between prison and community services. We have also expressed concerns that the draft Commissioning Outcomes Framework (COF) for Clinical Commissioning Groups, recently consulted on by NICE, made no reference to either drugs or alcohol, and we hope this will be remedied in development of the COF.

We also believe that further thought will need to be given to ensuring that the panoply of PbR initiatives that may impact on services and service users working on recovery and have been largely developed separately are joined up and coherent – these include the Drug and Alcohol Recovery PbR, the NHS-led alcohol PbR, the dual diagnosis work within the mental health PbR, the Work Programme, the development of PbR for the 'troubled families' initiative and PbR in criminal justice – including, for example, plans for PbR approaches to alcohol treatment for offenders that were included in the Alcohol Strategy 2012.

²⁰ Atos draft Training and Development Substance Abuse (Learning Set)

²¹ This issue is discussed in more detail in *Dual diagnosis: a challenge for the reformed NHS and public health – a discussion paper* from the Centre for Mental Health, DrugScope and the UK Drug Policy Commission' (2012), which includes practical recommendations for 'Ways forward'. This document is available at <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DSDualDiagnosisDiscussionPaper.pdf>

²² Not least that PCCs will be responsible for police authority areas and these are not co-terminous with upper tier local authority areas (so a single police authority area could include several Health and Wellbeing Boards). In addition, much of the business discussed by HWB will be of limited relevance to PCCs.

7. Unintended consequences, payment by results and outcome-based commissioning.

Many of our members are supportive of the principles behind payment by results and outcome-based commissioning, and we have welcomed the opportunities that we have had to work closely with the Department of Health on the design of the eight Drug and Alcohol Recovery PbR pilots. However, there are concerns about the potential unintended consequences of introducing what is a radically new approach to commissioning and funding services. We welcome the commitment to detailed monitoring and evaluation of the eight recovery pilots, but note that payment by results approaches are also being introduced in other localities that have not participated in the Department of Health led 'co-design' process and will not be subject to the same level of monitoring and evaluation.

Three issues, in particular, continue to be raised when we discuss payment by results. First, there remains a concern that PbR outcomes and payments may be set locally in ways that reward a focus on those service users closest to achieving the 'results', and not those with complex and entrenched needs ('cherry picking' and 'parking'). Second, there are concerns that only the largest private and voluntary sector organisations will be in a position to manage the cash flow and commercial risk issues associated with payment by results. Finally, service providers note that their ability to achieve and sustain outcomes for their clients depends on the degree of local engagement from other sectors and local economic and demographic trends (for example, access to housing and employment for service users).

8. Stigma and attitudes to people in recovery. As noted earlier, recent opinion polling has shown an encouragingly high level of public support for drug and alcohol treatment services and recognition of the paths that can lead people into substance dependency. It remains the case, however, that negative attitudes to individuals (as well as families and neighbourhoods) affected by drug and alcohol problems are a significant barrier to recovery.

A UK Drug Policy Commission report on access to employment found that two thirds of employers would not consider someone in recovery from a heroin or crack cocaine problem for work in any circumstances, even if they believed they were otherwise well qualified for the job. More recently, the UK Drug Policy Commission published *Getting serious about stigma*, which found that people with a history of drug problems are heavily stigmatised, and consequently subject to exclusion and discrimination in many areas. It concluded that the stigmatisation of people with drug problems has serious consequences for government policy as 'key policies seeking greater reintegration and recovery and moving people from benefits into work will not succeed while stigmatising attitudes are pervasive and, as a result, drug problems will remain entrenched rather than overcome'.

FOUNDATIONS FOR RECOVERY – TEN RECOMMENDATIONS

We welcome the Government's commitment to developing a recovery-orientated approach to drug and alcohol treatment, and look forward to continuing to work with Government to make a reality of a shared vision of recovery. There is a real opportunity for our sector to build on recent achievements and take the next step forward in developing world class services to tackle drug and alcohol misuse, its causes and consequences for individuals, families, communities and society as a whole. However, there are also risks for our members and for their service users during a period of financial austerity and policy reform.

There are ten key actions that we would ask Government and local decision-makers to take to ensure that our members are provided with the tools to deliver on the vision for recovery-orientated treatment.

1. While recognising the pressures on public finances that are affecting all local services, we ask Government and local decision-makers to ensure that there is sufficient investment in every local area to provide the tools needed if they are

to deliver on the ambitions of the 2010 Drug Strategy. With the removal of the ring-fencing from the pooled drug treatment budget, and the limited reference to drug and alcohol service provision in the 'Healthy Lives, Healthy People' documents, there is anxiety that there could be substantial disinvestment from drug and alcohol treatment provision in some localities. We do not believe this is the Government's intention, nor that it is something that local authorities and communities would want to see if fully informed about the likely impact (for example, on crime and anti-social behaviour, troubled families and social exclusion). Securing adequate investment to deliver the Drug Strategy objectives could potentially be achieved through a combination of appropriate indicators in the public health outcomes framework, grant conditions that incentivise local areas to invest in drug and alcohol services and robust monitoring of local service provision. The quarterly publication of national data on waiting times for access to drug and alcohol services in each local authority area would provide an effective early warning of disinvestment as well as a simple and powerful accountability mechanism. It is unclear where democratic accountability for the performance of drug and alcohol services will reside at local level, and we would welcome clarification on this, as well as of the Secretary of State for Health's responsibilities for ensuring that all drug and alcohol treatment is delivered in every local area in line with NICE guidelines and the NHS Constitution.

2. There is a real concern about local disinvestment in young people's services, with some VCS services reporting cuts of 50 per cent, and expressing concerns that there may be further cuts in the year ahead. We ask the Government and local decision-makers to address this situation as a matter of urgency, given, for example, the emphasis on the role of early intervention in the Drug Strategy, the potential impact on its ambitions to address the needs of the most troubled families and the compelling evidence for the cost effectiveness of specialist young

people's services. As a first step, we are concerned that there is a lack of systematic monitoring of patterns of disinvestment in young people's services. We would also welcome an assessment of the impact of reductions in community safety budgets on local drug and alcohol services for under 18s, as this has been identified as a key factor at local level by our members. We welcomed and responded to the discussion paper on substance misuse that was produced by the Department for Education as part of its 'Positive for Youth' programme in 2011. We would like to see the 'Positive for Youth' initiative serve as a springboard for the Department to develop its national leadership role on young people's treatment and drug education and articulate a compelling narrative that can inspire and inform local commissioning and delivery as effectively as the recovery vision for adult services. If appropriate action is taken to protect and promote young people's services now, then the transfer of responsibility for substance misuse to public health could present a real opportunity for improvements in prevention and early intervention work, as well as young people's specialist treatment – so long as local investment decisions are informed by research evidence on 'what works'.

3. We welcome the opportunities to integrate drug and alcohol services into public health at local level, but ask Government (and Public Health England once it is operational, picking up on on-going work by the National Treatment Agency) actively to promote the importance of drug and alcohol issues within public health and prepare Directors of Public Health (as well as other key local decision-makers, including members of local Health and Wellbeing Boards and Police and Crime Commissioners) for their new responsibilities for planning and commissioning drug and alcohol services. We recognise that the Government is reluctant to overload local authorities with guidance, but we believe this is an area in which local decision-makers would welcome more information and support to prepare them for their new responsibilities, and provide

orientation at a time when the drug and alcohol problems that affect their communities are taking new forms and local planning and commissioning structures are changing rapidly. Many of our members contributed detailed responses to the NTA's 'Building Recovery in Communities' consultation, and we are disappointed that no substantial guidance to support local commissioning for recovery has yet emerged from this process. There is a substantial workforce development challenge in preparing a wide range of local officials and professionals for new responsibilities for drug and alcohol issues, which could be led by the Substance Misuse Skills Consortium, working closely with other national agencies, such as the Association of Directors of Public Health and relevant Royal Colleges.

4. The Drug Strategy 2010 recognises the critical importance of social, physical, human and cultural capital to recovery from drug and alcohol dependency. Our members believe that this is key to delivering recovery-orientated services. We ask Government and local decision-makers to help us to ensure that people with drug and alcohol problems have access to the basic 'capital' that they need to support and sustain recovery.

The inherently cross-cutting nature of recovery should be reflected in all policy, planning, strategic and commissioning structures (including payment by results). At national level we would like to see Public Health England given a clear and designated responsibility for co-ordinating policy on recovery-orientated treatment. At local level, we believe it is critical that housing, employment support, family support and other recovery services are involved with Health and Wellbeing Boards (as well as working closely with Police and Crime Commissioners). It is hard to exaggerate the importance of having safe and stable accommodation for sustained engagement with services and recovery. We would welcome consideration of mechanisms for greater transparency and accountability in

allocation of Supporting People funding to balance a degree of local flexibility with the housing provision required to deliver the 2010 Drug Strategy. We would also ask Government to commit to commissioning a detailed independent evaluation and review of the impact of welfare changes (for example, changes to housing benefit) on recovery outcomes, which could be developed through the social justice strategy.

5. There is growing awareness of the high numbers of people in drug and alcohol treatment with 'dual diagnosis' and 'complex need'. The transition to public health will create opportunities for innovative approaches to 'joining up' services, but there are also risks that new gaps will open. It has been estimated that nine out of 10 people in contact with drug and alcohol services have some kind of mental health problem, predominantly depression and/or anxiety. We support the work of the Making Every Adult Matter (MEAM) coalition, which is bringing together Clinks, DrugScope, Homeless Link and Mind, with funding from the Calouste Gulbenkian Foundation, to influence policy and services for adults with multiple needs. We fully endorse and commend the findings and recommendations of the MEAM vision paper for multiple needs and exclusions, 'Turning the Tide'. We also applaud the commitment in the 2010 Spending Review to increase investment in psychological therapies, particularly for people with common mental health problems. We have had concerns that the Improving Access to Psychological Therapies programme has not always been accessible for clients of drug and alcohol services who would benefit from it, and welcomed IAPT's publication of a 'Positive practice guide for people who use drugs and alcohol' in 2012 in partnership with DrugScope and the National Treatment Agency.²³ We ask Government and local decision-makers to support more 'joined up' provision of drug and alcohol treatment and psychological therapy, and to help to ensure that the new public health and NHS Commissioning structures prioritise dual

23 The IAPT guidance is available at <http://www.iapt.nhs.uk/silo/files/iaptdrugandalcoholpositivepracticeguide.pdf>

diagnosis and complex need. We refer to a briefing paper on this issue that was produced by the Centre for Mental Health, DrugScope and the UK Drug Policy Commission (2012), and endorse its recommendations.²⁴ We also note the conclusion of Lord Bradley's 2009 report on diversion from the criminal justice system that dual diagnosis was endemic in the offender population and 'a vital component of addressing the issues of mental health and criminal justice'.

6. The Government has recognised the vital role of the voluntary and community sector (VCS) in working effectively with the most marginalised people in society to deliver recovery, including individuals, families and communities affected by drug and alcohol problems. This is a key theme in Government plans for the reinvigoration of local democracy and community participation. We ask that Government and local decision makers ensure that both the VCS and service users are key partners in the planning and development of drug and alcohol services. Local VCS organisations may lack the capital and confidence to participate in payment by results schemes and may not be favoured by other forms of outcome-based commissioning. Particularly at a time of financial austerity where the economies of scale offered by large organisations will be attractive for local politicians and commissioners, we would welcome further consideration of how the unique contribution of smaller VCS organisations can be protected and harnessed in a new commissioning environment (for example, local family support networks). The VCS should have representation on Health and Wellbeing Boards, and we believe that the Boards and Directors of Public Health would benefit from establishing local advisory groups on drug and alcohol provision with strong VCS involvement. We welcome the representation of service users on Health and Wellbeing Boards through Healthwatch, but would question the capacity of a generic patient

representative to provide a voice for users of drug and alcohol services, who we would like to see represented in their own right in local planning and commissioning structures. We welcome the emphasis on peer support and recovery champions in the Drug Strategy 2010, and believe that the Substance Misuse Skills Consortium can play a role in providing service users with the training and support they will need to undertake these roles. We urge all local areas to consider how they can involve service users in the development of local recovery systems - for example, building on the Royal Society of Art's work on Whole Person Recovery.

7. Our members work with some of the most troubled and damaged individuals and families in society, but have not yet benefited from a comprehensive work force development strategy. We ask the Government and local decision-makers to support the creation of 'the inspirational, recovery orientated workforce' that the Drug Strategy 2010 recognises will be needed to deliver on its ambitions. It is estimated that as many as 30,000 people are working in drug and alcohol-related roles in England. While some of these roles require specialist training, many do not currently require particular training or experience. This can mean that there are not the same career pathways for people entering the substance misuse field as in other areas of health and social care. As well as working closely with the Federation of Drug and Alcohol Professionals (FDAP), we have supported the establishment of the independent Substance Misuse Skills Consortium (SMSC) and believe this provides a real opportunity to drive development of a professional workforce, which is trained and supported to deliver on the recovery agenda. We welcome the funding that the Department of Health has made available to support the Substance Misuse Skills Consortium over the next three years. We would welcome clarification of the application of the pledges to and statement of rights of staff included in the NHS constitution

24 Centre for Mental Health, DrugScope and UKDPC (2012), *Dual diagnosis: a challenge for the reformed NHS and Public Health England* at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DSDualDiagnosisDiscussionPaper.pdf

to our workforce. We note that in the current climate there are anxieties about pay and conditions in the VCS sector, and potential for the inappropriate use of volunteers.

8. If we are to make a reality of recovery, then there is a clear need to address negative attitudes to people who have been affected by drug and alcohol problems, which are often a barrier to accessing recovery capital. We believe there is an important role for VCS organisations and independent funders, but we also ask that national and local government contributes to changing attitudes. We note that people in recovery from drug and alcohol problems do not receive protection under the Equalities Act. Given the recognition in the Drug Strategy 2010 of the important role that employment can play in recovery this must be addressed. In particular, we would urge central and local government to review their information, communications and media activity to ensure that it promotes positive perceptions of individuals who have made the commitment to recovery and are getting their lives back on track. We would also like to see Government departments and local authorities make a public commitment to provide training, work experience and employment opportunities in public sector organisations for people in recovery from drug and alcohol problems and develop active policies for promoting their inclusion.

9. There has been increased recognition of the role of families in supporting treatment and recovery as well as of the devastating impact that drug and alcohol problems have for families. We ask Government and local authorities to build on this progress, and to bring families in from the margins of drug and alcohol policy. The Drug Strategy places family support at the centre of drug and alcohol policy, stating that tailored and co-ordinated support for families in difficulty can deliver a saving of £49,000 per family each year. We also welcome the Prime Minister's announcement in December of

£448 million for a new programme to support 'troubled families'. We are working with the Troubled Families team at DCLG and other key Government departments to explore the role of drug and alcohol services in this agenda and ask Government and local authorities to ensure that work with 'troubled families', supported by community budgets, includes interventions around substance misuse, and to recognise the significance of this work for achieving the programme's other outcomes. The reality is that more still needs to be done to increase and improve the support that is available for families affected by substance misuse problems. We ask Government to consider as a priority options for improving support for families that have lost contact with or disengaged from a family member with a substance misuse problem. The issues were discussed in detail in a joint Adfam and DrugScope briefing on 'Recovery and drug dependency: a new deal for families' in 2009.²⁵ We believe that its recommendations are still relevant.

10. Drug and alcohol treatment has a critical role to play in the criminal justice system, where it makes a vital contribution to community safety and the reduction of offending and reoffending. We broadly welcomed the approach that was set out in the 'Breaking the Cycle' Green Paper. We would ask the Government and local decision-makers to ensure that the approach to treatment and recovery set out in the 2010 Drug Strategy applies equally to provision in criminal justice settings (including recognition of the role of 'medically assisted recovery'). There is a concern that the rise of prison numbers to record levels of nearly 88,000 in 2011 has created a barrier to delivering effective drug and alcohol treatment services for prisoners and to improving integrated offender management. For example, the Patel Report argued that increases in the prison population had resulted 'in a strain on limited staff resources, disrupted regimes and some prisoners being placed further from home'. We would

²⁵ Adfam and DrugScope (2009), *Recovery and drug dependency: a new deal for families* at www.adfam.org.uk/docs/recovery_dependency.pdf

ask Government to consider some of its earlier proposals for diverting offenders to community sentences, and particularly short-term prisoners who have committed non-violent offences, whose offending will often be driven by a drug or alcohol dependency. We note that the Bradley Report included proposals for effective diversion of the high number of prisoners with co-occurring mental health and substance misuse problems. We would also welcome further clarification of the role of Police and Crime Commissioners in the planning and commissioning of local drug and alcohol services from November 2012, and the integration of commissioning of community services through public health with the commissioning of prison services through 'offender health' under the auspice of the NHS Commissioning Board.

We believe that if these issues are addressed, our members can deliver on the ambitions of the 2010 Drug Strategy and work with local partners and colleagues to build recovery based services in every local area that can respond to local needs and priorities. Our members recognise their responsibilities to rise to the challenge of the Drug Strategy and to ensure that investment in drug and alcohol services counts in a period of financial austerity. We know that we have a critical contribution to make to improving public health, tackling social exclusion and reducing crime and anti-social behaviour in every local area. We look forward to supporting Government and Local Authorities to rise to this challenge.

The **Drug Sector Partnership** was formed by four national charities from 2009-2012 – Adfam, DrugScope, eATA and the Alliance – to

support community and voluntary sector organisations working in the drug and alcohol sector. The Partnership brought together charities working with families and carers, treatment providers, service users, drug education and prevention practitioners and others working to reduce the harms caused by drug and alcohol misuse.

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We welcome comments or responses to this paper as part of the ongoing dialogue about recovery and the challenge of building recovery in communities.

DrugScope is the national membership organisation for the drug sector and the leading independent centre of expertise on drugs and drug policy. DrugScope's aim is to inform policy development and reduce drug-related harms - to individuals, families and communities. The charity provides quality drug information, promotes effective responses to drug use, advises on policy-making, encourages informed debate - particularly in the media - and speaks for its members working across the drug and alcohol sectors.

DrugScope and eATA have announced plans for eATA's merger into DrugScope in March 2012.

KEY RESOURCES AND DOCUMENTS

Adfam and DrugScope (2009), *Recovery and drug dependency: a new deal for families* at www.adfam.org.uk/docs/recovery_dependency.pdf

Centre for Mental Health, DrugScope and UK Drug Policy Commission (2012), *Dual diagnosis: a challenge for the reformed NHS and for Public Health England* at <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DSDualDiagnosisDiscussionPaper.pdf>

DrugScope (2009), *Drug treatment at the crossroads* at www.drugscope.org.uk

DrugScope (2010), *Young people's drug and alcohol treatment at the crossroads* at www.drugscope.org.uk

Home Office (2010), *Drug Strategy 2010 Reducing demand, restricting supply, building recovery: supporting people to live a drug free life* at <http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010?view=Binary>

HM Government (2012), *Social justice: transforming lives* (the Social Justice Strategy) at www.dwp.gov.uk/docs/social-justice-transforming-lives.pdf

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Recovery Partnership – papers on housing and recovery, employment and recovery and payment by results are available at <http://www.drugscope.org.uk/partnersandprojects/Recovery+Partnership>

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Appendix 1: Drug treatment ‘consensus statement’

“We have come together because we are concerned to ensure that public debate about drug treatment recognises the progress that has been made in improving the lives of individuals, families and their communities. Drug treatment services are available to anyone trying to access them within a week on average, and most people coming into treatment are staying long enough to get real benefit from it.

There is overwhelming evidence that properly funded and evidence-based drug and alcohol treatment delivers benefits for individuals, families and carers, neighbourhoods, communities and society at large. This applies to the whole range of services, from programmes providing injecting drug users with clean needles to abstinence-based residential programmes

- There are an estimated 400,000 problematic heroin and crack cocaine users in the UK; nearly 1.5 million adults will be significantly affected by a family member’s illegal drug use. An estimated 1.6 million adults in the UK are dependent on alcohol.
- Treatment improves lives but also saves money in subsequent health, social and criminal justice costs. Estimates of the cost benefits have ranged from £2.50 to £9.50 for every £1 spent on drug treatment. While some have disputed the exact cost savings, no one seriously questions the cost-effectiveness of drug treatment.
- The introduction of harm reduction services in the UK in the 1980s and 1990s resulted in one of the lowest rates of HIV infection among injecting drug users anywhere in the world. HIV prevalence among injecting drug users has stabilised at around one per cent (although Hepatitis B and C infection is more widespread).
- Some people with serious drug problems commit crimes to pay for drugs, by removing or reducing dependence on illegal markets, drug treatment can break this link. The Home Office reports that acquisitive crime – such as shoplifting, burglary, vehicle crime and robbery – to which drug-related crime makes a significant contribution fell by 55 per cent between 1997 and 2007.

While recognising that we are building on solid and substantial achievements, we would like to see a commitment to taking the next steps forward to creating world class treatment services.

- We need to develop better links between different health, social care and support services to support recovery. Drug and alcohol problems do not occur in a vacuum, and they cannot be solved in a silo. Many of the people who use drug and alcohol services arrive at the door with multiple problems and needs - often their drug and/or alcohol use is linked to experience of childhood abuse or adult trauma, to mental health problems, homelessness, family breakdown and other problems.
- We need a balanced and integrated treatment system that is focussed on recovery, quality of outcomes and re-integration and not only the numbers of people coming into services. Drug services should not simply be about stabilising people on methadone or getting them off drugs, they should also be involved in finding people places to live and opportunities to learn or work.
- Treatment should be personalised, sensitive to ethnicity and diversity, with service users fully involved in decisions about their treatment with their needs driving the care planning process. The important role that families and carers can play in supporting treatment and

recovery should be acknowledged and supported.

- We need to develop drug treatment services that can work with different forms and patterns of drug misuse, such as stimulant problems and multiple or 'poly-drug' use, including alcohol. Our treatment system needs to balance a focus on heroin and crack cocaine with other forms of substance misuse and harms related, for example, to alcohol, cannabis, ketamine, GBL/GHB and so called 'legal highs'.
- Drug and alcohol treatment services should be available to all who need them - in prison, probation, community and residential services.

We believe that investment in drug and alcohol treatment is vital and should continue and be a priority for public health.

Above all, we are calling on all politicians - along with other decision-makers and opinion formers - to commit to an evidence-based and non-partisan approach to drug and alcohol policy, which respects the advice of independent experts, such as the Advisory Council on the Misuse of Drugs, and the National Institute for Clinical Excellence. In this respect, the same principles should apply to alcohol and drug treatment as apply to treatment of cancer, heart disease, diabetes, depression or schizophrenia.

Where investment in drug and alcohol services is driven by research and evidence, it delivers for tax payers and is cost effective too.

Decision-makers and opinion formers have a responsibility to make sure that taxpayers' money is spent wisely, on services that deliver on public priorities and with public benefits. We recognise that tough decisions need to be made between competing priorities, particularly at a time of spending restraint. But we also know that any disinvestment in drug and alcohol treatment services will leave some of the most excluded and marginalised in our society with no second chances and no route back. It will also result in greater costs in the long run, as we pay the price of not intervening in support of people who are prepared to face up to their drug or alcohol problems and try to get their lives on track."

The Consensus Statement has over 70 signatories, including more than 30 Chief Executives of key organisations delivering drug and alcohol treatment. A full list of signatories is available at www.drugsectorpartnership.org.uk/consensus.html

Appendix 2: 'The Principles of Recovery'

From Geoff Shepherd, Jed Boardman and Mike Slade 'Making Recovery a Reality', Sainsbury Centre for Mental Health (2008) – these principles for mental health were adapted from *Recovery – Concepts and Application* by Laurie Davidson, the Devon Recovery Group.

- Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.
- Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness.
- Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives ('agency') and by seeing how others have found a way forward.
- Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No 'one size fits all'.
- The helping relationship between clinicians and patients moves away from being expert / patient to being 'coaches' or 'partners' on a journey of discovery. Clinicians are there to be "on tap, not on top".
- People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services.
- Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability.
- The language used and the stories and meanings that are constructed have great significance as mediators of the recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity.
- The development of recovery-based services emphasises the personal qualities of staff as much as their formal qualifications. It seeks to cultivate their capacity for hope, creativity, care, compassion, realism and resilience.
- Family and other supporters are often crucial to recovery and they should be included as partners wherever possible. However, peer support is central for many people in their recovery.

Appendix 3: 'A vision for the future' for recovery-orientated drug treatment'

From '*Recovery-orientated drug treatment – An interim Report* by Professor John Strang, Chair of the Expert Group' (NTA 2011)

Our vision for the future is a system:

- In which the valuable role of prescribing continues to be recognised, though it is not an end in itself but a component of a phased, integrated package of treatment that minimises risk while being ambitious for each individual patient's recovery
- That develops and supports staff to adopt recovery-orientated practice and in which they are trained to deliver evidence-based psychosocial interventions alongside medical interventions
- In which everyone entering treatment is enabled to see and understand the range of treatment and recovery options open to them, the trajectories of the journey on which they are embarked, and the possible destinations of that journey
- That seeks to maximise what individuals can achieve with a clear sense of movement and progress for patients even during those periods when they are appropriately allowed to settle and stabilise
- That recognises the real achievement of preventing the deterioration that would otherwise have occurred to more severely damaged patients
- That closely involves families and carers in patient's treatment and supports them in their own right
- That has close links to its community, that works alongside other systems to facilitate access to a broad range of reintegration and recovery support
- In which there are well-defined roles for current and future medications in stabilising, maintaining and detoxifying patients, and preventing relapse in different settings.

Appendix 4: UK Drug Policy Commission Recovery Consensus Group

From *A vision for Recovery 2008* (www.ukdpc.org.uk/Recovery_Consensus_Statement.shtml)

UK Drug Policy Commission Consensus Group: a vision for recovery

Recovery must be **voluntarily-sustained** in order to be lasting, although it may sometimes be initiated or assisted by 'coerced' or 'mandated' interventions within the criminal justice system.

Recovery requires aspirations and hope from the individual drug user, their family and those providing services and support.

Recovery is about building a satisfying and meaningful life, as defined by the person themselves, and involves **participation in the rights, roles and responsibilities of society**. The word 'rights' is included here in recognition of the stigma that is often associated with problematic substance use and the discrimination users may experience and which may inhibit recovery. Recovery embraces inclusion, or a re-entry into society, and the improved self-identity that comes with a productive and meaningful role. For many people this is likely to include being able to participate fully in family life and undertake work in a paid or voluntary capacity.

Recovery is a **process**, not a single event, and may take time to achieve and effort to maintain. The process and the time required will vary between individuals.

The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and well-being, and participation in the rights, roles and responsibilities of society

Recovery is about the accrual of positive benefits, not just reducing or removing harms caused by substance use.

Recovery requires **control over substance use** (although it is not sufficient on its own). This means a comfortable and sustained freedom from compulsion to use. For many people this may require abstinence from the problem substance or all substances, but for others it may mean abstinence supported by prescribed medication or consistently moderate use of some substances.

Recovery may be associated with a number of different types of support and interventions or may occur without any formal external help: no 'one size fits all'.

Recovery **maximises health and well-being**, encompassing both physical and mental good health as far as they may be attained for a person, as well as a satisfactory social environment.