

Bringing evidence and analysis
together to inform UK drug policy

UKDPC

UK DRUG POLICY COMMISSION

Charting New Waters:

Delivering drug policy at a time of
radical reform and financial austerity

April 2012

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Abbreviations

ACPO – Association of Chief Police Officers

BCU – Basic Command Unit

BME – Black and Minority Ethnic

CSP – Community Safety Partnership

DAT – Drug Action Team

DAAT – Drug and Alcohol Action Team

DIP – Drug Interventions Programme

EIG – Early Intervention Grant

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

JCG – Joint Commissioning Group

JSNA – Joint Strategic Needs Assessment

NICE – National Institute for Health and Clinical Excellence

NTA – National Treatment Agency

PbR – Payment by Results

PCC – Police and Crime Commissioner

PCT – Primary Care Trust

POCA – Proceeds of Crime Act

PTB – Pooled Treatment Budget

TUPE – Transfer of Undertakings (Protection of Employment) Regulations

Report summary

Introduction

The funding, commissioning, management and delivery structures for addressing the problems associated with illicit drugs in England are experiencing an unprecedented level of change.

The government's 2010 Drug Strategy places considerable focus on improving the recovery outcomes for people with drug problems, alongside efforts to reduce the supply of drugs. It identifies the need for support from a range of different services such as employment, education and housing, and family networks to enable people to reintegrate into their communities. In contrast to the strong central oversight of previous drug strategies, it calls for far greater local control over service delivery by local areas and people accessing services (Home Office, 2010).

At the same time, substantial reductions in public spending are being implemented alongside wide-ranging public service reform, including structural changes to the NHS, policing and criminal justice reform and a drive to deliver the Big Society.

These changes raise key questions, which our study set out to explore, about the ability of areas to achieve the ambitions of the Drug Strategy and around the future security of investment in drug interventions. With considerable additional resources for drug interventions over the last decade much has been achieved but there is a real risk that the current level of change will lead to the dilution of these gains, with negative consequences for drug users, their families, for wider communities, and indeed for the wider economy.

Our study reveals a broad picture of upheaval and uncertainty and this summary sets out our study's main findings. The results will be relevant for national policy makers; commissioners and providers of drug treatment and recovery services; Directors of Public Health; those engaged in drug-related enforcement; and locally elected officials.¹

¹ Forthcoming research by UKDPC will explore further the 'governance' and processes for making drug policy in the UK. This will address some of the same issues covered within this report, such as leadership, accountability and stakeholder engagement, but with a focus on policy development. It will be published in winter 2012.

Our study

This study explored the way in which drug-related interventions (focusing on drug treatment and recovery services, drug-related enforcement and drug prevention activities) are changing in England in response to the current environment of increasing austerity and wide-ranging structural reforms.

The research was carried out between February 2011 and March 2012.² Therefore information here relates to a period prior to the full implementation of some of the most far-reaching and potentially impactful changes. Our research aimed to highlight risks, opportunities and emerging lessons to assist those who are seeking to improve service provision and manage the changes resulting from reforms to structures and systems.³

Study methodology⁴

The study drew on a combination of methods:

- Review of key national level literature and interviews with key stakeholders.
- The delivery of 81 semi-structured interviews in seven English case study areas. Interviewees included: key Drug Action Team staff (or the local equivalent structure for commissioning drug treatment and recovery services) and Police, Probation, Primary Care Trust, community safety, service user, elected member and GP representatives.
- National survey of police forces in England, conducted with support from the Association of Chief Police Officers. In total, 74% of forces, 25% of Borough Command Units and 9 other units responded.
- National survey of 142 English Drug Action Teams (or local equivalent), completed by 43% of teams.⁵
- Three national events: a roundtable workshop for Directors of Public Health, held in partnership with the Association of Directors of Public Health, a seminar for those responsible for commissioning and managing drug treatment and recovery services in 25 English areas, and a roundtable workshop for NHS drug treatment providers in England.
- Expert input from a high-level project advisory group, which included representatives from government departments, the local and community sector and professional police and public health bodies.

² The research focuses mainly on services for adults. A forthcoming UKDPC briefing will concentrate specifically on change to young people's services in the current environment and the potential impact of this on drug problems.

³ It was not assumed that decreasing overall public expenditure automatically meant a decrease in expenditure on drug interventions or lower-quality services as centrally allocated funding for drug treatment held steady for the 2011/12 and 2012/13 periods.

⁴ Separate briefings on the key findings from the national surveys, roundtable workshops and seminar are available: www.ukdpc.org.uk/localism-and-austerity-project/

⁵ Survey distributed to the Drug Action Teams for which accurate contact details were available.

Adapting policy and managing change

Since the election of the coalition government, a considerable amount of new policy and structures relevant to the delivery, management and funding of drug interventions has been rapidly introduced. This is in contrast to a previously 'evolutionary' model of policy development largely based on incremental change.

The cumulative effects of government policies are often unpredictable and increasing levels of decentralisation increases complexity due to the involvement of more actors with varying priorities and approaches. There is a balance to be struck between the priorities and perspectives of national and local actors (Institute for Government, 2011).

To ensure that the Drug Strategy is deliverable, there will be a need for the national government to adapt or steer the system if it is found to be deviating too far from the high-level goals of its policy. Our research aims to provide indicators of 'early warnings' which we hope can inform future decision making processes.

MANAGING CHANGE

Core principles apply to the successful implementation of change in any setting. For example, strong leadership is fundamental to keep change moving. It is vital to have a clear strategy, setting out the case for change and goals towards which progress can be measured, backed by the right resources and a team to implement this. It is also essential that there is a timetable, taking into account the issues that might pull progress off course. Alongside this, some quick wins are needed so people are able to see results from the change process. Taking the time to assess implications and consequences up front is valuable, together with clear metrics to measure success, assess value for money and to reinforce and embed the change. Finally, on-going and effective communication with staff and stakeholders is critically important (Local Government Improvement and Development, 2007).

Although public service organisations are familiar with managing change, albeit with varying levels of success, applying the principles above to so called 'wicked issues' such as drug misuse, which involve complex and often interlinked challenges, may prove to be particularly difficult in the context of austerity and extensive reform.

Unprecedented change

The changes key to our study's focus include:

- Structural changes to the NHS as set out in the Health and Social Care Act and the creation of a new public health system within local authorities which will include the commissioning of substance misuse treatment and recovery services. From March 2013, the current drug and alcohol treatment budget is likely to make up around a quarter of the total national budget for public health (around a third of the budget allocated to Directors of Public Health). This is alongside the expectation that the NHS will save £20 billion by 2014, the most ambitious savings target it has ever faced.
- Introduction of Police and Crime Commissioners to oversee policing. An area's Commissioner will have control of a budget which will include a proportion of the current Drug Interventions Grant. Overall funding allocated centrally to police forces in England and Wales is expected to reduce by 20%, in real terms over four years (by 2014/15).
- A reduction of up to 40% in funding of central government departments and significant reductions in local government funding at least up to 2015 (Bozio et al, 2011).⁶ The most deprived authorities are losing systematically the most spending power (Hastings et al, 2012). Spending reductions in local authorities and some national government services include the wider support services, such as housing, welfare and employment, for those with drug problems, and early intervention services for young people.
- Increasing localism, and public service reform to shift power from the centre back to the local level, opening up public services to competition by boosting local involvement and engagement and encouraging partnerships across the public, private and voluntary sectors. Payment by results is seen as a mechanism for achieving value for money and eight areas are piloting this approach in reference to drug and alcohol treatment services.

⁶ Central government cuts between 2010 and 2015.

Key findings

While there is much 'unfinished business' in relation to the application of austerity measures and the implementation of the systemic organisational, financial and governance changes, our research findings highlight the value of focused, integrated and evidence-based approaches to tackling drug problems during this time of change. It is important that timely and reliable evidence is collected early to allow the identification of any potential negative consequences, assess whether value for money is being achieved, and whether change is being managed effectively. Our core findings are:

- 1. An unprecedented level of change is being felt across every aspect of the delivery of drug interventions, but many practitioners have no clear understanding of what a 'final destination' might look like.** Every publicly funded service agency is facing systemic change and funding pressures. However, we found little evidence of a clear overall vision or 'road map' to explain how the processes of policing and justice reform, NHS structural changes, the drive to deliver localism, austerity measures and the ambitions of the Drug Strategy will fit together in a coherent way. There seemed to be little national or local understanding of what the real impact of change in one agency, or system, will be on another, and what this means for the existing complex web of relationships and partnerships between organisations. There was no consistent pattern in our case study areas of how decisions were being taken around investment and disinvestment in services. These processes need careful management and choreography, yet many people felt this was not happening sufficiently. Overall, this risks poor value for money in organisational effort.
- 2. Local players see opportunities in the changes to work more efficiently.** The movement to give local authorities responsibility for public health was seen as presenting opportunities to link with other services such as housing, employment and education. The transfer of funding for prison drug treatment from prison budgets to health and local control was appreciated as providing positive opportunities to integrate community and prison treatment services. Increased levels of service user engagement and involvement in the delivery of drug treatment interventions was recognised as integral to developing flexible and responsive recovery-oriented systems. The changing environment was perceived as a positive opportunity for increasing integration between alcohol and drug treatment services and for increasing investment and priority for alcohol interventions. Furthermore, new relationships between Health and Wellbeing Boards, Community Safety Partnerships and police force-wide Police and Crime Commissioners and Police and Crime Panels have the potential to unlock creative approaches to tackling drug and alcohol problems.

- 3. Yet, the current changes present considerable risks, including the potential for disinvestment, fragmentation and more bureaucracy.** Risks to effective drug interventions include the possibility of funding within the public health budget, previously ring-fenced for drug interventions, being used to meet the efficiency savings required by local authorities and of the prioritisation of public health spend being open to political influence. In policing, proactive drug-related enforcement activities, such as evidence-gathering, are expected to decrease due to austerity measures, which may result in a lessening of intelligence about drug markets and supply networks. New ways of working can achieve efficiencies but at the same time there may be unintended consequences. Cross-cutting policy issues could also end up neglected between the various agencies. For instance, treatment and recovery service provision that focuses on the 'average' client may not be able to adequately meet the needs of service users with more complex mental health and substance misuse problems. A reducing pool of medical addiction specialists and an increasing difficulty in supporting greater personalisation in the choice of interventions are also potential negative consequences. Nine out of ten Drug Action Team survey respondents were making changes in line with the Drug Strategy's vision. However, nearly half thought that changes to wider support services were having a negative impact on their ability to deliver a recovery-oriented drug treatment service.
- 4. Partnership working and collaboration are valued but capacity is under strain.** Most organisations, at the time of the research, with the exception of the police, did not seem to be stepping back from existing partnership working. However, collaboration takes staff time and resources. As changes take place and austerity bites, the sustainability of local collaborative and partnership mechanisms was seen to be vulnerable. Among Drug Action Team survey respondents, 45% were expecting the level of staff time in their organisation committed to working on drug-related activities to decrease, and future financial contributions to support partnership mechanisms and activities were insecure. Police survey respondents expected to undertake less partnership working in the future. For instance 38% of force-level respondents expected drug-related work with community groups to decrease and 34% expected to work less with local councils over the next 12 months.⁷
- 5. There is an important risk of fragmentation between the health and criminal justice agencies that are key to successful drug interventions.** Many of the emerging Health and Wellbeing Boards did not include criminal justice representation.⁸ Yet, public health interventions will not be sufficient on their own to achieve the Drug Strategy's recovery ambitions. Research respondents expressed concern about fragmentation between future health and justice structures, given the interplay between substance misuse, mental health problems and crime and justice. Without a strong local champion, drug-related issues may be considered a lower priority than other mainstream concerns within both public health and law enforcement. There is a risk that the momentum built up

⁷ April 2011 – 2012 timeframe.

⁸ In support of this finding, an eATA (unpublished) commissioned analysis of the membership of 31 Health and Wellbeing Boards found that 16% included criminal justice representation.

over the years for drug interventions, as fostered through the current partnership system, may be lost in the changing environment.

- 6. Many of the changes that are either taking place or being planned are underpinned by little robust evidence or detail.** In particular, there is a sparse evidence base for many recovery-oriented interventions and the relative value for money of different systems of delivery, and little detailed information on future delivery structures. The increasing focus on outcomes in drug treatment and recovery services, while welcome in principle, carries risks for service users and service providers. These include perverse incentives, particularly for services to cherry-pick those who are most likely to achieve outcomes, and risks around the development of a payment structure that is viable for voluntary and community sector organisations (UKDPC, 2010). A focus on outcomes requires robust data about what works and an understanding of the realistic timeframes for achieving these. However, in the on-going changes, it is not clear where the responsibility for the collection of this evidence lies. In short, a large social experiment is underway which is being driven by a confidence in untested approaches.
- 7. Forging a new balance between a centrally-led national Drug Strategy and more flexible, locally-led drug interventions is welcomed but brings substantial risk.** It will be a major challenge to reconcile and implement national and local priorities through increasingly decentralised systems with multiple local interests. Increasing localism needs to be underpinned by strong safeguards to ensure national priorities will still be delivered and protect the gains in drug treatment and crime reduction that have already been achieved. Previous UKDPC work has shown that the stigma experienced by drug users is a fundamental barrier to the delivery of the Drug Strategy (UKDPC, 2010). This new research reinforced that conclusion. Interviewees were concerned that if public health budgets are tight there is a real risk that the money currently spent on interventions for this 'undeserving' group will be diverted to other areas.
- 8. The changes underway have major implications for accountability systems.** The architecture for the delivery of many services is changing. Reform of the design and structures for drug treatment and recovery services is common, with around half of the Drug Action Team respondents in the process of re-design or re-commissioning local services. A consequence is that lines of accountability are shifting and increasingly complex. The mismatch between organisational boundaries, for instance, between Health and Wellbeing Boards, Clinical Commissioning Groups and Police and Crime Commissioners will amplify difficulties in tracking how money is being spent and in holding services responsible for outcomes. In addition to this, there is currently little evidence available in the public domain that local communities can easily utilise to hold both elected officials and those providing interventions to account.

Mitigating the risks

Our study has shown that delivery of the national Drug Strategy could be undermined by a number of potential risks for those operating at both the national and local level. Proposals for how these can be mitigated are set out below, divided between those directed at national policy makers and those for people that are working at the local level. We recognise that over the last two decades a number of principles have been established and a plethora of guidance to encourage partnership working has been produced aimed at those responsible for local public services. We do not wish to duplicate those. Our proposals are aimed at ensuring that work to address the problems associated with illicit drugs, continues to be underpinned by an infrastructure that is fit for purpose, and that people will have the skills, capacity and support to continue to deliver the aspirations of the Drug Strategy.

PROPOSALS DIRECTED AT NATIONAL POLICY MAKERS

Our study has shown there is a need for:

1. Improved co-ordination and integration between public health and criminal justice agencies

- Central government (Department of Health, along with the Home Office and Ministry of Justice) should provide a stronger steer with appropriate guidance aimed at ensuring local Health and Wellbeing Boards build proactive and strategic relations with the relevant Community Safety Partnerships, Police and Crime Commissioners and the Police and Crime Panels. For instance, through promoting the reciprocal co-options of people with health and criminal justice expertise (and especially enforcement) respectively onto Panel and Board membership.
- It is important for new collaboration to be stimulated between national professional health bodies (such the Association of Directors of Public Health and the Faculty of Public Health) and their counterparts working in police and justice bodies, around critical issues of mutual interest, such as drug, alcohol and mental health interventions.

2. Development of clearer guidance and improved communication on the detail of implementing policy changes

- We propose that the Home Office, Public Health England, Ministry of Justice and Department of Communities and Local Government initiate a series of regional collaborative learning events, bringing together the new Police and Crime Commissioners, Health and Wellbeing Boards, justice interests and service providers, focusing on the opportunities to develop creative local approaches to drug, alcohol and mental health problems.⁹
- In recognition of the needs expressed by those working at the local level, the Department of Health (through Public Health England) and the Home Office should create more opportunities

⁹ The Home Office funded Safer Future Communities Project, delivered by Clinks, is providing a series of regional briefing events to support frontline voluntary, community and social enterprise organisations in preparation for the arrival of Police and Crime Commissioners. www.clinks.org/services/sfc

to share practice and facilitate learning networks, such as a network for individuals commissioning and managing drug treatment and recovery systems.

3. A nationally managed and co-ordinated resource for authoritative evidence

- The Department of Health should ensure the development and promotion by Public Health England of a single port of call for authoritative sources of evidence relating to substance misuse treatment and recovery interventions, especially around analysis of comparative value for money studies, the collection of data around drug prevention and in providing information on what interventions are proven to be effective.
- The Department of Health should also ensure the inclusion of a strand relating to substance misuse in the activities of the National Institute for Health Research's School for Public Health Research, including studies to establish how best to deliver recovery-oriented services.
- As we have suggested in earlier UKDPC reports, there is a pressing need for the Home Office (and the new National Crime Agency) to set up a substantial programme of research evaluating the impacts of various enforcement efforts to disrupt the drugs trade. Unless this is done, we will never know whether enforcement interventions represent value for money (UKDPC, 2009).

4. Establishment of fiscal incentives to encourage and enable organisations to pool resources to achieve complementary objectives

- We propose that there should be a comprehensive study undertaken to explore the potential for a wider range of fiscal incentives, beyond payment by results, to underpin and stimulate collaborative interventions between police, justice, NHS and public health agencies to address cross-cutting issues such as drug and alcohol problems. Lessons from the Total Place and Justice Re-Investment programmes could be of value in such work. This might most appropriately be commissioned by the Cabinet Office.

5. Setting up of mechanisms for ensuring local commissioners and service providers are adhering to clinical governance and quality standards

- To ensure that drug treatment and recovery services are of the highest quality, and comply with the NHS Constitution, we suggest that Public Health England and the Care Quality Commission develop mechanisms to ensure that the appropriate NICE clinical and quality standards and mechanisms are being applied across the sector.

6. Monitoring and review of the formula relating to drug treatment within new public health ring-fenced funding arrangements

- Public Health England should commission an independent review of the impact of the new formula intended to incentivise local areas to sustain their support for local drug treatment and recovery services and outcomes. This should include consideration of whether there has been any change in the level of local investment in drug treatment and recovery services and whether local areas have been able to sustain performance and outcome levels.¹⁰ This could also include consideration of any interaction or overlaps with the operation of the proposed Health Premium aimed at encouraging local areas to tackle health inequalities.

PROPOSALS FOR THOSE WORKING AT THE LOCAL LEVEL

There is a need for:

1. A robust understanding, and promotion, of the current evidence base relating to the efficacy and value for money of particular drug treatment and recovery interventions

- Local drug service commissioners, drug treatment and recovery service providers and Directors of Public Health need to be active in promoting the evidence about the effectiveness of different drug interventions and how they enable recovery, including population-wide health and crime reduction benefits.
- It is paramount that Directors of Public Health give priority to the inclusion of local drug and alcohol problems in an area's Joint Strategic Needs Assessment and the local Joint Health and Wellbeing Strategy. Without this, efforts to tackle the problems will be seen as of second-order importance.
- As far as it is possible, local drug service commissioners should be pro-active in initiating links and networks with other commissioners to share knowledge and understanding of the evidence about drug interventions, as well as about the new procurement, operational and contracting arrangements that the movement to a new public health system will entail.
- Many councillors will need further information about what works in tackling drug problems. We believe there is an opportunity for the Local Government Association (LGA) and its constituent networks to act as an influential conduit for getting more and better information to elected council members, as well as Police and Crime Commissioners, about the benefits of evidence-based drug interventions and especially drug treatment and recovery services.

¹⁰ From April 2012, 20% of the overall national Pooled Treatment Budget allocation to local areas will be based the number of adult drug users that have successfully completed treatment and who have not re-presented to treatment anywhere in England for at least six months. See: www.nta.nhs.uk/uploads/overviewofhowtheptb12-13hasbeenallocated.pdf

2. Promotion of the joint agenda between Health and Wellbeing Boards and enforcement and justice systems

- Police and Crime Commissioners should be encouraged to establish a joint forum, in addition to Police and Crime Panels, to bring together representatives from local Health and Wellbeing Boards in their Force area to address strategic issues around drug and alcohol problems.
- The Director of Public Health has an important contribution to make to the development and implementation of Police and Crime Plans, which will take into account local drug and alcohol issues but this may be complicated by lack of co-terminosity between local authority and police force areas. Directors of Public Health should seek out ways to work with their colleagues in adjacent areas covered by the police force to ensure their contribution is coordinated and comprehensive.

3. Establishment and maintenance of strong relationships with other locally elected officials and key partnership configurations to build support for drug interventions¹¹

- Directors of Public Health need to be proactive in engaging with locally elected officials, particularly those that sit on the local Health and Wellbeing Board, Community Safety Partnerships, Police and Crime Commissioners and Police and Crime Panel members, in order to communicate the nature, range and benefits of drug and alcohol intervention services for communities and individuals.
- Directors of Public Health and local drug service commissioners need to ensure that they facilitate the inclusion of drug service user representation on HealthWatch in order that a group of people, traditionally marginalised from decision making, are enabled to have their voices heard in the future planning of public health services.

4. Access to specialist commissioning skills and knowledge of local substance misuse

- Amongst their many responsibilities, Directors of Public Health need to ensure that within the new structures they have access to specialist knowledge and expertise around commissioning and drug treatment and broader recovery interventions in addition to that relating to broader public health approaches.
- Directors of Public Health will need to engage proactively with their counterparts in Clinical Commissioning Groups to avoid fragmentation of responsibility arising from the different commissioning arrangements for individuals with mental health conditions as well as substance misuse problems (DrugScope, Centre for Mental Health and UKDPC, 2012). There is a huge risk such groups will fall between the two systems.

¹¹ See also an Adfam guide aimed at family support services: Adfam (2012).

5. Balanced approaches to drug-related enforcement activity

- Senior police officers need to continue supporting and promoting interventions which have deeper long term benefit in disrupting drug markets as well as those that have more immediate and visible benefits. Effective drug enforcement will rely on intelligence gathered by interventions that can include forensic testing and test purchasing in order to keep abreast of rapidly changing drug markets.

1. Introduction: Background, research aims and methods

Introduction

The funding, commissioning, management and delivery structures for addressing the problems associated with illicit drugs in England are experiencing an unprecedented level of change. The Government's 2010 Drug Strategy 'Reducing Demand, Restricting Supply, Building Recovery' places considerable focus on improving recovery outcomes for people with drug problems alongside efforts to reduce the supply of drugs. The Strategy identifies the need for support from different services such as employment, education, housing and family support to help people reintegrate into society. It also calls for far greater localism in service delivery (Home Office, 2010). This is in contrast to previously strong direction and oversight from the centre which has been the hallmark of drug strategies since 1997.

At the same time, substantial reductions in public spending are being implemented alongside wide-ranging public service reform aimed at delivering decentralisation.

The UK Drug Policy Commission's *Charting New Waters* study explored the way in which drug-related interventions, focusing on drug treatment and recovery services, drug-related enforcement and drug education and prevention services and activities, are changing in England in response to the current environment.¹²

This report provides a snapshot of a rapidly evolving landscape in England involving change to a number of public organisations at the same time – police, health, criminal justice and local authorities. It makes reference to established change management and value for money principles in order to assess the likely impact of the changes in relation to drug interventions. The research was carried out between February 2011 and March 2012, therefore it is important to note that information here relates to a period prior to the full implementation of some of the most far reaching, and potentially significant changes.

Although not comprehensive in its scope, the study presents a broad picture of upheaval and uncertainty which has major implications for the successful delivery of local and national plans to tackle drug problems, provide value for money and fulfil the Drug Strategy's aims.

¹² Forthcoming research by UKDPC will explore the 'governance' and processes for making drug policy in the UK. This will address some of the same issues covered within this report, such as leadership, accountability and stakeholder engagement, but with a focus on policy development. It will be published in winter 2012.

Background to the study: Unprecedented levels of change

Since 1995, there has been a strong central drive by Whitehall to provide coordination and leadership of successive national drug strategies. With substantial new and additional resources much has been achieved at the national and local level.

Following the 2010 election of the Coalition Government, a considerable amount of new policy has been rapidly introduced across all public services relevant to the delivery, management and funding of drug interventions. This is in contrast to a previously 'evolutionary' model of policy development largely based on incremental change, usually in one public service area.

These changes have major implications for the provision and delivery of local and national interventions to tackle drug problems. The structural reform of the NHS and creation of a new public health system within local authorities encompasses the commissioning of substance misuse treatment and recovery services (in the community and in prisons). From March 2013, local Health and Wellbeing Boards will oversee public health spend, including the current drug and alcohol treatment budget which is likely to make up around a quarter of the total national budget for public health and around a third of the budget allocated to Directors of Public Health in local areas. The NHS Commissioning Board will be responsible for the commissioning of health services for prisons, where many people with drug problems are found. Police and Crime Commissioners, introduced to shift power and accountability for policing to the local level, will have control of a proportion of the Drug Interventions Grant.

The Coalition's drive to deliver decentralisation is intended to open up public services by devolving power, money and knowledge to those at the local level, including elected local representatives, social enterprises, co-ops and community groups (DCLG, 2010). People are to be given direct control, wherever possible, either through direct payments, personal budgets or choices (HM Government, 2011a).

Furthermore, the planned cut in total public spending over five years from April 2011 will be larger in real terms than the UK has seen in any other five-year period since the end of the Second World War. The Coalition Government's ambition to eliminate the UK's structural deficit means a reduction of up to 40% in central government department funding (Bozio et al, 2011).¹³

Within this context, all public services are expected to work more collaboratively and imaginatively: pooling budgets, identifying innovative ways in which scarce resources can be made use of more efficiently and allocating resources on the basis of outcomes, including the adoption of experimental Payment by Results approaches.¹⁴

The cross-cutting nature of drug issues means that drug interventions necessarily encompass a range of activities by a wide variety of organisations. Also, drug use cannot be seen in isolation from wider social and economic policy issues. There are disproportionate numbers of people with

¹³ Between 2010 and 2015.

¹⁴ Chapter two of the report provides more information on Payment by Results.

drug problems in deprived areas, along with associated crime, and drivers for drug use involve a range of factors that include employment opportunities, inequality, social trends and other cultural influences.

Increasing public service austerity, alongside considerable, far-ranging policy and organisational change, therefore raises questions about the impact of this on the ability to continue to deliver and operate drug interventions and services in the same way as before. A real risk is that the national priority afforded to drug policy may not be reflected at the local level.

The radical nature of much of this change means that it is unclear whether the current direction of travel will deliver the outcomes that people need, provide good value for money, and help to control public expenditure. In short, a major social experiment is underway, the outcomes of which are uncertain.

The Research

Against the backdrop of extensive and unprecedented change, the UKDPC *Charting New Waters* study aimed to document the impact of increasing localism and decentralisation, together with rapidly increasing public sector austerity, on action in local areas to tackle the problems associated with illicit drugs.¹⁵

As legislative, administrative and financial changes are on-going, it is not possible to evaluate their full impacts. Instead, the research aimed to highlight risks, opportunities and emerging lessons to assist those who are seeking to improve service provision while the structures and systems are shifting around them. It has not been assumed that decreasing overall public expenditure automatically means a decrease in expenditure on drug interventions or lower-quality services.

The research gave participants the opportunity to describe and reflect on how policy changes were impacting on their services and local areas. One future use of the research findings will be in providing a framework around which assessment of the eventual impact of the changes could be structured.

AIMS AND METHODS

The research set out to:

- Gather national-level information about funding for drug-related interventions and activities and the way in which this might be changing.
- Draw lessons from case study examples and other available evidence of emerging responses to the changing landscape of public service commissioning and delivery, fiscal constraint and the building of the 'Big Society'.
- Identify from available evidence the different patterns of change, highlight likely consequences of decisions to cease or reform activities and to assist individuals and organisations to identify key issues to be addressed in this period of rapid change.

¹⁵ Research was carried out between February 2011 and March 2012. All outputs will be completed by the end of April 2012.

Information in this report is based on material gathered from over 80 interviews across seven case study areas, two national surveys and three national events. Further detail on the research methods is provided in the box below and included in the appendices.

Research methods

1. Review of key documents, literature and interviews with key stakeholders

Review of national and local literature sources to identify the key policy drivers and how areas are responding to these. This included collation and analysis of available information on drug treatment spend and activities in local areas. Around 20 meetings were held with key stakeholders. A Project Advisory Group was also established to provide expert input. This included representatives from government departments and the National Audit Office, the voluntary sector such as DrugScope, and professional bodies such as ACPO and Directors of Public Health.

2. Interviews in seven case study areas

Semi-structured interviews with 81 stakeholders of at least 45 minutes each, were carried out in seven areas: in London (two areas), the East Midlands, West Midlands, North West, North East and South West of England.¹⁶ Case study areas were chosen, as far as it was possible, to be broadly representative of a range of type, size and geographical spread of areas. The criteria used to structure the selection of case studies, more information on the case study areas and the interview schedule are included in the appendices. Interview questions were structured around the following issues:

- Expenditure (current and future) and levels of activity
- Partnerships and inter-agency working (current and future)
- Commissioning activities (and how these might be changing)
- Decision making and prioritization (including potential impacts on services/activities and accountability to local people)
- Engagement of local communities, localism and decentralisation
- Leadership and governance (including the sustainability of this).

In each area, interviews started with the Drug Action Team (DAT)¹⁷ and worked 'outwards' to partner bodies. Interviewees included: key DAT staff, the DAT chair and police, Probation, PCT, and community safety, service user, elected member and GP representatives.

3. Two national surveys

A national survey of police forces in England was conducted with support from ACPO, a survey to identify perspectives on what change is occurring at the local level and the impact this may have on drug-related policing activities was distributed to all English police forces and Basic Command Units. 74% of forces, 25% of BCUs and 9 other units responded. A follow-up workshop for police officers working in the field of drug enforcement explored the implications of the survey findings. A summary of the key findings from this survey and workshop is available (Beck, 2011).¹⁸

A national survey of English DATs (or local equivalent structure) looked at the perceived impact of

¹⁶ Areas anonymised and referred to in the report as: County one, County two, City one, City two, City three, Unitary one and Unitary two.

¹⁷ We have used DAT as a useful shorthand. It is recognised this simplification does not take into account the great variety of ways in which these functions are organised, and that these teams may also include alcohol services.

¹⁸ Available: www.ukdpc.org.uk/publication/drug-enforcement-an-age-austerity-findings-from-a-survey-police-england/

increasing austerity and localism on drug treatment funding, commissioning, partnership working and decision making was issued to 142 English DATs.¹⁹ This was completed by 43% of DATs. Full findings are included in the appendices.

4. Three national events

A roundtable workshop for Directors of Public Health was held in partnership with the Association of Directors of Public Health, the workshop explored Director of Public Health perspectives on the way in which responsibility for drug treatment fits their other responsibilities, the challenges they are facing and what support might be needed in the future. The event was attended by Directors of Public Health from 10 areas and included representatives from the NTA (NTA), Home Office and Department of Health (DH). A briefing paper on the findings of the event is available (UKDPC, 2012a).²⁰

A day-long event was organised aimed at those involved in the commissioning, management and delivery of drug treatment and recovery systems. This was attended by Joint Commissioning Managers from 25 English DATs, service users and provider representatives and participants from the NTA and Home Office. The seminar looked at different experiences of commissioning in the current environment and was aimed at enabling different DATs to share lessons, good and bad practice and identifying the different models of commissioning for recovery that might be emerging.

A roundtable workshop for NHS providers was held in partnership with the Central and North West London NHS Foundation Trust, the workshop explored the issues, opportunities and challenges faced by NHS providers in delivering drug treatment and recovery services and other related interventions in a rapidly changing environment. This was attended by 14 representatives from 9 NHS providers.²¹

SCOPE OF RESEARCH

Research focused on action by bodies in local areas with responsibility for the commissioning and delivery of drug interventions, including DATs (or the local equivalent structures that are responsible for commissioning drug treatment and recovery services), police and criminal justice organisations and public health professionals, including Directors of Public Health. It therefore mainly concentrated on treatment and enforcement activity. Due to capacity the study was England-wide only. Where alcohol was seen to impact on drug-related priorities and interventions, this was taken into account.

The project does not include analysis of how local areas are adapting to the new drug recovery Payment by Results pilots. None of the case study areas were participating as a pilot. Other UKDPC work has examined the implications of this change and there is a separate independent evaluation of this initiative underway.²²

The fieldwork for the case studies was carried out between April and December 2011. Information gathered by this project is based on respondents' views and perceptions at the time of research. It is, therefore, prior to significant changes such as the election of local Police and Crime

¹⁹ Survey distributed to the DATs for which accurate contact details were available.

²⁰ Available: www.ukdpc.org.uk/publication/illicit-drugs-public-health/

²¹ The perspectives of voluntary sector provider organisations were included in the Commissioning for Recovery seminar and case study interviews.

²² For more information on applying payment by results to drug recovery see: Roberts, M (2011) 'By their Fruits: Applying payment by results to drug recovery,' London: UKDPC. Available: www.ukdpc.org.uk/publication/by-their-fruits-applying-payment-by-results-to-drugs-recovery/

Commissioners, the full establishment of Health and Wellbeing Boards and the announcement of future drug treatment funding allocations and the shadow allocations for public health. Thus, respondents were in some cases making informed assumptions about what they felt was likely to happen but which may turn out differently in due course.

The report refers to the structures for the commissioning and management of drug treatment and recovery services as 'DATs' (Drug Action Teams). It is recognised this simplification does not take into account the great variety of ways in which these functions are organised, and that these teams may also include alcohol services, but is used as a useful shorthand. When the report refers to 'drug interventions' it is referring to drug-related activity in the round, including enforcement, treatment, recovery and prevention activities.

Certain perspectives were outside the remit of research, including those drug-related activities delivered through national bodies such as the Serious Organised Crime Agency and the Borders Agency as well as international interventions. Although the research did include a small number of service user interviewees, the drug service user perspective was not a primary focus of our study.

Managing significant policy change

The cumulative effects of government policies are often unpredictable and their real impacts result not just from their individual design but, perhaps more importantly, from their implementation and interactions. An increasing level of decentralisation increases complexity due to the involvement of more actors with varying priorities and approaches (Institute for Government, 2011). Therefore, in order to ensure national policy priorities, such as the Drug Strategy, have an impact, there is a balance to be struck between national and local actors as well the creation of appropriate systems to ensure delivery.

Thus to ensure the Drug Strategy is deliverable, there is a strong case for the national government to adapt or steer the system if it is shown that delivery is deviating too far from the high-level policy goals it has set. This research aimed to provide indicators of 'early warning' to inform such decision making processes during the current period of unprecedented levels of change in public service delivery. The principles of managing change, and providing value for money, were of direct relevance to the research. As far as it is possible, this report has set out to take into account these principles in its assessment of the implementation and management of change, including the implementation of the recovery-oriented ambitions of the Drug Strategy.

Public sector organisations are familiar with managing change, albeit with varying levels of success. Change management is necessarily complex and will be influenced by local and national circumstances. Cross-cutting change, across different organisations and service areas, will inevitably bring other agendas, personalities and priorities into the mix.

So called 'wicked issues,' or those issues that involve complex and interlinked challenges, may prove to be particularly vulnerable where austerity and systemic change make organisations more focused on their core business. Drug-related interventions, by virtue of their cross-cutting nature, fall into this group.

The literature about change-management is clear that there are a number of core principles underpinning effective implementation. Strong leadership is fundamental to keep change moving. It is vital to have a clear strategy, setting out the case for change and goals that progress can be measured towards, backed by the right resources and a team to implement it. The vision for change needs to be sold to the wider community. On-going and effective communication with staff and stakeholders is critically important (Local Government Improvement and Development, 2007).

It is also essential to have a timetable, taking into account the issues that might pull progress off course. Alongside this, some quick wins are needed so people are able to see results from the change process; if the overriding objectives of change are lost sight of, progress will flounder. It is valuable to take the time to assess implications and potential consequences of the change strategy up front. Clear metrics to measure success should be used to reinforce and embed the change. Implementation strategies have to be adaptable to take account of unintended consequences and empirical evidence.

The National Audit Office's 'Analytical Framework for Assessing Value for Money' states that '*good value for money is the optimal use of resources to achieve the intended outcomes*' (National Audit Office, 2010). An organisation spending public money needs to be clear about the way in which it will assess the performance of this spend, including the criteria against which performance will be assessed. It should draw overall conclusions based on the value for money achieved with the resources and what was intended. If there are gaps between what was achieved, and what was intended, the organisation should make recommendations on how to secure improved outcomes in the future.

Why change management succeeds

- Clear senior ownership and commitment at appropriate levels in the organisation.
- Clear and powerful vision for what the deliverable or outcome would be, and communication of that vision and clarity about what is required in terms of "new" behaviours and approaches that are consistent with the new vision.
- Link to the core objectives of the business, i.e. clear link between the programme / project and the organisation's key strategic priorities, including agreed measures of success.
- A sense of urgency or the initiative is given serious priority with adequate staffing and resourcing.
- Identification and removal of the obstacles to change.
- Creation of short-term wins with follow through, e.g. anchoring the change securely in the corporate culture.
- Effective engagement with stakeholders, e.g. consultation or communications with staff or customers to create a sufficiently powerful coalition to guide change
- Skills and proven approach to programme / project management and risk management, such as a single point of responsibility, and attention given to breaking the initiative into manageable steps.
- Procurement and commercial issues such as: evaluation of proposals driven by long-term value for money rather than initial price.
- Follow through on issues such as: finishing before being overtaken by the next initiative; continuation of budget and project to realise the benefits.²³

²³ Adapted from Local Government Improvement and Development, 2007.

Report overview and structure

This report presents the findings of the research project as a whole. The next chapter summarises the relevant national policy and practice drivers of change. Chapter three explores what is happening to funding and spend for drug-related interventions and the impact of this on levels of activity. Chapter four considers the way in which the commissioning and delivery of drug treatment services is changing and chapter five looks at changes to levels of local partnership working in the delivery and funding of drug interventions.

The anticipated issues and challenges for the delivery of drug interventions in the new public health system are explored in chapter six. Chapter seven looks at the level of community engagement and involvement in the delivery, management and direction of drug-related interventions. Chapter eight discusses the issues that emerged relating to processes of local decision-making and prioritisation.

Finally, the report concludes with a summary of the opportunities and risk factors found by the research, and the emerging lessons to assist those who are seeking to improve service provision and manage the changes resulting from reforms to structures and systems.

2: Policy and practice drivers of change

Summary of main points

- The past 15 years saw a big expansion in funding for drug treatment and local policing interventions alongside the development of a strong partnership focus. A system emerged with strong national leadership and performance management, underpinned by various ring-fenced funding arrangements.
- The 2010 Drug Strategy places considerable focus on improving recovery outcomes for people with drug problems.
- A considerable amount of other new policy and change relevant to the delivery, management and funding of drug interventions has been rapidly introduced since the election of the Coalition Government. What is unknown is how change in one part of the system will impact on another. This is of considerable importance for drug policy.
- The NHS is expected save £20 billion by 2014, the most ambitious savings target it has ever faced. Funding allocated centrally to police forces in England and Wales is reducing by 20%, in real terms over four years (by 2014/15). There are severe reductions in local government funding and spending power.
- The Health and Social Care Act is the most extensive piece of legislation relating to the health service since the establishment of the NHS.
- The Police Reform and Social Responsibility Act (2011) sets out a radical programme of reform for the police service in England and Wales.
- The Government has a particular interest in 'payment by results' as a potential mechanism for achieving value for money and controlling public expenditure.
- A developing agenda of increasing localism is expected to: shift power from the centre back to the local level; open up public services by boosting local involvement and engagement; and encourage people to play a more active role locally.
- A number of previous initiatives, administered by the previous Government and since superseded, have also looked at making similar changes to public service delivery as those being implemented currently.
- A considerable amount of other research by other organisations, with wide variability in terms of scope, sample size and representativeness, has also been conducted looking at the impact of decreasing public sector spending on different sectors.

The current UK drug policy and practice environment is probably best described as resting on shifting sands. The information presented here was correct at time of publication but the policy environment is constantly changing and adapting.

This chapter provides an overview the national and local structures for the delivery of drug policy. It presents a 'stock take' of the key financial, policy and practice changes relating to drug

interventions in England, at the point of research. These include the health and policing reforms, the government's localism and decentralisation ambitions, modernisation and reform of public services, movement to outcome focused delivery and relevant changes to services for young people. The chapter also considers relevant previous government initiatives, including Total Place and the Drug Systems Change Pilots, and briefly discusses other studies looking at the impact of increasing financial austerity on service areas that include housing, mental health and youth services.

Follow-up UKDPC research will look in more depth at how funding for services and activities addressing the needs of young people is changing in response to financial austerity and the drive to greater localism and how that may directly or indirectly have an impact on drug use and associated problems.²⁴

The delivery and management of drug policy

The most referenced estimate of the relative costs associated with drug misuse was £15.4 billion for Class A drug use in England and Wales in 2003/04 (Singleton, N et al (eds.), 2006).²⁵ Much of this estimate is associated with crime and criminal justice costs. In response to the problems associated with drug use, successive governments, including those in the devolved administrations, have produced national drug strategies.

While the delivery of some drug policy is through national bodies and government departments, much of it is the responsibility of local public services. The past 15 years saw a big expansion in funding for drug treatment and local policing interventions alongside the development of a strong partnership focus. Many agencies and organisations are involved in tackling drugs through local partnerships such as Drug (and Alcohol) Action Teams (DATs or DAATs) and Community Safety Partnerships (CSPs). Local Criminal Justice Boards have also taken an interest in this area of activity.

Through initiatives like the establishment of the National Treatment Agency (NTA) in England and the Drug Intervention Programme, Integrated Offender Management and the Integrated Drug Treatment System in prisons, coupled with extra resources, a system emerged with strong national leadership and performance management, underpinned by various ring-fenced funding arrangements.

The use of drug strategies is the UK's method of bringing coherence to the drug-related work of different public departments and bodies, with the aim of ensuring that they support one another to achieve common goals. The change of government at Westminster in 2010 was followed by a new Drug Strategy, 'Reducing Demand, Restricting Supply, Building Recovery' which announced a *'fundamentally different approach to tackling drugs and an entirely new ambition to reduce drug use and dependence'* (Home Office, 2010).

The Strategy ostensibly shifted the emphasis of policy, from seeking to reduce the problems

²⁴ Available summer 2012 www.ukdpc.org.uk

²⁵ There were many limitations to the data on which that was based. Some people think this is an overestimate.

caused by drugs, to seeking to reduce the level of drug use. It places considerable focus on improving recovery outcomes for people with drug problems and heralded a number of other changes, including:

- The integration of the functions of the NTA into a new national body, Public Health England.
- The demise of centralised performance targets and development of outcome frameworks with national indicators.
- Less guidance and hands-on intervention from Whitehall.
- Flexibility for local partners to decide their own local partnership arrangements.

The Strategy includes a commitment to developing and publishing the evidence base on what works, to develop an evaluation framework to assess the effectiveness and value for money of the strategy overall, and to review the strategy on an annual basis. Unfortunately, it is not clear yet how this will be done as the Strategy avoids identifying specific metrics by which success overall will be evaluated and the evaluation framework has yet to be published.

Despite the claims of novelty, there is in fact a great deal of continuity and similarity with preceding strategies (2008, 2002, 1998 and 1995). The main change, other than emphasis, has been that the 2010 Strategy places less overt emphasis on limiting the harms that can be caused by illicit drug use.

In addition to the 2010 Drug Strategy, a considerable amount of other new policy and change relevant to the delivery, management and funding of drug interventions has been rapidly introduced since the election of the Coalition Government.

In the past one might have anticipated major change happening in one or two public services at the same time. What distinguishes the changes underway now is that there is wholesale organisational and financial change taking place at the same time across all public services. What is unknown is how change in one part of the system will impact on another. This is of considerable importance for drug policy because crime, justice and health interests and outcomes are so closely interwoven.

For reference, a timeline of key developments in UK drug policy over the past 25 years is included in appendix seven.

Key relevant financial, policy and practice changes

INCREASING AUSTERITY

The ambition to eliminate the UK's structural deficit has resulted in severe reductions in local government funding and spending power, amounting to 28% of the central government grant and 14% in terms of overall spending power in cash terms over four years.²⁶ Reductions are unequal in

²⁶ Excluding education, police and fire.

distribution with the most deprived local authorities losing systematically the most spending power (Hastings et al, 2012). This is important for drug policy because there is a concentration of drug problems in disadvantaged areas.

Changes to those sources of funding relevant to tackling the problems associated with illicit drugs include the expectation that the NHS will save £20 billion by 2014, the most ambitious saving it has ever faced, and a 20% reduction, in real terms over four years (by 2014/15), in funding allocated centrally to police forces in England and Wales with reductions front-loaded over the first two years. Although some funding for drug-related enforcement comes from other sources, such as from a local precept or funding for specific programmes like the Drug Interventions Programme (DIP), the amounts received are variable and also, in many cases, likely to be subject to reduction.

A report by Her Majesty's Inspectorate of Constabulary (HMIC) 'Adapting to Austerity' sets out work by individual police forces to meet this decrease, but overall found that forces will need to find more savings if they are to achieve expected reductions. A lack of information on the advantages, disadvantages and potential gains likely to be associated with the available savings and efficiency options was not readily available, thus presenting a significant barrier to making informed choices about savings (HMIC, 2011).

Previous research has shown that the impact of recession on drug policy and drug-related expenditure is hard to assess. Research by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) on the impact of the recession in Europe in drug interventions looked at financial information provided by 19 countries. Of these, 15 reported reductions in funds available since 2008. Increasing austerity appeared to have affected different sectors of drug policy differently, with the majority of countries avoiding cutting their public spending for drug treatment. The most severely affected areas of expenditure identified were research, prevention, social reintegration and organisational activities. However, EMCDDA highlighted that information on the impact of austerity on sectors such as law enforcement and justice might have been under-reported (Storti, C et al., 2011).

STRUCTURAL CHANGES TO THE NHS

The Health and Social Care Act is the most extensive piece of legislation relating to the health service since the establishment of the NHS. The information presented here sets out the essence of the proposed changes at the point of publication (April 2012).

In essence, the Act aims to make the NHS more responsive, efficient and accountable, setting out complex transitional arrangements in the reform of the system.

The Health and Social Care Act provisions include²⁷:

- Establish an independent NHS Commissioning Board to allocate resources and provide commissioning guidance.
- Establish Public Health England a new executive agency to: deliver services such as health protection, public health information and intelligence and including the functions of the NTA; lead for public health by encouraging transparency and accountability, building the evidence base, building relationships promoting public health; and support the development of the specialist and wider public health workforce, for instance by appointing Directors of Public Health within local authorities.
- Move the responsibility for public health back into upper tier and unitary local authorities, under the leadership of Directors of Public Health from April 2013. Health and Wellbeing Boards for every upper tier local authority will be established to oversee strategy and expenditure, operating in shadow April 2012 – 2013.
- Reduce the number of health bodies to help meet the Government's commitment to cut NHS administration costs by a third, including abolishing PCTs and Strategic Health Authorities.
- Increase GPs' powers to commission services on behalf of their patients via the establishment of Clinical Commissioning Groups who will take over from PCTs. Clinical Commissioning Groups will be responsible for commissioning the majority of NHS services in England from April 2013 onwards and will have control of £80 billion to pay for this.
- Establish HealthWatch, a new patient-led body to scrutinise the performance of local health providers.
- Strengthen the role of the Care Quality Commission
- Develop Monitor, the body that currently regulates NHS foundation trusts, into an economic regulator to oversee aspects of access and competition in the NHS.

At a national level, the functions of the NTA are moving into Public Health England by April 2013. At the local level, the local authority controlled budget for public health interventions will include the currently ring-fenced pooled treatment budget (PTB) for drug treatment. Local authorities will be required to set up Health and Wellbeing Boards to oversee spending on public health and the commissioning of drug treatment and recovery services becomes the responsibility of the local authority.

It is likely the current drug and alcohol treatment budget will make up around a third of local allocations for public health. In some areas drug treatment and recovery services will be a new responsibility for local authorities, other areas already take on this responsibility. The local public health allocations will be ring-fenced for spending on public health interventions. However there will be no ring-fencing of money within the overall public health pot for specific interventions, including drug treatment.

Instead, DH's document setting out baseline spending estimates for the new NHS and public health commissioning architecture states that the government does not expect the local authority

²⁷ Information sources:

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131897.pdf
<http://services.parliament.uk/bills/2010-11/healthandsocialcare.html> and www.dh.gov.uk/health/2012/02/bill-factsheets/

public health grant to fall in real terms, unless in exceptional circumstances. The new public health ring-fenced funding arrangements include a 20% 'incentive payment' relating to drug treatment which is based on the number of adult drug users that had successfully completed treatment and who had not re-presented to treatment anywhere in England for at least six months (Department of Health, 2012a). Whether this level of incentive will be sufficient to persuade local areas to prioritise those with drug problems, and whether the incentive will continue in subsequent years, is of considerable importance.

A new Public Health Outcomes Framework sets out 66 key indicators of public health, focused around two overarching high level outcomes: increased life expectancy and reduced differences in life expectancy and healthy life expectancy between communities. Only three outcomes are drug and alcohol specific' (Department of Health, 2012b).²⁸

Finally, from April 2013, funding for mental health services for people who have dual diagnoses (severe mental health problems alongside a substance misuse problem) and the many people with substance misuse problems who also have less severe mental health problems will be the responsibility of Clinical Commissioning Groups. This is with the exception for this group of services in prisons and secure care; funding for the provision of prison-based drug treatment and mental health services will be in the charge of Offender Health, operating within the NHS Commissioning Board, and devolved to local areas. The NHS Commissioning Board will have overall responsibility for setting outcomes and overseeing the commissioning of all health services delivered in prisons and other forms of prescribed detention.²⁹

POLICING REFORMS

The Police Reform and Social Responsibility Act (2011) sets out a radical programme of reform for the police service in England and Wales. Aimed at changing the face of policing to make it more locally responsive and providing better value for money, it includes the following provisions:

- Introduction of elected Police and Crime Commissioners (PCCs) in each police force to shift power and accountability for policing to the local level. PCCs will be responsible for appointing and dismissing chief constables, determining local policing priorities, budgets and producing a five year policing plan. Police and Crime Panels, comprising members from local authorities within a force area, will scrutinise PCC activities.
- Establishment of a new National Crime Agency incorporating the Serious Organised Crime Agency.
- Phasing out of the National Policing Improvement Agency.
- Emphasis on the cutting of bureaucracy and red tape, removing restrictive health and safety procedures.

²⁸ Drug and alcohol outcomes: 'successful completion of drug treatment,' 'people entering prison with substance dependence issues who are not previously known to community treatment,' and 'alcohol-related admissions to hospital.' Although a number of other outcomes can be linked to substance misuse.

²⁹ See: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130781.pdf

- Enhanced role for communities in cutting crime through beat meetings, neighbourhood watch schemes and voluntary groups (Home Office, 2010).

The election of Police and Crime Commissioners from November 2012 (in London, since January 2012, the Mayor of London acts as a PCC overseen by the Mayor's Office for Policing and Crime) will have a key impact on action around drugs. From April 2013, an area's PCC will have control of Community Safety Fund budgets and a proportion of the funding for the Drug Intervention Programme (DIP). Drug treatment and recovery services are key to reducing drug-related crime, therefore a PCC's relationship with the Health and Wellbeing Board (or Boards) in their jurisdiction will be of considerable importance. However this will be made more challenging by the fact that Police force areas are often not coterminous with the areas the Health and Wellbeing Boards cover.

Additionally, the publication by the Home Secretary of the annual Strategic Policing Requirement (from summer 2012) will set out what, in strategic terms, the police need to do in order to fulfil their national responsibilities, such as action against terrorism and organised crime. Tackling drug production and trafficking play a major part of most local force activities to disrupt organised crime.

CRIMINAL JUSTICE REFORMS

The Ministry of Justice's 2010 green paper 'Breaking the Cycle: Effective punishment, rehabilitation and sentencing of offenders' set out proposals to radically reform criminal justice.

Plans include:

- Transform prisons into places of work and improving Community Payback
- Rehabilitating offenders, enabling people to tackle problems underlying their criminal activity, including moving to a recovery-focused system for drug-dependent prisoners
- Introduction of payment by results for reducing reoffending (see below)
- Overhaul of the adult sentencing framework
- Increase community access to information about criminal justice services
- Preventing more young people from offending.

As part of these reforms, the government has committed to piloting Drug Recovery Wings, focused on short-sentenced, drug-dependent prisoners, in five prisons.

OUTCOME FOCUSED DELIVERY

The 2010 Spending Review Framework document criticised '*top down performance management and too many politically motivated targets*' while emphasising that '*there can be no justification for spending public money ... without considering the impact on the outcomes that people care about*' (HM Treasury, 2010).

The Government has a particular interest in 'payment by results' as a potential mechanism for

achieving value for money and controlling public expenditure. Payment by results (PbR) is an approach to allocating resources to services that rewards activity or outcomes. Payment depends on what the service does or achieves, for example, on how many hip replacements it performs or how many people it gets into sustainable employment. A PbR approach underpinned the reforms to the National Health Service that were introduced in 2002 and has since been introduced into other policy domains.

The 2010 Drug Strategy identifies PbR as a method to incentivise the delivery of recovery outcomes and eight pilot sites for DH's Drug and Alcohol Recovery PbR Programme were launched April 2012. The areas, Bracknell Forest, Enfield, Kent, Lincolnshire, Oxfordshire, Stockport, Wakefield and Wigan, are working to three high-level outcome areas: free from drug(s) of dependence; offending and health and wellbeing. Some areas have included additional local outcomes and the way in which the system will operate (for example the services covered by the scheme, the amount of payment that is allocated to outcomes and between outcomes, and how outcomes are verified) varies from area to area.

Alongside this initiative, other PbR schemes are being rapidly rolled out across Whitehall. For instance, the Ministry of Justice has co-ordinated a number of PbR pilots for offender rehabilitation.³⁰ The first of which was the social impact bond pilot at HMP Peterborough, launched by Social Finance Ltd in September 2010. Under this, social investors support intensive projects run by a coalition of charities. If their investments deliver reductions in re-offending amongst male prisoners leaving the prison who have served a sentence of less than 12 months, government will pay investors a return. Early lessons from the implementation of the pilot are available (Disley et al., 2011).

Other PbR schemes which potentially overlap or intersect with drug interventions include: the Work Programme run by the Department of Work and Pensions; Department of Health PbR for mental health and alcohol treatment; emerging Department of Community and Local Government initiatives to tackle youth homelessness and as part of the approach in the government's programme of support for 'Troubled Families'. However, it should be noted that there is enormous variability between these various schemes in the way in which they operate, for example in the extent to which the results paid for are true outcomes or activities (such as best practice packages of care), the amount of payment that depends on achievement of outcomes, and the speed of implementation and proportion of services that are covered by the scheme.

DECENTRALISATION AND LOCALISM

The coalition government's drive to deliver decentralisation in a number of policy areas and ambitions for a 'Big Society', of which the changes discussed above are a part, is in contrast to previously strong direction and oversight of much local implementation from Whitehall.

A developing agenda of increasing localism is expected to shift power from the centre back to the

³⁰ For further details on the MoJ pilots see: www.justice.gov.uk/guidance/prison-probation-and-rehabilitation/payment-by-results/programme-overview.htm and for information on the DoH's Drug and Alcohol Recovery Pilots, see: www.dh.gov.uk/health/2011/10/drugs-recovery/

local level, open up public services by boosting local involvement and engagement, encourage people to play a more active role locally and encourage partnerships across the public, private and voluntary sectors. The 2011 Localism Act aims to provide new freedoms and flexibilities for local government, including the election of Mayors in English cities, provide new powers to communities to challenge planning decisions and take over the running of local authority services.

Department of Communities and Local Government's six essential actions for localism:

Lift the burden of bureaucracy by removing the cost and control of unnecessary red tape and regulation, whose effect is to restrict local action;

Empower communities to do things their way by creating rights for people to get involved with, and direct the development of, their communities;

Increase local control of public finance so that more of the decisions over how public money is spent and raised can be taken within communities;

Diversify the supply of public services by ending public sector monopolies, ensuring a level playing field for all suppliers, giving people more choice and a better standard of service;

Open up government to public scrutiny by releasing government information into the public domain, so that people can know how their money is spent, how it is used and to what effect;

Strengthen accountability to local people by giving every citizen the power to change the services provided to them through participation, choice or the ballot box (DCLG, 2010).

The Open Public Services White Paper set out the government's programme for the reform of public services based on the principles of choice, decentralisation, diversity, fairness and accountability (HM Government, 2011a). Based on a vision of a more diverse market in public services with a greater role for new, innovative (voluntary and private sector) providers to compete for contracts, allow for payment by results and the diversity of provision. Within this, drug rehabilitation is included as a commissioned service, to which these principles apply. The voluntary and community sector has made a significant contribution to drug treatment and prevention service delivery for many years, therefore the changes underway are likely to be of significance.

Other reforms and changes of relevance

- The Welfare Reform Act aimed at simplifying and capping benefits. Provisions include a penalty for those social housing tenants under-occupying social housing, changes to local housing allowances and the phasing in of a universal credit. From March 2011 – March 2014, recipients of Incapacity Benefit, Income Support or Severe Disablement Allowance will be asked to undergo the Work Capability Assessment. Failure to attend will result in sanctions.
- A programme of support for 'Troubled Families,' marginalised families with multiple problems, many of which will be affected by substance misuse problems. Funded through the use of community budgets, and co-ordinated from 2012 by a Troubled Families Team established in the Department of Communities and Local Government.
- Community Budget pilot sites receive central government funding to establish devolved budgets across local public service areas aimed at redesigning services, reducing duplication and aligning or pooling resources to tackle problems in a co-ordinated way.

- The completion of DH's National Transforming Community Services Programme. Aimed at providing better, more responsive health care, this included the separation of the commissioning of health services from the provision of services and the associated establishment of Community Foundation Trusts as independent providers of services.
- Simplification of the process to establish Academies, publicly funded, independent schools free from local authority and national government control. As of March 2012, there are 1,635 Academies in England.³¹ Plans to make Personal, Social, Health and Economic education (PSHE) compulsory have been dropped by the government. New, non-statutory advice from Department for Education and ACPO on drug advice in schools published (DfE and ACPO, 2012).
- The publication of 'Positive for Youth' (HM Government, 2011b) bringing together all government policy for young people aged 13 to 19 in England and £1 billion Youth Contract to help young unemployed young people April 2012 onwards.

Relevant previous initiatives

It is important to recognise that a number of previous initiatives, administered by the previous Government and since superseded, have also sought to make changes to public service delivery to tackle similar issues to those outlined above. These are briefly summarised below. The lessons from these initiatives remain valid today and should not be lost amid the rapid changes currently taking place.

TOTAL PLACE

Total Place was launched in 2009, aimed at creating a 'whole area' approach to public services to avoid duplication, deliver services at less cost and improve efficiency (HM Treasury and Communities and Local Government, 2010). 13 pilot areas participated, considering a range of issues, to show how places could benefit from the streamlining of funding and the cessation of a myriad of national ring-fenced grants designed to ensure that national policy priorities and programmes were not diluted at the local level. Three of the pilot schemes covering Birmingham, Leicester and Leicestershire (joint) and Gateshead, South Tyneside and Sunderland (joint) looked at a whole area approach to tackling drug and alcohol misuse, chosen in recognition of perceived duplication and 'silo approaches' in dealing with consequences of misuse, with the same service users and their families often presenting at multiple agencies, alongside limited data sharing between organisations.

DRUG SYSTEMS CHANGE PILOTS

Launched in 2009, seven pilot sites over two years were offered a variety of funding flexibilities and new freedoms to encourage innovative thinking about the commissioning, delivery and implementation of drug treatment services, both within the community and prison. The pilots aimed to test the potential for improving the way services are delivered to make them more user-led and outcome focused with better continuity of care and case management.

³¹ Source: www.education.gov.uk/schools/leadership/typesofschools/academies

Valuable lessons around the practical delivery of better integrated and joined up services, together with lessons about the pooling of budgets and implementation of continuity of care between prison and community settings are provided by the pilot sites. The final evaluation of this initiative was scheduled for publication in 2011.³²

THE DIAMOND INITIATIVE

A two year pilot programme, completed in 2011, the Diamond Initiative was the first high profile test of the principles of Integrated Offender Management. Established by the London Criminal Justice Partnership, working with the Metropolitan Police, London Probation and six local authorities to deliver a multi-agency offender management scheme for offenders serving custodial sentences of less than 12 months. This was aimed at breaking cycles of reoffending in some of London's most challenging locations, in order to reduce reoffending and generate cost savings.

Lessons provided by the initiative include the complexities of implementation of support packages across a number of agencies, including co-ordination, staffing issues and issues relating to different working cultures, the likely long timescales for demonstrable results, and practicalities around information, data sharing and in proving success (London Criminal Justice Partnership, 2011).

What other research has been done?

A considerable amount of other research, with wide variability in terms of scope, sample size and representativeness, has been conducted looking at the impact of decreasing public spending on different sectors. It is not possible to explore all of these in depth here. What we do know is that many people with drug problems also have chronic employment, accommodation and mental and physical health problems and a significant number are reliant on welfare benefits as their principal source of income and are frequent 'visitors' to the criminal justice system. It is not yet clear how the systemic changes underway will interact with each other and what the collective impact will be. The box below provides information on a small selection of other recent published research with findings that are relevant to the focus of this report.

³² Not yet publicly available <http://www.nta.nhs.uk/scp-evaluation.aspx>

Impact of increasing austerity

- A review of evidence for the Joseph Rowntree Foundation, found that the service areas most frequently identified for cuts, for 2011/12, were young people and early years, libraries and culture, sport, leisure and parks, with a pronounced tendency for reductions in funding to adversely affect services aimed at, or heavily used by, young people (Hastings et al., 2012).³³
- An online survey conducted by DrugScope in summer 2011, on behalf of the Recovery Partnership, found that 89% of respondents said appropriate, safe and secure accommodation in their locality for clients of drug and alcohol services was difficult to access. It also found that 53% of respondents reported reductions in Supporting People funding for their clients and 62% thought that appropriate accommodation would become less accessible in the next 12 months (Roberts, M, 2011).
- Research by the Local Government Information Unit and Circle Housing Group on housing-related support found that 43% of their respondent's councils were reducing their level of Supporting People services in 2011 and 90% of respondents thought that this would put vulnerable people at risk and create costs elsewhere in the system. Some local authorities were developing innovative models for making savings (LGIU and Circle Housing Group, 2011).
- A programme of research looking at voluntary and community sector organisations that work with offenders, carried out by Clinks, found that many had made changes in an effort to sustain support and increase effectiveness. However, research found an erosion in the ability and resilience of these organisations with 86% of those surveyed saying they had been negatively affected by the economic downturn and policy changes. Over 80% had experienced a reduction in income and 62% were using their financial reserves (Clinks, 2012).
- Homeless Link's annual Survey of Needs and Provision (2012), which provides an overview of the homelessness sector, found a shrinking capacity within the sector due to a reduction in available funding: 58% of projects surveyed received a reduction in funding in 2011/12 and there was around 1 in 10 fewer full and part-time paid staff. Conversely there has been an increase in the number of volunteers in the sector. The top issue reported by projects was 'funding' and services reported an increased demand for their support (Homeless Link, 2012).
- Research by St Mungo's on what the Big Society currently means for single homeless people, found that 70% of their homeless clients surveyed said they wanted to volunteer to "give something back to their local community" or to "help other people." However, only 14% of St Mungo's staff and clients believe homeless people are included in society. The research did not identify a systematic way for embedding the Big Society approach for disadvantaged groups across central Government policies, which leaves this vulnerable to being undermined by other competing agendas (St Mungo's, 2011).
- An Audit Commission review, based on analysis of council budget data, provides a national picture of local authority's responses to reductions in government funding in 2011/12. It found variation in the way councils were approaching this, with some protecting services more effectively than others. Many savings plans rely on large cuts in small service areas – an approach which may not be sustainable (Audit Commission, 2011).

³³ A number of other organisations have also looked at change in services for young people, including DrugScope, Children England and the Confederation of Heads of Young People's Services.

3. Funding, expenditure and levels of activity

Summary of main findings

DRUG-RELATED POLICING ACTIVITIES AND EXPENDITURE

- Drug-related policing expenditure and activity is expected to decrease and there was a perception that it is faring worse than other police activities.
- Proactive work related to the detection of drug supply was expected to decrease. For instance activities such as covert surveillance, test purchasing and other intelligence gathering work.
- The drug-related activities that appeared likely to increase are ones, such as asset forfeiture, that could contribute to income.

FUNDING FOR DRUG TREATMENT AND PREVENTION ACTIVITIES

- Funding for adult drug treatment in England (the Pooled Treatment Budget) had been relatively protected from significant reductions at the time of research. However, the level of future funding allocations was an area of concern, together with the movement of this money into the public health budget and removal of the ring-fence.
- Future contributions to partnership mechanisms and activities were identified as vulnerable, particularly funding from Supporting People and Community Safety.
- Funding for young people's treatment and prevention was identified as the most vulnerable area.
- Reductions in wider support services were reported as having an impact on the ability to deliver recovery-oriented treatment services.
- The current context was seen as a positive opportunity for integrating services, in particular for increasing investment in alcohol interventions.
- Services to families of drug misusers were expected to increase.

National expenditure

Funding for drug interventions comes from a range of different sources. So called 'labelled' public expenditure on drugs in England during 2010/11 was estimated to be £971 million (a 5% reduction on the previous year).³⁴ Table one provides expenditure by category.

Indirect expenditure, or 'unlabelled' public expenditure, on drug interventions, for instance state benefits, Accident and Emergency assistance, work by mental health services, neighbourhood

³⁴ Figures should be interpreted with caution as previous research (see the 2007 UK Focal Point Report available www.nwph.net/ukfocalpoint/) has shown that the majority of public expenditure on drugs is unlabelled.

police activity, court appearances, offender management and foreign assistance, is harder to quantify. One estimate is that around 83% of overall spend is unlabelled (Reitox National Focal Point, 2007).

Table 1: Labelled public expenditure on drugs in England (2010/11)

Category of public expenditure	Expenditure (£)
General public services	50.6
Public order and safety	270.9
Health	637.6
Education	0.5
Social protection	11.4

Source: Department of Health, 2011.

This chapter looks at what is happening to the level of funding and spend for drug-related interventions and the impact of this on levels of activity. It focuses on two areas:

1. Drug-related policing activities and expenditure, and:
2. Funding for drug treatment, recovery and prevention activities.

The public services discussed in this chapter are at different stages in implementing the savings they must make. For instance, on the whole, with the exception of London, police forces have frontloaded their savings and are generally further along this road in comparison to other bodies, such as local authorities.

Research was carried out prior to announcements of centrally funded drug treatment and public health allocations for 2012/13 and prior to the movement of the Pooled Treatment Budget into the new public health system. Police and Crime Commissioners will have an impact of future expenditure and the priority placed on particular activities, but due to the timing of research it was not possible to look at this. Respondents were in many cases making predictions about what they felt was likely to happen, and this may not in fact occur in practice.

Drug-related policing expenditure and activity

To identify different perspectives on what change is occurring at local level and the impact this may have on drug-related policing activities, a survey was distributed to all English forces and Basic Command Units (BCUs) with support from ACPO.³⁵

The survey was followed by a workshop in which representatives from four police forces discussed the possible implications of the findings for drug enforcement, and the knock-on effects for drug markets. The findings from the survey and workshop suggest that the continuing pressures to save money and identify efficiencies may be leading to a greater focus on policing the most visible

³⁵ Results are available www.ukdpc.org.uk/resources/Drug_related_enforcement.pdf A total of 29 English forces level responses and 52 'other' responses were received (43 BCUs and 9 others such as British Transport Police). Data submitted by forces and BCUs were analysed separately. For ease of analysis BCU and 'other' responses were collated together and referred to as BCU responses in analysis.

and pressing issues in the short-term.

1. Drug-related policing expenditure and activity is expected to decrease and there is a perception that it is faring worse than other police activities

Over half of both force-level (59%) and BCU-level survey respondents (61%) expected expenditure on drug-enforcement activities to decrease in the 2011/12 financial year. The level of staff time within individual forces committed to drug-related activities was also expected to decrease. A similar proportion of respondents expected reductions in expenditure on work to tackle drug issues undertaken as part of their organisations' wider remit, for example as part of neighbourhood policing.

The majority of force-level respondents (62%) said they felt drug-related activities were faring about the same as other areas of policing. However, a third (34%) felt that they were faring worse. Nobody thought drug-related activities were doing better than other types of policing. Those responding from BCUs painted a slightly more negative, but more mixed, picture of the situation on the ground. Of BCU respondents, 42% felt that funding for drug-related activities was faring worse than the other activities they carry out, while 36% said broadly the same and 12% that they were faring better (the remaining 10% said that they did not know).

A third of BCU respondents noted in response to an open-ended question that their unit no longer prioritises drug-related activity. 15% of BCU respondents commented that they now have very little, or no, funding allocated for drug-related activities. One respondent commented:

'Imminent removal of the BCU dedicated drugs team and complete withdrawal of funding for operations aimed at tackling drugs and alcohol misuse and their associated violent crimes. We realistically anticipate, and know this from experience, that the violence against person crime figures will rise due to a great reduction in anti-drug operations'
(Police survey respondent, South East)

The workshop participants felt that the increasing pressure to save money and identify efficiencies was leading to a greater focus on policing the issues that are the most visible and pressing. It was acknowledged that much drug-related policing activity generates work and, in the short-term, it can be tempting to avoid looking for additional problems to police. For example, in the current context, it is harder to keep a Street Level Up approach going, with the priorities of individual localities leading to a pressure to deliver results quickly and working against longer term, cross-border, co-ordination.³⁶

Reductions in expenditure and resourcing were felt to be of significant concern because of the long-term consequences of a reduction in drugs enforcement activities. For example, it was suggested in the workshop by one contributor that constant pressure from the police on drug-related crime is essential to ensure that associated problems do not entrench and escalate:

³⁶ Street Level Up is an ACPO-led initiative aimed at building on collaborative ways of working with law-enforcement agencies at all levels (from street level to importation routes) and other organisations such as education and health agencies in order to achieve long term and sustained reduction in the UK's drug markets.

'If you don't keep your foot on the pedal it just deteriorates back to what it was...and your short-term gains which you've had over the last few years, you just lose them, so then it's a bit harder next time' (Participant, workshop on drug-related policing activity)

2. Proactive activities related to the detection of drug supply are expected to decrease

A shift in focus away from proactive drug-related policing activities was evident. The drug-related activities that were most often mentioned as likely to decrease were mainly those that relate to intelligence and evidence-gathering around drug supply.

For instance, around half of all survey respondents expected their level of drug test purchasing activities to decrease: 45% of forces and 49% of BCUs reported that this would either 'decrease a little' or experience a 'major decrease'.

Alongside this, 44% of force-level respondents expected their level of drug-related forensic testing to reduce,³⁷ while over a third of all respondents (38% of forces and 37% of BCUs) said that they expected their drug-related covert surveillance to decrease. Over a quarter of force respondents (27%), and 25% of BCU respondents, expected the use of drug dogs to decrease.

In addition to the potential impact on the police's ability to prosecute those involved in drug supply, reduction in these types of activity has implications for the police's ability to identify and keep up-to-date with new drugs and capacity to forensically test substances. Reducing capacity to access intelligence about drugs in their area could also diminish their capacity to fulfil anticipated new powers around the temporary banning of new substances.

'We don't know what we're picking up intelligence-wise. And because of the implications for testing we're not emptying amnesty bins. We're not going looking for anything legal highs wise... I suspect if you took a straw poll of forces they would not know what they've got' (Participant, workshop on drug-related policing activity)

Workshop participants reported difficult choices. One participant noted that there are nearly 400 cannabis farms in the area that his force covers and it is impossible to investigate these without diverting resources from other priorities such as the investigation of gun crime, or enforcement activities around crack and heroin. He also noted the increasing use of people with little experience of investigating cannabis farms, for instance Safer Neighbourhoods Teams. This is limiting the success of operations in reaching higher level drug activity.

3. Those drug-related activities that appear likely to increase are ones that could contribute to income

There were very few drug-related activities that were likely to increase in the 2011/12 financial year. About a third of forces expected an increase in activities around asset forfeiture and POCA (Proceeds of Crime Act) investigations related to drugs and 28% of forces reported an expected increase in detection and prevention of drug money laundering.

³⁷ The organisational changes in forensic science services might explain some of the anticipated reductions in forensic testing.

These types of activity have increased in recent years in response to increasing evidence highlighting the potential impact these activities may have.³⁸ In addition to this, workshop participants were clear that these types of activities are an opportunity to accrue financial benefit to their force. However there are disparities in the way it can be claimed and timescales can be a key barrier. POCA opportunities increase if forces are able to spend more time investigating over the longer term, which depends on senior managers recognising the importance of this and forces having the capacity to dedicate resources and access expertise for these activities.

Drug treatment, recovery and prevention expenditure and activity

Interviews in the seven case study areas, together with the national survey of English DATs (completed by 61 DATs), provided a picture of what was happening to the level of spend on drug treatment and recovery services; the impact of any changes to the provision of activities; and people's perceptions of how things are likely to change in the future.

The findings suggest that future funding contributions, from both national sources and from local partner organisations, were of concern. Some areas of funding appear particularly vulnerable. The current environment is seen as an opportunity for rebalancing investment on drug and alcohol services and services to family members of drug users were expected to increase. However, cuts to wider support services (for example the Supporting People programme) are perceived as impacting on the ability of areas to deliver the Drug Strategy's ambitions.

Other key issues relating to future funding, that are explored in later chapters of this report, was a lack of knowledge about future allocations for public health and the movement of DIP funding to Police and Crime Commissioners.

1. Adult drug treatment funding (Pooled Treatment Budget) was relatively protected in 2011/12 but the level of future funding allocations were perceived to be of concern

In 2011/12 in England, the Pooled Treatment Budget (PTB) funding held broadly steady at £466 million nationally.³⁹ Although it should be noted that individual areas do receive different allocations, year to year, depending on their performance. Furthermore, and this is also discussed below, local funding contributions for drug treatment and recovery services vary quite markedly from area to area.

In a number of case study areas the movement of funding for prison drug treatment to DAT control had been a positive development in terms of boosting the DAT's sphere of responsibility (and associated funding), at a time when other public services were being cut back. It also has potential benefits for efficiency and continuity of care for individuals with drug problems moving

³⁸See for example, Matrix (2010) *The illicit drug trade in the United Kingdom* www.matrixknowledge.com/wp-content/uploads/the-illicit-drug-trade-in-the-uk.pdf and Police Foundation (1997) *The Independent Inquiry into the Misuse of Drugs Act* www.police-foundation.org.uk/site/police-foundation/latest/independent-inquiries/inquiry-into-the-misuse-of-drugs?

³⁹ Contribution also maintained for 2012/13. Source: www.nta.nhs.uk/funding.aspx

between prison and the community.

Overall, the privileged position of adult drug treatment funding, in terms of its relative protection from savings and in comparison to pressures experienced by other public services, was acknowledged by case study interviewees. There was a perception among interviewees that in the future, with the move to the new public health system, it was likely that local authorities would see funding for drug treatment as an area with 'fat to trim' due to this relative protection to date. Chapter six looks further at the perceived risks arising from the removal of the drugs money ring-fence.

Interviews in the areas were carried out prior to the announcement of centrally allocated community and prison drug treatment funding for 2012/13 and the level of these future funding allocations was perceived to be of concern amongst interviewees and survey respondents. For example, among the DAT survey respondents, 75% were expecting a change in their PTB 2012/13 allocation, with 65% expecting the level of funding available to the DAT to decrease, either by 'a little' (52%) or a 'major decrease' (13%). 62% were expecting their DIP allocation to decrease in 2012/13.

In the end, five out of the seven case study areas received a reduction in their total, centrally allocated funding.⁴⁰ Two of the case study areas were in the top 10% of areas that received the biggest cut in total funding. If this is compared to the national picture - 50% of DAT areas received a reduction, 42% received an increase and allocations in 9% of areas stayed the same.⁴¹

Work in the case study areas to understand accurately their total spending and funding allocations, including other sources such as the PCT contribution, had not been straightforward. For example, in one area, what had previously been reported in their published treatment plans, as the PCT contribution turned out to be around a third of what was actually contributed:

'Well it had opened a can of worms for us because when I first started we were reporting that the PCT's contribution was only about £400,000 to drug treatment services, and that was based on historical information that was coming from the service itself. When the PCT actually got to grips with what they were funding it turned out to be about £1.2 million' (DAAT Manager, County One)

Problems in accessing accurate data on drug service funding and expenditure was not confined to the case study areas. Chapter eight discusses work carried out for this study to understand change in drug service expenditure over time, recorded in DAT treatment plans and published by the NTA.⁴²

⁴⁰ This includes the adult PTB funding, young people's PTB funding and DH offender access (historic DIP) allocation.

⁴¹ Percentages add up to over 100% due to rounding.

⁴² Available: www.nta.nhs.uk/regional.aspx

2. Future funding contributions to partnership mechanisms and drug-related activities were vulnerable

Existing financial contributions from partner organisations for drug interventions were seen as vulnerable, with future funding allocations and commitment very unclear. This situation was by no means unique to the drug service context: uncertainty around future funding was endemic across all organisations that were interviewed, including uncertainty around future allocations and their financial contributions to partnership arrangements.

'Nothing is set in stone really, clearly if it comes to a choice of putting police officers out on the streets or funding that [the contribution to the DAT] then the police officers will win' (Police interviewee, City Three)

The notable changes to partnership contributions included the withdrawal, or reduction, of local authority funding for residential rehabilitation, reductions in Supporting People funding and a decrease in PCT contributions to DATs. Half (47%) of the DAT survey respondents, expected a change in their PCT/health mainstream funding in the 2012/13 financial year; 37% expected a change in the Community Safety Partnership's (CSP) contribution, and 35% a change in the financial contribution to their DAT from Adult Social Care.

Considerable time and effort was being devoted in working to sustain future contributions and negotiating commitment. Strong, personal relationships were highlighted as key to success in this.

3. Funding for young people's treatment and prevention was the most vulnerable area identified

Funding for young people's drug treatment and prevention services were perceived to be faring the least well: cuts to Youth Justice Board funding, the loss of Connexions and cuts to youth services and diversionary activities were perceived to be having a negative impact.⁴³

Among DAT survey respondents, 51% had observed a significant decline in funding for young people's substance misuse prevention services, 41% had observed a significant decline in funding for young people's substance misuse treatment services and 44% a significant decline in funding for other services that might have an impact on young people's drug use.

A key reason is that these services are more dependent on other local funding sources. For instance, the creation of the new Early Intervention Grant (EIG) for 2011/12 was having an impact on the funding of services. With no ring fences within the EIG, local authorities are free to allocate where they perceive to be the most need. Replacing former centrally-directed grants such as Young People Substance Misuse, Connexions and Teenage Pregnancy, there was a widely held view that this has led to losses in funding for young people's prevention services. For instance, the re-commissioning of a new targeted, early intervention young people's service in the City Three

⁴³ A forthcoming separate UKDPC research briefing focusing specifically on how funding for services and activities addressing the needs of young people, that may directly or indirectly have an impact on drug use and associated problems, will provide further detail, see www.ukdpc.org.uk

case study area was cancelled after funding from the EIG was withdrawn (the tender documents and specifications had already been drawn up).

4. Reductions in wider support services are having an impact

Most interviewees identified a cost saving or funding cut that had either impacted on their ability to do their job, or they believed that it would have an impact in the future. Overall, there was a general perception of decreasing capacity across most organisations. Nearly half (47%) of DAT survey respondents thought that changes to wider services which support drug interventions were having an impact on their ability to deliver a recovery-oriented drug treatment service.

30% of DAT survey respondents reported that over the last 12 months they had observed an increase in difficulty in accessing mental health services for drug service clients. One of the City case study areas reported an increased case load of clients whose primary need was mental health services rather than drug and alcohol services.

'What we find is because the threshold for mental health services is so high nowadays people that should be engaged in those services are being funnelled into addiction services' (DAT Joint Commissioning Manager, City One)

Cuts to bus services in the Unitary One area and Unitary Two case study areas were impacting on the ability of service users to access treatment. In the Unitary One area this has been accompanied by funding reductions to a local charity that provides community transport.

For service users, welfare and housing benefit changes were of significant concern. Particularly problems were arising from being left with no income after failing their Work Capability Assessment. There was also concern around the impact on recovery prospects due to changes to housing benefit for those aged 25 – 34 living in single accommodation.⁴⁴

Police interviewees in several areas highlighted reductions in administration and back office support as having an impact on their ability to do their job, alongside the reductions of funding to the voluntary sector.

'Our car has been withdrawn. So, we have to beg, borrow and steal. So, anything proactive, you're stuffed' (Police Drug Liaison Officer, Unitary One)

'...what we have clearly seen is that there is a shrinking capacity in the voluntary and charity sector to work with some disadvantaged groups or groups that are more likely to use drugs' (Police interviewee, City Three)

In most of the case study areas pathways for Supporting People funding were being remodelled, although at the point of research it was too early to tell the impact of this.⁴⁵

⁴⁴ Changes mean from January 2012 single people under 35 no longer receive Housing Benefit based on one bedroom self-contained accommodation. Source: www.direct.gov.uk/en/N11/Newsroom/DG_192415

⁴⁵ Other organisations have explored this. See a survey carried out by DrugScope www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/RecoveryPartnershipHousingPullout.pdf

5. The current environment is perceived as a positive opportunity for integrating services, in particular for increasing investment in alcohol interventions.

A key opportunity recognised within all the changes at the local level was the potential for greater integration of services, seen as opportunities for providing better services to meet the needs of the individual clients, and provide efficiency savings. Alongside this many of those in DATs saw a related opportunity to use this to widen a DAT's footprint and their sphere of responsibility. Integration was mentioned in a range of ways, including integration of:

- Commissioning of prison and community drug services;
- Treatment and recovery services;
- Drugs and alcohol services;
- Wider services, e.g. integrating sexual health and drug services for young people, linking with dental health; or having domestic violence workers in the drug treatment service.

Taking advantage of and learning from previous pilot programmes that have taken this approach, such as System Change and Integrated Offender Management, was highlighted as a good opportunity.

A positive story emerged in relation to alcohol services. Of DAT survey respondents, 73% had observed an increased priority given to alcohol services. Nobody had observed a decreasing priority. All the case studies were increasing their alcohol treatment services. Integration of alcohol and drug services was seen as an opportunity to make cost savings and achieve better quality services. The subsequent national Alcohol Strategy is likely to boost this direction of travel.

'They deserve to be fairly treated and equally treated. And my fear was that if I didn't bring them into the integrated service, if our budgets do go, they'd be the first target' (DAT Joint Commissioning Manager, City Two)

One case study area has sought to use their Pooled Treatment Budget funding for both alcohol and drug treatment services. DH in principle gave permission to do this, but warned that, should they miss their drug-related targets for 2012/13, they will incur a financial penalty. This was a very contentious issue with all interviewees at the time of visit, with the opinion expressed that this area was being held back from taking risks by central government, despite behaving innovatively and in accordance with local needs. This is a good illustration of the tension between balancing various national policy imperatives, in this case drug policy and increasing localism.

6. Services to families of drug misusers were expected to increase

All of the case study areas were either in the process of developing support and activities aimed at families of drug misusers – or were already active in this regard. Four out of the seven case study areas reported collaboration around services for complex families (two areas are participating as Community Budget pilots) and were proactively working to ensure the inclusion of substance misuse issues as part of this.⁴⁶

⁴⁶ Research was carried out prior to announcement of the Coalition's Troubled Families programme.

An online survey, carried out as part of another UKDPC-commissioned programme of research, investigated the nature and extent of current provision of services to the adult family members of illegal drug misusers.⁴⁷ On the whole, respondents to that survey were optimistic that their services to adult family members would continue to develop, with nearly two thirds of respondents in England (65%) thinking that their services would increase in the next 12 months. At the other end of the scale, 16% of respondents thought that their services would decrease a little or a lot or cease altogether in the next year (UKDPC, 2012b). However, it should be noted that while there has been welcome development in terms of acknowledgement of the importance of adult family members affected by a relative's drug problems, this is starting from a low base and the quantity and range of provision is insufficient when considered alongside the numbers affected.

⁴⁷ Issued in summer 2011 and conducted across the United Kingdom. The survey was aimed at services that provide support to adult family members and/or carers of people with drug problems. It received 253 valid responses, of which 145 were from service providers in England.

4. The commissioning and delivery of drug treatment and recovery services

Summary of main findings

- There was much uncertainty about the future architecture for the delivery and commissioning of drug services and significant perceived instability in DAT structures.
- Change in the design and delivery of drug treatment and recovery services was common, with about half (48%) of the DAT survey respondents reporting that they were currently in the process of re-design or re-commissioning.
- A key driver for re-commissioning and re-design was to increase 'resilience' by identifying cost savings and future efficiencies.
- The research found little evidence that the government's ambition of increasing the numbers and types of bodies involved in the provision of services was happening. Some provider organisations reported barriers in competing for contracts.
- Nine out of ten DAT survey respondents reported that they were making changes in order to implement the Drug Strategy's vision for recovery-oriented treatment services.
- There were key barriers to achieving the Drug Strategy's ambitions. Nearly half (47%) of the DAT survey respondents thought that changes to wider support services were having an impact on ability to deliver a recovery-oriented drug treatment service. A lack of information about likely budgets was seen to be impeding the future delivery of services.

The Drug Strategy places considerable focus on improving recovery outcomes for people with drug problems. It identifies the need for support from different organisations and services such as employment, education, housing, family support and wider health services, to help those in recovery reintegrate into communities. This vision for recovery has to operate therefore within the wider context of policy and political reform.

This chapter looks at the commissioning and the delivery of drug treatment and recovery services (at the time of the research) and the extent to which this is changing. Many of the changes set out below were 'work in progress' and it was not possible to evaluate their full impact.

Overall, there is no single approach or model to the commissioning of drug treatment and recovery services. Cycles vary, with contracts usually issued for three to five-year periods. There is also no data available to provide a national picture with regard to the extent of levels of re-design or re-commissioning over time. Many local authorities' financial regulations require them to 'test the market' at regular intervals; in other areas mental health trust providers who deliver drug treatment services as part of a broader mental health service may never, until recently, have been subject to commissioning or retendering.

The information below is drawn from a number of sources. The case study interviews asked

people how drug treatment and recovery services were currently commissioned and if this was changing, including if they were making changes to their systems to make them more recovery-oriented. The national survey of English DAT's incorporated a number of questions around commissioning. Additionally, the findings also draw on the reported experiences of individuals working to commission, manage and deliver drug treatment and recovery services. This came from a day-long seminar looking at ways of commissioning for improved recovery, together with the perceptions of NHS providers who attended a roundtable event.

An issue that that came through clearly is the enormous variability in the situation of different areas. Areas had different starting points, both in terms of structural arrangements and the level of investment and organisation of treatment services. On top of this, the financial situation has affected some areas more than others, with some adapting to the changes faster than others.

1. There is significant perceived instability in DAT structures

While the core funding for adult drug treatment appeared to be relatively steady at the time of research, the wider architecture for the delivery and commissioning of drug services was perceived to be in churn. Those working in DATs, or local equivalent structures, reported high levels of uncertainty about future delivery structures. Several of the DATs in the case study areas were operating under transitional arrangements, between the PCT and local authority, which was impacting on the legal regulations they were operating under, along with their lines of accountability.

For seminar participants from some areas an important aim was simply to keep the system going or "*keeping the boat afloat*" in a time of massive change. This was echoed by the case study interviewees:

'People are losing their jobs, organisations are changing but that doesn't mean people lose their heads as well. We've got a real responsibility to our service users, our partners, our local communities and I just think we need to stick to our guns'
(DAT Joint Commissioning Manager, County Two)

Current issues around future staffing and funding that were reported are summarised in table three. Over the next year 45% of DAT survey respondents expect the level of staff time in their organisation committed to working on drug-related activities to decrease, either by 'a little' (25%) or a 'major decrease' (20%).

Table 2: Issues DATs reported relating to staffing and funding

Issue (an example of the sort of response included in each category is shown in italics)	Percentage of DAT survey areas recording response (n=61) ⁴⁸
<p>Reduction in or pressure on staffing capacity <i>'In two years the DAAT has lost staff in the head of operations, directly employed analyst, strategy manager, young person's commissioner, drug commissioner, PA and has a vacant post for alcohol commissioner.'</i> <i>'Staff under ever increasing pressure to perform to targets and national agendas, stress, burn out and distress are becoming more common in what was always a high stress field.'</i></p>	16%
<p>Uncertainty about future funding <i>'Uncertainty of what will happen to PCT contribution once GP consortia take over the budget. Also uncertainty as to PTB allocated to drug services, once it comes down through Public Health.'</i> <i>'The uncertainty regarding funding allocations is causing us a lot of difficulty- it's de-stabilising for the service providers and staff, and very difficult to plan even for the year ahead never mind longer term.'</i></p>	11%
<p>Reduction in the capacity/staffing in partner agencies to tackle drug issues <i>'Maintaining a focus upon drug misuse is getting more difficult as other priorities emerge and Community Safety Partnerships try to respond to national and local drivers with less resources.'</i> <i>'Lean staffing structures across partner agencies as well as my own make progressing work much more laborious.'</i></p>	8%
<p>DAT structure disbanded <i>'The DAAT team has been disbanded following a PCT restructure. We now have a 0.5 WTE commissioner for substance misuse, and no performance management or information staffing resource.'</i> <i>'DAT has been disbanded as a group yet JCG has been retained. Accountability lies who knows where! Staff levels have decreased by half but team has been given additional commissioning responsibility for Stop Smoking services, all Sexual health services across three local PCT areas, alcohol commissioning as well as drugs.'</i></p>	7%

Source: National survey of English DATs

2. Re-design or re-commissioning of drug treatment and recovery services is common

About half (48%) of DAT survey respondents reported that they were currently in the process of re-design or re-commissioning their drug treatment and recovery services. In the last 12 months, 20% had re-designed or re-commissioned and 19% were expecting to start work on this in the next 12 months. A further 5% of the DAT survey respondents reported that they would like to re-commission but that it was currently not possible.

Of the seven case study areas, four had re-designed or re-commissioned their system in the last two years. One had recently re-commissioned, one was in the process of re-commissioning and

⁴⁸ It was possible to record more than one response. Answers given in reference to an open ended question 'Are there any key issues you are experiencing around funding or staffing that you would like to highlight?'

one area needed to re-commission but was unable to do so due to uncertainty about future budgets.

Table 3: Status of redesign and re-commissioning of drug treatment system reported by DATs

Answer options:	Percentage of DAT survey areas recording response ⁴⁹
Currently in the process of re-design, or re-commissioning	48%
Recently (within the last 12 months) re-designed or re-commissioned	20%
Re-designed or re-commissioned system in the last 2 years	19%
Expecting to start work on the re-design, or re-commissioning, in the next 12 months	19%
Partial re-design or re-commissioning	14%
Re-design/re-commissioning to establish an integrated drug and alcohol service	9%
Would like to re-commission but it is not currently possible due to uncertainty about future budgets and/or structures	5%

Source: National survey of English DATs (n=61)

High levels of re-commissioning were also reported in a 2011 survey of 226 addiction psychiatrists undertaken by the Royal College of Psychiatrists. This found that nearly three quarters had recently (in the last 2 years), were currently undergoing, or were about to undergo, the re-commissioning of their service.⁵⁰

There was significant variability in the way that areas were approaching re-design or re-commissioning. NHS provider representatives flagged the variation in tendering processes in different areas:

'There is no consistency in quality of their tendering process, of how you write the invitation to tender, the length of them, the framework. Although there are standards around these things they're not followed. The transparency of it, even the percentage to which the contract is judged on quality and the percentage to which it's judged on price all varies'
(Participant, NHS provider roundtable)

A third (33%) of DAT survey respondents reported a movement away from contracting large NHS providers in their area to voluntary sector provider organisations. NHS provider representatives reported significant financial challenges in competing against the voluntary sector and the importance of working constructively with commissioner contacts to avoid contracts going to tender.

⁴⁹ Totals add up to more than 100% as it was possible to choose more than one statement.

⁵⁰ Personal communication with the Royal College of Psychiatrists.

'The playing field isn't level though because we've got more constraints on us than the voluntary sector. We've got cost improvement programmes, we've got to take 20% out in three or four years. We've got the costs of the FP10⁵¹, We've got national pay scales, right, that we're tied to. We've got pension (costs). We can't compete.'
(Participant, NHS provider roundtable)

In addition, some NHS providers perceived a 'de-skilling' in the sector, with a reduction in the overall pool of medical addiction specialists as a result.

'It's taken a generation of investment to grow the expertise within substance misuse so that we're able to go and find the best quality high standard care. And in a couple of years it can all be lost. And it will then take a generation to grow again. And the sort of things that aren't considered is not just about the expertise to manage complicated patients, but it's about clinical leadership, it's about training the next generation of experts, it's about research, it's about audits, it's about governance'(Participant, NHS provider roundtable)

The cost (and associated time involved) of tendering for services was an issue for all treatment service providers. One medium sized voluntary sector provider has calculated it costs them around a minimum of £10,000 for each bid they prepare. In addition, the impact of change in providers on the continuity and quality of care for service users, particularly those who require complex care, was noted by many of those involved in the research.

The capacity of the local authority or PCT to support these processes of re-commissioning was also of concern. Issues encountered included the loss of dedicated procurement and contract management support, a developing 'distance' between drug service commissioners and PCT contacts, and an unwillingness amongst PCT contacts to engage with re-commissioning at a time where their own structures were undergoing such change and their capacity increasingly squeezed.

3. A key driver for re-commissioning or re-design was to increase 'resilience' in a rapidly changing environment

Every case study area, regardless of whether they were planning to re-design or re-commission their systems, had worked with service providers to identify cost savings and to find ways to do 'more for less.' In some case study areas it was reported that this had been positive in increasing provider efficiency, reducing duplication in some service delivery and providing opportunity to innovate.⁵²

'There's a lot more dialogue. We've had lots of days with everyone together and provider days and stakeholder days and service user days. Service users sit on the re-design group as do GPs. I think the big vehicle has been the redesign group, the contractual arrangements, the performance

⁵¹ FP10 costs are costs for prescriptions written by Trust doctors and taken to a community pharmacy for dispensing. The Trust is charged for the cost of the drugs and a dispensing fee.

⁵² Due to capacity, it was not possible for this research to evaluate efficiencies achieved in greater depth or validate these perceptions.

review which have pushed through change. We've used sticks and levers. So with the mental health trust we've made a huge savings plan'
(DAAT Manager, Unitary One)

In the areas that had chosen to undertake re-design or re-commissioning, this was perceived as an important opportunity to 'shore up' treatment and recovery systems in the current environment by identifying cost savings and efficiencies and providing some element of future stability over the life of the new contract. Re-design or re-commissioning had in some cases given the space to think differently about services and responsibilities. Other areas had used savings achieved by change to develop new, recovery-oriented support services.

Areas were looking closely at the type of services they fund and some were withdrawing funding for activities that they perceived as not linking directly to drug treatment. For instance, in the Unitary One case study area the DAT took the decision to withdraw their funding for an outreach service to the homeless, this has been picked up by Supporting People for the short-term. In the City Three case study area the funding directed towards midwifery from the drugs budget was reduced and the DAT worked with maternity services to try and fill this gap. This has led to the recruitment of a specialist midwife who now oversees and supports community midwives with more complex cases as well as working closely with the drug treatment service provider.

In contrast however, some localities had decided to subsidise a wider breadth of activities with their funding. For instance in the Unitary Two case study area the DAT funded a Manager for their Integrated Offender Management programme and a part time Housing Worker, which was previously paid for by Supporting People.

4. There was little evidence that the government's ambition of increasing the numbers and types of bodies involved in the provision of services is being achieved

Overall, the research found little evidence that the government's ambition of increasing the numbers and types of bodies involved in the provision of services is being achieved (HM Government, 2011a), with the key exception in some areas being the involvement of drug service user social enterprise organisations (see below).

Indeed the reverse might be the case. Reservations around the use of smaller providers were reported by individuals commissioning and managing treatment and recovery systems – mainly around concerns that such providers would not have the financial robustness to compete and the short contracts attached to drug treatment as being inappropriate for small organisations. This also seems to be the picture with the Payment by Results Drug Treatment and Recovery pilot areas.

Each of the case study areas had worked to draw together contracts to create efficiencies and reduce their contract management burdens, often replacing a number of individual contracts with a single arrangement that could include sub-contracting arrangements with smaller providers, described as an 'arranged marriage' by one seminar participant. Over half (56%) of the DAT survey respondents said they were drawing together treatment and recovery service contracts to

create economies of scale. This did not necessarily mean the use of a single provider, if a number of providers were used – a 'lead provider' had been identified to lead or co-ordinate activity.

*'In austere times what happens is you revert back to your economies of scale and squeezing money out of the system is effectively about making efficiencies where you can and it's difficult to make efficiencies on small little contracts, whereas it's easier to make efficiencies on something larger because then you have critical mass'.
(DAT Joint Commissioning Manager, City One)*

Creating multi-provider systems presented some practical difficulties. For instance, the appetite or ability of separate provider organisations, who are usually in competition with each other, to work together successfully and coherently. NHS provider representatives highlighted the particular skills that are needed to work as a 'lead' provider and the challenges that are entailed in co-ordinating different types and sizes of organisations. There was also concern raised by those in the NHS about the robustness and quality of clinical governance systems.

5. Considerable work was reported as taking place to implement the Drug Strategy's vision for recovery-oriented treatment services

Of the DAT survey respondents, 89% reported that they were making specific changes to their treatment system to make it more recovery-oriented. Four broad approaches (which were often overlapping) in commissioning strategies to improve recovery outcomes were apparent from survey and seminar participants.

1. Working with current providers to improve recovery focus.

This may involve simply a closer monitoring of outcomes and using this as a focus of commissioning discussions, but may also involve recovery events with provider staff, more detailed work around referral protocols and pathways and lead to more extensive changes.

2. Commissioning additional services, often quite small-scale and innovative.

Additional services ranged from commissioning groups such as SMART recovery⁵³ or peer mentor services to work alongside traditional treatment providers, through setting up recovery cafes or other drop in facilities, to 'recovery banks' where people could earn credits through things like volunteering which could be put towards things to assist recovery such as courses, a laptop or gym membership.

3. Re-commissioning the treatment system.

Putting all, or large parts, of services out to tender and incorporating the requirement for a greater recovery focus into specifications. This often incorporated some payment for outcomes or quality element into the contracts. The approach was seen as appropriate where incumbent service providers have seemed unable to become more recovery-focused and an opportunity to extend the provider market although in almost all cases the tenders led to a single contract with a smaller

⁵³ A 4 point recovery programme using motivational, behavioural and cognitive methods, see: www.smartrecovery.org.uk/about

number of providers.

4. A user-focused approach.

A recurrent theme was the importance of involving service users throughout the commissioning process and as champions or peer mentors - making recovery visible to people with drug problems as well as to services and the wider community. Some areas were organising or supporting recovery conferences.

Overall, the diversity of approaches was notable. This is also picked up in other research examining the provision of advocacy for drug service users in English DATs which found, in the absence of a clear national policy direction, a variety of informal and ad hoc modes of provision (Cargil et al., 2012). Table 4 provides examples of the actions DAT survey respondents said they were taking to make their area's treatment system more recovery-oriented.

Table 4: What actions is your DAT taking to make your treatment system more recovery-oriented?⁵⁴

Action	Examples	% of areas
Working with current providers and partners to improve recovery focus, including review of the way in which the current system is working	<ul style="list-style-type: none"> Develop multi-agency recovery plan, empower service user-group to become independent and set up as a social enterprise, invest in the recovery infrastructure, work closely with housing, Job Centre Plus, Work Programme Provider, Probation, prison and police, colleges, Training institutions to develop education and training programme. Whole system approach been taken and training provided across both community and prison settings to instil recovery focussed treatment philosophy across the partnership. All our providers have held their own recovery focussed events this year and for one provider in particular this has resulted in a kind of 'light bulb' moment with the staff really engaging with the recovery agenda. We have worked hard on improving processes to change the focus of drug treatment from a clinical model towards one which advocates abstinence as the ultimate goal of treatment. We have had limited success in changing the culture of some drug treatment services in this way. In the New Year (2012) we will therefore be undertaking a full, in-depth strategic review of drug services in order to inform future commissioning. 	48%
Re-commissioning the drug treatment system	<ul style="list-style-type: none"> Re-commissioned with Recovery 'PbR' outcomes integrated Re-commission to improve integration of services - now moving to one provider. System already has good selection of wrap around services, care and service user involvement and Elected member buy-in. 	28%
Introducing or increasing a user-focused approach	<ul style="list-style-type: none"> We have a growing number of Recovery Champions or mentors and commission recovery-oriented services. We are also supporting the development of more mutual aid. Creating charitable organisation from current service user group and increasing peer led activities. Increase in user involvement, including peer mentoring, mutual aid and volunteering. Support groups of various shades are developing enabling clients in recovery to find a group which meets particular needs on the road to recovery. 	23%
Commissioning additional services, often quite small-scale and with a focus on the innovative	<ul style="list-style-type: none"> The DAAT is commissioning specific recovery related projects and activities for service users, including an education, training, employment and volunteering service. Service provider is delivering training to peer mentors and volunteers, and recovery cafes have been established across the DAAT area. We have piloted an intensive 16 week opiate community detox programme which we intend to amend and offer to all opiate users who are on doses at or below 30mls. We have re-specified the Aftercare service to increase the focus on reintegration. We are merging the main prescribing service with the day programme to ensure all clients receive psychosocial interventions alongside prescribing. Creating a centre that will provide a drop in facility and base for providers such as colleges, employers, job centre plus. Looking at social enterprise projects that provides volunteer and employment opportunities. 	17%

⁵⁴ Areas were able to record more than one response, responses to an open question. Source: National survey of English DAT's. n=61.

6. However, there are key barriers to achieving the ambitions of the Drug Strategy for more recovery-oriented services

Barriers were reported in implementing the Drug Strategy's vision. The lack of a developed evidence base on value of some recovery-oriented interventions was seen as an important issue (explored later in the report). Also nearly half (47%) of the DAT survey respondents thought that changes to wider support services were having an impact on their ability to deliver a recovery-oriented drug treatment service.

'Because the threshold for accessing other services goes up, so, floating housing support and stuff like that... the problem is that when you're working with the most vulnerable people they don't engage in things easily. They're not necessarily going to attend every appointment...but when you've got budget cuts and increased pressure. How are you going to get them to engage with you when you do not have the time to be scheduling them an appointment?' (Hidden Harm Worker, City Two)

The achievement of recovery-oriented systems may entail a culture change, both in service provider organisations, and those managing and commissioning services. Questions were raised around the skills and ability to achieve this. Some treatment providers, particularly those that might have provided services for some time in an area, were perceived as resistant to change or as lacking in some knowledge around the recovery agenda.

'In those circumstances there is a need not to micromanage because that just gets in the way, but actually to have some kind of reflective dialogue.' (Participant, commissioning seminar)

Some areas were struggling to cope in the context of such far-ranging change. In one case study area, a lack of information about future delivery structures and public health allocations has impeded the commissioning of their treatment system:

'The biggest impact in terms of austerity has been around commissioning. We're in a position where technically we should be re-commissioning all of our services this year...But what they've told us we're only allowed to give a twelve month contract. So the resource that you're putting in to undertake the whole tendering... is highly costly, and also possibly highly dangerous when we're at this position where we should be reconfiguring service, to us then move to the local authority and then they say, well, we want something completely different.' (DAT Joint Commissioning Manager, Unitary Two)

The area approached their Strategic Health Authority who referred the final decision to the PCT. In turn, the PCT will only commit to 12 months:

'We can't go past 2013 because we can't say with certainty what the money will be past then. ...And I don't even think it's a question of being risk averse or not risk averse because I think it would be negligent to say, "Well I am quite confident we'll have the money for, you know, and therefore we'll do it for five years."' (Assistant Director for Health Improvement, LA and PCT joint appointment, Unitary Two)

In contrast, another case study area had been successful in managing to secure permission from their Strategic Health Authority to commit money beyond the life of the DAT and successfully re-commissioned the treatment and recovery service system. The procurement documentation included the proviso that funding was subject to change because it was dependent on national allocations and local determinations. This suggests that in the current environment there will be winners and losers. However, it raises the possibility that the range of success and failure will in the future become more extreme.

Issues relating to Transfer of Undertakings (Protection of Employment) Regulations (TUPE) were of note at a number of levels. TUPE applies if services are transferred from one provider to another and are aimed at protecting employees if the organisation in which they are employed changes hands. A clear understanding of potential TUPE liabilities is a key part of good quality commissioning, together with the capacity within providers to take on these liabilities. Doubt was expressed that this was the case in some areas. For instance, in one case study area, which de-commissioned a mental health trust and commissioned a smaller voluntary provider, problems were experienced immediately after the transition because the TUPE burden was far larger for the new provider than initially anticipated.

'They then TUPE'd a group of staff who I think quite clearly were used to working in a particular way...it was monolithic provider they came from...they were then exposed to a very different sort of organisation. It's a social enterprise for a start which has a very different ethos' (DAAT Manager, County One)

The variation in legal interpretations of arrangements relating to the commissioning of drug treatment and recovery systems emerged as an important consideration. Due to the lack of central guidance, different localities access different sources of legal advice, which vary in their interpretation due to different understandings of contract law.

'I work in the local authority and I haven't got a procurement team, it's me, so as well as the commissioning and doing everything else I've also got to go out and do the procurement and the tendering, and to try and have to do that and keep up with contract law every couple of years, it's a nightmare' (Participant, commissioning event)

Legal issues surrounding re-commissioning clinical services in a local authority context were of relevance. In one case study area, issues had been encountered in regard to the local authority holding a contract for a prescribing service: a contract that does not include support elements in addition to the health element. Without clarification on this issue, the case study areas in question felt this raised key future barriers with the move to a new public health system and the development of future contracts in a local authority setting.

Overall, the ability to innovate and develop new models of delivery in a context of systemic change was questioned:

'The burden is huge which grinds staff down, services are being decommissioned or re-commissioned and you have got some of the other organisations outside the field where there are swingeing cuts too. It is not exactly in my experience the most conducive atmosphere for innovation.' (Service Provider Lead, City One)

5. Changes to partnerships and inter-agency working

Summary of main findings

- At the time of research, organisations did not generally seem to be stepping back from existing partnership configurations and there was an on-going appetite for partnership working and appreciation of the importance of this in the current context.
- Keeping in touch with personal contacts and sustaining productive and mature relationships (which was not always straightforward) was highlighted as particularly important in the current environment given the level of change and structural upheaval being experienced.
- However, despite aspirations for continued partnership working, the capacity to support this, underpinned by the funding, is under strain.
- There are weaker links in partnership working and inter-agency collaboration around drug-related activities. Weaker links include a lack of engagement with the Work Programme prime providers, Academies, private business and joint working with mental health services.
- The introduction of Police and Crime Commissioners was controversial and people were unsure about how they will engage and influence PCCs when they are in post.
- Police respondents expected to undertake less partnership working in the future and were perceived to be stepping back from engaging with others. This could be an indication of the future for other agencies as on the whole the police are further ahead in making their budget cuts.

Drug interventions encompass a range of activities by a wide variety of organisations with many service users moving across different services. Inter-agency partnership working is therefore essential for effective delivery and has been a cornerstone of drug strategies over many years.

In the current fluid environment, partnership working should be of increasing importance. For instance, the Drug Strategy's ambitions for change in the way drug interventions are delivered are premised on good quality multi-agency partnership working. However, one potential outcome of a more austere financial climate is that organisations will tend to focus on their 'core business.' Activity that is seen as discretionary or more marginal to core business could be liable to be cut first. At the same time, many partner agencies are also currently the subject of major reorganisation and/or significant budget reductions which are likely to have a knock-on effect for activities.

This chapter explores what is happening to levels of partnership and inter-agency working relating to drug interventions, drawing on information collected in the case study interviews, the national surveys of English DATs and of English police forces, and the day-long seminar of commissioners and managers of drug treatment and recovery systems. New configurations

relating to the move to the new public health system and partnership working with service user groups and community organisations are considered separately later in the report. The findings provide a picture of the direction of travel in different agencies and pinpoint potential weaker links in partnership configurations.

1. On the whole, organisations did not seem to be stepping back and there was a continued appetite for partnership working.

The majority of case study interviewees talked positively about changes to partnerships, such as reconfiguration, and better collaboration with existing mechanisms, which was often born out of the necessity to identify efficiency savings.

Overall, most partner agencies (with the apparent exception of some police forces) were continuing to engage in existing partnerships, were not withdrawing from existing configurations and were participating in efforts to make them work better in more creative ways.

'I think there's an enthusiasm to try and do things differently. There's a recognition that we're in difficult financial straits, that we need to deliver services more effectively, more efficiently, more cohesively'. (Head of Youth Offending Service, County One)

For instance in the City Three area, Joint Commissioning Managers were meeting to look at the potential for economies of scale around the joint commissioning of residential rehabilitation. In the County Two area a framework agreement was already in place for collaborative commissioning across five PCTs around the provision of residential rehabilitation detoxification services.

Five out of the seven case study areas reported better collaboration with Supporting People colleagues around pathways into services and service user consultation, both because of a recognition that they were often working with the same clients, and also out of necessity due to reductions in funding. In some instances, partnership structures had developed to fill gaps arising from cuts to services.

'We thought if we didn't think in a silo fashion then we could better manage that 40% cut [to Supporting People] because at that point we can commission someone to work with offenders, or with drug and alcohol problems, or with mental health. What matters then is how the partnerships work round it'. (DAT Manager, Unitary One)

Two areas were participating in pilots to test local payment by results approaches to reducing re-offending and were contributing DIP funding for this.

Existing partnerships were being reviewed or re-organised to avoid duplication with other structures and to encourage the continuing involvement of existing partners. Several areas were reviewing or re-structuring their DAT board memberships to ensure a wider spread of organisations such as housing, voluntary sector, employment and GPs in acknowledgement that a broader spread will be key to the delivery of recovery-oriented services.

Effective communication is fundamental to good quality partnership working, together with the ability to share data and information. In one case study area the police had translated the region’s Drug Assessment into a shorter, easier to understand and partnership friendly document. Another case study area was developing a plain English DAT local delivery plan which will be aligned to their drug treatment plan.

Some interviewees did talk of an increasing formality of partnership working; with positive examples provided of the use of formal partnership agreements, as well as more negative examples of more rigid partnership configurations which provided less scope for external representatives to attend and influence.

Two areas make use of official partnership agreements and spoke positively of these:

‘What it does do is set out a standard of interaction and operation between the providers. So it’s not enforceable by law but it’s definitely something that can be used for holding people to account’. (DAT Joint Commissioning Manager, City One)

Only a minority of DAT survey respondents expected their levels of existing engagement with partner agencies to reduce over the next 12 months, although key questions are around their capacity to sustain this engagement (see section below). Among respondents, 80% expected their level of engagement to increase with local Clinical Commissioning Groups and, in line with expectations about the further development of recovery-oriented services, around half expected to increase their level of engagement with the Work Programme and with housing services (not including Supporting People).

Table 5: Agencies with whom DAT survey respondents expected to increase engagement (‘a little’ or ‘a lot’) over the next 12 months⁵⁵

Agency	Percentage of respondents
Local commissioning groups	80%
Local community organisations	57%
Families of service users	53%
Councillors/elected members	52%
Service users (including self help/recovery groups)	52%
Housing services (not including Supporting People)	50%
PCT cluster	49%
Work Programme	48%
NHS Commissioning Board	45%
Mental health services	45%
Prisons and probation	31%
Supporting People	30%

Source: National survey of English DAT’s (n=61)

⁵⁵ Agencies that recorded a response of 30% and over.

Over half of the survey respondents expected to increase their level of engagement with local community organisations, families of service users, service users and elected members. Chapter seven explores local engagement in drug interventions in more detail.

2. The funding, and capacity, to support partnership working is under pressure

Despite clear aspirations for the continuation of partnership working and appreciation of the rationale for this, future partnership funding contributions to support the delivery of drug interventions were extremely uncertain. Coupled with this, an increasing pressure on organisations to identify savings and efficiencies was perceived to be impacting on the capacity to spend time working on individual activities and engage in partnerships. This was seen as something that will be under increasing pressure in the future.

Change in staffing within partner organisations was of significance and keeping in touch with personal contacts was highlighted as particularly important, although not always straightforward in the current environment. Change within PCT structures was highlighted as having an impact on day to day operations. Some interviewees spoke of increasing difficulty of keeping track with existing contacts, especially their financial/contracting contacts, and in keeping up-to-date with cluster arrangements. In some of the areas the PCT finance representative had stepped back from attending DAT partnership meetings.

'An example is finance within the PCT. They used to be a member of our joint commissioning group, now they only come quarterly because of the austerity measures and the remit on them to cover a wider patch. They can't give us the time that we need.'
(DAT Joint Commissioning Manager, Unitary Two)

Uncertainty was of particular significance in the DAT areas dependent on individuals within the PCT for financial sign off of their budgets. In the County Two case study area, funding carried forward by the host PCT on behalf of the DAT was unexpectedly recouped by the PCT cluster to contribute to their efficiency savings. Negotiations by the DAT Partnership Board ensured 60% of this amount was made available to the DAT to meet commitments they had already made.

Where power and influence lies at the local level depends on the structure of the local authority. The county case study areas faced additional complexities due to the fact that there was often no single forum in which to hold discussions and have influence. Although these challenges were not new, issues around limited capacity to attend multiple meetings and pressures on the time available to co-ordinate with a range of different partners were of increasing salience in the environment of great change.

3. There are weaker links in partnership working and inter-agency collaboration around drug-related activities

Weaker links in partnership working and inter-agency collaboration around drug-related activities included a lack of engagement with the Work Programme prime providers, mental health services, Academies and private business.

Case study interviewees highlighted practical barriers in engaging with the Work Programme providers, namely in understanding who they should contact. A key issue was the discontinuation of the Job Centre Plus Drug Coordinators and decommissioning of Progress2Work programme which had in some areas led to a fragmentation or breakdown in lines of communication around issues related to employment, and concern about an increasing complication in pathways for service users.

Some interviewees, and not just those from the DAT's, reported a lack of basic information about the way in which to engage with the Work Programme prime providers. A third of DAT survey respondents reported 'virtually no engagement' with the Work Programme prime providers in their area.

'The Work Programme stuff- there is no logical link to local commissioning.... there's a real tension' (Head of Probation Trust, County One)

Issues in the joint working between substance misuse services and mental health services were also flagged as a concern. Although by no means a new problem, it was perceived that fragmentation between services was compounded by the current nature and pace of health reform and general austerity. In particular, issues identified included difficulty in accessing mental health services for drug treatment users; unclear pathways for those that have co-existing mental health and drug and alcohol problems; and a lack of clarity around the future situation due to the transfer of responsibility for commissioning community mental health services to Clinical Commissioning Groups.⁵⁶

Some of the case study areas flagged up weak links with housing services and adult social care. Again, existing weaknesses were intensified by the wider context of a high level of change in structures and rising austerity. Some interviewees expressed concern that these services were increasingly struggling to cope with demand alongside the need to make savings.

Concern was also expressed around the issue of engagement with Academies, as independent bodies, on drug educational activities.

Finally, partnerships between DATs and the wider private sector, such as local businesses and enterprises, was by and large absent from discussion, with the exception of one area that wanted to explore this as a possibility,. Although, some areas were supporting service user groups to establish social enterprises in order to provide recovery services and peer support.

4. The introduction of Police and Crime Commissioners was controversial

In every case study area the introduction of a Police and Crime Commissioner was reported as a cause for concern. This was mainly due to the movement of a proportion of Drug Intervention Grant funding into the control of the Commissioner, but was also related to the scale at which

⁵⁶ For more discussion on the issues see: DrugScope, Centre for Mental Health and UKDPC (2012) 'Dual Diagnosis: A challenge for the reformed NHS and for Public Health England: A discussion paper.' Available: www.ukdpc.org.uk/resources/dual_diagnosis_final_01-03-12.pdf

they will operate (some Police force areas span several top-level local authorities with very different characteristics) and the lack of detailed information from the national level as to how they will operate. In particular, people felt that the election of a force level Commissioner, with control of a proportion of local DIP funding, went against localism and were unsure about how they would be able to influence or engage with the Commissioners. The introduction of a PCC could be damaging for existing local work if the decision is taken to divert funds away from a locality by the Commissioner.

'You know, we should know our area and our residents' needs better than anyone else. If we do our job properly in terms of the needs assessment. And obviously the concern is...it's putting these funding decisions at a very high level.'

(Community Safety Partnership Manager, Unitary Two).

Alongside this, there is concern about the potential for a 'personality' to be elected into post, and risks associated with this.

'Personally I think we'll end up policing the city through a political whim won't we, if you have got a politician holding the money'. (Borough Commander, City Two)

In most case study areas representatives from the relevant CSPs were meeting to prepare a co-ordinated response to the PCC once elected, including consideration of the implication of the transfer of funding, partnership agendas and future partnership arrangements and protocols.

5. Police survey respondents expected to undertake less partnership working in the future

The case study areas interviewees reported that out of all their partner agencies it was the police that were the most likely to be reducing their involvement in partnership structures.

Police interviewees were very aware of their declining capacity to work in partnership and that this was the result of the considerable cost savings that all areas (aside from the London forces who, on the whole, were waiting until after the Olympics to implement their main savings) were in the midst of carrying out, which was leading to a necessary greater scrutiny of the value of continuing to engage in partnership structures. On the whole the police have frontloaded their cuts and are further along this road than many other public sector organisations.

The national survey of police also provided some evidence of pulling back to core business amongst respondents and a reduction in levels of collaboration across different organisations. Around half of all survey respondents expected discretionary spending relating to drugs, such as the provision of match funding for local projects, to decrease across the 2011-12 financial year.⁵⁷ Almost a third, 31%, of forces expected drug education and work in schools to decrease over the 2011-12 financial year. Also, 38% of force-level respondents expected drug-related work with community groups to decrease and 34% expected to work less with local councils over the next

⁵⁷ 52% of forces and 44% of BCUs reported that this would either 'decrease a little' or experience a 'major decrease'.

Charting New Waters

12 months.

However, BCU-level respondents expected their levels of partnership working to stay broadly steady, with the exception of working with PCTs (18% expected a decrease) and DATs (18% expected an increase) and the National Offender Management Service (20% expected an increase).

The knock-on effects due to a reduction in activities provided by other organisations on policing were noted.

'Local authority reconfiguration is meaning it has reduced visible uniformed patrolling presence which may impact on community intelligence around drug misuse, withdrawal of young person's substance misuse funding and withdrawal of money for proactive policing and engagement activities'(London BCU)

One participant gave the example of a project in his area which provides support to recovering drug users. The project has lost funding and is being scaled back. He felt that this would lead to increasing crime if people turned back to drugs in the absence of support.

Chapter nine of this report discusses potential knock-on effects in more detail and considers if the findings above could be understood as an indication of the direction of travel for other agencies.

6. The new public health system

Summary of main findings

- Public health professionals and those working to commission, manage and deliver drug treatment and recovery services recognised opportunities from the creation of a new public health system within local authorities, namely in facilitating better links with other public services.
- Planning for new structures was difficult in the absence of key detail. Among DAT survey respondents, 63% reported that they either knew 'a little' or 'no information at all' about where they will sit in relation to future public health structures.
- Future funding, expertise and priority for drug treatment and recovery services was felt to be vulnerable, as was the continuation of the addiction and treatment skills base.
- Risks from removing the drug money ring-fence included the possibility of funding being used to meet efficiency savings and prioritisation of spend being open to political influence.
- Drug users are a stigmatised and marginalised group which could impact on the level of future priority given to drug services by local areas.
- Most of the areas studied will not include criminal justice representation on their Health and Wellbeing Board.
- There was concern around the future role and commitment of Clinical Commissioning Groups to drug treatment services and the potential fragmentation impacting on service users.
- In order to deliver a successful service, public health teams must have access to commissioning skills, for instance contract management and the ability to hold providers to account, as well as specialist knowledge.

Responsibility for public health, which will include the commissioning of substance misuse treatment and recovery services, is moving back to local authorities under the leadership of Directors of Public Health.⁵⁸ This will entail more than the inheritance of structures for the delivery of drug services; it also includes the assumption of the new responsibilities around recovery, for instance housing and employment support.

This chapter looks specifically at the issues and challenges for the delivery of drug interventions in the new public health system, using information collected at a roundtable workshop involving Directors of Public Health, interviews in the case study areas which asked interviewees what was happening in the regard to the move to public health in their areas, and the national DAT survey. The information below was collected between summer and December 2011 and prior to clarification and implementation of many of the changes. For instance in the majority of case

⁵⁸ Chapter two provides more information on the new public health system and the health reforms in general.

study areas the Health and Wellbeing Board was at a very early stage of development. In addition, the Directors of Public Health that attended the roundtable workshop chose to attend this because they were professionally interested in the way that their responsibility for drug treatment and recovery services will relate to their other responsibilities. Therefore, this was a 'warm' and interested audience.

Information below is divided into two, between the perceptions of:

- 1. Public health professionals**
- 2. Those working to commission, manage and deliver drug treatment and recovery services.**

Overall, this research did not find evidence of drug service user engagement in the embryonic HealthWatch structures and as a whole, this voice appeared absent in discussions. This is an important area where further investigation is required.

Perceptions of public health professionals

1. The creation of a new public health system within local authorities brings opportunities but planning is difficult in the absence of key detail

It was felt that the move back to a local authority setting would give an opportunity to integrate approaches to alcohol and drugs, and link with other services such as housing, employment and education. However, the transition to public health and the way in which responsibility for commissioning and delivering drug interventions will work was unclear in most areas.

New structures and processes were, at the point of research, having to develop in the absence of key pieces of information which were needed in order to plan for responsibilities after April 2013, for instance publication of the size of the ring-fenced public health budget. It was noted that differences in working culture between local authority and health professionals pose challenges. Different local authority structures also pose complications in making the links with different services, with district and county councils having different responsibilities.

The continuing delivery of safe, effective and high-quality services is critical during the Health and Wellbeing Board's 'shadow' operating year of 2012/13 while the process of organisation change continues to be in progress.

2. Key risks were recognised in removing the ring-fence from drugs funding

While public health allocations were still undefined at the time of the round table it was known that the Pooled Treatment Budget (PTB) allocations were likely to remain at a similar level to 2011/2012 which, with the movement to a new public health system and the removal of the specific ring-fence around this funding, raises the possibility of PTB funding being used to meet the efficiency savings required by local authorities.

It was recognised that drug users are a highly stigmatised and marginalised group and this could impact on the level of local priority given to drug services, as future prioritisation of spend on these services will be open to potential negative political influence.

Furthermore, at a population level, drug problems are less prevalent than other problems which could influence the priority given to drug interventions by public health teams. Drug problems cause 1,600 deaths annually, alcohol causes 35,000 deaths and smoking 115,000 (NTA, 2012).⁵⁹ Such comparisons do not however take account of the wider cost of drug addiction, its impact on families, neighbourhoods, public health and crime.

3. Strong partnerships, particularly between criminal justice and public health, are critical

Public health professionals are used to working in partnership, managing complexity and working across different organisations. In the current climate it was recognised as even more important to invest time and energy on this, despite shrinking resources producing a pressure to cut back. Participants at the roundtable were clear that Health and Wellbeing Boards must bring together the right partners and involve key strategic and senior local authority partners.

However, it was stressed that it cannot be all things to everybody and membership by every agency wanting to be around the table is not feasible. For instance, most of the Health and Wellbeing Boards in the areas represented at the roundtable were not planning to include criminal justice representation on their Health and Wellbeing Board. This is borne out by the findings from other work.⁶⁰ Yet, criminal justice partners are key to maintaining focus and attention on drug treatment and historically they have been critical in promoting investment. They are key allies in making the argument for continued funding for drug services and also have a major interest in other health and social care services such as to address alcohol problems and mental ill-health.

4. Fragmentation within the new health system is a key risk and leadership commitment and partnership working are important in militating against this

Directors of Public Health have many 'large agendas' to lead on and there is a risk that attention to drug interventions will be dwarfed by their other responsibilities. Fragmentation within the new health system is a key risk for the delivery of an integrated and good quality service.

For instance, responsibility for prison drug treatment now lies with the NHS Commissioning Board and will be devolved through new arrangements to get closer to local areas. Mental health services on the other hand will be commissioned by Clinical Commissioning Groups, with implications for the integration of support for people who have dual diagnoses or co-morbidity between mental health and substance misuse (the lead responsibility for substance misuse interventions rest with Public Health).

⁵⁹ Available: www.nta.nhs.uk/uploads/whyinvestjan2012.pdf

⁶⁰ An eATA (unpublished) commissioned analysis of the membership of 31 Health and Wellbeing Boards found 16% included criminal justice representation. See also Humphries et al (2012).

The roundtable participants felt that there is real variety in the quality of GP leadership and the evolving Clinical Commissioning Groups. GPs are also important providers of substance-use interventions, and reluctance, amongst some GPs, to engage with substance misuse may be a significant barrier to successful delivery and may result in inequalities of provision between different areas.

It was felt by participants that, in reality, it does not particularly matter who leads on drug interventions, whether it is the Director of Public Health or another representative, as long as somebody at a senior level does lead and engages strategically with local partners. The inclusion and consideration of local drug and alcohol problems in an area's Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy will be an important vehicle in the development and delivery of integrated services.

5. Substance misuse commissioning skills are essential

Finally, participants highlighted that in order to deliver a successful service, public health teams must have access to commissioning skills, for instance contract management and the ability to hold providers to account, as well as specialist knowledge. Alongside this, it was agreed that getting the principles of commissioning agreed among partner organisations can minimise problems from the start.

Perceptions of those working to commission, manage and deliver drug treatment and recovery services

1. Opportunities from the creation of a new public health system within local authorities were recognised

In common with public health professionals, those involved in the management and delivery of drug treatment and recovery services recognised a number of opportunities arising from the move to public health. These were: improved integration with local authority services, such as employment and housing, which are often key to recovery from drug problems; better overall partnership working; and in providing more impetus and support in refocusing attention on alcohol treatment services. It was also hoped that the movement to a new public health system would provide the opportunity for a greater focus on prevention and early intervention.

In one case study area the PCT Public Health staff had already moved across to the local authority and this was highlighted as a positive move by all interviewees who talked of the benefits this has brought in terms of being able to access additional expertise on public health and data about their local population's health needs.

Some interviewees highlighted the move as an opportunity to sell or promote their skills as specialist drug treatment commissioners both to the Health and Wellbeing Board and to Clinical Commissioning Groups.

'For a GP who's been involved in the treatment of their own practice population, to suddenly be managing the budget of a population area, they're going to need a whole world of information so that presents an opportunity for those commissioners of drug and alcohol services... those commissioners need to seize the opportunity to say this is what we can do for you, this is how we can help you meet your priorities, these are the responsibilities you have, this is the nature of this population.' (Primary Care Lead, City One)

2. The way in which substance misuse will fit into new public health structures was unclear

Uncertainty about future structures was high and a perceived lack of clear overall policy direction, alongside the lack of detail on future allocations, was of frustration. Of DAT survey respondents, 63% reported that they either knew 'a little' or had 'no information at all' about where they will sit in relation to future public health structures.

In all of the case study areas it was too early to define where the responsibility, and delivery structures, for drug treatment will lie in relation to their area's Health and Wellbeing Board and it was unclear what the transition to the new system would mean in regard to the future architecture of the DAT.

It was also unclear how existing relationships with CSPs and criminal justice agencies would continue, including for instance if DAT boards would continue to report to the CSP, and if the public health directorate in the individual areas would be a standalone directorate or subsumed into a larger directorate such as Adult Social Care.

Questions were raised around the compatibility of existing DAT structures in terms of their commissioning functions in relation to new public health structures. In two case study areas the re-commissioning of the drug treatment system had either stalled or been delayed as a result of this uncertainty. Several case study areas questioned the positioning of drug treatment and recovery services in the new public health structures and were planning to keep structures aligned to the CSP.

Finally, the level of drug service user engagement and influence in public health structures, such as the developing HealthWatch structures, was found to be more or less absent at the time of research. This is despite five out of the seven case study areas participating as HealthWatch pathfinders.

3. The future funding, priority and expertise for drug treatment and recovery services was felt to be vulnerable

In common with the perceptions of public health professionals there was concern regarding the transfer of funding for drug treatment services to the general public health budget. The key risks identified were around a reduction in funding arising from the savings local authorities must find, the redirection or re-designation of spend; and a loss of priority given to drug treatment and recovery services due to the lack of an evidence base demonstrating recovery outcomes from

many recovery-focused interventions, for example peer mentoring. This was together with the need to compete against significant public health agendas such as obesity and smoking which are more persuasive when viewed from a population health perspective.

The ability to argue the continuing value of drug services in this context was felt to be critical, and something many of the areas needed further support in doing. As noted earlier, linking into an area's JSNA was also noted as being valuable in moving forward and retaining priority.

The reliance on one person (the Director of Public Health) to champion the cause of drug services in future structures contributed to feelings of vulnerability. There was some scepticism that Public Health would have the future prominence, influence and independence it is supposed to have. In budgetary terms it will be far smaller than other local authority directorates such as Adult Social Care.

In common with the perceptions of public health professionals, there was some concern around the future role of Clinical Commissioning Groups. Risks highlighted were the lack of appetite among some GPs to engage with drug users; skills gaps or training needs for GPs; and confusion around the future allocation and control of funding for primary care substance misuse services. Fragmentation in the future links between primary care mental health services and drug services was of concern and was felt to be of significance in the impact this could have on service users, particularly those requiring access to a number of services.

For example, in the Unitary One case study area, 60% of drug service users were accessing drug services via their GP. Under new public health structures the continuation of this service was not certain.

'And we have now got a pretty solid I think PCT-based primary care drug service. It's interesting, when I say PCT-based, because at the moment one of the unresolved issues is what the hell they are going to do with them in the PCT, as it disappears.'
(DAT Manager, Unitary One)

In one of the County case study areas, the pot of money held by the PCT, which funds GP surgeries to provide prescribing and shared care services, had been unexpectedly moved to the Clinical Commissioning Group. The DAAT Manager and Joint Commissioning Manager felt frustrated by this development as they had hoped to expand these services and felt de-motivated at the prospect of working anew to convince other members of the Clinical Commissioning Group of the value of this work.

Interviewees were aware of the question mark over the continued need for a separate DAT and specialist drug commissioners once public health people have transferred over into the local authority.

Delivering drug policy at a time of radical reform and financial austerity

'Where are the economies of scale to be had? The risk is they look and they say okay contracting we don't need...it can just be done by adults and children's section contracting...data analysis can be done by some central data place...your admin can be done by X, Y and Z...And actually all you need is a single champion for drugs and alcohol – who could be your Director of Public Health'
(DAT Joint Commissioning Manager, Unitary Two)

If staff and structures are reduced, this could have an important impact on the skills and expertise base for commissioning and delivering drug treatment and recovery services, which would be costly to replace and will be required, as observed by the public health professionals above, within the new public health structures.

7. Local engagement in drug-related interventions

Summary of main findings

- The level of engagement by the case study DATs with 'wider' communities (those local residents, community groups and local representatives broadly unconnected to existing services relating to drugs) was virtually non-existent, although expected to increase in the future.
- The involvement of communities in services relating to drugs was perceived by interviewees as something to be managed very carefully as drug users are a highly stigmatised and marginalised group.
- Service user engagement and involvement was recognised as key to the successful delivery of recovery-oriented systems. There are key benefits from engaging more widely. Elected members' priorities do tally with substance misuse issues.
- A greater localism and decentralisation is predicated on the assumption that the capacities and competencies of areas are fit for this purpose. The research raises questions around this. The research also found a number of contradictions between government rhetoric around localism and the reality on the ground.

This chapter looks at the engagement of local communities in the delivery, management and direction of drug-related interventions. It draws mainly on the information collected in the case study areas and DAT survey. It looks at the engagement of the case study DATs with both 'wider' communities (including local residents and elected members) and the involvement of drug service user communities.

In each case study area it was aimed to interview at least one service user and the DAT's service user involvement officer (if such a position existed). This was not always possible.⁶¹

1. Direct engagement with wider communities in the case study areas was virtually non-existent

The level of engagement with 'wider' communities (those local residents, community groups and local representatives that are broadly unconnected to existing services relating to drugs) was either absent or extremely low in all of the case study areas.

The majority of the DATs did not have regular links or lines of communication with elected members. There was generally no regular outward facing promotion of substance misuse services in their local community. Interviewees were upfront in the acknowledgement that this

⁶¹ In the end, Service User Involvement Officers were interviewed in six out of the seven case study areas. Four service users in three case study areas and two councillors from two case study areas also agreed to be interviewed.

was an area that needed more development. Of DAT survey respondents, 69% reported either 'a little' or 'virtually no' engagement with local community organisations. Although, around a third reported 'a lot' of engagement.

Links with Community Safety Partnerships (CSPs), or with contacts in the police (often those that also attended the DAT's partnership or delivery board meetings) were the main way areas kept up-to-date with local communities and an avenue for hearing if problems or issues were raised at individual neighbourhood forums relating to drugs. The focus by these bodies was usually in regard to issues relating to crime and substance misuse.

It was recognised that conceptually, the definition of community and what localism means in practice is not straightforward. There is no single 'local community' and no single local level. Good quality engagement around drug-related issues, and with local communities, is a skilled job. It requires time and effort. Reaching out to different people requires different methods of communication. CSPs and the police have a track record in the engagement of communities and the delivery of local projects. Therefore, the impact of budget reductions on these agencies, alongside the move to a new public health system within local authorities, raises questions around the ability for individual DATs to continue to make use of these methods and the capacity of these bodies to provide support.

Joint Commissioning Managers in two case study areas observed that they had very limited capacity to engage with their local communities. One observed the tension of asking their service providers to spend time on user engagement versus providing the other services they are contracted to do.

'I do believe that there is a place to involve the community more. I just don't think that our services are quite at that level yet. Because we've been putting all of our energy and focus into the recovery agenda.' (DAT Joint Commissioning Manager, Unitary Two)

In contrast, in another case study area the DAT Manager had recently held an event for Councillors aimed at explaining the work of the DAT as a way of raising their profile ahead of the move to a new public health system.

'I think we've started winning a bit of a trick, which is going for elected members. I think that's a smart thing, if you go for local communities who should have more say ... and cut out the people in the middle who aren't making it happen.' (DAT Manager, Unitary One)

The integration of the voice of service users into new public health systems seems to remain on the starting blocks. As mentioned earlier, drug service user representation on evolving organisations such as HealthWatch, appeared to be minimal. Although, recognised as an area to develop, the gulf between service user representatives, in terms of their backgrounds and priorities, and most HealthWatch volunteers was noted as a barrier to be overcome. Stigma and negative public attitudes towards people with drug dependence identified in earlier UKDPC research (UKDPC, 2010) contributes to this challenge.

2. Greater localism in drug interventions carries risks

The engagement of wider communities in services relating to drugs was perceived as something to be managed very carefully. As mentioned above, drug users are a highly stigmatised and marginalised group. Previous UKDPC research has raised concerns around increasing localism as this group are vulnerable to slipping down the list of local priorities and less able to advocate on their own behalf (UKDPC, 2010).

Every case study area was able to give an example where engagement had been unsuccessful. Vociferous campaigning against the location of drug treatment services in a particular area was not unusual. This can result in reticence amongst some professionals around the engagement of local communities and in engaging with elected members:

'Councillors in our area just want tourism, tourism, tourism, so therefore, anything to do with drugs and alcohol affects their tourism, because it's not nice for people to see that. I was told this week by a councillor if I shut all your services I'll save a six and a half million pounds, which can go into tourism, and, therefore, we won't get all these drug addicts on the streets.'
(Participant, commissioning seminar)

However, elected members' priorities do align with what can be achieved through substance misuse interventions. For instance, drug treatment and recovery services are critical to achieving local successes around the reduction of crime and the improvement of individual, family and area health and wellbeing. Recovery champions are key to reaching out to wider communities and in communicating their experiences (explored further below).

A Service User Involvement Co-ordinator noted the importance of engaging more widely:

'Changing a drug service that's hidden up some backwater alley and maybe having it more in the public domain. We need to actually be out there... It's actually avoiding anticipated challenge and we all know that anticipated challenge is usually far more in your headspace than in reality'
(Service User Involvement Co-ordinator, City Two).

3. Service user engagement and involvement was recognised as key to the successful delivery of recovery-oriented systems

The advantages of engagement with services users in terms of the delivery of services has already been highlighted in chapter four. Drug service user representatives or recovery champions are essential in communicating their experiences, can bring ideas of innovative and flexible solutions and are an important way of reaching and convincing a wider range of audiences.

'We have got a service user council who I am happy to say are absolutely amazing. They have all got slightly different interests, they come from slightly different backgrounds with slightly different treatment programmes, so they have all got masses of experience and they all bring really innovative ideas... Hopefully that improves their employment opportunity and now they are starting to bring in new volunteers. So for me the contagious bit, we are starting to see it.'

(Participant, commissioning seminar)

Examples of service user engagement and involvement included the use of peer mentors, involvement of service users in the re-design or re-commissioning of treatment systems, supporting service user groups to become social enterprises, service user mystery shopping to inform service delivery and engagement in consultation around proposed changes to services. One area had established a credit scheme for individuals working towards recovery:

'One of the new things we have just done in the last year is a service user said one of the barriers to getting into recovery and employment was that they had no CV's. They had no education because a lot of them fall out of school at fourteen or fifteen. So we have come up with a 'Give Yourself Credit' scheme where if they are a peer mentor or they are a volunteer on our services they can earn credits at minimum wage and we then put those credits towards courses or towards driving lessons or towards buying a bike or something like that which will enable them to get into employment, into full time education, and that has really gone down a storm.' (Participant, commissioning seminar)

In one of the City case study areas, the remodelling of Supporting People was considering opportunities to improve service user engagement across the worlds of drugs and housing (there is a large degree of cross-over in people using both services) as a way to increase efficiency in reaching out to people.

The involvement of service user groups in service delivery and direction also requires time, capacity and skills. Service user groups, like all community or voluntary groups, go through cycles of involvement. Stigma between different service users can add another layer of complexity to work around engagement.

'The intention is in time that we'll develop a steering group and then a committee and then it can go off on its own again. But I'm not in any great rush to do that, at the moment it is simply setting up a support group.' (Service User Co-ordinator, Unitary Two).

Two positive examples of service user engagement collected in the case study areas are provided below.

Service user involvement in the 'City Three' case study

The service user organisation was described as one of the best things about this case study area's treatment and recovery system. This was established in 2007 and followed the example of a successful mental health empowerment team that was active in the city at this time.

'They're the jewel in the crown of drug services' (Drug service user)
'We flaunt the group everywhere, we're very proud of it' (DAT Joint Commissioning Manager)

The group are funded from the PTB. Their funding was cut by 5% in 2011/12. The DAT did request a 10% reduction for this period but the group were able to negotiate a smaller reduction by demonstrating where they could make savings without impacting on activities.

The group has a Service Level Agreement with the DAT to provide activities for drug service users, to develop user forums to communicate with treatment providers and promote wider communication between drug users. They hold 40 forums a year which includes twelve women only groups and forums with different providers, including Probation. The group runs a website, a magazine and a text messaging service and provide access to skills and training. Nine people since January 2011 have found and sustained employment as a result. They also organise activities such as football, boxing and gardening.

The group are based within the Voluntary Sector Council and receive a lot of support, and access to expertise, as a result. They have one full time worker, a part time admin worker and 12 volunteers. The worker attends a lot of community events in order to talk to people about their work and to try and tackle any stigma there might be around drug service users by providing a 'face' to addiction. He also keeps in contact with a number of Councillors.

In 2010/11 the group saw around 10% of the service user population in the area that the DAT covers.

'We are a friendly face, we're not formal, we've all been there and nothing shocks us...we could definitely do more and it would be silly to let places like this go...need more service users on the frontline as people are more likely to come back' (Service user volunteer)

The manager of the group sits on the DAT's Joint Commissioning Group and is vice chair of a steering group established by the DAT aimed at getting key representatives around the table to discuss the future direction of treatment services in their area and the ways in which they need to change. It includes sub-groups looking at workforce issues, pathways, criminal justice and data and performance. The manager of the group also provided support to a neighbouring authority when they went out to tender.

Service user involvement in the 'City One' case study

Two service user reps sit on the DAAT's Joint Commissioning Group (JCG) and there is service user representation on most DAAT sub groups and partnership meetings. Service user groups are attached to each of the treatment system's service teams and representatives from these groups are nominated to sit on the area's User Council. Their strength is in bringing a real perspective of what is happening on the ground and how it is affecting people. The Council represents those in both alcohol and drug treatment services, and people at different stages of recovery.

Service users were consulted around changing the structure of the JCG. Some work had been carried out already on revising the terms of reference and looking at membership, and service users were asked for endorsement. They did not agree with the proposed change so this did not happen.

Each year a service user audit is carried out by the Council, they try to talk to 10% of those in treatment (in 2011 they interviewed 180 people) about how they think the treatment system is working, what might not be working and what improvements could be made. An audit report sets out the main recommendations for follow-up actions. For instance, in the past service users said that there need to be longer opening hours and that there should be peer led services and activities. They have found this audit to be an effective tool in communicating with commissioners and providing the evidence around what service users would like.

Service users have been involved in reviewing hostel provision in the area in response to cuts to Supporting People and undertook a number of focus groups to talk to people living in the hostels to get their views of provision.

The Black, Minority Ethnic (BME) Service User Group have been particularly active in reaching out to the wider BME community because they feel there is a gap in knowledge about what is available for drug and alcohol users in this community. They attend community events and visit faith groups.

'When they have a table they get loads of people coming up to them and saying, "Where can I go to get help? It's not for me, it's for my son, or my girlfriend or my husband, or whatever," and they think there needs to be a lot more communication into the community. And I think drug services try and be discreet so they're not so obvious, which is great but it means the community don't know they're there' (Service User Involvement Officer)

A new peer mentoring service has been established due to service user demand and because it was felt that key workers have increasingly less capacity to engage with service users around their wider needs. Five members of the Service User Council have established themselves as a social enterprise and have secured funding from the PCT until April 2013.

4. Greater localism requires a shift in culture and the development of new skills

With the movement of public health back into local authorities and ensuing elected member influence over the budget, it is very important that those delivering and commissioning drug services are able to appear locally relevant and link to local priorities, strategies and assessments. Accordingly, a greater future level of local engagement was expected, with over half of the DAT survey respondents expecting an increased involvement of local communities in local work around drugs over the next 12 months.

Table seven: Percentage of respondents expecting their level of engagement to increase over the next 12 months (by 'a little' or 'a lot')

Organisation	Percentage of respondents
Local community organisations	57%
Families of service users	53%
Councillors/elected members	52%
Service users (including self help/recovery groups)	52%

Source: National survey of English DAT (n=61)

However, respondents to the police survey reported different expectations: 38% of force-level respondents expected their drug-related work with community groups to decrease in the future. Although at the BCU-level almost as many respondents said these activities would increase (13%) as thought it would decrease (19%).

A greater localism and decentralisation is predicated on the assumption that there are the skills and competencies within individual organisations to deliver this together with a strong community and voluntary sector.

It was recognised that working with communities and elected members requires a level of expertise and political experience that some DATs, especially those that have been based in PCTs, may not previously have required. In the future, the skills and evidence to communicate

and demonstrate the value of services will become even more important, alongside a level of political literacy to navigate local authority processes and committees.

The research found a number of contradictions between government aspirations of localism and the reality on the ground. As discussed in the previous chapter on the commissioning and delivery of services, there was little evidence that the government's aspirations for a more diverse market, with a greater involvement of smaller, community-based organisations, were being achieved.

Furthermore, an 'era of localism' anticipates that local people will be able to track the quality of services provided to them, including data on how money is spent and to what effect. The research found little evidence of this currently being possible in regard to drug interventions. The next chapter explores this issue.

8. Prioritisation and planning

Summary of main findings

- There was no set 'pattern' to decisions being taken around investment and disinvestment. The wheels of decision making were often oiled by existing contacts and relationships in partner organisations. Pre-emptive or proactive engagement in decisions about disinvestment had been successful.
- DAT respondents felt disengaged from wider decision making, especially around structures for future delivery and funding.
- Good quality data and evidence around spend and its impact is critical in making the case for continued investment. There is frustration about the poorly developed evidence base on the value of recovery-oriented treatment services. Complexities included that benefits are experienced quite some time after investment and a funding allocation may take place in one area and the benefits felt in another.
- The pace of change is impacting on the ability to make effective decisions. The capacity to plan robustly, and on a long-term basis, was felt to be very constrained. Better information on details of policy is urgently required.
- There is a risk that, amidst the change and uncertainties, the services to a very vulnerable group of individuals may be reduced or reconfigured in such a way that the gains from the last 20 years are lost.

This chapter identifies the broad issues, as far as it is possible, that emerged over the course of research relating to processes of decision making and prioritisation around spend and activities and, how these are changing in response to increasing austerity and reform.

Interviews in the case study areas asked people about the information they were using to take decisions around investment and disinvestment. It was intended to build a 'road map' of the different decision-making journeys, identifying the mechanisms to track outcomes, together with the way in which disinvestment decisions were taken, including the manner in which different perspectives, including marginal voices, were being taken into account.

It was not possible to build this picture in any depth. Much was unknown and in a state of flux. Uncertainty surrounded everything from future funding allocations to the individual structures responsible for delivering future services. Changes to wider, relevant support services were especially difficult to unpick.

Indeed, more research in general is required around the way different public organisations are taking decisions about future investment and disinvestment. For instance, there is a general lack of publicly accessible risk management plans around the withdrawal of funding.

1. There was no set 'pattern' to decisions being taken about investment and disinvestment

A range of different decisions had been taken about investment and disinvestment in drug treatment services and these differed case by case. The wheels of decision making were often oiled by existing contacts and relationships in partner organisations.

One case study DAT, which was initially unsure which approach to take in planning for the 2011/12 financial year, took the decision to cut 10% off all funding streams and re-commissioned the treatment service on this basis. They also managed to negotiate a funding freeze from Adult Social Care for three years.

Other areas had asked their provider to decide where efficiencies and cost savings could be achieved. A number of case study areas were engaged in delicate juggling acts. For example, one area had used their previous year's under-spend to subsidise the establishment of a number of new recovery-oriented services. They were hoping the funding to continue these during 2012/13 would be found from savings resulting from the re-commissioning of their clinical prescribing service by reducing prescription costs.

Examples were provided where pre-emptive or proactive engagement had been successful. For instance, after the loss of Early Intervention Grant funding for a new targeted, early intervention service for young people in the City Three area, the Young Person's lead negotiated Early Intervention Grant funding for the reinstatement for a Healthy Schools Advisor post:

'I sent over a load of stuff on the Drugs Strategy and sent over some of the Needs Assessment and the Treatment Plan and said preventative and early education is a crucial component of the process that was set in our area for Young People's Substances so, yes, we did get a small slice of the cake' (Young Person's Lead, City Three).

In a couple of areas, people had offered their savings cuts before they were announced. In one area the Young Person's Commissioner decided to reconfigure their budget so they were entirely funded by the Young People's Pooled Treatment Budget. Previously half the funding for their post originated from an Area Based Grant contribution, which had since been subsumed into the new (not ring-fenced) Early Intervention Grant. It was felt by the Commissioner that, being entirely funded by the specialist treatment grant would provide greater security of employment in the future.

2. Respondents, particularly the DAT respondents, felt disengaged from wider decision making, especially around structures for future delivery and funding

Research participants felt at some distance from decision making about structures for future delivery and funding. At one level this is perhaps unsurprising. But of particular issue was the movement into the new public health system, future funding allocations and wider PCT and local authority change and re-organisation leading to a change in those in management or in previously useful networks or contacts.

Of DAT survey respondents, 70% felt they had a lot of involvement in decisions relating to future drug-related activity. In regard to their ability to influence, responses were split with around half feeling they had little or no influence at all.

Table 7: Level of involvement and influence in the future funding and direction of drug-related activity (percentage of respondents)

Answer Options	A lot	A little	Not at all
Extent of INVOLVEMENT in decision making about future funding and direction of drug-related activity	70%	31%	0
Extent you feel able to INFLUENCE decisions about future funding and direction of drug-related activity	53%	45%	2%

Source: National survey of English DAT's (n=61)

Disillusionment and de-motivation were reported, especially amongst DAT and service provider interviewees. For example, a number of those working in roles relating to services for young people spoke of the frustration of being characterised as a fluffy or 'nice to have' service. Also participants sometimes expressed concern about whether, in the new arrangements, there was someone charged with championing their cause at a senior enough level, locally and nationally.

'The NTA was a pain at times, but at the same time it gave a very good profile to commissioning, to the accountability of money, the Part 4s which we used to do, and debate with the finance directors not siphon the money somewhere else, and all that. Localism is great, but I think those are some of the challenges which commissioning is facing'. (Participant, commissioning seminar)

3. Good quality data and evidence around spend and its impact is critical in making the case for continued investment

There was a perception that with the move of public health it is likely local authorities will see funding for adult drug treatment as an area with more 'fat to trim' due to their previous relative protection, unless it can be proved otherwise. It is critically important to clearly and persuasively provide evidence for the value of services and interventions and use this to get on the agenda of the local authority and included in strategies and assessments, including the Joint Strategic Needs Assessment and an area's Joint Health and Wellbeing Strategy.

'I think sometimes you rely on personalities, but we've got to get things written into the Children's Plan, it's making sure that there's that strategic direction and that buy-in' (Young Person's Lead, City Three)

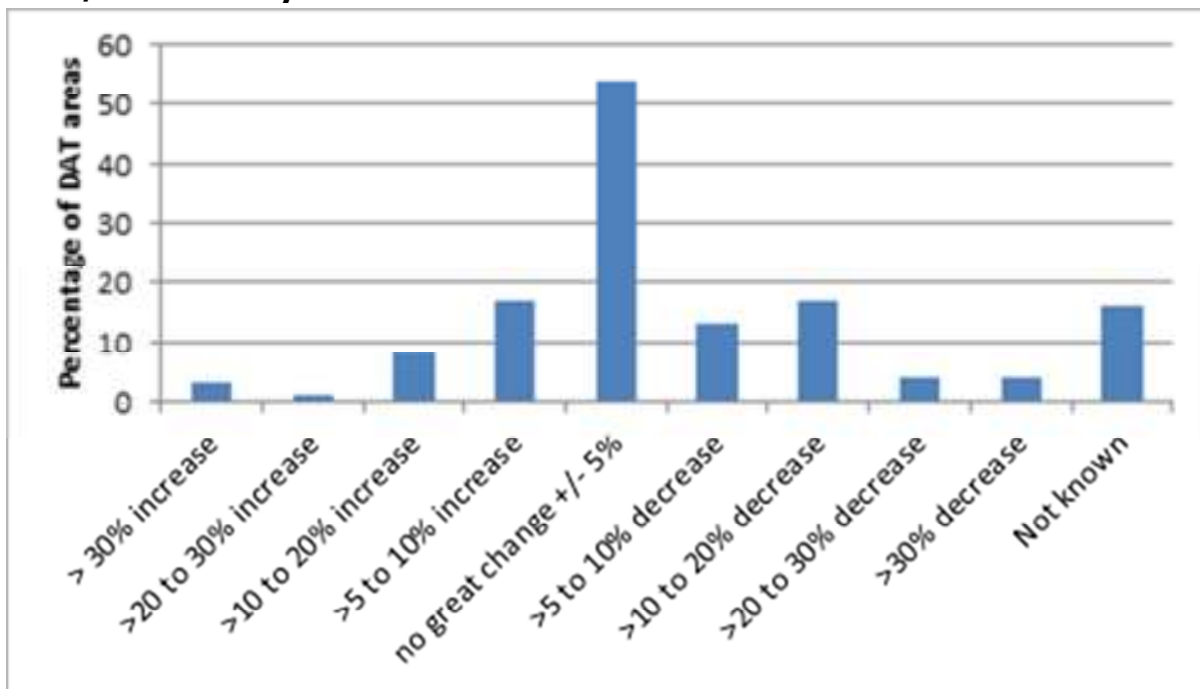
In the case study areas work to understand budgetary allocations and their value for money had not been straightforward. Complexities included the way benefits may be experienced quite some time after investment and that a funding allocation may be in one area and the benefits felt in another, sometimes many months or years down the line.

It was hoped that this study would track and collate, on a national basis, change to drug treatment funding and expenditure over time in order to understand how spend on services, and

the various different sources of national and local funding might be changing. However this was not possible. The financial data recorded in 'part four' of DAT area treatment plans, published by the NTA, was found to be very incomplete and often inconsistent.

For example, the figure below looks at overall change in funding for drug services, recorded by English DAT areas, between the 2010/11 and 2011/12 financial years. It was not possible to identify change in 12% of areas. In the future the quality and level of drug service financial data is likely to get worse as it is no longer compulsory to record or publish this information.

Figure 1: Change in funding for drug treatment services between the 2010/11 and 2011/12 financial years



Source: UKDPC collation of treatment plan funding information ⁶²

Significant frustration was expressed by interviewees around the poor quality data and a poorly developed evidence base on the value of particular interventions in delivering recovery mentioned previously. This shortage of data is a clear threat to both funding and priority, and the delivery of the ambitions of the Drug Strategy.

I'm not a value for money expert, but there's a difference between cashable savings...the only real cashable savings are in the Work Programme and employment stuff, and it's difficult to calculate the cashable savings from drug treatment and housing and all sorts of things. No one's ever really done it'. (Participant, commissioning seminar)

It was highlighted that this is an area that requires national co-ordination and over-sight to ensure that data and evidence are developed robustly and consistently rather than individual areas collecting data in different ways. This can be done while still allowing research and developments at the local level as in the case of one NHS provider who described the

⁶² Available: www.nta.nhs.uk/regional.aspx

establishment of a club drug clinic to manage detoxes and carry out particular psychosocial interventions. This was contributing to insight into the efficacy of particular interventions.

The case study areas were asked if they had used the NTA's Value for Money tool. Three areas out of the seven had tried this but decided not to use it further. In one area this was because they wanted to input their own data. One area felt concerned about the accuracy of the results produced by the tool.

4. The pace of change is impacting on the ability to make robust decisions

The capacity to plan robustly, and on a long-term basis, was perceived to be very constrained. As noted earlier in the report, many decisions were being taken in the absence of key details such as future funding allocations, knowledge about future staffing, structures, lines of accountability, or areas of future priority. Future funding for drug treatment was of concern for most interviewees. The main issues were a lack of knowledge about public health funding allocations, uncertainty of future funding contributions from partnership agencies and the movement of DIP funding to Police and Crime Commissioners. In a couple of case study areas a lack of information about likely budgets had impeded or stalled the commissioning and redevelopment of services.

These issues were having a major impact on ability to make decisions about the future. For instance, a Councillor in one of the City case study areas reported that he had attended a budget planning meeting for 2012/13 which included a presentation by the local authority providing indicative headline figures for their service areas. Public health was not included and when questioned he had been told that this was because they had no idea as to what this allocation would be so it was impossible to plan at that stage.

Better guidance on details of policy is urgently required. There was a sense that people were working blind in the absence of this and that inconsistency in messages from different government departments was causing confusion or duplication of effort. There is a real risk that amidst the change and uncertainties, the gains from the last 20 years will evaporate, with negative consequences for drug users, their families and crucially, for wider communities and the economy.

Table 8: DAT survey respondents views on support needed from central government

'Clear unambiguous guidance at the earliest opportunity would be helpful as it feels like landscape/direction changes daily.'

'It would be useful to have further steer around how the DAAT board is expected to be aligned to the Health and Wellbeing Board.'

'A consistent message to partnerships informing them that although DAT related work will become a function undertaken by Public Health that the drug partnership will remain in some function and decide local priorities, and spend, in conjunction with wider structures such as Health and Wellbeing Boards and the role of the Police Commissioner.'

'Clarity and cohesive approach across departments re substance misuse issues rather than the myriad of departments all having some different slant on how to deal with substance misuse, with the usual contradictions, resulting in parallel developments and pilot funding resulting in the inefficient use of resources or over emphasis on one aspect without consideration of the whole system.'

'More guidance on the role of drug partnerships in the future. Lack of guidance is ensuring that this is moving off the agenda for all partners and not a priority especially for the police.'

'More 'joined up thinking! Policies across all government departments, especially the Department of Health, Ministry of Justice, Home Office, and agreement about what 'local decision making ' actually means.'

Source: National survey of English DATs (n=61)

9. Conclusions and implications

Summary of key points

- The review provides a broad picture of upheaval and uncertainty which pose threats to the future success of drug interventions and the ability of local areas to fulfil the Drug Strategy's aims.
- There was little evidence of a clear vision or road map on how the processes of NHS structural reform, policing and justice reform, localism, austerity measures and the ambitions of the Drug Strategy will fit together in a coherent way.
- Significant questions surround the extent to which the withdrawal of the detail of national direction, knowledge and support at the same time as the implementation of multiple, radical, new policy and public spending ambitions are compatible, realistic or manageable.
- Those working at the local level see a number of opportunities in the current context, but they also identified considerable risks. New ways of working may achieve efficiencies but at the same time there will be unintended consequences.
- Our concluding proposals are aimed at ensuring that work to address the problems associated with illicit drugs, continues to be underpinned by an infrastructure that is fit for purpose, and that people will have the skills, capacity and support to continue to deliver the aspirations of the Drug Strategy.

Austerity and localism in context

While there is much 'unfinished business' in the application of austerity measures and reform, this report provides a snapshot of how the funding, commissioning, management and delivery structures for drug-related interventions are currently navigating and managing an unprecedented level of major and extensive change.

Drug policy over the last two decades has had a strong national priority supported through successive strategies, accompanied by new and ring-fenced funding arrangements. How national priorities are to be reconciled and implemented through increasingly decentralised systems is going to prove a major challenge at all levels. There is a strong argument for government to adapt or steer the system if it is deviating too far from the high level goals of the policy (Institute for Government, 2011).

Finding this new balance is already proving problematic. An issue that came through very clearly is the enormous variability in the situation and experience in different areas. Local areas had different starting points, both in terms of structural arrangements and the level of investment and organisation of treatment services. In addition, the financial situation has affected some areas more than others.

At the local level, implementation of the national Drug Strategy is predicated on a system of partnerships and funding which has evolved over the past two decades. The present high level of structural national and local public policy change cannot avoid creating a number of knock-on effects which will present serious challenges to the fulfilment of the Drug Strategy's aims. It is important to be alert to what some of these unintended consequences might be in order to avoid or mitigate them as far as possible.

This research has aimed to take into account the way in which a wide range of drug-related interventions, including treatment, prevention and enforcement services and activities are changing in response to the current environment. Seminars and events provided a space for those people charged with implementation and delivery to reflect on the way policy and funding changes were panning out in their areas. National surveys captured the ways in which different localities were adapting interventions and services and collected perspectives on unfolding future funding arrangements and partnership structures. Over 80 interviews in seven case study areas gave an in-depth insight into responses to the changing landscape of public service commissioning and delivery, the impact of increasing fiscal constraint and the building of a greater 'localism'.

In the future, as we know, there will be less resources for public services, and in this context of austerity, national public policy can be decisive in providing constructive solutions to local problems. However, if policies and actions are driven too far simply by concerns around expenditure, these can also amplify undesirable consequences (Storti et al., 2011). The research aimed to provide indicators of 'early warnings' to inform future decision making processes. The review presents a broad picture of upheaval and uncertainty which pose threats to the continued success of drug policies and raises questions around the future security of investment in drug interventions. On the one hand, there is a risk that, amidst the change and uncertainties, the services to a very vulnerable group of individuals may be reduced or reconfigured in such a way that the gains from the last two decades are lost. On the other, efforts to reduce the availability of drugs through enforcement may be compromised. The consequences of this are potentially damaging not just to the service users, the individuals with drug problems and their families, but also to their communities, wider society and the economy, which would also suffer the fall-out, such as through increased health care costs, increased crime, higher benefit bills and loss of productivity.

In this final chapter we set out a number of overall high-level findings that emerged during the course of the review. Chapter one of this report explored the elements that underpin successful change management and these are returned to below in considering whether, based on the findings of the research, the current direction of travel in the re-modelling of drug interventions can be considered to be adhering to these. Next, the broad tenets underpinning the Drug Strategy and the government's aspirations for greater localism are tested against the main findings of this survey. Risks and opportunities arising from the current context are highlighted. Finally, the findings present a number of risks for those operating at the national and local level and, to conclude, ways in which national policy-makers and local practitioners can mitigate these risks are provided.

Key findings: Localism and austerity in drug interventions

Our core findings are:

1. An unprecedented level of change is being felt across every aspect of the delivery of drug interventions, but many practitioners have no clear understanding of what a 'final destination' might look like.
2. Local players see opportunities in the changes to work more efficiently.
3. Yet, the current changes present considerable risks, including the potential for disinvestment, fragmentation and more bureaucracy.
4. Partnership working and collaboration are valued but capacity is under strain.
5. There is an important risk of fragmentation between the health and criminal justice agencies that are key to successful drug interventions.
6. Many of the changes that are either taking place or being planned are underpinned by little robust evidence or detail.
7. Forging a new balance between a centrally led national Drug Strategy and more flexible, locally-led drug interventions is welcomed but brings substantial risk.
8. The changes underway have major implications for accountability systems.

Assessing the change management process: Impact of the current environment on the delivery of drug interventions

THE IMPLEMENTATION OF CHANGE

As set out in Chapter one, there are some widely accepted principles for implementing change effectively. These include a clear strategy or vision, setting out the case for change and clear goals or metrics by which progress can be measured, backed by leadership commitment, and an overarching strategy for communicating this change to stakeholders.

Our starting point has been that there is a clearly understood national Drug Strategy in England and that there is a universal appreciation that austerity will bite. Unfortunately we found little evidence of a clear vision or route map on how the complementary processes of NHS reform, policing and justice reform, localism, austerity measures and the ambitions of the Drug Strategy will fit together in a coherent way. There seemed to be little (national or local) understanding as to what the real impact in one agency, or system, is going to have on another and what this

means for the complex web of relationships and partnerships between organisations. There was no set pattern in our case study areas as to the ways in which decisions were being taken about investment and disinvestment in services. These processes need careful management and choreography, which many people felt was not happening sufficiently. Overall, this is indicative of poor value for money in organisational effort.

We could find no clear metrics established for measuring progress. It remains unclear how it will be known if the desired change has been achieved. The research revealed frustration amongst those on the ground responsible for implementing change at the lack of detail and clarity about managing and delivering this process available from those at the national level. 'Light-touch' at the centre can be interpreted at the local level as being 'rudderless'. In many cases people were making decisions in the absence of information about future funding allocations or staffing and delivery structures. The pace of change was impacting on the ability to make robust decisions and to plan on a long term basis.

It is recognised that the reduction in central oversight, coordination and leadership is in line with the government's aspirations for leaner national structures and greater local determination. However, our independent research raises significant questions around the extent to which the withdrawal of the detail of national direction, knowledge and support at the same time as the implementation of multiple, radical, new policy and public spending ambitions is realistic or manageable.

This is reflected in the advice and consultation material published by DH about the new public health system, where there is very limited reference to substance use in the documentation and few relevant outcomes included in the Public Health Outcomes Framework. This is in many respects remarkable, given that the current spend on drug and alcohol services will represent around a quarter of the total national budget for public health and around a third of local public health allocations.

Overall, the police are further along the road in terms of the budgetary reductions they must make and this report found some difference in their responses in comparison to other agencies.⁶³ For instance, police respondents expected to undertake less partnership working in the future. The findings of our national police survey suggested that there is a view amongst those responsible for drug enforcement that the continuing pressures to save money and identify efficiencies may be leading to a greater focus on policing the issues that are the most visible and pressing in the short-term. The danger is that this could be at the expense of activities which are of long-term and 'deeper' benefit. There was a perceived risk that these shifts in focus might have a negative impact on other key policy initiatives and lead to a vicious circle and, paradoxically, reduced, rather than increased, effectiveness.

⁶³ With the exception of London.

BUILDING RECOVERY-ORIENTED DRUG TREATMENT SYSTEMS

The positioning of the responsibility for drug interventions within public health departments in local authorities was generally welcomed in the sense that it was seen as providing the opportunity for greater focus on prevention and early intervention, as well as improved integration with services, such as employment and housing, which are often key to recovery from drug problems.

The research found significant work reported as taking place to implement the Drug Strategy's vision: nine in ten of the national DAT survey respondents said they were making specific changes to their treatment system to achieve this. Many case study interviewees talked positively about changes to partnerships and of better collaboration and the majority of DAT survey respondents expected to engage more with partner agencies in the future. There was an on-going appetite for inter-agency working and an appreciation of the importance of this in finding efficiency savings and developing new and innovative approaches.

However, the research raises significant questions around the capacity of some local areas to achieve the Drug Strategy's ambitions and create innovative 'whole-system' services and well informed plans in the context of the wide-ranging changes being experienced.

Nearly half of the national DAT survey respondents thought that changes to wider essential support services were having an impact on their ability to deliver a recovery-oriented drug treatment service. Future funding contributions from partner agencies was very uncertain. Churn and re-organisation in these agencies was impacting on the ability to keep in touch with key contacts. Weaker links in partnership working included the Work Programme and mental health services. Early prevention and intervention activities for young people appeared particularly vulnerable to austerity measures.

At the same time, the structures for the delivery and commissioning of drug services, essential to the practical delivery of the Drug Strategy aspirations, were changing and in many cases shrinking: of DAT survey respondents 45% expected the level of time in their organisation that is committed to working on drug-related activities to decrease. Lines of accountability were shifting and increasingly complex.

As the new local public health structures emerge, it is important that the essential partnerships with police and criminal justice agencies, and with mental health and primary care providers, are maintained or strengthened. However, the research identified fragmentation between health and justice structures in the new public health system as a key risk. Many of the emerging Health and Wellbeing Boards did not include criminal justice representation and many respondents expressed concern at this, given the inter-play between substance misuse, mental health problems and crime and justice interests. In many areas it was too early to say how and where substance misuse would fit into new public health systems and structures.

MOVEMENT OF POWER TO THE LOCAL LEVEL

The Government's drive towards the decentralisation of public services is aimed at enabling people to get involved with and direct services leading to the production of locally appropriate strategies. The relaxing of control of national regulation is intended to lead to the development of locally appropriate measures, which take into account change in drug markets and service needs.

However, a number of contradictions were found by the research between the rhetoric around localism and the reality on the ground.

DATs serve two broad communities – that of the service users who need help and the 'wider' community: those local young people, residents, community groups and local representatives broadly unconnected to existing specific interventions relating to drugs. Service user engagement was recognised and valued as an important element in delivering recovery-oriented treatment systems. In the case study areas, and amongst DAT survey respondents, considerable effort was dedicated to supporting and facilitating this engagement. However, the level of engagement with 'wider' communities was largely non-existent in the seven case study DATs.

Previous UKDPC research has shown that the stigma of drug users is a fundamental barrier to the delivery of recovery aspirations as set out in the Drug Strategy, and this was echoed in this research (UKDPC, 2010). Addressing stigma is important to facilitate the recovery from drug use. In straight value for money terms the financial gains made through treatment will be lost if the reintegration of people back into communities is not achieved. Furthermore, many people expressed the view that if public health budgets are tight there is real concern that the money currently spent on interventions for this 'undeserving' group will be diverted to other areas.

Those delivering drug interventions were expecting to become more engaged with their areas and local communities in the future. Yet, a greater localism and decentralisation is predicated on the assumption that the capacities and competencies of local areas and key actors are fit for this purpose. The research raises fundamental questions about the skills and capacities of local partnership areas to do this.

The commissioning of drug treatment is one of 17 responsibilities for Health and Wellbeing Boards. Risks from removing the drugs money ring-fence highlighted by research respondents include the possibility of funding being used to meet the efficiency savings required by local authorities and prioritisation of spend on these services being open to political influence and, as observed above, being spent on more 'deserving' areas. This may be exacerbated by the fact that many of the costs associated with the potential negative consequences that might arise from such disinvestment, e.g. higher crime, more Accident and Emergency attendances, will be borne by other departments.

The case study areas welcomed more scope for local direction of services and spend. Rebalancing of resources, particularly towards greater integration of treatment for alcohol and drug dependence, is likely to be of benefit; however it is important that this is not done in such a way as to jeopardise the gains made in tackling drug problems. Increasing localism needs to be

underpinned by strong safeguards to ensure national priorities will still be delivered and protect the gains in drug treatment and crime reduction that have already been achieved. Without a strong local champion, drug-related issues may be considered a lower priority than other mainstream concerns within both public health and law enforcement. Without proactive and strategic links between criminal justice partners and Health and Wellbeing Boards the scope for effective local leadership is compromised.

Finally, the research found little evidence to suggest that the government's aspirations for a more diverse market of community based, service provider organisations are being realised. Greater austerity is acting against the creation of a more diverse market, with many areas instead drawing together contracts to create economies of scale. The expectation that individuals commissioning and managing treatment and recovery systems will facilitate or develop markets of providers relies on the necessary knowledge and skills base to do so. This raises important questions around the capacity of commissioners, at present, to respond to these expectations.

OPENING UP DRUG SERVICES TO PUBLIC SCRUTINY

In an era of localism, local people need access to information about their local services, which includes how money is spent and to what effect, if they are to be involved in setting priorities and holding services and elected members to account.

While it is welcome that there are commitments in the current Drug Strategy to develop and publish the evidence base on what works, to develop an evaluation framework to assess the effectiveness and value for money of the strategy overall, and to review it on an annual basis, the Strategy avoids specifying specific metrics by which overall success will be evaluated. In addition, the Public Health Outcomes Framework includes few outcomes specific to drug treatment, out of 66 key indicators.

Current evidence suggests that recovery is as varied as the individuals who experience dependence and a range of recovery pathways and support services will be necessary. While there is strong evidence underpinning a range of specific treatment interventions, research to establish how best to deliver recovery-oriented systems to meet the range of needs from the very earliest stages of engagement with services to sustaining recovery is now essential. UKDPC has recommended the inclusion of a clear programme for research development and evaluation of drug strategies and policies alongside the promotion of evidence amongst professionals in future drug strategies (UKDPC, 2012c).

A further challenge is the growing difficulty, under increasing decentralisation and localism, of identifying and managing the costs and benefits of particular policies, when funding may be allocated in one area (e.g. public health) and benefits felt in another (e.g. crime reduction). For instance, the actions of enforcement and criminal justice agencies can have important ramifications for public health systems. Nowhere is this more evident in the substance use and mental health fields. What is not clear from our review is how the government expects those working at the local level to practically handle this dynamic. As we have seen, already some agencies are shrinking back to core business.

The mismatch between organisational boundaries at the local, regional and sub-regional levels amplifies the risks and costs of collaboration, for example between Health and Wellbeing Boards, Police and Crime Commissioners, Clinical Commissioning Groups and the NHS Commissioning Board. It is not clear how national cross-cutting and inter-departmental priorities will be reflected and implemented at the 'local' level and there appears to be no fiscal device to support the 'transfer' of costs and benefits between organisations.

Various initiatives like the Pooled Treatment Budget, the DIP and the Integrated Offender Management programme have in the past sought to achieve better pooling of resources between organisations to encourage collaboration. This is now more difficult to achieve given the lack of clear outcomes or a model for interventions, let alone the necessary spending on monitoring, research and evaluation to underpin any process.

In the case study areas work to understand budgetary allocations for drug and alcohol treatment and their value for money had not been straightforward. Interviewees spoke of the importance of being able to prove the 'added value' of recovery-oriented treatment interventions and of being included in strategic strategies and assessments. Frustration was expressed about the poor evidence base on the value of some recovery-oriented interventions and the difficulty of measuring sustainable benefits, across different service areas.

Perceived opportunities and risks

Our research and review has shown that those working at local levels see a number of opportunities within the new landscape of localism and austerity. However, they also see many potential risks. A summary of the key risks and opportunities identified are summarised below.

Summary of opportunities and risks identified

OPPORTUNITIES

- Movement of public health to the local authority level should encourage better links and integration between many services.
- With the lifting of the drug treatment funding 'ring-fence' there is the chance to rebalance the priority and spend between drug and alcohol treatment services.
- An increased service user involvement should lead to better services and greater recovery focus.
- Increased involvement of the wider community could raise the profile of drug treatment and recovery services.
- Elected member priorities to reduce drug-related crime and anti-social behaviour in their neighborhoods will, in part, be realised through drug treatment services. The latter can help persuade elected members of their value by increasing their visibility.
- Austerity leads to a greater scrutiny of value for money by both commissioners and providers and could lead to better efficiency across some drug interventions and

services.

- There is the opportunity to redesign treatment and recovery services to provide better integration for service users.

RISKS

- Current weaknesses or shortfalls in the operation and delivery of drug interventions may be compounded or exacerbated by the current context and the range of failure may become more extreme – increasing inequalities across the country.
- An increased focus on short-term responses, for example on cutting certain types of drug enforcement interventions or de-commissioning specialist addictions services, may prove to have longer term negative consequences.
- The welcome moves to more focus on longer term recovery could be undermined due to staffing churn and re-organisation within partner agencies and DAT/partnership structures.
- A widely perceived risk that the new Health and Wellbeing Boards and Police and Crime Commissioners may afford lower priority to action to tackle drug problems and hence fewer resources to deal with the problem.
- With the lifting of the Pooled Treatment Budget 'ring-fence' may come an increasing vulnerability of funding within public health and more competition with other public health services.
- An increasing fragmentation of local responsibility for action around drugs, including lack of connection between criminal justice agencies and public health; and also with mental health services and offender health.
- Lack of clarity from Whitehall and corresponding uncertainty at the local level are making it very hard for local players to plan medium to long-term.
- Challenges in communicating to locally elected members the complexity of drug treatment and recovery services and realistic outcomes for communities in short time scales.
- Widespread antipathy and social stigma towards drug treatment service users could lead to shifts in local spending to what are deemed to be more 'worthy' causes, leading to disinvestment and reversal of the health and crime gains from the recent expansion in treatment provision.
- A shortage of good quality data and evidence, especially in enforcement and justice interventions makes it difficult to demonstrate value for money. The lack of data profoundly undermines efforts to look at the totality of interventions and expenditure in order to provide more integrated, comprehensive and sustainable local responses.

Mitigating the risks

Our study has shown that delivery of the national Drug Strategy could be undermined by a number of potential risks for those operating at both the national and local level. Proposals for how these can be mitigated are set out below, divided between those directed at national policy makers and those for people that are working at the local level. We recognise that over the last two decades a number of principles have been established and a plethora of guidance to encourage partnership working has been produced aimed at those responsible for local public services. We do not wish to duplicate those. Our proposals are aimed at ensuring that work to address the problems associated with illicit drugs, continues to be underpinned by an infrastructure that is fit for purpose, and that people will have the skills, capacity and support to continue to deliver the aspirations of the Drug Strategy.

PROPOSALS DIRECTED AT NATIONAL POLICY MAKERS

Our study has shown there is a need for:

1. Improved co-ordination and integration between public health and criminal justice agencies

- Central government (Department of Health, along with the Home Office and Ministry of Justice) should provide a stronger steer with appropriate guidance aimed at ensuring local Health and Wellbeing Boards build proactive and strategic relations with the relevant Community Safety Partnerships, Police and Crime Commissioners and the Police and Crime Panels. For instance, through promoting the reciprocal co-options of people with health and criminal justice expertise (and especially enforcement) respectively onto Panel and Board membership.
- It is important for new collaboration to be stimulated between national professional health bodies (such the Association of Directors of Public Health and the Faculty of Public Health) and their counterparts working in police and justice bodies, around critical issues of mutual interest, such as drug, alcohol and mental health interventions.

2. Development of clearer guidance and improved communication on the detail of implementing policy changes

- We propose that the Home Office, Public Health England, Ministry of Justice and Department of Communities and Local Government initiate a series of regional collaborative learning events, bringing together the new Police and Crime Commissioners, Health and Wellbeing Boards, justice interests and service providers, focusing on the opportunities to develop creative local approaches to drug, alcohol and mental health problems.⁶⁴
- In recognition of the needs expressed by those working at the local level, the Department of Health (through Public Health England) and the Home Office should create more

⁶⁴ The Home Office funded Safer Future Communities Project, delivered by Clinks, is providing a series of regional briefing events to support frontline voluntary, community and social enterprise organisations in preparation for the arrival of Police and Crime Commissioners. www.clinks.org/services/sfc

opportunities to share practice and facilitate learning networks, such as a network for individuals commissioning and managing drug treatment and recovery systems.

3. A nationally managed and co-ordinated resource for authoritative evidence

- The Department of Health should ensure the development and promotion by Public Health England of a single port of call for authoritative sources of evidence relating to substance misuse treatment and recovery interventions, especially around analysis of comparative value for money studies, the collection of data around drug prevention and in providing information on what interventions are proven to be effective.
- The Department of Health should also ensure the inclusion of a strand relating to substance misuse in the activities of the National Institute for Health Research's School for Public Health Research, including studies to establish how best to deliver recovery-oriented services.
- As we have suggested in earlier UKDPC reports, there is a pressing need for the Home Office (and the new National Crime Agency) to set up a substantial programme of research evaluating the impacts of various enforcement efforts to disrupt the drugs trade. Unless this is done, we will never know whether enforcement interventions represent value for money (UKDPC, 2009).

4. Establishment of fiscal incentives to encourage and enable organisations to pool resources to achieve complementary objectives

- We propose that there should be a comprehensive study undertaken to explore the potential for a wider range of fiscal incentives, beyond payment by results, to underpin and stimulate collaborative interventions between police, justice, NHS and public health agencies to address cross-cutting issues such as drug and alcohol problems. Lessons from the Total Place and Justice Re-Investment programmes could be of value in such work. This might most appropriately be commissioned by the Cabinet Office.

5. Setting up of mechanisms for ensuring local commissioners and service providers are adhering to clinical governance and quality standards

- To ensure that drug treatment and recovery services are of the highest quality, and comply with the NHS Constitution, we suggest that Public Health England and the Care Quality Commission develop mechanisms to ensure that the appropriate NICE clinical and quality standards and mechanisms are being applied across the sector.

6. Monitoring and review of the formula relating to drug treatment within new public health ring-fenced funding arrangements

- Public Health England should commission an independent review of the impact of the new formula intended to incentivise local areas to sustain their support for local drug treatment and recovery services and outcomes. This should include consideration of whether there has been any change in the level of local investment in drug treatment and recovery services and whether local areas have been able to sustain performance and outcome levels.⁶⁵ This could also include consideration of any interaction or overlaps with the operation of the proposed Health Premium aimed at encouraging local areas to tackle health inequalities.

PROPOSALS FOR THOSE WORKING AT THE LOCAL LEVEL

There is a need for:

1. A robust understanding, and promotion, of the current evidence base relating to the efficacy and value for money of particular drug treatment and recovery interventions

- Local drug service commissioners, drug treatment and recovery service providers and Directors of Public Health need to be active in promoting the evidence about the effectiveness of different drug interventions and how they enable recovery, including population-wide health and crime reduction benefits.
- It is paramount that Directors of Public Health give priority to the inclusion of local drug and alcohol problems in an area's Joint Strategic Needs Assessment and the local Joint Health and Wellbeing Strategy. Without this, efforts to tackle the problems will be seen as of second-order importance.
- As far as it is possible, local drug service commissioners should be pro-active in initiating links and networks with other commissioners to share knowledge and understanding of the evidence about drug interventions, as well as about the new procurement, operational and contracting arrangements that the movement to a new public health system will entail.
- Many councillors will need further information about what works in tackling drug problems. We believe there is an opportunity for the Local Government Association (LGA) and its constituent networks to act as an influential conduit for getting more and better information to elected council members, as well as Police and Crime Commissioners, about the benefits of evidence-based drug interventions and especially drug treatment and recovery services.

2. Promotion of the joint agenda between Health and Wellbeing Boards and enforcement and justice systems

- Police and Crime Commissioners should be encouraged to establish a joint forum, in addition to Police and Crime Panels, to bring together representatives from local Health and Wellbeing Boards in their Force area to address strategic issues around drug and alcohol problems.

⁶⁵ From April 2012, 20% of the overall national Pooled Treatment Budget allocation to local areas will be based the number of adult drug users that have successfully completed treatment and who have not re-presented to treatment anywhere in England for at least six months. See: www.nta.nhs.uk/uploads/overviewofhowtheptb12-13hasbeenallocated.pdf

- The Director of Public Health has an important contribution to make to the development and implementation of Police and Crime Plans, which will take into account local drug and alcohol issues but this may be complicated by lack of co-terminosity between local authority and police force areas. Directors of Public Health should seek out ways to work with their colleagues in adjacent areas covered by the police force to ensure their contribution is coordinated and comprehensive.

3. Establishment and maintenance of strong relationships with other locally elected officials and key partnership configurations to build support for drug interventions⁶⁶

- Directors of Public Health need to be proactive in engaging with locally elected officials, particularly those that sit on the local Health and Wellbeing Board, Community Safety Partnerships, Police and Crime Commissioners and Police and Crime Panel members, in order to communicate the nature, range and benefits of drug and alcohol intervention services for communities and individuals.
- Directors of Public Health and local drug service commissioners need to ensure that they facilitate the inclusion of drug service user representation on HealthWatch in order that a group of people, traditionally marginalised from decision making, are enabled to have their voices heard in the future planning of public health services.

4. Access to specialist commissioning skills and knowledge of local substance misuse

- Amongst their many responsibilities, Directors of Public Health need to ensure that within the new structures they have access to specialist knowledge and expertise around commissioning and drug treatment and broader recovery interventions in addition to that relating to broader public health approaches.
- Directors of Public Health will need to engage proactively with their counterparts in Clinical Commissioning Groups to avoid fragmentation of responsibility arising from the different commissioning arrangements for individuals with mental health conditions as well as substance misuse problems (DrugScope, Centre for Mental Health and UKDPC, 2012). There is a huge risk such groups will fall between the two systems.

5. Balanced approaches to drug-related enforcement activity

- Senior police officers need to continue supporting and promoting interventions which have deeper long term benefit in disrupting drug markets as well as those that have more immediate and visible benefits. Effective drug enforcement will rely on intelligence gathered by interventions that can include forensic testing and test purchasing in order to keep abreast of rapidly changing drug markets.

⁶⁶ See also an Adfam guide aimed at family support services: Adfam (2012).

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Appendix 1: Groups and individuals consulted as part of the research

PROJECT ADVISORY GROUP MEMBERS

Name	Organisation and job title
Adam Sampson (Chair)	Chief Ombudsman for the Office for Legal Complaints and UKDPC Commissioner
Mandie Campbell	Director of Drugs and Alcohol Directorate, Home Office
Chris Heffer	Deputy Director, Alcohol and Drugs, Department of Health
Colin Bradbury	Head of Delivery, National Treatment Agency
Pete Burkinshaw	Skills and Development Manager, National Treatment Agency
DCI Trevor Williamson	ACPO Drugs Committee Coordinator, Essex Police/ACPO
Laura Wilson	Senior Policy Advisor, Home Affairs Unit, Cabinet Office
David Chater	Team Leader - Substance Misuse and Youth Crime Prevention, Department for Education (corresponding member only)
Tom Woodcock	Strategic Director, Lancashire DAT
David MackIntosh	Policy Advisor, London Drug and Alcohol Policy Forum
Steve Broome	Director of Research, RSA
Dr Marcus Roberts	Director of Policy and Membership, DrugScope
Ian Mulheirn	Director, Social Market Foundation
Glyn Gaskarth	Policy Manager, Local Government Information Unit
Colin Wilkie-Jones	Chief Executive, eATA
Anna Turley	Independent member, Associate Researcher, Future of London
Angela Mawle	Chief Executive, UK Public Health Association
Tom Gash	Fellow, Institute for Government
Aileen Murphie	Director of Home Affairs and Criminal Justice, National Audit Office
Kate Davies	Executive Lead for Equalities, NHS Nottinghamshire County

INDIVIDUALS CONSULTED OR INTERVIEWED

Organisation	Name
National Treatment Agency	Colin Bradbury Corinne Harvey (Yorks and Humber region) Alison Keating (London region) Claire Pennell (West Midlands region)
Home Office	Andy Feist Lauren van Staden Anna Richards Mark Bangs Chris Ashley Ashton Cotier
Cabinet Office	Laura Wilson
Department of Communities and Local Government	Mark Carroll
Mentor UK	Andrew Brown
Local Government Association	Alyson Morley
National treatment provider organisations	Meetings with five individuals at Chief Executive or senior management level

Appendix 2: Criteria used to structure selection of case study areas

The criteria used to structure the selection of the seven case study areas were:

- Change to local authority's overall 'revenue spending power' (low/medium/high scale of reduction) for 2011/12 financial year as compared to the previous financial year (Communities and Local Government data), and:
- Evidence of emerging responses designed to boost localism, change levels of expenditure and establish new partnership configurations. For instance, if they were a pilot area or an exemplar of a particular approach that was relevant to the study's focus.

To further aid selection, it was attempted to represent the following factors in the choice of areas:

- Case study region and if rural or urban.
- Type of local authority.
- Political control of council.
- Contacts within the area already or some existing knowledge of area.

Appendix 3: Case study summaries

City One

Area information

A Labour-controlled urban local authority in the London area. It received a 'high' reduction in overall revenue spending power for 2011/12 financial year as compared to the previous financial year.

The health of people is mixed compared to the England average and deprivation is higher than average (Department of Health, 2011 data). Problematic drug use prevalence estimates suggest that there over 5,500 problem drug users in City One. Around 39% accessed treatment services in 2010/11 (University of Glasgow, 2008/09 and 2010/11 Adult Drug Treatment Plan).

City One has participated in, or is currently piloting, a number of relevant centrally led initiatives aimed at boosting localism, establishing new partnership configurations and testing innovative approaches to the delivery of public services, including criminal justice services.

Summary of drug treatment and recovery system

Responsibility for drug and alcohol treatment and recovery services in the City One area is a joint responsibility between the PCT and LA (at point of research). Commissioners are employed by the PCT but located within a local authority directorate. In 2010 significant service re-design was carried out and a consortia of treatment providers established. Re-design has included service re-alignment to shift greater resources to primary care. Prior to this the system was fairly fragmented with most investment focused on secondary care.

Centrally allocated funding for drug and alcohol treatment and recovery services in 2012/13 was subject to a small decrease.

City Two

Area information

A Labour-controlled urban local authority in the London area. It received a 'medium' reduction in overall revenue spending power for 2011/12 financial year as compared to the previous financial year.

The health of people in City Two is mixed compared to the England average and deprivation is higher than average (Department of Health, 2011 data). Problematic drug use prevalence estimates suggest that there approximately 3,000 problem drug users in City Two, with around 40% engaged in treatment services in 2010/11 (University of Glasgow, 2008/09 and data supplied by City Two).

The area has participated in, or is currently piloting, a number of relevant centrally led initiatives aimed at boosting localism and testing innovative approaches to the delivery of public services, including criminal justice services.

Summary of drug treatment and recovery system

The Drug and Alcohol Action Team is located within the local authority. Services were re-commissioned in 2010 and a multi-treatment provider, multi-system unit was replaced with an integrated drug and alcohol treatment and recovery system led by a voluntary sector provider. From spring 2012 treatment outcome indicators will form part of the treatment contract, these outcomes will need to be achieved by the provider organisation(s) in order to receive full payments from the DAAT.

The DAAT received a significant reduction in centrally allocated funding between 2011/12 and 2012/13.

City Three

Area information

A Labour-controlled city council in the Midlands. A couple of prisons are in the area. It received a 'high' reduction in overall revenue spending power for 2011/12 financial year as compared to the previous financial year.

The health of people in City Three is generally worse than the England average and deprivation is higher than average (Department of Health, 2011). Problematic drug use prevalence estimates suggest that there around 2,600 problem drug users in City Three. Around 44% were in effective treatment in 2009/10 (University of Glasgow, 2008/09 and 2011/12 Adult Drug Treatment Plan Needs Assessment).

City Three participated in a pilot initiative aimed at testing new approaches to the delivery of criminal justice services.

Summary of drug treatment and recovery system

A small DAT based within the local authority but employed by the PCT (at time of research). At point of visit options for re-commissioning the drug treatment system in City Three were being considered, following the identification of significant cost savings in the 2010/11 financial year and some re-organisation of delivery. A year's notice has now been served on the existing NHS provider. The prisons in the City Three area are not within the DAT's commissioning boundaries.

Centrally allocated funding for drug treatment services in City Three increased between the 2011/12 and 2012/13 financial years.

County One

Area information

A county council in the Midlands under Conservative control, with the population split between a number of small urban areas, extensive suburban areas and a range of rural settlements. A number of prisons are in the area. The local authority received a 'low' reduction in overall revenue spending power for 2011/12 financial year as compared to the previous financial year.

Deprivation is lower than average and the health of people in this area generally better than the English average (Department of Health, 2011 data). Problematic drug use prevalence

estimates suggest that there approximately 1,900 problem drug users in County One, with around 75% accessing treatment services in 2010/11 (University of Glasgow, 2008/09 and County One Substance Misuse Treatment Plan 2010/11).

The council has piloted, or acted as an exemplar of, a number of relevant government initiatives aimed at boosting localism, establishing new partnership configurations and testing innovative approaches to the delivery of public services.

Summary of drug treatment and recovery system

A Drug and Alcohol Action Team located within the local authority. A complete system re-design, leading to the re-commissioning of an integrated drug and alcohol treatment and recovery system, was completed in 2011. A voluntary sector provider was appointed and replaced a NHS provider. Prior to re-commissioning, arrangements in place had predated the establishment of the DAAT.

The level of centrally allocated funding that the DAAT received for the 2012/13 financial year held broadly steady from the previous year.

County Two

Area information

A county council under Conservative control in the North of England covering a large number of district council areas and a mix of coastal, rural and urban localities with different economic and social needs. A number of prisons are in the area. The local authority received a 'medium' level of cut to its overall revenue spending power for 2011/12 financial year as compared to the previous financial year.

Deprivation is higher than average and the health of people is mixed compared to the England average (Department of Health, 2011 data). Problematic drug use prevalence estimates suggest that there approximately 6,000 problem drug users in County Two with around 64% accessing treatment services in 2010/11 (University of Glasgow, 2008/09 and Community Drug Partnership Plan 2010/11).

At the time of research County Two had participated in one government initiated policy pilot relevant to the study's focus.

Summary of drug treatment and recovery system

A Drug and Alcohol Action Team hosted by the PCT (at the point of research). The DAAT received a 4% reduction in its centrally allocated funding between 2011/12 and 2012/13. The re-commissioning and modernisation of an integrated drugs and alcohol treatment services, using a 'prime provider' model, whereby one provider organisation acts as a lead over a consortia of other organisations, has been carried out in stages across different localities. The first contracts expire in 2012.

Unitary One

Area information

A unitary authority in the South of England, under no overall political control, covering a dispersed spread of towns and smaller settlements. The local authority received a 'low' reduction in overall revenue spending power for 2011/12 financial year as compared to the

previous financial year.

The health of people in Unitary One is generally better than the England average and deprivation is lower than average, although there are significant inequalities between areas (Department of Health, 2011 data).

Problematic drug use prevalence estimates suggest that there approximately 1,700 problem drug users in Unitary One, with around 70% in structured treatment in 2010/11 ((University of Glasgow, 2008/09 and Community Drug Partnership Plan 2010/11).

Summary of drug treatment and recovery system

A Drug and Alcohol Action Team which, at the time of visit, had recently moved into the local authority and was operating under transitional arrangements responsible to both the PCT and local authority. The drug treatment system had not been re-commissioned since its establishment. Instead, the DAAT led on the re-design of the treatment system from 2009 onwards.

Centrally allocated funding for drug treatment services in Unitary One increased between the 2011/12 and 2012/13 financial years.

Unitary Two

Area information

A Labour-controlled unitary authority in the north of England which covers a large urban conurbation and many smaller commuter towns, rural villages and settlements. The area includes one prison. Unitary Two received a 'high' reduction in overall revenue spending power for 2011/12 financial year as compared to the previous financial year.

The health of people in Unitary Two is mixed compared to the England average and deprivation is higher than average (Department of Health, 2011 data). Problematic drug use prevalence estimates suggest that there over 1,000 problem drug users in Unitary Two, with around 53% engaged in treatment services at 31st March 2010 (University of Glasgow, 2008/09 and Unitary Two Drug Treatment Needs Assessment 2011).

Summary of drug treatment and recovery system

A Drug and Alcohol Action Team located within the PCT (at time of visit). The treatment system is a multi-provider model with a large voluntary sector organisation as the lead contact and operating a central care co-ordination 'hub' which has contact with most clients and brokers the services they receive.

The existing treatment service provider contracts ended at the end of March 2011 however this provision has been extended for 12 months, including a 12 month (pilot) recovery service. The DAAT wish to re-commission services however, due to the transition arrangements relating to the move to public health remaining un-ratified, neither the PCT nor local authority (at point of visit) were willing to take over the procurement commissioning functions.

The DAAT received a significant reduction in centrally allocated funding between 2011/12 and 2012/13.

Appendix 4: Interview schedule

INTRODUCTION

We've been given funding for a year's research project to document the impact of increasing localism and decentralisation, alongside decreasing overall public service expenditure, on activities in local areas to tackle the problems associated with illicit drugs <give the interviewee a copy of the one page summary of the project>

As part of this project I'm visiting a small number of case study areas to gather a depth of information around emerging responses to the new context. Over the next hour or so I'd like to go through a series of questions with you to gather information around four main areas: funding for your service and levels of activities; levels of partnership and inter-agency working (current and future); commissioning activities (if applicable) and decision making and prioritisation around spend and activities in the area you work in.

We're after your perceptions of the impact of the current context on your service and your experience in relation to this. Most questions concentrate on this - although we will ask a small number of questions about the wider context you're working in.

A. To begin, could you briefly describe your role and responsibility, including who you normally work with, please?

EXPENDITURE (CURRENT AND FUTURE) AND LEVELS OF ACTIVITY

This section of the interview asks what is happening to the level of funding and spend for drug related interventions and the impact of this on levels of activity.

A. Thinking about this current financial year, can you tell me what is happening to the level of your organisation's funding for drug related activities, including anything that might be changing in regard to specific sources of funding?

If sources of funding are stopping/being reduced – why? If funding was threatened, how did you manage to retain this?

B. Did you experience any change in funding for activities relating specifically to drugs in the last financial year? If yes, how did it change? Level of funding?/Impact on activities?

C. Do you know what is happening to your level of funding for the next (2012/13) financial year? If yes, how does this compare to this financial year? If no, when is this likely to be decided? If they don't know – why don't they know? What do they think is likely to happen?

- D. Are the level and type of drug related activities currently carried out by your organisation changing? If yes, could you tell me which activities are changing and what specifically is happening to them? Has anything stopped completely? New activities carried out? Why?
- E. Thinking more widely, how do you feel your area of work/drug related activities is faring in relation to other services and activities carried out by your organisation/the council/Police force? Are wider cuts to other services impacting on your work?
- F. Have you seen any evidence of a movement of funds (either in your organisation or in the area you work in) away from drugs to other service areas or priorities?
- G. Related to this, what would you say is the level of priority given to drugs within your area? Choice of high/low/medium. If high, what is the driving force behind this? If low, why?
- H. Where is leadership or driving force with respect to drug-related activity for your work area located? Is there one particular person that is seen as the main driver for the delivery of drug policy or services?
- I. What is your perception of the quality or strength of this leadership? Is it changing? How sustainable are leadership and governance arrangements? What happens if particular individuals leave? Are there structures in place to fill this gap? If none – why and what are the consequences?

PARTNERSHIPS AND INTER-AGENCY WORKING (CURRENT AND FUTURE)

Moving on to look at levels of partnership and inter-agency working in the delivery and funding of drug interventions and how these might be changing.

- A. Who do you/your organisation normally work in partnership with in the delivery and funding of activity? Who are your partner agencies? How do you make links between crime, public health, employment, housing, education, prevention, children and young people's services and social services?(if not specifically mentioned already?) Include CSPs/LSPs and Local Criminal Justice Boards.
- B. Broadly, how strong do you perceive your partnerships to have been?
- C. What community and voluntary groups do you regularly work with? Do you have links with elected members?
- D. What is the involvement of local people in the development and scrutiny of your service area? Does your organisation provide support/training to facilitate the engagement of your local communities? Is this changing? If yes, in what way(s)?
- E. Thinking more broadly, how connected and linked is your organisation to its local community? Do you think there is scope for it to be championed by local areas?

Charting New Waters

F. Currently, is the level of partnership working that you and your service is engaged in changing? If yes, in what ways?

G. Is the location of your organisation/location of responsibility for your work changing? (i.e. moving to LA from PCT). If yes, how much involvement have you, and members of your organisation, had in decisions around this? What is the timeframe for moving forward? If moving to the local authority – are there opportunities arising from this?

H. If re-organisation and the reduction of staff happening – what has been the impact of this? For instance on the delivery of services and on inter-agency working?

I. Thinking about the next 12 months, what additional changes are expected in the level of partnership working and collaboration? Are other new structures being set up currently or planned?

J. Finally, has anything unexpected happened in regard to partnerships? Any new partnerships created that aren't mandated? Are any opportunities arising from the current context?

MARKET AND COMMISSIONING ACTIVITIES

Moving to look at the context in which the commissioning and delivery of services is taking place and if this is changing.

Firstly, are you responsible for commissioning services or do you yourself have to bid to provide services?

If interviewee commissions services:

A. Could you tell me about how services are currently commissioned? Where does the commissioning function sit? How recently were services commissioned? If re-tendered, why? If using outcomes – how did they devise these?

B. Are you changing how you approach commissioning? If yes, in what way? What do you think the impact of this will be?

C. What is the involvement of community organisations in providing activities? Do you encourage the voluntary sector to commission for services? What structures are in place?

D. When commissioning and decommissioning services how do you ensure local communities priorities and needs are taken into account?

E. Is there any training or knowledge that you need?

All interviewees:

F. The stated aim of the coalition government is to increase the numbers and types of bodies involved in the provision of services and, where possible, for commissioners to break contacts

into smaller lots, have you seen any evidence of this happening in your service area? If yes, what type and size of organisations? Are more community providers entering the market? Have you seen evidence of more diversity of provider? Innovation as a result? Evidence of private sector moving into the market?

G. If changing, do you think this will provide people with a better standard of service? What would localism in commissioning and delivery look like? Do you think people have more choice as a result of these changes?

H. Do you think there is scope for a greater level of involvement of community organisations in the provision and delivery of drug related services?

I. Has your organisation considered other new ways of working (that has not been covered by previous questions?) or alternative models of financing?

DECISION MAKING AND PRIORITISATION

In the final section of the interview I'd like to look at the type of data that is collected in your area, the way in which decisions and priorities around spend and activities are being taken in relation to your area of work and the level of community engagement and involvement in this.

A. Is the regulation and monitoring of your service area changing? If yes, in what ways?

B. What information is available to local people to track the quality of services provided to them, including data on how money is spent and to what effect? Do you anticipate the availability of this data to change in future?

C. What involvement have you, and members of your organisation, had in regard to decisions about priorities around your future spend and activities? At what points have you/members of your service been involved? (What does the decision making journey look like currently?)
Level/seniority of people involved? Are there any key people/organisations missing?

D. What scope do local communities have to get involved with decisions? Are they engaged in the discussions about allocations to resources to these services?

E. In your experience, are there any disconnects between local and national priorities? Are there any disconnects between the priorities of your service area and local communities? If there are tensions, how is this mitigated? How balance different needs?

F. Do you know what information and evidence has been used to make decisions about priorities for your service area in the current context?

G. Has an equalities impact assessment been carried out? How are risks being taken into account by the decision making process? How would risk be recognised? How is it being managed?

Charting New Waters

H. If disinvestment in your service is happening – how are these decisions being taken? Who is involved? How weigh up who misses out? Do you know how the case is being made to local people?

I. Are there any groups that you are think are being/will be particularly affected? How are marginal voices being taken into account?

J. Are the long term impact of these decisions being considered? In what way? What mechanisms are being set up to track outcomes and feed into decision making processes? Are recovery outcomes linking to other services?

K. Is anything happening that wasn't expected as a result of these decisions being taken?

L. Finally, is there anything that you would like from central government that you are not getting?

Do you have any other comments/observations you would like us to record?

Appendix 5: National survey of English Drug Action Teams

A short survey looking at the perceived impact of increasing austerity and localism on drug treatment funding, commissioning, partnership working and decision making was issued to 142 English Drug (and Alcohol) Action teams.⁶⁷ This was completed by 43% of DATs. The results to the closed questions are provided below.

Do you work as part of a:

Answer Options	Response Percent
Drug Action Team	9%
Drug and Alcohol Action Team	69%
Community Safety Partnership	12%
Other	9%

Please tell us what is happening, and what you expect to happen, to the level of overall funding available to your DAT (or your local equivalent):

Answer Options	A major increase in funding (%)	Funding to increase a little (%)	Level of funding to stay essentially the same (%)	Funding to decrease a little (%)	A major decrease in funding (%)	Don't know (%)
In THIS financial year (2011/12)	7	8	37	42	5	2
In NEXT financial year (2012/13)	0	7	15	52	13	13

If the level of available funding is expected to change in the next financial year (2012/13) is this because of a change in: (respondents could choose all that apply):

Answer Options	Response (%)
The Pooled Treatment budget allocation?	75
The Drug Interventions Programme allocation?	62
Funding for prison-based substance misuse treatment?	5
PCT/health mainstream funding?	47
Financial contribution from the Community Safety Partnership?	37
Financial contribution from the police?	8
Financial contribution from adult social care?	35
Financial contribution from children and young people's services?	12
Financial contribution from probation?	10
Funding for alcohol treatment services?	15
Financial contribution(s) from other organisations or funding source?	10

⁶⁷ Survey distributed to the DATs for which accurate contact details were available.

Please tell us what is happening, and what you expect to happen, to the level of staff time in your organisation that is committed to working on drug-related activities:

Answer Options	Response (%)
A major increase	6
Increase a little	3
Time committed to stay broadly the same	36
Decrease a little	25
A major decrease	20
Work to stop altogether/DAT to be disbanded	5
Don't know	5

Please tell us which statements apply to your area's drug treatment system (respondents could choose all that apply):

Answer Options	Response (%)
Expecting to start work on the re-design, or re-commissioning, in the next 12 months	19
Currently in the process of re-design, or re-commissioning	48
Recently (within the last 12 months) re-designed or re-commissioned	20
Re-designed or re-commissioned system in the last 2 years	19
Would like to re-commission but it is not currently possible due to uncertainty about future budgets and/or structures	5
Partial re-design or re-commissioning	14
Re-design/re-commissioning to establish an integrated drug and alcohol service	9

Please tell us about your DAT's (or local equivalent) current level of engagement and partnership working with the following organisations and programmes:

Answer Options	A lot of engagement (%)	A little engagement (%)	Virtually no engagement (%)
Local clinical commissioning groups	22	45	33
PCT cluster	37	44	19
The National Commissioning Board	0	8	92
Youth services	39	47	15
The Work Programme	13	53	34
Schools and Academies	10	55	36
Housing services (not including Supporting People)	27	62	11
Supporting People	60	38	2
Mental health services	41	52	6
Local police force or command unit	72	28	0
Prisons and probation	77	23	0
Treatment providers	95	5	0
Service users (including self-help/recovery groups)	83	17	0
Families of service users	45	47	8
Local community organisations	32	59	10
Elected members/Councillors	27	52	22

Please tell us what you expect to happen to this level of engagement over the next 12 months:

Answer Options	Increase a lot (%)	Increase a little (%)	No change (%)	Decrease a little (%)	Decrease a lot (%)
Local clinical commissioning groups	33	47	20	0	0
PCT cluster	19	30	43	6	2
The National Commissioning Board	7	38	52	2	2
Youth services	7	17	76	0	0
The Work Programme	10	38	48	2	2
Schools and Academies	2	20	72	7	0
Housing services (not including Supporting People)	14	36	50	0	0
Supporting People	11	19	65	5	0
Mental health services	9	36	52	3	0
Local police force or command unit	5	16	73	6	0
Prisons and probation	10	21	68	2	0
Treatment providers	11	17	72	0	0
Service users (including self-help/recovery groups)	16	36	48	0	0
Families of service users	17	36	47	0	0
Local community organisations	16	41	44	0	0
Elected members/Councillors	19	33	48	0	0

The following is a list of changes that we have been told may be happening in local areas. Over the last 12 months, have you observed any of the following in your area? (respondents could choose all that apply):

Answer Options	Response (%)
Drawing together of treatment contracts to create economies of scale	56
Movement away from large NHS providers to voluntary sector provider organisations	33
Involvement of an increased number, or diversity, of drug treatment providers in the market	19
Significant decline in funding for young people's substance misuse TREATMENT services	41
Significant decline in funding for young people's substance misuse PREVENTION services	51
Significant decline in funding for other services that might have an impact on young people's drug use	44
Increase in difficulty in accessing mental health services for drug service clients	30
Increased involvement in local communities in local work around drugs	41
Increased priority given to alcohol services	73
Decreased priority given to alcohol services	0
Increased priority given to drug services	3
Decreased priority given to drug services	12

Significant change in funding for early intervention activities	16
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Are you making any specific changes to your treatment system to make it more recovery-oriented?

Answer Options	Response (%)
Yes	89
No	8
Don't know	3

Are changes to wider support services and sectors, for instance the voluntary and community sector, mental health, housing and youth services, having an impact on your ability to deliver a recovery-oriented drug treatment service?

Answer Options	Response (%)
Yes	47
No	29
Don't know	24

Please tell us about your level of involvement in decision making around the future funding and direction of drug-related interventions/activity in your area and your perception of your ability to influence future decisions:

Answer Options	A lot (%)	A little (%)	Not at all (%)
Extent of INVOLVEMENT in decision making about future funding and direction of drug-related activity	70	31	0
Extent you feel able to INFLUENCE decisions about future funding and direction of drug-related activity	53	45	2

How much do you know about where your DAT (or local equivalent) will sit in relation to future public health structures (Health and Wellbeing Board and Clinical Commissioning Groups)?

Answer Options	Response (%)
A lot	37
A little	49
No information at all	14

Appendix 6: Timeline of key developments in UK drug policy, including national strategies, funding arrangements and accountability mechanisms

1983: Department of Health Central Funding Initiative for Drug Services expanded the provision of drug treatment services by the voluntary sector.

1985: Creation of Cabinet Ministerial Sub-Committee on Drug Misuse and District Drug Advisory Committees. Publication of the Home Office's 'Tackling Drug Misuse' strategy document.

1986: NHS Drug Advisory Service of England and Wales established to evaluate local drug services (later becomes Substance Misuse Advisory Service, subsequently subsumed into the National Treatment Agency). Department for Education funding for local Drug Education Coordinators in Local Education Authorities to coordinate and promote drug education and prevention in schools.

1990: Home Office Drugs Prevention Initiative (DPI) in 20 localities in England, Scotland and Wales, piloting a community-based approach to drugs prevention.

1995: 'Tackling Drugs Together' White Paper published. Creation of Drug Action Teams (DAT) and funding for local DAT coordinators and establishment of a small Central Drug Coordination Unit located in the Cabinet Office. 12 local Drug Prevention Teams in England established.

1998: New role of the Drug 'Czar' and UK Anti-Drugs Coordination Unit established in the Cabinet Office to replace the Central Drug Coordination Unit. 'Tackling Drugs to Build a Better Britain: The Government's ten-year strategy for tackling drugs misuse' published. Establishment of local Crime and Disorder Reduction Partnerships.

1999: Publication of the UK's Anti-Drugs Co-ordinator's Annual Report 1998/99 (which also sets out UK Performance Targets for 2005 and 2008). Commitment of substantive new local funding, via the Comprehensive Spending Review, for drug treatment, criminal justice interventions and drug education and prevention.

2000: Publication of the UK's Anti-Drugs Co-ordinator's Second National Plan 2000/2001, setting out local performance targets. Drug Prevention Advisory Service (DPAS) replaces DPI.

2001: Establishment of the National Treatment Agency (NTA) and regional NTA teams. Setting up of the local Pooled Treatment Budget. Drug 'Czar' and Anti-Drugs Coordination Unit moved to the Home Office from Cabinet Office. DATs realigned with local authority boundaries. Proceeds of Crime Bill and Communities Against Drugs Fund established .

2002: Publication of updated Drug Strategy. Resignation and abolition of the role of the Drug 'Czar'. Creation of the Drugs Strategy Directorate in the Home Office to replace the UK Anti-Drugs Coordination Unit. Regional Government Office teams replace DPAS. Department of Work

and Pensions Progress 2 Work programme which includes assistance to improve the employability of those recovering from problem drug use.

2003: Criminal Justice Act replaces the Drug Treatment and Testing Order with the Drug Rehabilitation Requirement. Establishment of the Criminal Justice Intervention Project (to become the Drug Intervention Programme). Establishment of the Building Safer Communities Fund and FRANK public information campaign. Introduction of the DIP. Establishment of the Supporting People programme which includes housing support for drug users.

2004: Establishment of Local Strategic Partnerships and three Public Service Agreement targets for the Drug Strategy. Publication of 'Tackling Drugs. Changing Lives' which sets out progress made in delivering the Drug Strategy and planned action for the period to 2008, accompanied by increases in local expenditure under the 2004 Comprehensive Spending Review. Publication of 'Every Child Matters: Change for Children.'

2007: Merger of Government Office drug teams and NTA regional teams. Comprehensive Spending Review 2007 provides additional funding for drug treatment.

2008: Department of Health funding to support Drug Coordinators in Jobcentre Plus offices.

2010: Publication of 2010 Drug Strategy 'Reducing Demand, Restricting Supply, Building Recovery.' Publication of 'Policing in the 21st Century' and 'Healthy Lives, Healthy People' White Papers.

2011: Introduction into Parliament of the Health and Social Care Bill, setting up Public Health England and integration of the functions of the NTA into it from 2013. Police Reform and Social Responsibility Act sets up Police and Crime Commissioners from 2012. Establishment of Early Intervention grant replacing a number of Department for Education funding streams including the Children's Fund, Young People Substance Misuse and Connexions.

Appendix 7: About UKDPC

The UK Drug Policy Commission (UKDPC) is an independent body providing objective analysis of evidence related to UK drug policy. It aims to improve political, media and public understanding of drug policy issues and the options for achieving an effective, evidence-led response to the problems caused by illegal drugs.

The views, interpretations and conclusions set out in this publication are those of the authors and are not necessarily those of the UK Drug Policy Commission.

UKDPC brings together senior figures from policing, public policy and the media along with leading experts from the drug treatment and medical research fields:

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