Advocating for treatment and recovery at the strategic level

Lessons from a roundtable of commissioners

On behalf of the Recovery Partnership

Introduction

The 2010 *Drug Strategy*[1] makes a commitment to support communities to "build networks of 'Recovery Champions' who will spread the message that recovery is worth aspiring to and help those starting their journey." It envisages the creation of 'Recovery Champions' in local areas, and this includes 'strategic recovery champions' – people in strategic positions, such as Directors of Public Health (DPH) and substance misuse commissioners, to promote systems which are both evidence based and 'recovery oriented'.

This briefing is part of a programme of work conducted by DrugScope on behalf of the Recovery Partnership, which considers the challenges and opportunities associated with advocating for treatment and recovery at the strategic level, seeks to share good practice and offers support to those occupying strategic positions in the drug and alcohol sector.

It brings together the findings from the initial part of the project, which include telephone discussions with commissioners and a roundtable event held in March 2015, attended by drug and alcohol commissioners from around England. In addition to acknowledging the challenges that substance misuse commissioners face, it also includes some suggestions of how commissioners might make the case for substance misuse treatment at a time of budgetary constraints and competing public health and social priorities.

It considers the challenges that drug and alcohol commissioners face in making the case for engagement with and investment in the sector, challenges which may include budgetary constraints at a time of austerity, the existence of competing priorities in public health, and the difficulties associated with building and sustaining effective partnerships. However, roundtable participants shared many examples of good practice in attempts to overcome these challenges, and these represent the focus of this paper. Case studies, developed with commissioners from Lancashire and Sutton, offer two examples of how this has been achieved in practice. The paper concludes with recommendations for drug and alcohol

1 Home Office (2010) *Drug Strategy 2010: Reducing demand, restricting supply, building recovery.* Accessed online at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf

commissioners looking to make the case for the sector at the strategic level, and signposting to resources which may be useful to this end.

Context

There was a recognition among the participants at the roundtable that the drug and alcohol commissioning landscape is changing. Not only has there been greater integration of drug services with alcohol services, but the *Review of drug and alcohol commissioning*[2] conducted by Public Health England (PHE) and the Association of Directors of Public Health (ADPH) indicates that many local areas are exploring greater integration of substance misuse services with related fields, such as housing, criminal justice, and mental health. This shift brings with it opportunities for commissioners – to build new partnerships in ways which address local need, for instance, and to offer better joined-up support for people with multiple and complex needs.

Building partnerships

However, the current commissioning environment also presents a number of challenges for those advocating for treatment and recovery in strategic roles. While the nature and degree of partnership work was characterised by considerable variation, many roundtable participants reported that building effective partnerships can be extremely challenging. In a context of budgetary constraints across the public sector, limited resources and competing priorities, it was put forward that potential partners do not always have the capacity to engage on a meaningful level with the substance misuse agenda. In addition, where investment in drug and alcohol services has been deprioritised at a local level, it was suggested that potential partners may be less likely to engage proactively with the sector, particularly given the risk of retrenchment at a time of financial challenge for public services.

Some commissioners present reported that GPs and pharmacies can be difficult to engage with, they have their own duties to fulfil and targets to meet, and substance misuse is not their primary concern. Others noted that Community Rehabilitation Companies (CRCs) and Police and Crime Commissioners (PCCs)

2 Public Health England and the Association of Directors of Public Health. *Review of Public Health Commissioning*. Accessed online at http://www.nta.nhs.uk/uploads/review-of-drug-and-alcohol-commissioning-2014.pdf

consider substance misuse beyond their remit, and some expressed the concern that Clinical Commissioning Groups (CCGs) are not active participants or well engaged with the substance misuse agenda. However, other participants said that GPs, CCGs, and PCCs had been important sources of support for the substance misuse agenda in their own local areas, even providing funding for specific projects that meet these partners' agendas. One example cited was the provision of funding from a CCG to a substance misuse team, to work towards reducing alcohol related hospital admissions.

Budgetary constraints and reduction in capacity

Respondents to the survey of commissioners conducted by PHE and ADPH reported that maintaining sustainable drug and alcohol services in the face of uncertainty surrounding future funding, including the potential impact of removing the ring-fence on the public health grant, represents a significant challenge.[3] DrugScope's *State of the Sector 2014-15* survey suggests that these concerns are shared by many service providers. 60 community services and 11 residential services reported a decrease in funding over the previous year, compared to only 17 and 11 reporting an increase respectively.[4]

According to the *State of the Sector 2014-2015* survey, 53% of respondents reported a reduction in front line staff, and 40% reported a reduction in back office staff and managers. Several participants at the roundtable reported that the drug and alcohol teams in their areas had also experienced significant capacity reductions, with one commissioner reporting that with the transition to public health in April 2013, their Drug and Alcohol Action Team (DAAT) decreased from 20 people to 2.5 people. Similar concerns surrounding the capacity of commissioning teams were also identified as a key challenge for commissioners in the PHE/ADPH survey. More recent research found that Directors of Public Health (DsPH) have also expressed concerns about the potential removal of the ring-fence on the public health grant, and are experiencing difficulties in making the case for investment in public health more broadly.[5]

3 Public Health England and the Association of Directors of Public Health. *Review of Public Health Commissioning*. Accessed online at http://www.nta.nhs.uk/uploads/review-of-drug-and-alcohol-commissioning-2014.pdf
4 DrugScope (2015) *State of the Sector 2014-15*. Accessed online at http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/SoSFinal2015.pdf
5 Willmott, M., Womack, J., Hollingworth, W. and Campbell, R. (2015) *Making the case for investment in public health: experiences of Directors of public Health in English local government.* Journal of Public Health. *Accessed online at http://jpubhealth.oxfordjournals.org/content/early/2015/03/15/pubmed.fdv035.short?rss=1*

Competing priorities

Another key challenge communicated by many of the commissioners at the roundtable was making the case for substance misuse treatment and recovery within a context of multiple agendas in public health and related areas, such as obesity, smoking cessation, children and families, and community safety. While reducing harmful drinking and smoking cessation are listed among PHE's seven priorities for the next five years[6], drug misuse and treatment does not feature in this list.

The inclusion of the new condition attached to the ring fenced public health grant for 2015-16, which states that local authorities should seek to improve the take up of and outcomes from drug and alcohol treatment services[7], is welcome. So too is the inclusion of the drug treatment indicator as part of the Health Premium Incentive Scheme, to reward local authorities for health improvements in this area[8], though the efficacy of both of these are untested Commissioners need to consider the many ways in which addressing drug and alcohol problems contributes to other public health priorities and outcomes. Developing creative approaches of this kind has the potential to deliver outcomes across the public health agenda while also reducing expenditure.

Many participants at the roundtable recognised valuable and innovative approaches to treatment and recovery that emerged in their local areas outside of traditional commissioning structures. For instance, commissioners referred to peer -led recovery groups which they felt were making an important contribution towards helping people to develop sustained recovery and engage with the wider community. While some commissioners reported that they have been able to support these projects, it was also noted that supporting non-traditional initiatives such as peer-led projects can involve taking calculated risks.

6 Public Health England (2014) *From evidence into action: opportunities to protect and improve the nation's health.* Accessed online at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf
7 Department of Health (2014) *Local Authority Circular 17th December 2014*. Accessed online at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388172final_PH_grant_determination_and_conditions_2015_16.pdf
8. Department of Health and Public Health England (2015) *Health Premium Incentive Scheme. Response to Technical Consultation.* Accessed online at *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/410815/health-premium-respons.pdf*

Encouragingly, participants at the roundtable shared many examples of ways in which they have worked strategically to address these issues, and in doing so continue to make the case for drug and alcohol treatment and recovery effectively within a challenging context.

Making recovery visible

With less political focus on substance misuse, commissioners highlighted the importance of making recovery visible to others in strategic positions, including Directors of Public Health and Police and Crime Commissioners, in order to

Case Study: Engaging strategic recovery champions in Lancashire

Over recent years, commissioning in Lancashire has seen the growth of recovery orientated treatment provision, the development and growth of an independent and visible recovery community and the development of a new recovery infrastructure organisation. This approach has been driven by a strategic view that recovery cannot be commissioned, but those occupying strategic positions can commission the space for recovery to develop and grow into an independent, sustainable and diverse community; recovery is not something treatment services do to people, it is what people do for themselves.

The visible recovery community is built in part on the success of the Lancashire User Forum (LUF). The LUF is one of the biggest recovery forums in the country, meeting both on a locality basis (North, East and Central Lancashire) but also on a county basis, and this has developed into a mini conference every two months. Emerging out of the LUF and the Recovery Infrastructure Organisation (RIO), delivered by Red Rose Recovery, are a number of volunteer activities such as 'flash' community clean ups. Commissioners have also created a 'building recovery in communities' (BRIC) fund which is managed by the recovery community itself, and has been used to fund events, new groups including family forums, social enterprises, and sporting activities.

The reality of asset-based commissioning has proved attractive and has been crucial in enabling the development of strategic recovery champions. The Director for Public Health in Lancashire gave up a day of his schedule in 2014 to do a 'deep dive' into treatment and recovery, to witness first-hand the reality of recovery oriented treatment, the role of peer mentors and the achievements of the broader recovery community, including social enterprises.

Attention from other national figures has included the PHE Recovery Lead, Chief Executive of PHE Duncan Selbie, Members of Parliament, the Minister for Public Health, the head of Civil Service and Lancashire County Council's Chief Executive, and this attention has significantly increased 'buy in' at the strategic level.

This positive attention has been beneficial for all involved, particularly the recovery community itself which has had its identity and achievements affirmed.

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generate support for and investment in the work of the sector. It was emphasised that data on treatment penetration and outcomes is an indispensable means through which to demonstrate the value of the drug and alcohol system, but that it is also important to expose others in strategic positions to the value of recovery more broadly. While this may be more difficult to quantify, it was suggested that physically showing these individuals the work that drug and alcohol services and recovery communities do can be an effective means through which to get them on board with the treatment and recovery agenda.

Despite the frustrations that some commissioners had experienced in their attempts to sustain existing strategic partnerships and build new ones, several roundtable participants emphasised the value of continued efforts in this area.

Supporting other agendas

A widely expressed view at the roundtable was that a crucial aspect of making the strategic case for drug and alcohol treatment and recovery is to show that addressing substance misuse helps to deliver on other agendas which are

Case Study: The Accident and Emergency (A & E) pilot at St Helier Hospital, Sutton: A change to the norm.

Sutton drug and alcohol commissioners have developed a pilot which aims to give drug and alcohol workers access to patients in A & E departments, ensure all patients entering A & E with drug and alcohol related needs are seen by a professional, and reduce drug and alcohol related re-entry to A & E. The key criteria for this pilot was that all key stakeholders would be on board and would be passionate about its success.

Initially commissioners met with the Urgent Care Board to ascertain the level of buy in, and met a motivated team of staff, from the ambulance team to the head of urgent care. Commissioners met with A & E staff regularly and, due to the interest in the plan from the first consultant for A & E, more consultants as well as frontline staff and administrative staff joined the meetings to give their views. The commissioners were clear that they wanted all members of the A & E team on board as they all play a crucial role in the patient pathway. The administration manager and her team provided important support in the production of statistics that could be measured against the next year, and the final Project Initiation Document (PID) was produced.

Setting this up was more complex than just attending meetings and writing a PID. Ensuring that everyone remained motivated and saw the worth of the project involved several steps:

- Arranging intervention and brief advice training for all local providers
- Negotiating funding for emergency sickness cover for A & E
- Regularly meeting with all of the team at their chosen venue
- Agreeing alterations up to the date of commencement and convening regular meetings to ensure change was continuous
- Paying consultants to attend meetings so they can cover their absence
- Organising further training to include novel psychoactive substances (NPS), chemsex, men who have sex with men (MSM), blood borne viruses (BBV), HIV, hepatitis C, and harm reduction so that all staff have a chance to

engage in effective training which was Continuing Professional Development (CPD) certified

- Extending the pilot to include a ward liaison post, so that those clients who are admitted to the wards from A & E receive the same service as those in A & E.

The project is still subject to evaluation. Whether or not it generates a decrease in the amount of re-entry to A & E, the pilot will at least ensure that everyone who enters A & E with drug or alcohol related needs will be seen by a professional at the most likely time for them to engage – no one will enter A & E and not be followed up, and no one will be admitted to the wards at St. Helier and not seen by a senior clinician, assessed, followed through and kept engaged within services.

In the experience of the commissioner leading the pilot, the most relevant points for any commissioner or service engaging with external stakeholders are:

- Work closely with external stakeholders on projects which will affect them is essential
- Be proactive: go to meetings and talk to the people you need to engage (some people will get on board because of their belief in you as an individual, as much as their belief in the role)
- Always consider advice provided and re-write documents as many times as needed to get them right
- Work with the service professionals
- Keep working with the team to ensure the idea continues to develop
- Work the occasional weekend to help engage with the work of the team
- Show appreciation towards the other key stakeholders for their work on your project.

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considered to be local or national priorities. It was suggested that this is particularly important in attempts to build or sustain partnerships at a time when most potential partners are working with limited resources.

Commissioners suggested that in order to do this, they had attended meetings held by potential partners, some of which were not directly relevant to their own work (GPs meetings, for instance). These meetings could function as a platform from which to advocate for treatment and recovery, and to convince potential partners that engaging with the substance misuse agenda could help them to meet their own agendas.

Making the 'value for money' case

Participants at the roundtable emphasised the need to demonstrate the value for money of drug and alcohol interventions when making the case for treatment and recovery. PHE suggest that focusing on social return on investment (SROI) can help local authorities to make informed decisions about public spending, and that it is crucial the substance misuse sector shows local decision makers where investment in the sector contributes to public health, social care, and community safety outcomes.[9] In order to conduct an SROI analysis, the relationship between the inputs (for instance financial investment or paid/volunteer work), outputs (including the number of people receiving and completing treatment), and outcomes (for example improved health and reduction in criminal activity) of drug and alcohol interventions must be illustrated. The outcomes must also be evidenced and given a value so that the SROI may be calculated.[10]

It was also highlighted that the drug and alcohol sector has been extremely successful in the past in demonstrating value for money, particularly with regard to HIV/AIDS and reducing rates of acquisitive crime. Some commissioners emphasised that these kind of cost-benefit arguments can be given new focus and force where information and communication resources spell out the health, social, and economic costs of disinvestment. Commissioners wishing to present the bigger picture on treatment and recovery and caution against the risks of

9 Public Health England (2015) *A guide to social return on investment for alcohol and drug treatment commissioners.* Accessed online at http://www.nta.nhs.uk/publications.aspx

10 More information on calculating SROI can be found in the PHE guide, which can be accessed at this link: http://www.nta.nhs.uk/uploads/a-guide-to-social-return-on-investment-for-alcohol-and-drug-treatment-commissioners.pdf

disinvestment may find DrugScope's *Making the Case* guide[11] and PHE's *Local Value for Money and Cost Effectiveness tools*[12] useful.

Conclusions and Recommendations

Drug and alcohol commissioners face a number of challenges in their attempts to maintain and increase investment in and engagement with the sector, including budgetary constraints, competing public health priorities, and difficulties around building effective partnerships. While the scale of this challenge should not be underestimated, encouragingly participants at the roundtable were able to share many examples of good practice and suggest ways in which these challenges might be addressed.

Key recommendations for commissioners looking to advocate for drug and alcohol treatment and recovery that emerged from the roundtable include:

- Make the impact of treatment and recovery visible by showing others in strategic roles promising services and initiatives. This might include councillors, the DPH, PHE representatives or individuals from related sectors, for instance PCCs.
- Demonstrate that drug and alcohol interventions can support other agendas and function as vehicles for the delivery of broader health and social outcomes – which might include reductions in criminal activity or alcohol related hospital admissions.
- Map out the variety of ways in which drug and alcohol services can deliver to public health, social inclusion, and criminal justice outcomes.
- In order to build partnerships, attend the meetings of potential partners (GPs, for instance) and utilise these meetings as a platform from which to make the case for the drug and alcohol sector.
- In order to sustain projects with external partners, work collaboratively with the relevant partners so they have a say in work that will affect them.

11 DrugScope (2014) *Making the Case: A practical guide to promoting drug and alcohol treatment and recovery services locally*. Accessed online at http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/MakingTheCase.pdf

12 Public Health England (2014) *The Local Value for Money and Cost-Effectiveness Tools: Demonstrating the return on investment of drug treatment*. Accessed online at http://www.lho.org.uk/Download/Public/18361/1/140129%20London%20K&I%20network%20-%20Virginia%

- Demonstrate the value for money that drug and alcohol treatment represents, potentially focusing on SROI, and consider mapping out the health, social, and economic consequences of disinvestment in substance misuse., as well as using the available cost benefit analysis and information and communications resources

Resources:

Alcohol Concern, Centre for Mental Health, and DrugScope *Making recovery a reality in your community* - A briefing for commissioners of mental health, drug and alcohol services. http://www.centreformentalhealth.org.uk/pdfs/recovery_dual_diagnosis_paper_2013.pdf

DrugScope's *Making the Case* - A practical guide to promoting treatment and recovery http://www.drugscope.org.uk/POLICY+TOPICS/Making+the+case+for+drug+and+alcohol+services

PHE tools to help local areas develop JSNAs and joint health and wellbeing strategies and to communicate the benefit of investing in drugs and alcohol treatment locally http://www.nta.nhs.uk/healthcare-JSNA.aspx

PHE *Guide to social return on investment for alcohol and drug commissioners* http://www.nta.nhs.uk/uploads/a-guide-to-social-return-on-investment-for-alcohol-and-drug-treatment-commissioners.pdf

PHE *The Local Value for Money and Cost-Effectiveness Tools: Demonstrating the return on investment of drug treatment*. http://www.lho.org.uk/Download/Public/18361/1/140129%20London%20K&I%20network%20-%20Virginia%20Musto%20-%20PHE%20drugs%20treatment%20value%20for%20money%20tool.pdf

Appendix

The roundtable on advocating for recovery and treatment at a strategic level took place on Tuesday 10th March 2015 at The Guildhall, London, 2pm – 4.30pm. DrugScope would like to thank the Guildhall and the London Drug and Alcohol Policy Network for hosting the event, and the participants of the roundtable for their valuable contribution to this briefing.

Attendees

Andrew Brown, DrugScope (Presentation)

Julanta Carriere, Waltham Forest

Anne Charlesworth, Rotherham

Andy Collins, Doncaster

Lauren Garland, DrugScope

Nick Germain, Doncaster

Rebecca Hayden, Sutton (Local overview)

Elaine Hopwood, Dudley

Paul Jessop, DrugScope

Will Johnston, Warwickshire

Chris Lee, Lancashire (Presentation)

David MackIntosh, London Drug and Alcohol Policy Network (Chair)

Steve O'Neill, Gloucestershire (Local overview)

Michael Pierce, Merton (Local overview)

Katherine Reid, West London Tri-Borough

Dr Marcus Roberts, DrugScope

Kathryn Scott, Hackney

Carole Sharma, Federation of Drug and Alcohol Professionals

Bhavna Taank, Telford and Wrekin

Rosie Winyard, Worcestershire

James Yallop, Sutton

About DrugScope and the Recovery Partnership

DrugScope is the national membership organisation for the drug and alcohol field and is the UK's leading independent centre of expertise on drugs and drug use. We represent more than 300 member organisations involved in drug and alcohol treatment, supporting recovery, young people's services, drug education, prison and offender services, as well as related services such as mental health and homelessness. DrugScope is a registered charity (number 255030). Further information is available at: http://www.drugscope.org.uk/

DrugScope, the Recovery Group UK and the Substance Misuse Skills Consortium formed the Recovery Partnership in May 2011 to provide a new collective voice and channel for communication to ministers and officials on the achievement of the ambitions set out in the 2010 Drug Strategy. The Recovery Partnership is able to draw on the expertise of a broad range of organisations, interest groups as well as service user groups and voices. More information is available at: http://www.drugscope.org.uk/partnersandprojects/Recovery+Partnership

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Recovery Partnership

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By DrugScope on behalf of the Recovery Partnership