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Informing Policy with Evidence



‘Feast or famine.’

Barriers and solutions to
deploying one-year funding
for the Universal Grant and
Inpatient Detoxification

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**P R A Partnership for
E P A REsponsive
L R E Policy
REsearch**

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Executive summary

Context

Dame Carol Black's Review of Drugs highlighted the rise of local accountability for commissioning, the reduction of treatment budgets, and the deskilling of the treatment workforce as key drivers for worsening drug outcomes across multiple domains. Of particular concern are record levels of deaths from drug poisoning, and significant problems with crime. Whilst the association between heroin use and acquisitive crime has been long documented, the rising dominance of 'county lines' and organised crime within the class A drug market mean that these drugs are now also associated with up to half of all homicides.

In its response to the Black Review, the Government highlighted an announcement made in January 2021 to make £80m available to improve drug treatment in England for the most marginalised populations over 2021-22: 'the largest increase in drug treatment funding for 15 years' (HM Govt 2021). This included the £55m, one-year 'Universal Grant,' divided between Local Authorities (LAs) based on indicators of treatment need, and focused specifically on opiate users, harm reduction and criminal justice pathways; and a smaller fund intended to revitalise in-patient detoxification (IPD) through grants awarded to regional and sub-regional consortia.

This study was commissioned to understand how this influx of one-year funding – comprising 20% of some LAs' annual treatment budget – had been deployed. Specifically, what had been the barriers to deploying funding, and what solutions had LAs found for overcoming these barriers?

Methods

Using a maximum variation approach to purposive sampling, 60 semi-structured interviews were conducted with:

- 26 Local Authority commissioners;
- 18 Providers;
- 10 Public Health England (regional and national) representatives; and
- 6 inpatient detoxification providers and consortium leads.

These were conducted in an approximately one-month period, beginning in mid-July 2021. They consequently covered the first quarter in which additional funding was available, and so describe initial challenges in deploying funding. Subsequent

developments are not covered here. Interviews were recorded, fully transcribed and coded using NVivo.

At the outset, it should be noted that many interviewees had little involvement in processes around inpatient detoxification. Concomitantly, whilst experiences of Universal Grant funding were widely shared, experiences of IPD funding were much more localised making it hard to extract themes qualitatively. In consequence, whilst some themes within this report do speak specifically to inpatient detoxification (the setting up of new facilities, for example) there is a greater focus on the Universal Grant.

Findings

Findings are presented to reflect policy implementation, beginning by exploring the situation before funding arrived. I then turn to the arrival of funding, and the development of bids and proposals within a very short timeframe. After this come barriers (staff and non-staff) and solutions to perceived problems in scaling up to use what were often very considerable grants, in several areas comprising up to 20% of a Local Authority's annual treatment budget. I then outline what was enabled by the additional money – the packages of interventions and new capabilities that had either hit the ground, or that would be delivered as soon as staff could be found. Next, I begin to approach the end of the funding: the ways in which packages of programmes were shaped or limited by the insecure one-year offer, and measures (where any existed) to support sustainability – providing a legacy for aspects of provision even if the funding were not renewed. Finally, I outline two sets of 'asks.' Firstly, what interviewees felt they still needed in terms of policy changes and governance structures. Secondly, which areas of treatment and support they felt needed additional investment and support in order to enable substance misuse services to deliver.

Reflecting back: before the funding

A large proportion of interviewees had longstanding experience of working within substance misuse. There was a broad sense that the shift defined by the 2012 Health and Social Care Act, with a move from the National Treatment Agency (NTA) to Public Health England (PHE) along with widespread budget cuts and the loss of ring-fenced budgets, had brought some initial benefits. Whilst a few areas (providers in particular) felt that they had managed budget cuts reasonably well, most interviewees felt the sector had ultimately been hit too hard.

Interviewees highlighted:

- That not all areas had suffered equally;
- Initial gains from austerity, particularly in reducing waste and inefficiencies;

- Loss of skills in the sector;
 - An increase in silo working;
 - A related difficulty in supporting people with complex needs;
-
- Large caseloads, often of 80 to 90;
 - Loss of dedicated criminal justice teams;
 - Shrinking provision towards core / irreducible functions;
 - Increased deaths, in some areas.

The arrival of funding

On 10th March 2021, commissioners and providers were informed of the existence of the Universal Grant funding through letters informing them of the scale of their award, and asking them to identify what they wished to fund from an indicative menu of interventions. These issues were particularly relevant to the Universal Grant – for interviewees focused on IPD delivery, establishing consortium membership was a more critical focus. Interviewees described how they:

- Developed packages of interventions;
- Used the Universal Grant template to mitigate the chaos of a compressed planning process;
- Explored options for creative commissioning;
- Faced the timeframes available: 2-3 weeks to bid, for the Universal Grant;
- Suffered the impact of insecure funding;
- Were constrained by the need to use existing providers; and
- Were hampered by governance structures and procurement rules, preventing the use of obvious partners.

Barriers to implementation – staffing challenges

Staffing challenges affected the delivery of both Universal Grant initiatives and, with a widespread shortage of nurses and qualified staff, the development of new IPD capacity. A couple of areas managed to fully deploy nasal naloxone, and a couple had managed to fill all funded staff posts. However, overwhelmingly, sites described huge difficulties in getting funding working on the ground and one PHE regional team interviewee stated that ‘almost exclusively, all of our local authorities did their quarter one returns with nil spend.’ Finding staff proved to be one of the most widespread difficulties in getting funding up and running across sites. Difficulties with recruitment were compounded by several factors, including:

- A lack of available, appropriate potential recruits in the community;
- Competition for available staff from neighbouring areas (and other organisations);
- Cost of living – when multiple areas were recruiting, affordable areas became the most attractive;
- Multiple preceding rounds of recruitment for other recent funding pots (prominently including rough sleepers), diminishing the pool of potential recruits;
- The need to offer (unattractive) fixed-term contracts;
- Timescales for recruitment – new recruits invariably needed DBS checks. Many needed to serve notice periods before they could start in new roles; and
- The impact of COVID on recruitment.

Barriers to implementation – non-staff challenges

Recruitment was undoubtedly the biggest hurdle to getting funding up and running. However, it was not the only one. Other barriers to operationalising grants included:

- Governance structures, restricting creativity. Large providers had to ensure all provision was standardised;
- Overburdened management chains; and
- Managing multiple separate funding streams.

What was enabled by the funds?

Having noted the barriers to implementation and the measures interviewees took to address them, it is important to recognise much of the planning and vision that the additional funding enabled. The funding was seen as exciting, opening up genuine possibilities for new services and capacities. The additional funding was believed to have enabled:

- Renewed focus on harm reduction;
- Renewed focus on crime reduction;
- Gendered and trauma-aware provision;
- New partnerships, including new IPD consortia;
- IPD gains – new beds, and new facilities;
- Residential treatment gains – new funding, new capacity.

Having detailed these plans, a related question is explored: what, at the time of interview, was up and running?

This resulted in a mixed bag of replies. Many were getting there – they had recruited to a portion of posts, or filled posts in some areas, but were not quite up to delivering everything yet. Beyond this group, a very small number of commissioners and providers were fully up to speed – they had recruited to all new vacancies, and were delivering services. Finally, at the opposite end of a spectrum, a significant proportion of sites were struggling with issues around recruitment and staffing, in particular. As the first quarter of funding ended, a notable proportion of interviewees had no additional services from the new funding operational.

Provision: limitations of fixed-term funding

The unifying feature of the Universal Grant and IPD funding was that they were fixed-term, one-year funding pots. The Universal Grant, in particular, was rooted in the Black Review with an implicit message that funding should be not only sustained, but increased. The IPD funding – particularly in areas setting up new facilities – risked becoming very inefficient if services and contracts had to be run down after a year. Within this context, interviewees particularly highlighted limitations of fixed term funding in these areas:

- An inability to secure a full year of delivery from a one-year fund;
- A reluctance to promote time-limited new services;
- The impossibility of achieving – or evaluating – impact within a year;
- Disproportionate impact of other processes – for example, if retendering within the one year.

When funding ends... Sustainability

Central to the legacy of the fixed-term funding was whether or not commissioners would be able to build in any elements of sustainability. Clearly, this presented a challenge. Years of cuts had stripped services back to irreducible and core functions. The one year funding had then allowed a resurgence of IPD use and interventions focused on crime and harm reduction. Should the funding end, it was hard for many commissioners to see how they could not be back where they were before it arrived. This noted, all commissioners had thoughts about sustainability, and some of these were in the form of structured plans for retaining important aspects of services or funding streams. Perspectives on sustainability included:

- Specific plans for alternative funding streams to retain important work;
- A lasting legacy of some interventions, even if no new funding arrived.

Less encouragingly, many interviewees saw little hope for retaining services without renewed funds. These participants expected:

- A loss of newly-employed staff;
- A loss of newly-established facilities;
- Somewhat bleakly, a loss of all gains arising from the one-year funding;
- A loss of trust from service users, obstructing future engagement.

What do you still need? Policy and governance

Interviewees welcomed additional funding, and many had decades of experience and strong visions of what gold standard local service provision might entail. All interviewees had views on what they still needed to reach their goals. These answers are broken into two sections: what they needed in terms of governance and policy arrangements; and what they needed in terms of additional funded programmes or elements of need. Policy and governance needs identified were:

- Secure, long-term funding;
- A skills and career framework for drug workers;
- Joined up and strategic government thinking;
- Help with the cost of medication. Some interviewees felt that national purchasing could greatly reduce costs.

Reflecting a core theme within the Black Review, across interviews there were conflicting desires for localisation and accountability. Some interviewees – at all levels – saw complete localisation as the only way forward, with commissioners allocating (perhaps ring-fenced) treatment budgets on the basis of local needs assessments. Contrastingly, other interviewees saw significant centralisation – grounded in a new cross-governmental Drugs Unit – as ideal. They saw real benefits arising from centralisation – from established standards, outcomes frameworks, and ring-fenced and dedicated budgets (for example, for crime and opiate treatment). These interviewees welcomed significantly greater accountability within this. There was a sense from some stakeholders that localisation was partly responsible for worsening treatment outcomes. Between these two views, a significant number of interviewees expressed a desire for some increased accountability – maintaining the ability to respond to local needs, but with a degree of new oversight.

What do you still need? Service user needs and support

Cutting across many interviewees' accounts was the understanding that substance misuse cannot be treated alone. The rise of silo working began to emphasise this, along with the loss of partnership work and pooled budgets. As funding had reduced, so provision became more thinly stretched and core partners had less reason to be around the table. Framed by this context, interviewees set out the aspects of treatment that

they felt were still underserved, and that they felt needed increased attention (and funding) in order to enable treatment services to function effectively. These included:

- Access to enhanced funding for alcohol treatment;
- Prevention and youth work;
- Mental health support;
- Decent, safe and secure housing;
- Education, training and employment support;
- Residential rehabilitation, particularly as a follow-on to inpatient detoxification;
- A holistic offer for long-term drug and alcohol users; and
- Support in accessing primary care.

Discussion and conclusion

Commissioners and providers heaped praise on the Black Review. They saw real value in its findings, and felt that they had finally been heard. They felt real hope, sometimes for the first time in years, but also recognised the need for more than sustained funding if negative outcomes were to be changed. More than anything else, they recognised a need for sectoral change. Perhaps the most important point to note here is that the barriers interviewees described in getting funds up and running were structural. Skilled staff could not be recruited, because they simply did not exist. Concomitantly, solutions were individual. With few exceptions, they did not create skilled staff – rather, for the most part, they seconded them in from other services or poached them from rivals. This did not address the problem – it just moved the locus elsewhere.

More broadly, short-termism reflected a structural threat to delivery. Interviewees described living in a perpetual state of overworked panic, responding to a succession of requests to bid for a succession of discrete funds (many of which ultimately sought to benefit the same small cohort of heavily marginalised drug users). This short-term approach forced interviewees to recruit to deeply unattractive fixed term contracts; to expend a great deal of time and effort on the start and end of contracts; to waste resources on dereliction costs¹; to lose fixed-term staff as their contracts approached an end; and to endure a range of commissioning and governance problems that arose because of this fragmented approach. Short-termism also left commissioners and providers reluctant to advertise new services, aware that service users needed access to long-term, stable support that was not liable to end after a few months. The need to bid swiftly in response to short timeframes also meant that best value was not being

¹ Funds reserved to remove beds from wards, or return facilities to their previous states, when fixed-term funding ran out.

secured – a slower process could enable local needs assessments to be carried out, service user voices to be engaged, and the relevant evidence bases to be reviewed.

Finally, there was an important sense that interviewees had been hugely relieved by the arrival of the funding. They wanted to make best use of public funds, but the conditions around it made them unable to deploy it effectively – or in some cases, at all. Within this context, it appeared that changes in governance could yield a step change in the value achieved by working to long-term, strategic, clearly defined goals within a measured and realistic timeframe. The broader aspects of capacity building appeared essential here; looking towards longer-term upskilling of the workforce and accepting that some solutions might take time. There was also a clear sense that cross-governmental work was essential for marginalised offenders, as their needs were very far from discrete. Substance misusers needed access to better housing, alcohol provision, and mental health care, as well as employment opportunities. However, with cross-governmental collaboration and planning, there was a real sense that very real and very substantive impact on measures of concern could be achieved. As several interviewees noted, joined-up, cross-governmental work has been delivered before; it could be done again – and, potentially, done better.

Background, aims and objectives

Context for this study

The immediate drivers for this report lie in Dame Carol Black's *Review of Drugs* (2020; 2021). This highlighted the impact of several key factors – notably the rise of local accountability for commissioning, the reduction of treatment budgets, and the deskilling of the treatment workforce – on worsening measures across multiple domains. Of particular concern are record levels of deaths from drug poisoning, and significant problems with crime. Whilst the association between heroin use and acquisitive crime has been long documented, the rising dominance of 'county lines' and organised crime within the class A drug market mean that these drugs are now also associated with up to half of all homicides.

In its response to the Black Review, the Government announced investment of £80m to improve drug treatment in England for the most marginalised populations over 2021-22: 'the largest increase in drug treatment funding for 15 years' (HM Govt 2021). This was to run alongside significant pots of funding for multi-year projects in the form of £52m for rough sleepers projects, and £59m for eight two-year 'ADDER' pathfinder projects, aimed at reducing reoffending. However, the funding also included a couple of funding pots that were to last for one year only. These comprised the £55m 'Universal Grant,' divided between LAs based on indicators of treatment need, and focused specifically on opiate users, harm reduction and criminal justice pathways; and £9.8m intended to revitalise inpatient detoxification (IPD) through grants awarded to regional and sub-regional consortia. These two funds offer potential for developing and deploying additional treatment capacity, but the one-year structure militates against some of the core points raised in the Black review. Of particular importance is the long-term damage done to the sector through years of disinvestment and deskilling: many skilled staff have left the sector; few new recruits come with robust skills or established qualifications. Black consequently notes that the steps needed to get the sector to a point where it can operate fully and effectively will need to be systemic, and long-term.

Within this context, this study was commissioned to understand how this influx of one-year funding – comprising 20% of some LAs' annual treatment budget – had been deployed. Specifically, what had been the barriers to deploying funding, and what solutions had LAs found for overcoming these barriers?

Background

Recent developments cannot be taken in isolation. A full view of the policy concerns and responses to opiate users, crime and harm reduction needs to stretch back at least

twenty years – not least because a good proportion of the UK’s “ageing population of heroin users” (Black 2020:5) have been in treatment for this long (as, indeed, have many of the managers and commissioners responsible for their care). Here, a wave of research conducted at the turn of the millennium was integral to establishing that:

- In cohorts of arrestees, 80% of ‘drug misusing repeat offenders’ wanted to access treatment but were unable to do so (Holloway and Bennett 2004:33);
- In cohorts of treatment-seekers, heroin users were (on average) committing crime costing £10,617 per quarter (c.£20,000 per quarter, adjusted for inflation, in 2021) (Godfrey, Stewart and Gossop 2003:703);
- And that every £1 spent on structured treatment yielded a saving of between £9.50-£18, almost entirely due to reductions in crime (c.69% after one year, c.49% after two years) (Godfrey, Stewart and Gossop 2003).

Whilst such ambitious cost-benefit figures have not been replicated in subsequent studies, these findings supported a very significant refocusing on moving Class A drug users into structured treatment to reduce acquisitive crime. The 1997 Drug Strategy set out an ambition to place drug workers in every custody suite in the UK (HM Govt 1997). The 2002 Drug Strategy set out further ambitions to establish drug teams in courts, in every prison, and providing case management through and after the prison gates (HM Govt 2002). Drug treatment requirements (initially Drug Treatment and Testing Orders, latterly Drug Rehabilitation Requirements) were also established to provide treatment as a sentencing option.

This was a time of significant investment, though almost all of it was directed to indefinite methadone maintenance for heroin users, as indicated in the evidence base around crime reduction, in or at the periphery of the criminal justice system (e.g. Barton and Quinn 2002, HM Govt 2002). The Black Review notes that...

The pooled treatment budget, originally £50m a year at its inception, reached £467 million by 2012/13. This was on top of an estimated £200 million spent by local health and criminal justice budgets and councils. The number of adults in treatment more than doubled over that time, with England having one of the highest rates of heroin users in treatment in the world and average waiting days fell from 12 weeks to 5 days (2020:18).

Much criminal justice work was delivered by the Drug Interventions Programme (DIP), wherein treatment teams were routinely high-skilled. In a 2013 study of six DIP teams, workers included a diversity of retired criminal justice professionals, trainee social workers, and others with extensive portfolio careers across the third sector. Lived experience was also a prominent presence (Page 2013:106-113), and inexperienced workers a closely supported minority:

Site 1 [Arrest Referral] had a small group of young, female, recent graduates whose inexperience evoked anxiety for some of their colleagues. Four interviewees voiced concerns that young graduates might struggle to identify with and effectively engage an overwhelmingly older, disadvantaged male client group beset by poverty and marginalisation. Partly in response, strong informal support networks were widely in evidence, gladly taken up by less experienced or confident workers (Page 2013:111)

With abundant funding and large teams, DIP caseloads could be as low as 15-25 services users per worker (Page 2013:92;122), allowing extensive outreach and engagement based on wide-ranging pragmatic support. Whilst robust impact evaluations of criminal justice interventions were lacking, by 2008 the delivery of enhanced treatment options across the criminal justice system was associated with “a fall in recorded acquisitive crime of around 20 per cent” over the preceding decade (HM Govt 2008:4).

However, over subsequent years, treatment priorities shifted. Harm reduction – and long-term Opioid Substitution Therapy (OST), in particular – began to be criticised on the grounds that it was acting as a ‘bottleneck,’ wherein...

...[d]rug users had been accessing treatment and stabilising their drug use through substitute prescribing... but not necessarily exiting treatment successfully, fully overcoming their addiction and reintegrating into the community (Duke 2013:47; see also e.g. Easton 2006; Ashton 2008).

A gradual shift towards a recovery-oriented system began, calling for a shift away from long-term OST and the prioritisation of opiate users, and instead calling for the centring of treatment on ‘the user, not the drug’ (Centre for Social Justice 2007:19). By 2010, England’s National Treatment Agency had taken some of this on board, and were calling for an end to people being ‘parked indefinitely on methadone.’

Following the election of a Coalition Government in 2010, the ‘drugs-crime cycle’ (e.g. Home Office 2012) once again came to the forefront of policy, though this time in the form of abstinence-focused programmes. A ‘recovery agenda’ now came to the fore, with treatment services incentivised to achieve two goals: to progress heroin users towards exiting services free of OST; and to provide more support for people with non-opiate and alcohol dependencies (e.g. Home Office 2010; Ministry for Justice 2010). There were early signs that opiate users were struggling in this new context. Despite an initial boost in the numbers leaving treatment drug free, figures soon returned to their pre-‘recovery’ levels. Where intensive abstinence-focused services were set up, in many instances there were few signs that these were either aimed at – or engaging – long-term opiate users (e.g. ACMD 2013; Page *et al.*, 2015). In this sense, the recovery agenda achieved some key goals – supporting non-opiate users, in particular, towards

abstinence and providing some additional and intensive support. However, there were real signs that opiate users, consistently identified as the most problematic and socially costly cohort, were having their needs less well met by this approach (Duke 2013; ACMD 2013; Lloyd et al., 2016).

In 2012, further changes then took place, with the Health and Social Care Act moving responsibility for treatment from the National Treatment Agency (which was abolished) to Local Authorities and Public Health England (Black 2020:18). As a part of this move, ringfenced treatment budgets for opiate users and offenders were diluted, moving to a wider ringfenced Public Health Grant, leaving commissioners free to spend their budgets according to local priorities (Black 2020:18). The Black Review documents how, between 2014 and 2018, Local Authority treatment budgets fell by an average of 14%, with some areas cutting up to 40% from their treatment spend (2020:18). Again, this also masks the double loss of resources faced by opiate users who were concomitantly seeing allocations for their treatment being diluted and reallocated as dedicated protection for treatment budgets dwindled and year-on-year available funds diminished alongside them.

The impact of disinvestment has become increasingly apparent over the subsequent decade. Rates of drug-related death in England and Wales have increased by 61% since 2010, from 49.4 to 79.5 per million (ONS 2021). The number of deaths reached over 4,500 in the same year: the highest level since records began (ONS 2021). Approximately half of these were related to opiates – again, a new record – whilst deaths related to cocaine (777) are over five times their 2010 level (144). Morbidity is also a pressing issue, with older heroin users facing increasingly complex patterns of health related need (Black 2020). Social and economic costs have risen alongside this, with the Black Review assessing the annual economic cost of drugs at £20bn, with heroin and cocaine associated with for half of all acquisitive crime and murder (Black 2020).

These social and economic costs are now rooted in a structural context. With the abolition of the NTA went the ‘pooled budget’ – a budget shared between the Department of Health and the Home Office, leading to highly collaborative work (evidenced in the highly collaborative local partnership work of Drug (and Alcohol) Action Teams). Without this embedded collaboration, criminal justice agencies had less of an incentive to collaborate with drug services increasingly focused on managing their own budgets, often reprioritising them to work towards priorities other than offending (Black 2021). Along with this have gone other partnerships – with mental health, with housing, and with education, training and employment (Black 2020:20). Significant capacities – including residential detoxification and rehabilitation – have also disappeared as LAs have funded priorities elsewhere (Black 2020:19).

Additionally, as budgets have dwindled much of the highly skilled workforce has either left drug treatment altogether or has gone to work in better-paid and fully professionalised sectors. The Black Review reflects:

Like in the adult social care market, drug treatment providers have been squeezed, staff are paid relatively badly and there has been high turnover in the sector and a depletion of skills, with the number of medics, psychologists, nurses and social workers in the field falling significantly. The unregulated role of drug and alcohol or recovery worker, which is inconsistently and poorly defined, makes up the vast majority of the workforce. The number of training places for addiction psychiatrists has plummeted from around 60 to around 5, meaning there is no capacity to train the next generation of specialists (2020:18).

Those workers who are left find themselves undervalued and under-supported, managing large caseloads with little time to deliver intensive, structured, supportive work.

It is within this context that the Government announced additional one-year funding of £55m for harm reduction interventions and the improvement of criminal justice pathways, alongside additional funds for capital and revenue expenditure on IPD. Clearly, given the extent of needs and the staffing constraints within the sector, scaling up provision within a year would be a challenge. This report consequently explores how sixty PHE national and regional teams, commissioners, service managers and IPD consortium leads approached the scaling up of provision, with a particular focus on the barriers they identified to scaling up and any solutions they identified.

Methods

In February 2021, the Department of Health and Social Care submitted a request for a rapid piece of research exploring the implementation of one-year funding for the Universal Grant and IPD. The DHSC particularly sought to understand...

- What factors influenced the priority setting and the delivery plans of LAs (e.g. how did the uncertainty of additional funding beyond 21/22 affect their approach)?
- What were the barriers to scaling up drug treatment services in the coming financial year?
- What barriers did LAs anticipate? What were their mitigating actions?
- What additional challenges did LAs face in planning and commissioning services?

The request came to York's PREPARE team in early April. Following an iterative process of development, a proposal was agreed in June (see Appendix A for final version).

The final proposal was highly ambitious for the time available, setting out plans to conduct, analyse and provide an interim report on semi-structured interviews with 25 commissioners, 15 providers (substance misuse services and IPD) and 8 PHE representatives in time to inform the August spending review. The belief that this could be done was supported by PHE's faith in the active enthusiasm of commissioners and providers to participate in the study – a belief confirmed by subsequent experience. The proposal received ethical approval from the University of York's Health Sciences Research Governance Committee.

The sampling process was developed rapidly, based on the principles of maximum variation to ensure that a wide range of views and experiences were secured. Drawing on the limited set of PHE indicators available, lists of the top, middle and bottom five LAs were drawn up for:

- Adults in treatment in specialist drug misuse services per 1,000 population;
- Deaths in treatment, mortality ratios;
- Successful completion of treatment – opiate users;
- Budget – net current expenditure – drug misuse, adults;
- Budget – net current expenditure – preventing and reducing harm from drug misuse in adults.

From these lists, 25 sites were chosen with the aim of ensuring cross-regional representation, and representation of at least two LAs from each 'top,' 'middle' and

'bottom' five of each indicator. Significant overlap between indicators helped here. A final check confirmed that the draft list included decent coverage of both key cities (including London), and of rural areas. An initial set of 25 LAs was then shared with PHE for feedback on any potential problems. Due to an oversight, no Local Authorities from one region were chosen. However, we interviewed representatives from all PHE regional teams.

For commissioners and IPD consortia, an initial approach to PHE regional teams was made by PHE national, through a structured letter setting out the purpose of the study, introducing the lead researcher, and identifying chosen LAs within their region. PHE regional teams then cascaded information about the study to commissioners within those LAs. We expected a positive response to the study given that the focus was on the challenges of managing one-year funding, and this was the case – all identified commissioners and PHE regional teams were willing to be interviewed, and only one was missed (due to annual leave). Separate approaches were made to the national teams of lead providers, yielding a further five national and four local provider interviews.

The final sample exceeded our target. Over a period of five weeks beginning in mid-July 2021, sixty interviews were conducted with Local Authority commissioners, service providers, and PHE regional and national staff. Whilst all interviews with commissioners covered IPD to an extent, a small number of interviews were also IPD-specific and focused on consortium leads and IPD providers. The totals secured were:

- 26 Local Authority commissioner interviews;
- 18 Provider interviews;
- 10 PHE regional and national interviews; and
- 6 IPD-specific interviews.

A handful of interviews covered people with two roles (for example some, though not all, IPD consortium leads were also involved in commissioning for Universal Grant provision). Some interviews involved multiple interviewees – though these were relatively rare, at the top end eight people were interviewed across two interviews. Dual interviews were more common, mostly comprising a commissioner and provider from the same local authority. These worked well, with interviewees 'bouncing off' each other as they narrated a shared set of experiences. Finally, thirty interviews involved just one person.

Semi-structured interviews lasted between 21 and 73 minutes, with a mean of 40.5 minutes. They covered:

- The situation prior to the arrival of additional funding (levels of harm reduction, IPD, etc);
- The use of the grant, including local priorities;
- Barriers faced in deploying the grant (staffing, resources, organisational change);
- What will happen when one-year funding ends, including plans for sustainability.

All interviews were fully transcribed, and analysed using Layder's 'adaptive theory' (1997). This recognises the benefits of both inductive and deductive approaches, beginning within an initial framework but also searching for new concepts, ideas and themes within the data. This led to some swift adaptations to our schedule – within the first few interviews, it became apparent that very few interviewees could identify lessons learned from other LAs' commissioning approaches, and so this question was dropped. Contrastingly, other themes – for example, the positives of austerity – were not within our initial framework but emerged as prominent themes.

Limitations

Whilst maximum variation sampling seeks to engage as wide a range of interviewees as possible (and so encompass as broad a range of experience as is possible), the qualitative nature of this study means that it cannot be generalised. Interviewees' experiences can be described, and it is notable that many coalesced on a very familiar set of themes. The timescales for bidding had been nowhere near long enough. The funding was universally welcomed, but very difficult to deploy. Difficulties with staffing and recruitment were near-universal. These experiences were represented across LAs, across regions, across local and national providers, and through commissioners and PHE teams, too.

However, the reliance on purposive sampling means that these experiences cannot be taken as representative of any broader group. It is entirely possible that commissioners and providers in other areas may have had experiences that are not represented here. Some areas may have developed solutions to staffing problems that are not described here; some areas may have found recruitment easy. This is entirely possible – this study cannot speak to experiences outside of our direct sample.

It should also be noted that sampling relied on information being cascaded from PHE national, through PHE regional, to local commissioners and providers (or from PHE national directly to a small number of national providers). It is possible that this may have unduly influenced people to participate, though there was no obvious sense of this within interviews (and most interviewees were clearly enthusiastic to discuss the difficulties they had experienced arising from one-year funding). It is also possible that this sampling process may have affected how they presented their views. Likewise, interviews with two or more people often gave a sense of being more productive – of

interviewees who had worked together for a long time sharing experiences. There may, though, have been some instances where additional interviewees also acted as an inhibiting factor. Again, there was no clear sense of these factors affecting interviews, but it is possible.

It should also be noted that many interviewees had little involvement in processes around inpatient detoxification. Concomitantly, whilst experiences of Universal Grant funding were widely shared, experiences of IPD funding were much more localised making it hard to extract themes qualitatively. In consequence, whilst some themes within this report do speak specifically to inpatient detoxification (the setting up of new facilities, for example) there is a greater focus on the Universal Grant.

Finally, interviews covered the first quarter in which additional funding was available, and so describe initial challenges in deploying funding. Subsequent developments are not covered here.

Findings

Introduction

Findings are presented in rough chronological order, reflecting the structure of interviews. They begin by exploring the situation before funding arrived – interviewees’ experiences of austerity, localised provision, and the reshaping of provision over the preceding decade. We then turn to the arrival of funding – how interviewees first heard about the additional money coming their way, and the development of bids and proposals within a very short timeframe. After this come barriers (staff and non-staff) and solutions to perceived problems in scaling up to use what were often very considerable grants, in several areas comprising up to 20% of a Local Authority’s annual treatment budget. We then turn to explore what was enabled by the additional money – the packages of interventions and new capabilities that had either hit the ground, or that would be delivered as soon as staff could be found. Next, we begin to approach the end of the funding: the ways in which packages of programmes were shaped or limited by the insecure one-year offer, and measures (where any existed) to support sustainability – providing a legacy for aspects of provision even if the funding were not renewed. Finally, we turn to two sets of ‘asks.’ Firstly, what interviewees felt they still needed in terms of policy changes and governance structures. Secondly, which areas of treatment and support they felt needed additional investment and support in order to enable substance misuse services to deliver.

Reflecting back: before the funding

A large proportion of interviewees had longstanding experience of working within substance misuse. There was a broad sense that the shift defined by the 2012 Health and Social Care Act, with a move from the NTA to PHE along with widespread budget cuts and the loss of ringfenced budgets, had brought some initial benefits. Whilst a few areas (and providers in particular) felt that they had managed budget cuts reasonably well, most interviewees felt the sector had ultimately been hit too hard.

Interviewees highlighted:

- That not all areas had suffered equally;
- Initial gains from austerity, particularly in reducing waste and inefficiencies;
- A loss of skills in the sector;
- An increase in silo working;
- A related difficulty in supporting people with complex needs;
- Large caseloads, often of 80 to 90;
- A loss of dedicated criminal justice teams;
- A shrinking of provision towards core / irreducible functions;
- An increase of deaths, in some areas.

An unequal distribution of pain

The Black Review makes clear that not every area has been hit equally by changes to the system. Some areas – the North, in particular – have been hit hard, with worse outcomes in almost every measurable domain. Other areas have remained relatively unscathed. A handful of interviewees – mostly providers in services that had quite recently been commissioned – sought to emphasise that they had been well protected and amply-funded by their LAs.

I've been working [here] since 2015, and during that time I would say they've actually put more money in, so we've gained a drug-related death co-ordinator, for example. And certainly, there hasn't been a reduction in funding for the services. We might have changed the way we fund things... but that hasn't meant there's been a reduction for the agenda. And certainly, having this new post is an increase (Provider).

Others felt that they had not benefited, but nor had they suffered any overall loss of capacity or competence. There was a sense from these interviewees that they had managed the cuts; that there had been no point at which the losses had been too great, or genuinely painful decisions had needed to be made:

We started off with well too many staff and had to then suck up the attrition because people disappeared and weren't replaced. I always liken it to cutting your cloth accordingly and, you know, you have to make the changes that fit with that (Provider).

This is not a picture that straightforwardly squares with the nationally available data. Certainly, indicators of lost capacity within criminal justice teams, rising caseloads and rising deaths seem to have been a significant concern across the board – and, indeed, were a major concern in at least one of these sites (deaths had increased significantly despite sustained funding). Nonetheless, a small group did feel they had emerged relatively unscathed – on occasion, even stronger – from the changes that had seriously affected other LAs.

Initial gains of austerity, particularly in reducing waste and inefficiencies

From a large pool of other interviewees, there was a general sense that under the NTA the treatment system had been almost too bloated. As two interviewees said...

R1: There was also a lot of waste in the old model...

R2: Exactly, so it wasn't like we were reducing a service that was lean to begin with, if I'm honest (Commissioner and provider).

Within this was a broader sense of 'cut[ting] down on some of the fat,' and refining and improving treatment delivery as the first wave (or first few successive waves) of budget cuts kicked in:

As the cuts started to happen, when they first began to happen, I think we were in a position more where we need to really look at our efficiencies, look at what we could do differently, and it started to drive some really great efficiency and some really great practice... (Provider).

However, as austerity progressed and budgets in most areas continued to dwindle, core functions began to disappear: very few interviewees thought that they had reached the 2020s unscathed. In the following excerpt, a provider the point at which cuts began to become unsustainable, resulting in a loss of key posts and capacities:

There came a point, when the balance tipped in the wrong way, where actually, we've started to have to make cuts to particular posts, and I think that, you know, for us for example, loss of psychology and clinicians, we had to start changing in terms of structures around management roles, so they started to become even more broad than they were (Provider).

Similar experiences were widespread, mirroring the account set out in the Black Review. Funding went; skills were lost; and capacity rapidly reduced.

Loss of skills in the sector

The Black Review (2020:6) notes that...

A prolonged shortage of funding has resulted in a loss of skills, expertise and capacity from this sector. Treatment providers often have to prioritise the severe needs of the long-term heroin using population, meaning that services for other drug users have had less investment... Even if more funding became available for treatment (which is vital), there would be a lot of work to do to build up capacity and expertise in this market. In addition to dedicated funding, the re-introduction of incentives and levers, and locally held joint responsibility and accountability, would go a long way to regenerate and vitalise the system.

Skills were seen as an essential part of delivering decent work to an increasingly complex and highly marginalised client group. As a commissioner reflected...

You don't want to get somebody just in the post for the sake of it. I mean you are dealing with really vulnerable people that are, you want the most skilled people as possible within that grade (Commissioner).

However, particularly for interviewees who had been in substance misuse for a considerable time, there was a consistent sense that the skill-base had been removed from the workforce. Part of this was because of the turmoil affecting the sector:

In terms of austerity and the last ten years, we have seen a lot of experience leave the sector, for many reasons, through cuts, through redundancies, through restructures, through people not wanting to do this work anymore (Provider).

The loss of national structures compounded this – DANOS² was fondly mentioned by multiple interviewees, whilst the loss of central accountability and central structures for treatment were thought to have led to local, lower-skilled solutions requiring a lower-skilled workforce:

With the NTA going and having all the DANOS stuff, I think that's had a massive impact on upskilling people because there was a requirement that people if they didn't have it when they came in, after so long they would have it. And we don't have that any more and, kind of, that infrastructure that was there that supported

² the Drug and Alcohol National Occupational Standards, introduced in 2008.

that, now that's gone, it's kind of really wishy washy in trying to upskill someone (Provider).

The move away from national standards was thought to have created a context in which multiple providers developed training programmes piecemeal, and almost invariably delivered to a lower level than had once been the case:

There is something about that within low level mental health and drug and alcohol charities where we're all grappling with our own solutions and I don't think we're...we're not quite giving our frontline staff that cast iron training and qualifications, wouldn't recognised in the outside world. We're just not doing it (Provider).

I'll go back to the NTA days, there used to be training that we would collaboratively put on with the GPs, with psychiatry, you know, we would collaborate within all of that upskilling of the workforce. That's all now left down to the providers, so whatever the providers can deliver in terms of mandatory training, whatever that is there...that's left to them. So there isn't anything in the sector that builds that workforce externally and bringing it in, so how we're going to recruit all these people, all we'll do is create gaps in the system elsewhere to plug them somewhere else for nine to 12 months worst-case scenario, so we'll lose maybe outreach workers in a system who'll then become criminal justice outreach workers or continuity of care coming from prison or whatever that may look like in the custodies or the courts (PHE).

Finally, structural factors had chipped away at the available workforce. Without a structured career path, other sectors looked much more appealing leaving substance misuse struggling to manage a shortfall from the point of recruitment on:

There's no standards for the workers. There's no career path. If you want to be a nurse you can go and be a nurse and there's quite clear career paths. If you want to be a psychiatrist and then branch off and specialise in addiction, there's a very clear career path for that. There are no career paths for drug and alcohol workers (PHE).

Compounding this, pay and conditions were generally seen as stronger in other sections – again leading potential recruits to look elsewhere:

We already have staff that are paid significantly less than our social care colleagues, which is where they invariably end up wanting to go, 'cause they're working so closely with them now (Commissioner).

Even when promising and appropriately skilled new recruits could be found, pay and conditions contributed to difficulties in retaining staff – again, other sectors had more appealing long-term offers, leading many substance misuse workers to leave the sector once they had developed an adequate skill base:

It's also challenging to retain a workforce when there isn't necessarily a kind of professional development route for people. So what we tend to see is we recruit really great people, we train them up and then they leave and go to probation or to other places where they can get that professional progression. So we constantly are on a churn of training of new staff, it feels like, and we've then lost the longer term experience (Provider).

Burnout and disenchantment added a final touch. Staff with dedicated or specific expertise found themselves working in roles that came to be devoted to managing general caseloads, stripped of the opportunities or specific work that they enjoyed.

When I was still working in services, I was a women-specific worker for a while, and we had a criminal justice lead and we had...you were allowed to have these different posts that really only worked with a particular cohort of service users. That disappeared very quickly and so there was just the fact that you lost the diversity of workers, you lost the skilled workers because pay became...people were getting paid less, and the work was more, so people became quite...they either became burnt out or they became completely disillusioned with...so you ended up with possibly people coming into the sector who...it's not necessarily...maybe not quite their skillset, but they were willing to accept the work and the money (Commissioner).

There's some benefit to allowing...to playing people to their strengths. If someone's really good at working with alcohol users for whatever reason, well, why don't we just let them work with alcohol users and do a good job? Why do we try and tie ourselves up in knots and say, no, you've got to do all this other stuff? (Commissioner).

All of these factors contributed to a single, over-riding outcome: skilled staff were very thin on the ground. They could not be recruited, because few skilled staff existed and other sectors offered more appealing conditions. Once engaged, they could rarely be rigorously trained or offered a robust career path, because systematic training and structured careers did not exist. For those that stayed around, other sectors again began to look appealing after a fairly short period, because the work available through substance misuse services was high pressure, limited, and routinely centred on delivering non-specialist substance misuse work.

Increase in silo working

The Black Review further notes the significance of the pooled budget, wherein the Home Office and Department of Health and Social Care were required to work together in order to deliver meaningfully collaborative treatment services. Amongst interviewees there was a strong sense that this model had provided a wide baseline of partnerships, and that with available funding decent holistic provision had been reasonably available.

Within the current context, joined-up working was seen as essential for delivering meaningful support to the service users with complex needs coming through treatment services.

We've had lots of conversations...and a lot of it centred round this yesterday, is this silo working that's been going on for years. And I think it's especially true of our cohort, drug and alcohol cohort, especially the drug cohort. So...and treating it...treating those people. This idea, you know, what are you treating, when you're treating someone for drug and alcohol use. What are you treating? Are you treating sort of some quite dated model of addiction, where it's just this psychosocial intervention and you're expecting them to either stop or massively reduce their use, yeah (Commissioner).

Moreover, there was a real desire in many areas to deliver this good, joined-up work, and in some instances this spilled over into frustrations at the restrictions placed on spending grant money. Some would have preferred outcomes to be specified – leaving open the possibility of recruiting multi-agency teams – rather than having the spend limited to workers in a limited set of roles:

If they just pooled that whole money and said, these are the outcomes that we want, we could then have a multiagency team within a local authority, pool all that money, and try to get them to work as a whole team. Whereas at the moment, we're going to have to say to some workers, oh no, you're just substance misuse, so you can't touch whatever else it is, so you need to just focus on [inaudible 19:47] mental health and substance misuse, which then creates silo working because they've got separate outputs and outcomes to report on (PHE).

A good proportion of longer-serving interviewees remembered times in the NTA, working with pooled budgets and with the Drugs Intervention Programme, when partnerships had been a core part of their professional life. PHE representatives talked of times when they had been part of full partnership arrangements – not only part of large NTA teams with their hands on everything taking place across a small selection of

LAs, but as part of DAATs and of treatment teams where shared money brought shared buy-in.

I went on a call recently about partnership work, and I think when...you don't want to be harking about the past all the time, you sound like a right old fogey, don't you, but I think when had drug action teams and people round the table, because they were making a genuine contribution, not just...it was skills, experience and influence, of course, but also money, never hurts, does it? People had a bit of cash on the table as well, and they were round that table because they wanted to see that money being spent appropriately, you know, so probation were chucking in a few quid, wanted to probation, of course they did, but they actually turned up in person and talked about it, and you had this joint arrangement, you know, joint commissioning groups. I think that's completely gone, and I think we keep talking about having partnership work and seamless joined up strategies and all of this type of stuff, where people...and I think, well, we've already had that. You're harking back to something we had ten years ago. Now I think when we talk about partnerships, it's often...it doesn't strike me as a true partnership, it's more of a transaction arrangement. I want you to do something and I'm going to try and convince you to do it. Once you've done it, you'll never hear from me again, that's not a partnership. Partnerships are where people are in it for the long term (Commissioner).

However, austerity had bitten. As one commissioner explained, part of the problem centred not only on agencies being able to do less, but on this meaning that other agencies' expectations were not met. The inability of services to continue delivering as they always had done (as they 'should') meant that relationships with their partners failed.

It's like all of these little things that actually require people to be able to stand alongside that person, help them register with the GP, make sure they get to their appointment, make sure they're able to ask the questions they really want to ask, make sure they're on the script so there's some stabilisation, all of that became unbelievably difficult because there just wasn't...and what also came from that was a sense that there was...I think it made relationships fractured because it's harder to maintain those rela...if you think that in some way another service is holding back on you and not doing what you feel they should do for the person you're working with, that creates a kind of fracture. And so I think during austerity we actually did see more siloed working because people a. felt very protective of resources that they had, but also were quite wary of being called out for not doing what other services thought was required (Commissioner).

With the loss of the pooled budget and the de-prioritisation of opiate-focused and criminal justice work, relationships with criminal justice agencies had also dwindled. Under LA commissioning arrangements, criminal justice Drug Interventions Programme work had died in all but a few areas, and the introduction of privatised probation in the form of Community Rehabilitation Companies had then acted as a body blow to several remaining criminal justice partners:

I'm just thinking touching on the criminal justice system as well, so I was of the day of the drug intervention programme, the CARAT³ workers in prisons, and that integration of criminal justice from prison out into community and that close working with probation at that point. And I also saw that dec... just to point out that that's also been decimated, so when I would still sit in strategic meetings finding it really difficult to link in with the CRC⁴ and probation. And that change came in 2014-15... [over about a year] the landscape just looked totally different because it had all been fragmented and we never really got that real connection with the CRCs working with our substance misuse services, I think they were never really properly round the table (PHE).

After some years of increasingly distanced working relationships, there was a sense in some areas that criminal justice agencies had become wary of engaging with substance misuse services at all:

The criminal justice world are not an easy group of people to do anything with. They're... a reluctant lover. If we're like a panda in our mating style they are also another panda – so that's hard work... We [haven't] got partners [in] Probation... The courts who are... oh my God. The police are not in a good state at the moment... I think the prisons are probably the most resilient part of the system, but no-one is out there [looking to work in partnership with us] (Provider).

Covid had not helped here, making a troubled relationship worse. As restrictions kicked in, the viability of drug testing people soon dwindled. A sizable number of commissioners and providers identified that, without weekly drug tests, courts and probation saw little value in Drug Rehabilitation Requirements; and so pulled back, leaving services still more siloed in their work.

³ Counselling, Assessment, Referral, Advice and Throughcare teams, established in UK prisons in 1999.

⁴ Community Rehabilitation Companies began providing probation-style supervision for low- to medium-risk offenders following changes introduced in 2010.

Supporting people with complex needs

Clearly related to a rise in silo work were difficulties in supporting people with complex needs. This was less of an issue in small, rural LAs where long-term heroin users were relatively rare. However, IPD interviewees (who were seeing increasingly complex referrals), commissioners and providers from bigger urban centres, and regional and national provider and PHE teams, had much clearer oversight of this kind of problem. When they presented, the levels of need were often exceptional – matters of life and death:

We need the NHS involved because they are using the NHS anyway when we are not putting them into services and they are dying and they are dying young.... We don't want to think about tobacco, we don't want to think about alcohol, we don't want to think about drugs, we don't want to think about homelessness. We want to think about complexity and marginalised groups et cetera, et cetera (PHE).

Within this was a sense that complexity had increased over austerity – that drug dependent people were ageing, and that siloed services meant their needs had been escalating without support, sometimes for a considerable period of time:

Consistently, across the board, what we're seeing is people with much higher need. So far more complexity than we might either have been aware of previously or been able to support previously. So complexity is a real key theme to us (Commissioner).

Mental ill health presented a concern for nearly every commissioner. Whilst the failure of the NHS to implement the landmark 2001 Dual Diagnosis Strategy was well known by 2009, when the Bradley Report highlighted the systemic failings of the criminal justice system in adequately supporting mentally ill people, this now looked like a halcyon age. Provision for mentally ill drug users was now seen as almost non-existent:

The one thing which is really prominent now because it's so challenging to get into mental health services, is there appears to be an awful lot of people who have significant mental health issues that actually because of their addictions, they just get bounced between both...yeah, both pathways (Commissioner).

Interviewees saw the obvious solution as being linked to the previous section – a move away from siloed work, towards integrated care pathways. Aspirations to develop 'one stop shops' were apparent in several areas:

We've been talking about having much more of a vulnerable person type approach and dealing with several issues rather than "we can only deal with this problem here and you need to go into another service over there now" (Provider).

And even for those with inordinately complex needs, who were approaching death, there was a sense that well-targeted resources could still save both resources and suffering.

We've always got to be realistic that we've got an aging profile of service users in some areas. I mean, it's not the, you know, they're just one group, but that group will consume vast amounts of health and social care spend. They, and they may not recover from their illness. I mean, I'm getting people referred to us who are on End-of-Life pathways. You're like, "well, do you think you want to give up heroin?" "Well, no thanks." Why would you? But what they do need is good social care. You know, and that will keep them out of hospital. There'll be savings in the system if that could be, you know... (Provider).

Caseloads

Within enhanced criminal justice drug services a decade ago, target caseloads were realistically put at 15-25 service users per full-time equivalent drug worker. Interviewees recognised the benefits of this, and caseload size was universally seen as essential to having a decent treatment offer. As a commissioner reflected, smaller caseloads were really at the core of provision.

Many substance misuse services have caseloads of 60 plus. That's ridiculous. It's really not fair on anybody to have to try and... Addiction's about relationships... People become unwell in relationships, they get well in relationships (Commissioner).

Despite this, caseloads had gone up across the board. Few interviewees described mainstream treatment caseloads of below fifty; numbers between 60 and (more commonly) 80-90 were widespread.

Last time I had a caseload which was in [another LA] probably about six years ago, I had 93. That's the difference between the two places. So, [in this LA] now, we were always trying to stay below 50, in terms of caseload numbers, we're just creeping over that now (Provider).

You have astronomical caseloads and so if you've got a caseload of 50, 60, 80 people, how do you address their needs? You can't. It's back to the, here's your script, you're doing alright, off you go (PHE).

These rises in caseloads were clearly and explicitly related to LA budget cuts which, in several areas, were seen as largely unrelated to planned changes to services. Rather, new and lower levels of funding were set; and services were then reduced (and caseloads increased) to fit these new budgets:

Deciding the level of savings was very much a finger in the...you know, there was no sort of calculation or, well what's the level of savings that is reasonable to make? It was just, you've got to make X percentage of savings, just do it. So you just ended up shaving a huge amount of money off the contract price from what was there before. Then that automatically puts you in the situation of you're trying to buy probably more than what you had before, is you're moving more into different emphases but for a lot less money. It has knock-on effects for services, it has knock-on effects in terms of the size of the caseloads that they carry, and therefore how much attention that they can really devote to people (Commissioner).

This fuelled some real frustration at some of the messages commissioners received around austerity and provision – and particularly the idea that more could be achieved for less, when all of the 'fat' had been trimmed long, long ago.

Yeah, you know, and we get these fucking mantras come down, and it pisses me off. More for less, was the one that really fucking done my head in. Well, how? "More for less?" I just, you know... it's... caseloads. Our providers are always on to us about, "our caseloads are massive, we need more funding, we need more funding." So yeah, I don't know how you... Yeah, if someone can tell me how that magic equation works, and more for less (Commissioner).

Target caseloads – numbers that could allow for decent relationships, robust interventions and meaningful case management – were generally put between 25 and 40. Whilst some areas aspired to reach these figures with the arrival of additional funding, no LAs were yet approaching this level.

Loss of dedicated criminal justice teams

A hallmark of provision through the early part of the millennium was dedicated treatment services for opiate-dependent offenders. The Drug Interventions Programme received in excess of a billion pounds of funding over this time to work with class A drug using offenders (Home Office 2009), despite a lack of rigorous evaluation (see pp.17-18). With the removal of ringfenced budgets for opiate users and offenders, provision for these groups rapidly dwindled. A large proportion of interviewees had begun working during (or before) the DIP era, and remembered aspects of its approach with real fondness:

DIP is really useful, right... It can work for those really entrenched, sort of opioid and crack users. Now, we have... what's the word ...a large population, much larger for it's size, you know, per capita, whatever, than other regions, of IV, heroin and crack users (Commissioner)

However, with the widespread defunding of DIP, the scaling down of criminal justice capacity had been near-absolute. Some regions were left with no substantive provision at all:

Criminal justice has shrunk considerably. Yes, I mean we're talking about one or two practitioners at the most in most of our areas. Some areas hung onto their criminal justice teams longer than others. [One LA], I think, were last to hang onto a dedicated criminal justice team but when their team leader took another job and moved off it ended up that when they went through the recommissioning process, they just decided to almost write it out of their spec (PHE).

Interviewees felt a real loss from DIP's widespread disappearance and the dwindling of criminal justice support, believing that a great deal of good work had disappeared with it:

That loss of capacity, loss of specialism, loss of pretty much all of that DIP programme, and all of the good work that used to come, in terms of the links with the Criminal Justice System, has had a huge impact, and that's undeniable for me (Commissioner).

Criminal justice, absolutely, that has been a massive gap, since DIPs, as I say, I've been around too long, since the drugs intervention programme (Commissioner).

Particular absences were noted in court:

if you lose the court worker then you lose that ability to be able to do rapid assessments and get people while they're most motivated at the point in court when they...you know, to get them on to a DTTO or a DRR⁵, or whatever the...you know, DRRs these days, isn't it? (Commissioner).

And as a follow-on from prison, where Community Rehabilitation Companies and probation were not felt to have picked up the slack with short-sentenced prisoners:

⁵ DTTOs no longer exist, having been replaced by DRRs. Both were community sentencing options

But I have seen people come out of prison with no fixed abode recently, which I find that unbelievable to come out of prison and to go no fixed abode and to just sign someone to the streets is just...yeah, so alarming (Commissioner).

I think the other issue for us is that during lockdown we got a bit of a mixed bag of people who have received some...received support, some haven't. And all the old problems of the prison service dumping people out on the streets, and all those types of things, they've all reappeared in effect as a result of austerity (Commissioner).

Perhaps unsurprisingly, the loss of post-prison and broader support for some of the most marginalised and chaotic drug users was associated with some very bad outcomes. The following excerpt was not a widespread view – but reflected the experiences of some: deaths had been attributed to the loss of dedicated care:

I mean we've seen deaths massively increase. And one of the highest rates in the country now. We do have a lot of problems... I think with the service losing capacity and that, the ability to really engage those people who really do need that extra support in order for them to engage with a service and who may be dropping out, coming in and out of treatment. That element really was taken care of much better when we had more of a CJIT or DIP⁶ type of approach (Commissioner).

Whilst loss and absence reflected the general experience, not all areas felt equally deprived. One LA had managed to scale up their provision in the months before the one-year funding was announced, delivering almost-daily prison visits, weekly satellite clinics in approved premises, and incorporating a dedicated women's DRR⁷ worker. This account was a one-off; but nonetheless notable, as a reflection of one area's local priorities. It also bears note that not all aspects of DIP were missed – 24 hour coverage of police custody suites was widely seen as a poor use of resources.

Reducing provision to core functions

Along with cuts to criminal justice provision came broader cuts to mainstream service. As a succession of budget cuts came in, commissioners and providers had to reflect on which elements of their services they could least do without. In a not-uncommon

⁶ Criminal Justice Integrated Teams (CJITs) were largely synonymous with Drug Interventions Programme (DIP) teams – providing multidisciplinary support for class A drug users within the criminal justice system.

⁷ Drug Rehabilitation Requirements – a requirement to engage with drug treatment as part of a Community Order (a non-custodial / community sentence).

picture, one commissioner described putting several proposals for services together, including one that effectively provided no treatment other than prescribing:

I had to do a number of papers, the original was, “what happens if we didn’t have a service?” Because drug and alcohol isn’t a mandatory service like sexual health is... And then I had to do a paper to describe the service if a million pounds was reduced. So really, if they only had about £600 or £700,000 left in the pot, to describe what that service would give. And... really the answer is “you won’t have a service ’cause £500,000 would probably only cover the medicines. And the GP shared care contract” (Commissioner).

First, the more ‘luxury’ programmes went:

We used to deliver lots of other nice stuff, like we did recovery through nature and things like that that really, really we saw so many benefits for service users from, and all those kind of things went when the money went (Provider).

Next, any peripherals that were not directly related to statutory duties:

Upwards of £4 million was taken out of [public health] alone, which is a massive amount of money. And what you end up with is...as a lot of the services that we had prior to that what local authorities and other bodies have to do is they have to maintain a statutory duty above all else. So, you end up with, you know, the statutory duty being managed, but anything else around that, like the type of stuff that suddenly come back, you know, with, say, Carol Black stuff, it disappeared really, it sort of bled away unless we had money coming from outside (Commissioner).

Interviewees talked widely of reducing everything to absolutely core functions – and then reducing provision still further. Needle exchanges often survived; but capacity was widely reduced:

I think the other problems...other challenges have been the reduction in harm reduction, so needle exchange, so the number of pharmacies across the whole of [this county], I think it used to be in the thirties, I think we’re now [below 20] (Commissioner).

Core functions within this could be lost – for example, as the Black Review notes (2020:19), losing any capacity for outreach:

[Services] suffered as a result really of the cutbacks that we’ve had to make to services over the last ten years. I think we really... obviously we have needle exchange, but the ability to outreach had gone really (Commissioner).

This came with twin financial benefits – not only was there no need for workers to conduct outreach, no new (and costly) clients were brought into services.

Our lean system and our process now, relies on people who want to engage. If they choose not to engage, we let them go. We don't put our effort and energy in re-engaging them, when really, we probably should. So it absolutely does ring true (Provider).

The harms within this were implicit – the most marginalised, often with highly complex needs, were increasingly unable to access provision.

The services that were left were those that were irreducibly 'core'. Harm reduction *was* widely felt to have survived the absolute worst. Even when other provision was cut and cut again, a degree of harm reduction remained – and some areas remained very proud of their harm reduction offer:

I think there's a very good harm reduction service in [this LA] still. I think that, you know, we've kind of ringfenced or saved that as a service really. So, that's quite positive (Commissioner).

Within this, shared care was protected as 'core business' in many areas, and prescribing in all:

I would say, our providers, if you have this conversation with our providers, they will say to you, yes, that 25 per cent, 30 per cent cut in services, has had a massive impact. And I think it...I think we've tried to keep the core of our services, so we spend a huge amount on harm reduc... on shared care (Commissioner).

I think what we could round preventative stuff as well because that's always the first thing that goes, isn't it? We end up focusing on...a lot of it is scripting costs (Commissioner).

However, as this previous interviewee notes, preventative capacity had largely gone out of the window. Services had become reactive, managing the cases they held with no time or capacity to try and prevent any future cases entering the system (or current cases from becoming worse):

Particularly when I think of addiction services, the year on year cuts have forced the service to, in some senses, focus on drug-related death prevention, so you're focusing on your more urgent life threatening needs instead of being preventative, and supporting people to not get to where you don't want them to get to (Commissioner).

There was also a sense that services had lost much of their tone and colour – survival of clients, and of workers, became essential, and all of the added value or negotiable programmes had been lost:

I think at least 20 per cent of funding has been taken out locally, out of treatment services and it's led to us only really being able to deliver the core of what we want to be doing. So a lot of the stuff around the edges that really adds value and really helps recovery and keeps people safe and alive, we just can't do those things. It's really focused on the core safety for service users and managing caseloads really. So it has been an incredibly challenging, the amount of funding that's been taken out of services. We also have seen increased deaths, definitely, locally. Over the last couple of years but particularly over the last five years, I'd say we've seen an increase in the rates of death (Provider).

This, then, presented a picture of services in a difficult place. Many – most, even – had held onto a core of irreducible (and often reactive or harm reduction) functions, though the scale and reach of these had often been reduced. The peripherals had long gone, with many commissioners having to contemplate – at times – provision with no psychosocial offer at all.

Deaths

As the Black Review notes, one driver for the increased funding was rates of drug deaths reaching their highest point in 2020-21 (see p.16). The Universal Grant and associated measures seek, in part, to reduce drug related deaths. Given the significance of this outcome, it is perhaps surprising that it caused a more mixed response from interviewees than almost any other question about the current state of provision. Geography – and local rates – were clearly core drivers here. Some areas had persistently low mortality rates:

I think for me, our drug-related deaths were low prior to the pandemic, but, you know, and they've remained low through, so I know that's quite unusual (Provider).

Others saw them as hitting broadly moderate and sustainable levels:

I mean, in terms of deaths, for me I think we've seen a bit of a spike in deaths since maybe 2014, drug-related deaths, but they've plateaued over the last maybe three years. We're [consistently under 100], which is still high but then compared to core cities, we don't fare too badly. We're sort of middle of the pack, we're not the best and we're not the worst, which is where we like to be (Commissioner).

In other areas, investigations into local deaths had identified causes that – again – left interviewees relatively unconcerned:

I mean, we certainly have had deaths in service. We, I think, my limited understanding of the detail behind that is that it was, you know, our in-treatment profile was, you know, an aging one, when it came to heroin use and there were, you know, significantly higher rates of death in that group compared to general population. Which is not surprising but obviously, it was happening and, you know, that was an ongoing issue in; I mean, in terms of austerity (Commissioner).

One commissioner unpacked this picture more fully, explaining that in her LA many of those who died were on end-of-life pathways, or seriously ill for other reasons.

And when I look at some of the drug related death information that we have, this is probably going to be quite controversial. Because in lots of ways, we've kept people alive longer because of the things like the end of life provision that we have, the shared care services being able to support people in nursing homes even. Lots of different things like that, when we review our drug related deaths, it's sad and challenging but it's good to see that we have been able to keep people alive as long as possible. But really speaking, that's not...we would like them to have had more intervention earlier on (Commissioner).

The vulnerability of long-term, aging, multiply-marginalised class A drug users was apparent here.

Other sets of interviewees were clear that drug related deaths were a real concern. Indeed, drug related mortality was one of the indicators driving site selection, and this was clearly reflected in some accounts. Within one region, deaths had spiralled – over the period of lockdown alone:

I think during the pandemic, we've had a 40 per cent increase in drug and alcohol-related deaths for people in treatment. So in terms of that kind of broader public health role and responsibility, drugs and alcohol has come out quite badly, I think (PHE).

Alcohol and opiates were specifically linked to mortality:

We have some of the highest rates of drug-related deaths...well, we do have the highest rates of drug-related deaths across the whole country, so that's always been a high focus. And obviously opiate and alcohol were the highest rates (PHE).

And through them, many interviewees – once more – linked mortality to multiple indicators of deprivation.

So it's not just the sort of core, and the worst indicators, like the drug and alcohol related deaths, but things like domestic homicide reviews are the highest ever on record. All of this related sort of deprivation, where deprivation is at the root of it. And all these other sort of indicators and lifestyle indicators, are really sort of all right up there (Commissioner).

I mean we've seen deaths massively increase. And one of the highest rates in the country now. We do have a lot of problems. Deprivation and a lot of rough sleepers, a lot of issues. So mitigating issues really that lead to drug related deaths (Commissioner).

Cuts to services contributed to this – leaving seriously marginalised populations without necessary levels of support:

I mean, the austerity, we can't get away from it, and I think, as a...there's...it's an undeniable correlation. Despite arguments for and against that, the disinvestment, and the loss of specialism, both on the commissioning and Public Health side, as well as more acutely on the delivery side. I think, there's for me, an undeniable correlation between that and the record levels of drug related deaths and alcohol related deaths that we're now seeing (Commissioner).

I mean, certainly, I think at least 20 per cent of funding has been taken out locally, out of treatment services and it's led to us only really being able to deliver the core of what we want to be doing... We also have seen increased deaths, definitely, locally. Over the last couple of years but particularly over the last five years, I'd say we've seen an increase in the rates of death (Provider).

I guess is there a cause or link between that and a reduction in access or increase in drug related deaths, perhaps it's hard to say but at the same time, this year, we have both the highest levels of drug related deaths and alcohol related deaths (Provider).

Finally, some commissioners felt that they lacked access to the data that they needed. One could only access a broad dataset, including a wide range of deaths that were not necessarily able to inform their treatment planning and decisions:

We have not seen huge increases in drug related deaths either, although that data is very difficult to get, obviously, in real time, we have potentially seen a slight increase in deaths in treatment which is different to drug related deaths. We monitor those very closely, they include alcohol, they include all deaths including suicide et cetera. So, I wouldn't be able to say categorically whether we've seen that big increase at the moment because it's too early to say, there is some

potential, we have got slightly increased figures in our in-treatment deaths in the last 12 months (Commissioner).

A second again reflected on the limitations of the available data – which provided a decent picture of deaths *in* treatment but missed those who had died out of treatment, the population of greatest concern:

The problem that we have with the death data is that it's not...so it's on PHE, PHE will tell you how many per 100,000, but we don't see that data, as in...we don't see granular level data. I look at the 72-hour reports. I can see what's coming through. I can see the work's being done, but that's the people in treatment. So we can deal initially with the people in treatment and go, okay, what lessons do we learn? What could we have done differently? Is there anything we missed? And make sure that that's properly embedded in practice. But we can't see about...what about the people that aren't in treatment, that have been bowling in and out of treatment, that are struggling because their caseworker has got 60 people and hasn't been able to call them for... (Commissioner).

The arrival of funding

On 10th March 2021, commissioners and providers were informed of the existence of the Universal Grant funding through letters informing them of the scale of their award, and asking them to identify what they wished to fund from an indicative menu of interventions. These issues were particularly relevant to the Universal Grant – for interviewees focused on IPD delivery, establishing consortium membership was a more critical focus. Here, we describe how interviewees...

- Developed packages of interventions;
- Used the Universal Grant template to mitigate the chaos of a compressed planning process;
- Explored options for creative commissioning;
- Faced the timeframes available: 2-3 weeks to bid, for the Universal Grant;
- Described the impact of insecure funding;
- Highlighted need to use existing providers; and
- Described governance structures and procurement rules, preventing the use of obvious partners.

Developing packages of interventions

As the previous section details, the Universal Grant and IPD funding came after more than a decade of cuts to budgets and reductions in many services. Many commissioners and service managers realistically thought that they had reached a point where nothing more could be cut. The funding was consequently hugely welcomed:

It is that gratitude of, like, “oh my god, we were so desperate for money!”
(Provider).

I don't want to be that provider after – I don't know – years and years in austerity, going, “ooh, now we've got money, we don't know what to do with it.” Well, we do know what to do with it and it's about having competent and qualified people in order to work with those people locally where we have real gaps around our delivery (Provider).

...it's better to welcome crumbs from the table, than hold out for a feast that's never coming. (Commissioner).

The funding brought with it a new sense of possibilities – of potential growth for people who believed that this was what the system needed. As one commissioner noted, they could begin to think meaningfully of cost-benefit again, and of the community benefit they felt this new funding could leverage:

I think, you know, the long term benefits of this funding, far outweigh sort of the immediate...you know, so the cost effectiveness of this. You know, there's lots of equations, as you know, out there. And I've read them over the years, they vary from, you know, £10 spent on drug treatment, saves...no, a pound spent on drug treatment, saves £10 to our local economy, to I think, the latest one was about £3. But every time that equation is done, it shows a long term cost effectiveness of drug and alcohol support and treatment. And I think that's the case. Here, it's quite obvious (Commissioner).

Almost without exception, interviewees were thoroughly pleased with the sum they had been allocated which represented a very significant proportion of their annual budgets:

It's a 20 percent increase, massive. So, you know, brilliant, in terms of additional funding (Provider).

So we received [a decent six figure sum]. And our annual budget is...oh, crikey, I don't know. I can't remember. But a big chunk of cash... yeah, we were pleased with our allocation (Commissioner).

I think it's really constructive, you know, when...it's really positive us getting some funding, us, I mean, local authorities, so the universal grant was incredibly welcome, you know, here's some more money, and I think my experience was that I think people have got a little bit more than they expect they were going to get. We certainly did, I didn't expect to get as much as we got (Commissioner).

This enabled a great deal of new work, and overwhelmingly the target of the funding was welcome.

I think for me, I think targeted monies for the criminal justice element is well needed. I think that the reduction in funding over the last ten years, did have an impact on the criminal justice element. There was a lot more work done in DIP-like services prior, so again it just feels like that's been mobilised again and a bit more thought coming in from how we will manage (Provider).

Now, the bits that I think are really positive about the additional funding, are the focus around the harm reduction, so as we know, we've just had data released this morning, in terms of drug related deaths, and there was some stuff from alcohol just recently, a couple of weeks ago. But I think, actually, you know, the focus around the Naloxone, the needle exchange, the peer led needle exchanges I think are very exciting as well. So, I think that emphasis is really great. Although, that's not just for criminal justice clients, you know, that's for any kind of opiate client or poly-drug user (Provider).

[Being able to fund criminal justice teams] was useful to us... That was helpful to us because it was something that we'd actually wanted to do for a long time and struggled to find the resource (Commissioner).

The thing is on this, what I would say, in reference to the universal grants a couple of things. It's great, what it's enabled me to do (Commissioner).

I mean, the Inpatient Detox is, funding is really positive (Commissioner).

There are some really positive innovations and announcements that have been made, in terms of some of the things that the Government has brought to the region recently (Commissioner).

Providers and commissioners found themselves thinking through the available options, and thinking through how they could draw on known models to provide the most effective support for their most vulnerable and complex service users:

Speaking to service managers, they definitely have welcomed this money and they'll be able to do the enhanced provision with some of the most highest risk people that we work with (Provider).

We didn't have anything around criminal justice at all. And I work really closely with [two other] cities... And [one of them] has a well-established criminal justice team. So actually it felt like a really good opportunity to nick their model and put a criminal justice team in place. So it was really exciting (Commissioner).

There was often a real sense of excitement here; a commissioner reflected that although the timelines were tight, "it's exciting roles though!"

In all areas, the bulk of funding was allocated to staff. A significant proportion of interviewees wanted to explore creative, evidence-based commissioning opportunities. Some of this felt that this was adequately covered by the available options:

I mean, obviously there was a menu of interventions that we could choose from. I think they were pretty broad, I don't think they were...you know, I didn't feel too constricted by them, you know, because you had...you could employ more staff, you could pay for some more rehab, you could get some funding to do some buprenorphine depot stuff, and it gets Naloxone, we didn't know that. So actually, I thought, right, fair enough, it's quite...it's pretty...I don't feel as if, you know, if it had come in and it was only about staff, that wouldn't have been a problem, but I think there was a missed opportunity here (Commissioner).

However, a significant proportion felt that significantly more innovation (or evidence-based work, or use of new providers) could have greatly bolstered the efficacy of their work (see pp.48-49)

Compressed timeframes, chaos, and the Universal Grant template

The process of developing packages of interventions attracted a mixed bag of feelings. Timeframes were compressed, with very little time between hearing about incoming funds and the deadline for submitting local plans. Some interviewees thrived – they had a good sense of what their area needed, they had thought about potential treatment models in the past, and they were able to hit the ground running:

I think it was a really positive experience. I think given the timeframes it was there wasn't time to start scrutinising data and looking into evidence and things like that, we had to make some quick decisions based on gut instinct and what we knew about the local area. We had conversations regularly, so I think we had a good sense of that (Provider).

The suggested template for funding allocations helped here – again, a handful of commissioners noted that this made their task significantly easier.

I thought the template was very good and submission of the bid. Even though I had to submit it twice or something because they said, I missed something. But the actual template was very good I thought. It was better than the previous bids that we've done (Commissioner).

So like all this funding that comes forward, Geoff, and I've had a lot of money from PHE in recent years and stuff like that, you can get very into the process, very into what's going to happen, it's always last minute, it's always, you know, sometimes you don't know what you're getting, you put it in. Obviously it needs government sign-off at the end so you tend to get two weeks kind of... I think in the universal we had a fairly upfront view of how much the money would be and stuff (Provider).

Indeed, PHE regional teams described a small role here – some tweaking and refining of bids, but overwhelmingly commissioners' proposals were well worked through.

Other interviewees expressed more mixed feelings. None were unappreciative, but some felt gratitude tinged with considerable frustration at the very short turnaround:

So I think people appreciated that and the people worked round the clock. Some commissioners had to cancel leave. It was a real challenge to turn around those

proposals. But I think in some cases it was...well, in all cases it was very much welcomed (PHE).

A second PHE regional interviewee expressed similar feelings – sincere appreciation, but sincere appreciation expressed from the sidelines whilst chaos subsumed providers:

I think it's brought chaos, chaos on all levels, for treatment providers, for commissioners, for us, it's all welcomed and everybody said, listen, we cannot say no to this money, so first and foremost, we welcome the money, and I think you'll find that providers and commissioners will all say the same thing, we welcome the money. But the process, the ask, has been difficult (PHE).

Despite these frustrations, nearly all interviewees were happy with packages they requested, believing they contained significant interventions that would provide a real boost to local treatment offers. Where there was a sense of shortfall was in the belief that with more time or preparation, they could have done better still. More time was a persistent refrain – both in terms of longer time frames for available budgets:

We are so glad to have had money in the system. You can't say no to money when we are poor, right. So, we have made absolute best use of it. But if the government want to maximise the benefit from the money, then they have to start thinking a bit longer term (PHE).

And in terms of more time to plan, and more notice of future funding. One LA's provider would have liked to incorporate service users' perspectives much more clearly into planning:

I mean, it was a really quick turnaround, because I was on annual leave for a week and I came back and the plans had been drawn up. And they were like, "I hope you're happy with these." And I was like, "yeah." Like it was so quick, and whilst I am really happy with actually what we've drawn up and it is really good, there wasn't maybe the chance to be really thoughtful and really take... We certainly didn't get a client voice or a service user voice or a peer voice or the voices of people with lived experience (Provider).

A PHE regional summarised this perspective well.

It sort of, it sort of makes us sound ungrateful; we're not, it's just things could have been so much better (PHE).

It is just really we needed more time. Time to think things through to plan it and just to make sure it is...I am sure what we have done in the time available is the

best we could get. And if we couldn't have done it in the time, we wouldn't have got the money, so I am not ungrateful. But if we could have a plan going forward it would be to allow people more time to really consider and understand need, understand models and deliver what is right for their areas (PHE).

The funding was thought to be well targeted, well managed, and well-deployed, then. But more time could have helped deliver even more fully considered proposals.

Working towards creative commissioning

Commissioners found themselves negotiating a core tension. On the one hand, many recognised the need to bolster basic provision and core staffing levels to get services back to a baseline of stability:

You know, people talk about we're going to do something new, we're going to do something very innovative, but unless you've got a stable foundation, i.e. you haven't got staff who are falling apart at the seams, you're not going to do anything, and you can add on as much stuff as you want, but if staff are still struggling with 50, 60, 70 people on their caseload, you're never, ever going to achieve anything. It's classroom sizes, it's just not going to happen, so if you can spend your money, and often what I find is that, sometimes you've got to spend the money on what might be classed as the boring stuff that people aren't going to be particularly...what did you spend your grant on? Oh, we got some more staff in. Didn't you do something innovative? No, really boring, I'm afraid, we created a bit less hassle for frontline staff (Commissioner)

On the other hand, there was a strong desire amongst a good proportion of interviewees to reach beyond core provision towards meaningfully creative commissioning. Local teams wanted to be able to incorporate service users' voices (see pp.48-49), to roll out evidence-based interventions, and to premise their chosen treatment programmes on reasonable assessments of local (or regional) need:

You know, local authorities years ago used to carry out a needs assessment every year as part of their pooled treatment budget. They would carry out a needs assessment. They would submit treatment plans. They would submit plans so we knew what the money was going on and where it was going to. Now, what we're asking people to do is, here's £500,000 or whatever, we'll give you for a year, and as you say, you know, really that's seven or eight months' worth of service, we'll give you that for a year. We want you to submit this proposal in three weeks, oh, and you haven't done a needs assessment. That's alright, we'll still take your proposal (PHE).

They wanted to develop innovative, tailored local solutions to local problems – and saw that the potential for this lay in decent resourcing.

We've got quite some blue sky thinkers in our [team], so we're fortunate in that respect. But with blue sky thinking and being able to bring innovation you need quite a bit of resource behind that, to be able to project manage it, to work through new initiatives, to work through the paper, the protocols, all the governance structures that you need to do. And it takes a lot of work to do something new and direct attention (IPD consortium lead).

Perhaps more importantly, there was not only a strong desire for creative commissioning amongst interviewees, but a firm belief that time and space could enable wider and deeper planning:

If we'd had notification much earlier that we could do a system view in terms of what our needs were and how we could structure a team in the round to support specific cohorts, then I think there would have been massive economies of scale and much more strategic thinking around how we could have achieved that (Commissioner).

One example here centred on the capacity to plan for partnership work between local authorities in one region, so that they shared a prison worker between them – instead of each recruiting their own prison teams. Succinctly, then, the desire for imaginative evidence-based collaborative commissioning was strong; but hampered by several features of the process.

Timescales for choosing options

A second obvious constraint upon creative commissioning was the time available. There was simply no time to develop substantive plans, as has already been noted:

So we had literally a couple of weeks where it was, spent a million pound or something, it was almost a million pounds across the areas. It was kind of how to spend a million in a week. And that was challenging in itself to come up with a model of what we felt we needed (Provider).

Again, this meant swift selection from the suggested menu of options, often with a few tweaks to meet local priorities, instead of considered and engaged planning:

We had a meeting of probably not even an hour, where we said, this is how much money we're getting, this the template of what we can get. Can we please focus on the harm reduction and can we please focus on needle exchange and naloxone,

really doing something around drug-related death? And then also having some capacity for criminal justice so that we're also improving that, which is what most of the message was very heavy on, criminal justice. But could we try and tip the balance on the other side to do more harm reduction (Provider).

The lack of time for partnership work meant that, inevitably, some commissioners submitted their best guesses as to what would be deliverable, aware that these would have to change as time and practicalities unfolded:

Now you cannot, and you will never be able to effectively commission services in three weeks, it's physically impossible. We have to submit information on what we were going to do with that money before we could even properly talk to partners. So actually, what I'm going to probably end up spending that money on, and what I originally planned to spend it on aren't going to be the same thing because we're in a different place now, just a few months later (Commissioner).

Finally, it is important to note that this is not just a gripe: interviewees wanted to do better. They wanted to secure best value for public funds, and to deliver services that could be meaningfully life-changing. Rapid funding went some way towards this, but time to plan could have enabled them to leverage their skills and understanding to deliver more effective work:

I think we probably could have done better; I think we've learnt a lot, more people involved earlier, more resources allocated to it earlier but the timing was pressured, I think, maybe we can come back to that. But I think from my perspective, hopefully that's some insight into the development process of the proposals (Provider).

I certainly didn't have time to look into best evidence, having discussions about what is the most evidence-based? (Commissioner).

There was consequently a sense that the funding – whilst hugely welcome – also contained missed possibilities – that it was a step in the right direction, but significantly more impact could have been achieved for the same overall level of money.

It was so quick that there were potentially missed opportunities. What we've got is pretty good, I think, but we didn't have time to weigh up: do we want to explore nasal naloxone or...? We didn't really have time to discuss that and look at the need for that, it was just like, right, okay, what are we going to do? (Commissioner).

Insecure funding, preventing long-term planning

A second main obstacle to creative commissioning centred on the time-limited nature of the funding. Whilst a couple of areas were ambitious and willing to recruit on open contracts, there was a general sense that the time-limited nature of the funding meant that horizons, creativity and planning were all necessarily constrained. A commissioner expressed the tensions between their sense of excitement and their frustration at the lack of ability to plan long-term:

It sounds great. You know, you think, oh, God, [c.£300,000], and then you think, yeah, but I'll only get it for a year. You know, and there's so much other stuff, that actually, you could do, if you had that certainty, that that [c.£300,000] was going to be an ongoing commitment (Commissioner).

A significant feature here was Buvidal (long-acting, injectable buprenorphine). As a partial opioid agonist, it is effective at blocking the effects of heroin – reducing or eliminating the high, and reducing any potential for overdose. A sizable subset of commissioners and providers saw real value in Buvidal, but were reluctant to commit to it unless they were able to guarantee its availability over the longer-term. The one-year funding did not allow this, leaving several thinking that the only way they could provide it was if (in subsequent years) they found additional funds for existing budgets to cover the costs.

R: We also...we didn't go down the Buvidal route, because the one year funding is pointless. Because then what happens at the end of it? Who's going to pay for it, at the end of it?

I: So the concern is that you're leaving people high and dry, with expectations that can't be fulfilled.

R: Or huge expense that we can't afford, yeah.

A second inhibition centred on promoting new services. Some commissioners who were planning imaginative provision were wary of advertising it, for fear of creating an expectation that they could not meet when funding disappeared:

If the money's only for one year, I'm not going to do a big, massive educational advertisement about this brilliant new resource. Because what happens at the end of one year? So we're not going to invest loads of time and effort, and energy into advertising this as a brilliant opportunity, when it might not be there (Commissioner).

There were broader impacts of the time-limited funding, too. Interviewees felt that a longer cycle would enable a clearer approach towards bigger, system-wide change – embedding the gains from one-year funding within treatment structures:

I would just say the security of long-term funding or longer term funding is huge. Because at the moment, what is needed is systemic change and you can't plan systemic change in a year or enact that in a year. And the longer term, we haven't got time. (Commissioner).

And within this was a feeling of disruption and uncertainty – what *would* the funding landscape look like at the end of the funded year? Having a clearer sense of this would – again – enable commissioners to mainstream initiatives that they had started; or to know that they should plan to go without.

In our commissioning cycle we're at the point where we're kind of 12 months off the end of the current contract. So, we're deciding now about...you know, part of the service review is about looking at what sort of system might we want in an ideal world, and not being able to have a full picture of what the budget might be kind of hampers me in terms of designing the best system I can because I don't know how much money there is. (Commissioner).

Reliance on existing providers

Thirdly, creativity was constrained by process. Turnarounds were so swift that there were no options but to go to existing providers. Generally, this was not seen as a huge problem – commissioners and providers generally had good and well-established working relationships, though even many of these would have appreciated more time for consideration:

I mean, we wouldn't have had the time, you know, with this level you couldn't have commissioned, you couldn't have gone out to the market and gone, come to us with your ideas, you know, we couldn't have done that. What we could have done is, you could have had some wider conversations, you could have put on some sort of consultation event and teased things through like that. (Commissioner)

However, particularly for some functions and in some sites, there was a sense that commissioners would have liked the possibility to put elements of new provision out to tender, or to seek new partners for some aspects of work:

We weren't really able to think really strategic and bring in partners. And, you know, we tried to go back to our drug and alcohol action plan, and our priorities, and say, right, what do we need to do? But in reality, it was like, "oh, my goodness,

let's...we need to do something quite quick, and we're going to lose it. So, right, what do we need quickly?" (Commissioner).

Moreover, reliance on established providers necessarily constrained creativity. The ability to seek out new patterns of work and new possibilities just weren't there; for many Local Authorities, it was a case of drawing on existing services to see what they could realistically do:

We quite quickly had some quite quick conversations and, sort of, said right where do we think our things should be around applying for this. And then just working with those providers quickly to say, right develop something that...what do you think you can deliver, where are we going to make the biggest difference here, what's the thing for us. (Commissioner).

One commissioner described trying to go 'off the book' to commission a provider who had established relationships with criminal justice services, but not with substance misuse. This caused significant administrative difficulties, and some concerns that they could be sanctioned (or 'breached').

Distinctive problems with IPD were described here, too. Although a couple of new facilities were being set up, many areas were using IPD funds to buy additional capacity from existing providers. This led to a particularly strong sense of creativity – and additionality of services – being constrained by the lack of ability to identify new providers.

So much money has come in that what is really needed is some additional work with some additional providers with additional beds. And if you're only able to go to the same old service providers you're inevitably commissioning just more of the same, and if they've only got so many beds you can't do much more with it. (Commissioner).

Challenges related to procurement and governance

Finally, procurement processes and governance requirements meant that commissioners were not entirely free to think creatively. In many areas, the additional funding caused real administrative headaches. The serial release of multiple small pots was causing profound difficulties for one commissioner, who had now received so much additional funding that he would soon need to retender:

This money is in danger of...how far do I go when I'm being recorded, that money...the trend of providing additional funding for specific bits of work has got to the point where it is...we will have to re-procure anyway, because there are

local and national procurement rules. We can't just keep throwing money at one provider... Obviously, we've got rough sleepers [funding]... And so, I've got a treatment service that we've had to enhance to include family safeguarding as a big piece of additional work last year... I've got the custody work, [the] significant additional resource from the universal grant. And I've got contracts that I can only legally change by ten per cent. We are at the point where we can't change our contracts anymore, we can't give any more money to our treatment provider, for the same service, but for extra staff without recommissioning them. (Commissioner).

This was a service where commissioner and provider got on well. They were a significant distance into a long-term contract. However, the funding streams they benefited from were not a clean fit for procurement rules – and this triggered major additional workloads on top of the already-huge work of bidding for and commissioning these services. Whilst this pressure to recommission reflected an unusually painful experience, a decent number of sites were also under new bureaucratic burdens. As this commissioner notes, all funding came with new and often-unwelcome streams of paperwork:

Timescales were just ridiculous and really challenging. Had to do contract variations, all that contractual stuff, that maybe PHE don't necessarily think about in terms of the logistics of making it happen. Because we can't necessarily just give our provider half a million, which is what our money was, and then not think about due diligence and all that sort of stuff. (Commissioner).

Budget deployment, then, required significant consultation and was constrained by multiple practicalities.

Barriers to implementation – staffing challenges

Staffing challenges affected the delivery of both Universal Grant initiatives and, with a widespread shortage of nurses and qualified staff, the development of new IPD capacity. A couple of areas managed to fully deploy nasal naloxone, and a couple had managed to fill all funded staff posts. However, overwhelmingly, sites described huge difficulties in getting funding working on the ground and one PHE regional team interviewee described how 'almost exclusively, all of our local authorities did their quarter one returns with nil spend.' As this brief overview suggests, finding staff proved to be one of the most widespread difficulties in getting funding up and running across sites, compounded by several factors. Here we describe:

- Difficulties with recruitment;
- A lack of available, appropriate potential recruits in the community;

- Competition for available staff from neighbouring areas (and other organisations);
- Cost of living – when multiple areas were recruiting, affordable areas became the most attractive;
- Multiple preceding rounds of recruitment for other recent funding pots (prominently including rough sleepers), diminishing the pool of potential recruits;
- The need to offer (unattractive) fixed-term contracts;
- Timescales for recruitment – new recruits invariably needed DBS checks. Many needed to serve notice periods before they could start in new roles; and
- The impact of COVID on recruitment.

Difficulties with recruitment

To begin with a positive: a (genuinely) small number of sites had managed to recruit substantially or fully to all newly-funded posts. A provider describes:

So we've just started this very week, yesterday. Three posts, one volunteer and peer coordinator, one needle exchange, needle and syringe programme coordinator, and one drugs death prevention coordinator. (Provider).

Such accounts were rare but did exist, overwhelmingly due to the proactive solutions described on pp.63-70; succinctly, by drawing on established networks, by offering enhanced pay, or by recruiting using open contracts. The majority of interviewees described much greater difficulties in getting some – or all – posts operational. As most costs were staff costs, this meant that a fair few areas (and the majority of one region) had nil spends in the period to August 2021:

We're not spending it, and this is a little bit of a problem, hopefully one that we're going to make go away quite soon, is it was quite a lot of money to drop on the system at one point, I suppose, so we've asked our service to recruit what amount to six new staff, you know, six new staff, start getting your buprenorphine licence in place and all your fridges and your training, buy all that Naloxone and do everything else that we asked them to do. So we're kind of...it hasn't gone off as quick as we would have liked. (Commissioner).

Many provided accounts of going out to recruitment for multiple posts multiple times, without managing to find any appropriate recruits:

I've had funding available within our treatment and recovery service for a hidden harm worker. You know, I think they've gone out three times to recruit and I think, so... (Commissioner).

In areas where people were applying, commissioners and providers could find themselves inundated with wholly inappropriate applications. Mirroring the general deskilling of the sector, there was a widespread sense that anyone now felt able to apply for substance misuse posts if they had even a peripheral interest in the field:

Literally I had, like, 45 for a team leader post and there was only six who could even been interviewed because they just haven't got the skill base. And so I had to go back to HR... People are seeing it on Indeed or anywhere and I've had so many emails from people saying, "I've worked in a factory for the last eight years, I'm interested in this job, could you tell me more?" So, I've had to say, "can you be really explicit that you need a qualification for this in the advert, because we're out for the third time at the moment for that role and it's been really difficult to get anyone." (Provider).

A PHE interview summarised these difficulties – noting the combination of compressed timeframes, a lack of available skills and a lack of community interest that together made recruiting profoundly difficult:

The sort of pond that we're fishing in is really, really small, so, in our area we definitely have problems, because we have such a short time-frame to actually get the job descriptions written, get adverts written, get them recruited. Half of them don't turn up to the interview because they've got an interview somewhere else that's going to pay them a couple of thousand pounds more. And that's been quite, I think quite frustrating, really. (PHE).

A lack of available recruits

The central difficulty underpinning recruitment difficulties was a lack of available, eligible, minimally skilled workforce. With the deskilling of the substance misuse sector (see p.16), many potential workers had left for more appealing jobs with more promising career structures:

Recruitment is one of the trickiest parts of my job, I would say. It's really hard to find people that are experienced, or those that are experienced want to leave because of the pay. Not everyone but it's harder to hold people because they would go to comparative fields that are better paid for what they're doing. (Provider).

This was widely associated with structural problems within the sector, with a pervasive sense that many of those who *could* potentially be appropriately recruited into substance misuse work were most likely already working in it:

With the recruitment we've got, it's very very clear that the skills base for substance misuse treatment has gone. The skills base exists, I think, in existing services now so it's very very difficult to actually get qualified and competent staff for the vacancies that are now appearing, so it's a real challenge. (Provider).

Many interviewees consequently painted a picture of long-term vacancies – of posts that they had been advertising for long periods without any substantive success.

If I look at a recent funding pot that we were successful with a couple of years ago, it's not that recent, a couple of years ago, it's taken a year and a half to recruit somebody. So although I'm confident, we will be able to deliver the service. The reality is actually getting someone in post eventually to deliver the service. (Commissioner).

Vacancies were the norm; recruitment difficulties endemic. These had been compounded as time went on. Initially, a handful of posts could be filled by seconding in experienced workers from mainstream services. However, as new funding streams continued to arrive and new recruitment remained difficult or impossible, secondment soon became unsustainable:

And it's a difficult time, because now, all the...all this funding coming in, and posts being created left, right and centre. So it's really affected our treatment services, because there's been secondments. But then it's backfilling secondments, and it's really stretched our services. And some of them are still...some of the interventions from those proposals that have been agreed on, we are going to really struggle. So recruitment is going to be one of the biggest challenges. (Commissioner).

In the early days of some of this funding, [our provider] were happy to [second staff into new roles from existing services], but they're, sort of, now saying, we can't really do that 'cause it's just opening up holes elsewhere that we've got to fill, so they're really trying to bring people in. But...so I am not...you know, it's a really difficult question because everyone's trying very very hard to do the recruitment, but we've got...across the whole piece, not just these ones, the other grants we've got vacancies everywhere. So, I don't think we'll ever be in a place where they're all fully...where it's fully running. (Commissioner).

Competition from other areas

A second factor complicating recruitment was the scale and structure of the new and additional funding. Every LA benefited similarly at the same time. Every LA had consequently developed ambitious plans for ambitious interventions, predicated on

securing ambitious levels of new staff. The picture here was blunt, routinely re-iterated, and centred on the same difficulty: not only were there insufficient potential recruits, every nearby LA wanted them for their services, too:

The universal grant is about 13 posts I think, and it's a nightmare, is the blunt reaction to that because, of course, every region's trying to do the same thing at the same time... So, you've got, you know, lots of criminal justice workers trying to be recruited, you know, all across the country it's a real issue. We have got some of those people in post, but the IOM⁸ contract, for example, they were trying to put three workers, they were on their third round of recruitment, yet to recruit anybody. (Commissioner).

It's huge and what it showed you is that we've got ten local authorities all vying for a set of people, staff members, who have got the same skill set. And now we're struggling to recruit because we're going to get into a position where we'll need to... For us to be able to recruit to that complement, we might have to start vying against [the LA next door] and against other local authorities and increase the amount of money that we pay for it. By doing this nationally, all of a sudden it becomes a recruiter's market. (Commissioner).

Cost of living

Arising from competition between LAs, it was apparent that those services in areas with a high cost of living faced still more pronounced challenges in securing appropriate new staff. Any potential recruit was able to see a plethora of posts being advertised at one and the same time, and were consequently unlikely to choose a post in an area where they would find themselves on the breadline:

It's really difficult, we're just on the edge of the London, sort of, area in terms of when you can attract additional payments for staff. Yeah, house prices are almost as high in [our area], so we really do have that problem. And our service has been fantastic at attracting people in but not at the rate that we're currently seeing the need to expand. (Provider).

National recruitment campaigns from national providers could make this situation still worse. A PHE interviewee described how a successful applicant for one post would be offered a very wide range of posts in a wide range of areas – with a clear and immediate choice making the cost of living an even more prominent factor in their decisions:

⁸ Integrated Offender Management – multi-agency partnerships focused on reducing reoffending by priority offenders.

[A national provider] has a centralised recruitment process so they're putting out all these posts, whatever, without the geographical location on them. So 30 recovery workers wanted here and nurse prescribers there and criminal justice workers here, there and everywhere and whatever. Rather than leaving that as a kind of rolling advert, what they're doing every now and again is they're closing the advert and then pulling in all the applications they got and interviewing them. Again, it's the economics of it. If someone's applied for a recovery worker post and whatever and they're successful at interview, they get offered about six posts from [the Midlands] to [London], to [the East of England], to wherever. If people are looking to move, they aren't moving [here] because they can't afford to, particularly on a short-term contract because of the lack of availability of renting properties and all the rest of it. (PHE).

Multiple preceding rounds of recruitment

Just as competition between LAs reduced the potential pool of available funds, so had multiple previous rounds of funding. This was a problem that was not raised in a wide range of areas – but was clearly noted in some, particularly in those with significant success in securing support from several recent funding streams. A provider explained how this had diminished the potential pool of new recruits for posts funded by the universal grant:

Ten additional staff each time [a new initiative has come along], I'm not talking one or two, there isn't 30 drugs workers out there, waiting to just come and do this we need to expand the workforce and you need a longer-term plan to do that. And you need to be much more competitive in what you offer, and they're not, drug services aren't competitive. (Provider).

Whilst a commissioner reflected on a core paradox of this approach – whilst multiple discrete streams had funded multiple separate areas of provision, the people who benefited from the funding were largely (if not entirely) the same individuals:

So, it's really problematic I would say, and I think it's added to the fact that...and this is a knock-on effect that, I think, we're dealing with about seven different pots of short-term funding now, from PHE and MHCLG. Often roughly around, you know, if you have a Venn diagram it's all around the same cohort of people so, you know, where are all those workers going to come from? (Commissioner).

As in some other domains, this supported a sense that clearer strategic thinking and forward planning could help rationalise both recruitment and service delivery.

Fixed-term contracts

Compounding the organisational challenges of finding appropriately skilled workers, in a sector contending with competition between funding streams and between authorities, was the additional complication of short-term funding. At the outset, it should be noted that not all providers offered fixed term contracts – a handful were willing to absorb the risk of recruiting to open contracts (and this approach met with considerable success – see pp.74-5). However, the funding was available for one year, leaving many providers and LAs with little choice but to offer one-year posts. One interviewee was able to comment directly on the difference this made:

So in the rough sleepers one I was given enough of a nod and a wink to persuade my accountant to...what I did was I just had a punt and I got half of them in permanently and the other half in fixed term. Which is very naughty because they're only supported by one year's money, though I do think it'll be two – that was a nod and a wink. This lot are all literally fixed term and as a result, you know, you're not going to attract as many candidates and you're going to struggle to fill them. (Commissioner).

This was supported by a very widespread view that fixed-term contracts were not, in any substantive sense, appealing. Those who might be desirable, skilled workers were usually in other posts – and the prospect of leaving these for a profoundly uncertain position seemed dim.

The difficulty is, it's all time limited money, and the posts are all fixed term. So especially, with the pandemic, Brexit, all the uncertainty that's come along with that, the key challenge has been to find good people to recruit into these roles, that are fixed term. People are a bit wary of taking the risk basically (Commissioner)

The 12 month thing has been so difficult, and if that money that we'd got had been two years or something, just a year is so hard to get somebody to leave their job for. I wouldn't want to leave my permanent role for a 12 month role, even though some of them are like dream jobs, they're great roles, but just... (Provider).

Some of these accounts drew on direct conversations with potential employees, emphasising that the roles were good, and the posts potentially exciting – but the fixed-term nature of them was massively unappealing.

You know, people say, I'm not going for that, I've got a good job here, permanent contract, I'm not going for...so that sort of puts people off. And I know that has been the case, because people have said, "oh, I've seen that job that you've created, you know, you lot, and it looked really good, but it's a shitty year contract, I can't

go to that.” So, you know, they’ve got mortgages, kids, whatever they’ve got, they’ve got other considerations. So yeah, I think that has been... (Provider).

Such limitations might have been manageable at scale. However, the difficulties of short-term contracts interacted with some of the barriers to recruitment already described. Most areas were not looking to recruit one or two people – some were looking for large numbers, and fixed-term offers at this scale had little prospect of success:

We’ve got about 35 to 40 jobs that have been brought on by this additional funding, that is quite a significant amount of extra jobs you’re trying to fill. And the issue is, if we were saying to all of those, they were three, five, eight, ten-year posts, I think we...if you’re saying to someone it’s a year, you know, that’s really tricky. (Commissioner).

Time to get people into post

Beyond finding people, recruitment involved getting people into post – and, ultimately, into delivering effectively within their roles. These two stages presented separate – but equally significant – challenges. In terms of the first a number of interviewees identified that, with a following wind, ideal recruitment would usually take about three months as local recruitment processes and procedures were gone through:

[Recruitment] is a huge undertaking for commissioners. Because not only have we got to go through all of the recruitment, you can’t just recruit. Unless you actually recruit through your provider, you actually have to go through several layers of government structures within your local authority. Because when you start to put new posts on a structure, that becomes a financial liability for your organisation. So even though they’re trying to provide us with some support, actually it becomes very labour intensive to get that person... (Commissioner).

And criminal record checks were secured and notice periods served:

The recovery coach is due to start next week and I have started the team leader and two of the coordinators on 1 September. The others are still awaiting DBSs, what’s holding them back. And then obviously naturally once the DBS comes through they will then have a notice period to serve. So I’m probably looking at 1 September as the earliest. (Commissioner).

So, that is one of the biggest challenges, is that it was a very short turnaround in terms of the submissions, only three months to go live, which actually, a kind of a

regular recruitment process takes about three months, just if everything kind of goes your way with DBSs' and notice periods et cetera. (Provider).

With only one year of funding available, this would have been a fairly insurmountable challenge. In recognition of this, some flexibility had been built into the Universal Grant. Spend could extend for an additional quarter, leaving commissioners with a quarter to recruit and a year to spend. Whilst this was welcome, recruitment within this timeframe was still proving unattainable for some interviewees:

I think the one-year thing is difficult. And I know that we've kind of been given a bit of grace with quarter one, but still in quarter two I've only got half of the staff recruited – not even half. So it's difficult. (Provider).

The second set of challenges centred on ensuring staff were appropriately trained, experienced and embedded to be delivering within their role. To an extent, this could be addressed through secondments – through bringing in experienced workers from other parts of treatment structures – and this was a widespread solution, particularly for criminal justice and other high-skilled roles. However, a sizable proportion of sites were aiming to recruit large numbers of new staff, with direct implications for the time it would take for them to deliver well. As both of the following interviewees commented, many workers would just be hitting their stride as the funding ended:

It's not just getting them on the system or in the structure but getting them recruited and then getting them trained up. Getting them to deliver something viable within 12 months... (Commissioner).

The problem is we need people to hit the ground running because they need to deliver, so yeah, we've got volunteers, but people need time to bed in, they need to train, they need to understand their service, they need to understand their client group, what their job...and that can take several months, can't it, for anybody to get their head round. So we're looking for people to hit the ground running and to be delivering now by the end of June 2022. (PHE).

In addition to all of the staffing and recruitment difficulties described so far, this time to 'bed in' has clear implications for any evaluation of the impact of the universal grant over its first year.

COVID-19

Finally, it is important to note that Universal funding landed amidst the disruption and chaos of a global pandemic. This was not a dominant theme within interviewees' transcripts – but it was significant. The core point here was that many people's lives had

been turned upside down as COVID arrived and took hold of the UK. Futures – and livelihoods – became uncertain in new and unpredictable ways. Consequently, stability gained new traction – new posts in new, time-limited initiatives took on whole new aspects of risk.

You can't also forget about the pandemic which we've been going through, you know. If you're in a steady stable job while the world around you is looking at a state of flux, you're probably going to stay where you are, aren't you? (Commissioner).

But we're coming out of a pandemic, so our services have been a bit different in that respect. And you've got a workforce that's having to constantly deal with shifting sands because of all the changes through the pandemic as well. And then to feel that there's this pressure that we need to be able to make use of this resource immediately essentially to really have the numbers. It's not really how things work. That's not how...if we think about the people. (Commissioner).

At an uncertain time, advertising uncertain posts appeared optimistic.

Barriers to implementation – non-staff challenges

Recruitment was undoubtedly the biggest hurdle to using the funding up effectively, but it was not the only one. Other barriers to operationalising grants included:

- Governance structures, restricting creativity. Large providers had to ensure all provision was standardised;
- Overburdened management chains; and
- Managing multiple separate funding streams.

We recognise that the establishment of IPD consortia presented another challenge – and one that was specific to the additional inpatient funds. However, we were able to identify few strong themes or narratives here beyond offers of participation being sought or sent out, either from consortia leads or from LA commissioners. We consequently recognise this as an issue; but (despite specific questions) have not been able to address this robustly on the basis of the data secured.

Governance requirements – big organisations

Large providers brought some significant advantages with them. They could centralise recruitment, taking significant work off local teams. They could develop role descriptions, and manage significant planning and offer significant support across all areas of bids. This was apparent from interviews with several teams – some were well ahead of the curve and had begun planning months in advance, as these providers in discussion note:

R1: the first thing, we heard about this was through the PHE national meetings where we have some representatives attending... That information was cascaded from those representatives down to our national senior leadership team. I think at that point, certainly I was thinking, this could be really massive, and we just look at the total amount of funding and we think that we deliver about a third of the services, it's easy for us to do some rough and ready sums on how much money that might be, what proportion of that funding might be allocated to staffing and therefore how many new staff might we need. Then you think, oh it's only for a year, so I think at that stage, me and [a colleague] were talking then, we wrote a paper which we took to our executive team saying this need some attention basically, it's not going to sort itself out and from there, we then moved through into some of the mechanisms.

R2: Yes, and we basically had the rough sleepers programme all set up, so we just widened that scope. I think once we saw the universal proposal template that [my colleague's] team worked with the services to put in the bid, we had a bit of insight

about what we would need to really focus on, as an organisation, which a lot of the interventions, we already have a lot of work being done on those. So, things like harm reduction, Naloxone the Buvidal, we had the pilot sites, but we wanted to bring people together.

However, being part of a large organisation also brought complications and additional regulations around necessary processes. One national provider, for instance, was not able to second any existing staff into new posts:

Our HR policy says that any post, over six months, needs to be externally recruited, so that will prevent you from ringfencing that for an internal secondment essentially... But actually, in practice, that's not a bad strategy... particularly where you've got something like ADDER, which is getting quite a lot of attention and the roles are relatively specialist. It perhaps would make more sense to second in your more experienced staff, managers, et cetera, into those projects and backfill their posts. (Provider).

Moreover, large organisations had commitments to fair treatment across their existing staff teams. Roles and role descriptions had to be standardised, as did pay bands. Again, this left large contractors at something of a disadvantage – not only could they not second staff into new posts, they also lacked the ability to out-compete other local authorities by offering enhanced pay or conditions. To do so would have meant a pay increase nationwide:

I think for the HR perspective, where we're such a big organisation, localisms around salary scales, we can't mobilise. So, if we had an admin in [a Southern city], for instance, that's on the same job description as an admin in [a Yorkshire city] but the salary scales are different, we're open to grievances from staff nationally. So, we have to manage that in a national way, we actually had to do a national piece of due diligence with [thousands of] staff to make sure that the salary scales were consistent across the piece to be able to cost these job roles up. (National provider).

Overburdened management chains

A second barrier centred on the capacity of existing leadership structures within current services. Interviewees described one significant advantage of the IPD over universal grant money here, as the ability to fund additional management or governance posts, enabling (for example) the allocation of beds within a consortium to be managed by new staff. Whilst universal funds were used to provide additional commissioning capacity in a couple of areas, there was an occasional sense that it left

something of a gap in management, with areas taking on significant new staff struggling to find senior staff with the capacity to manage them.

One of the other challenges that we faced is that it was difficult to be able to put managers into the structures. So, that was kind of quite a push back through PHE and through commissioners, I think from PHE to commissioners, that actually there was a reluctance to have, they need to be front facing or client facing staff, and I think that presents real challenges. When you're bringing in, even six or seven people, into a service, that's kind of a span of control for somebody in terms of a Senior Recovery Worker, or a Team Leader, that kind of thing. So, I think that has presented some challenges as well. (Provider).

This was far from an existential threat to the delivery of grant funding; but presented another complexity for a proportion of providers to overcome.

Managing multiple separate funding streams

A related concern for many commissioners was the sheer volume of work involved in getting yet another bid off the ground. The Universal Grant was not so onerous here – the 'universality' of it, the menu of available options and suggested budget splits helped. Still, it was additional work; and the seeming relentlessness of a constant stream of short-term funding opportunities was wearing many commissioners down:

We cannot keep answering to all these grant funding opportunities, as much as we do want the money. You know, we really welcome the money, thank you very much, we want it, but we just can't keep up this level of work. (Commissioner).

It's a bit...it's like, you know, your question about, how do you manage it, it's a massive piece of work on top of everything else that you're asked to do. (Commissioner).

Within this context, it was striking that a notable minority of commissioners had not bid for IPD funding at all because they did not think the work was worth it. (A significant further proportion had to be talked into it, or only bid because they feared they might miss out on future opportunities if they did not bid in this initial round). Others were actively seeking ways of avoiding funding rounds:

It's exhausting. We've got more money and it's like the money that's coming down and I've just gone, I've not got the time to do anything to do with this, so can we not apply for it please. I don't want to apply for it. So, we're losing out because we just haven't got the time or the energy to keep doing it. For that bid, as I said, we were working evenings and weekends, we can't constantly keep...you know,

“here’s another bit of money for another year.” It’s just absolutely bonkers. (Commissioner).

Both capacity and time were problems here, with a sense that multiple pots were arriving with very little time to turn around large workloads.

I mean we’re so busy at the moment with other things, that it’s difficult to find the capacity when PHE say here’s a...there’s an opportunity to bid for this, but you’ve got to get the bid back within three weeks or four weeks. It’s difficult then to talk to all the people that you need to talk to have a proper coordinate approach. (Commissioner).

The additional concern centred on a feeling, already touched on, that much more co-ordination could reduce the work involved and leverage much more cost-effective commissioning. Interviewees highlighted what they saw as a ‘piecemeal’ approach, in which duplication and contract problems were persistent presenting concerns:

So just off the top of my head the things that we’ve done in the last four months is the universal inpatient detox, IPS and now we’re rough sleeper drug and alcohol treatment grant. There’s the probation dynamic framework monies that have come in... So you’re already talking about four separate funding bids and the capacity that comes behind that, just from a drug and alcohol commissioning team point of view, never mind a provider aspect. And there’s potential for massive duplication across that. (Commissioner).

Our procurement team got really twitchy, because there’s been funds, not just for drugs and alcohol, but for domestic violence, for mental health, for homelessness, coming into local authorities, unparalleled. It’s just, there’s money being chucked at us all of a sudden, in these really tight timeframes. Right, here’s some money, you need to spend it. And everyone’s like...so that’s what made the local authority really twitchy. (Commissioner).

Perhaps unsurprisingly, there was consequently a significant call for more planned out or strategic approaches to rolling out new funding pots.

Could they be a little bit more joined up about additional funding and grants? Because they’re flinging them all at us at the same time. So, I’ve been involved in [a separate funding stream] as well and we’ve got other ones coming down as well, and it’s just like they’ve got to remember some of the commissioning teams are very small. Some of them are, you know.... (Commissioner).

Solutions

Every interviewee acknowledged persistent difficulties in some areas of rolling out new funding and initiatives. As noted, these predominantly centred on recruitment and staffing, and the same issues cropped up time and time again. However, some areas had found decent, workable ways of addressing the difficulties they encountered. Not all could be upscaled or applied in every area, and some approaches would inevitably invite problems if adopted on a wider scale – not every area can increase pay to attract workers from neighbouring LAs indefinitely. However, they had proven effective at a local scale, and all solutions merit documentation. They included:

- Seconding staff from core services into new (and often highly skilled) roles;
- Offering increased pay, to attract staff from neighbouring areas;
- Recruiting partly or exclusively on open contracts, assuming either sustained funding or churn would make this viable;
- Recruiting from previous peer or volunteer pools;
- ‘Selling’ exciting or specialist roles;
- Drawing on networks of contacts, or known potential staff;
- Utilising the experience or resources of big organisations. NHS providers could draw in staff for new IPD services. A great deal of work on bids and recruitment was taken on by national teams for the larger providers, drawing on national expertise

It is perhaps worth noting that in some sites, ‘new’ roles funded by the universal grant had been entirely filled. However, this had been done entirely through secondment – meaning that core services were now noticeably understaffed.

Secondment

Undoubtedly the predominant solution to staffing new posts was secondment. Whilst one major national provider made clear that they could not second people into new posts (all posts over six months had to be advertised externally), the vast majority of areas had used secondments to some extent, drawing staff over from main services to fill new gaps or posts.

So the recruitment has been probably the biggest challenge, in terms of finding people. So we’re looking at solutions, such as growing our own, particularly with a lived experience sort of slant. We’ve got a really strong ambassador and peer mentor, but that...they’re obviously, more medium term solutions, I think. So in the short term, we’re trying to offer secondments where we can. (Commissioner).

Secondments offered a swift solution, ensuring skilled staff were able to hit the ground running, and so that new initiatives got off to a strong start:

I did have to make some decisions about what positions I was going to open up as secondments, but there was two positions in particular that I felt would benefit from somebody who already had local service knowledge and one of those positions has been filled by somebody internally. (Commissioner).

This was particularly important for skilled or complex roles:

One of the posts, they're going to look at having somebody that's already in post, so that's got the knowledge of working with criminal justice and the local drug and alcohol service, in the drug and alcohol service to take over that post and for someone else to backfill their posts. So they've already got somebody that's skilled up. So that's one of the things. (Commissioner).

Secondment also held out real benefits for existing staff. People could take on new and exciting roles – for example, working with dedicated or specialist criminal justice or harm reduction caseloads – sometimes for the first time in years. Such high skilled roles could offer genuine career progression, and opportunities that had been unobtainable for many years:

We're getting one of the staff who is already within our addictions service, is going to second across into this new role, it's like a career development opportunity for them, and it lasts 12 months or 15 months or whatever. (Commissioner).

Moreover, they could do so without facing an existential risk – when the one year of funding ran out, “[g]reat, they’ll go back to their old substantive post” (Commissioner)

At the same time, this key benefit also points to the core challenge of secondment. When people were moved from mainstream services, posts had to be backfilled. Sometimes, the illusion of filled posts within newly funded programmes masked the gaps they left behind:

We're 100 per cent recruited... We've got, what, three or four people in through employment but we've got to get to 10.5 through secondments, which doesn't ultimately help at all. (Provider).

The gaps to be filled had to be addressed with agency staff or by recruitment to fixed term contracts that lasted until seconded staff could return. And so, the problems of recruitment were not avoided – they were just passed down the line.

One [new recruit] was from [a neighbouring LA], and that has now left a role that needs filling. The two criminal justice workers have been internal, so then now we are recruiting to backfill their posts, which is a nightmare. And that kind of feeds into Carol Black's stuff about the loss of experienced or skilled and well trained staff. (Provider).

Some areas had consequently begun by seconding people into roles, but had stopped when this became unsustainable. A commissioner wryly noted that their secondment to date had been 'robbing Peter to pay Paul.'

Offering enhanced pay

A second notable strategy was to outcompete other areas. If staff could be drawn in from neighbouring LAs, then this fixed a recruitment problem – for the area offering enhanced pay, at least. In some areas, this was seen as necessary – high local costs of living could profoundly complicate recruitment.

I think when people move now, we get them to fi...it's so incredibly expensive to live in [this area], so when I'm bringing people in, I'm virtually bringing people in on the top of the scale, because I can't expect them to take a wage cut, I can't expect them... So I suppose I've got a bit more the confidence to tell my organisation that's what I'm paying. (Provider).

However, in other areas, new funding enabled improvements in pay and conditions with the hope of improving the appeal of new posts – particularly in contrast to neighbouring authorities who had NHS contracted and funded services:

But I have to be honest with you, the quality coming through from agencies, is poor. We've also done a pay review because being the third sector, we're obviously in competition in [this region] with, basically, the NHS run about half the services and the voluntary sector run the other half. So, we did a pay review and, you know, increased our offer basically, for first line recovery workers to make it a bit more competitive. Not as competitive as the NHS and we are losing some staff to the NHS. And, yes, so that, I mean, that's how we've approached the recruitment. (Provider).

The problems within this solution were clear – in a zero sum game, the pool of available skilled workers was not increased but their distribution was altered. Where one area benefited, others lost out.

Open contracts

With fixed term contracts widely recognised as a major obstacle to recruitment, three commissioners identified that they had addressed this by recruiting to open contracts. One (of three) national providers also identified that a portion of their recruitment had been through the use of open contracts. A PHE interviewee describes much of the thinking behind such approaches:

Some areas have actually put posts out permanently, so they're like hedging their bets that we'll get additional funding, but if not they're willing to take that risk because they just think that they'll get better quality of people applying and obviously they've got more chance of recruiting people if it's a permanent post. So a couple of areas have done that.

And for one provider, recruiting to permanent posts reflected a moral stance:

I: But you're recruiting on fixed term contracts...?

R: No, no, I don't do any of that, Geoff...

I: Okay, so all of the posts that you're recruiting for are down as open.

R: Yeah.

Clearly, consideration had to be given to what would happen at the end of the year. In the small number of sites that were implementing an open contract approach, the response was similar. All were planning to manage a surplus of new employees by absorbing new staff through redeployment and churn.

I: I think you told me they're all open contracts?

R: Yes, they are. Yeah, so we work with [our provider], we have a relationship that is incredibly important, and that's built on trust and respect amongst many other things. And now, since 2015, obviously, a long period of time of working together, where they know that we will support them fully, and for that they take risks that other areas just do not take. And we work with them on that risk, and they know that if push does come to shove and the money does stop, then there will be another place that they can redeploy that person to, because what you're never short of is work for drug and alcohol workers, not at the moment. So, they're all, you know, they don't have fixed term contracts generally, but most other areas do because of the risk, so we don't have that here, we live with the risk, but it is a huge risk for our providers. (Commissioner).

The acknowledged risk, and acceptance of it, was clear within this account. Moreover, it was striking how close this was to the account of a national provider who was only recruiting through fixed contracts – again, the sense was of a real reluctance to lose people and a determination to avoid redundancy. However, they felt unable to absorb the risk and so remained within the one-year timeframe of the available funding.

Generally we have recruitment challenges in services anyway, so I think there will be opportunities to redeploy staff, there will be opportunities for people to move around the organisation, seek promotion et cetera. I think having invested the time and resources and money into training a large number of staff in a year, we would not be looking to lose those individuals and I think we would have a view on future funding opportunities as well as natural attrition within services to try and reduce...I think we would be loath to make anyone redundant and certainly a large number of people. So yes, I think we would do our best to try and hold onto everyone and there might be different ways that we would think about doing that, but we need to be fully prepared and understand what potential risks and liabilities are, financial and otherwise. (Provider).

It is striking that no-one wanted to lose skilled staff at the end of a year, though only a handful felt able to recruit to permanent contracts. This gave a further indication of the potential value of long-term funding – for not only had those sites with open contracts either filled all available posts, or were very close to doing so; they also avoided another concern in many areas, that those on fixed contracts would leave for more secure positions as their funded year approached an end.

Recruiting from peer mentors and volunteers

Former service users provided another potential pool of recruits, drawn on in some – though not all – areas. Perspectives on the use of peers varied. At one end of a spectrum, a couple of areas had recruited heavily, sourcing many – even most – new staff from existing programmes. A commissioner describes:

[Our providers] have done the majority of [recruitment] through staff that are already there, and peer mentors, they've got a fantastic peer mentor scheme. A lot of those they've managed to bring in as staff, a lot of those have started, I think they've got eight, started as recovery workers which is brilliant, they were already well known to the service. (Commissioner).

Real, embedded value was also seen in taking this approach. This was recovery in action – developing a new workforce, providing a pool of local skills, and developing the workforce of the future. This offered clear principled – and pragmatic – rewards:

And in terms of who we're recruiting, what we're finding is the recovery workers just don't seem to be out there with the skills and experience, not surprisingly. So, we're recruiting, you know, it's a good news story, quite a few people are being peer mentors, who have come through the recovery route, brilliant....Personally, I see it as a, the opportunity is, if we recruit 20 staff, you know, at the end of it, if there's some funding left and we've managed to develop ten decent recovery workers, we've done a good job. (Provider).

At another, peers or volunteers were barely used at all. Nearly all providers and commissioners were asked about their use of peers, but they only five sites identified a substantive role for them. In part, this may have been due to reservations about practicality and planning. Peers may have decent local knowledge and a solid grounding in relevant skills, but could need significant time and investment to get them delivering fully and effectively:

So the recruitment has been probably the biggest challenge, in terms of finding people. So we're looking at solutions, such as growing our own, particularly with a lived experience sort of slant. We've got a really strong ambassador and peer mentor, but that...they're obviously, more medium term solutions, I think. (Commissioner).

There were also some reservations about employing peers *en masse*. The following provider was a clear enthusiast for workers with lived experience, but still acknowledged the risk of taking on a large cohort at one time:

On my team, what, 35 of them were ex-service users and there's massive advantages to employing your ex-service users. You know, you grow your own, your peer mentoring scheme has a purpose to it. Obviously there's massive disadvantages to employing a whole load of peer mentors in one go because it's a chronic relapsing condition. And so I think a lot of services that have done that, it's a brilliant thing but it's going to be really tough and all of that guilty feeling that have you asked too much of someone? A lot of people are employing their peer mentors. (Provider).

Particularly in areas with well-established programmes, then, peers could provide a partial solution. Where they were used, they brought real advantages with them – and made manifest some of the core principles of recovery services. However, very few areas saw them as a full solution – drawing on volunteer pools could only realistically plug a part of the gap.

‘Selling’ exciting or specialist roles

Not all solutions to barriers were directly asked about, or expected. However, one that cropped up from a small number of providers centred on the sheer exciting-ness of the new roles that the Universal Grant enabled. The resurrection of dedicated harm reduction and criminal justice – and women’s workers – roles were seen as a real boon for motivated, high-skilled professionals, and this enabled some managers to keenly advocate for known staff to take them on.

Honestly, I really targeted people that I’ve worked with before that were really good and just said to them, you will have such freedom to review whole areas, naloxone provision and have creative ideas about how to improve it. The same with needle exchange, these are ‘a chance in a lifetime’ jobs that don’t come around a lot. And for those workers whose primary interest is harm reduction, that has been kind of cut adrift in the last however many years, like that, luckily, has been really attractive to people. But it was a lot of selling. (Provider).

A second provider was perhaps more moderate about the specific appeal of specific roles, but again gave a clear sense of how they had managed to fill new posts – selling them as an excellent fit for existing workers’ interests, and as outstanding opportunities for professional development.

A lot of that, different kind of roles, for me it’s about giving workers a different experience, it’s about developing them, it’s about...we do a lot of that, I think you’d be really good at this, I think you’d be really good at that, give it a go, and being clear about that. (Provider).

These solutions – giving the hard sell to posts to known individuals – clearly tied in with some of the broader problems discussed earlier. Exciting roles may be enough to encourage someone to apply for a new post; but reassuring them that their old post would still be there when the funding came to an end was often a critical part of ensuring staff members felt able to take the risk of taking on a fixed-term post.

Drawing on networks, or known potential recruits

One provider had managed to fill all new posts through a very active programme of headhunting of former colleagues and workers in neighbouring authorities.

So those three people that just started yesterday, it relied on a huge amount of professional connections and assertive headhunting, like going to people that I’ve worked with or other people have worked with in other areas or other things and really selling the roles. (Provider).

This was a unique response; but indicated the clear benefits of being well-embedded within an area with good, long-term relationships with current and former colleagues.

The benefits of big organisations

Finally, there were some indications that LAs with contracts managed by large organisations could leverage some substantive benefits resulting in meaningful savings of time and effort. National teams supported commissioners in identifying priorities for funding, and in developing and assembling their bids:

As an example, we provided relatively detailed guidance to services on the types of jobs roles and interventions that they might like to use with costings attached to those, to help them put their proposals together in partnership with their local authorities. (Provider).

National teams could also take some of the work away from service managers by deploying HR resources to work on many aspects of recruitment, up to and including interviews:

We had a central HR team that came together to focus specifically on this work and also a national strategic group which I was part of which made things quite easy. So that central HR team put together all of the job descriptions, all of the adverts, all of the questions for interviews, sat on panels if we needed them, so that really took the pressure away from other local services. (Provider).

Indeed, one provider managed all of this centrally – with people applying for standardised roles, and then given a choice of areas to work in. As noted earlier, this strategy came with a balance of benefits and disadvantages. Large organisations also came with restrictions, including (for one) an inability to second staff into roles. This left one provider with nearly two-thirds of nearly four hundred posts remaining unfilled by the time of interview.

A second efficiency leveraged from large contractors was identified by a couple of interviewees working with NHS teams. For these interviewees, access to hospital trusts meant that secondment was available on a grand scale – not only for psychosocial provision, but enabling significant new staffing resources to be found for IPD facilities, too.

We've got an advantage over say someone...some of the private sector firms that don't have that footprint, so you might have...in [this region] you might have in, say, [one large city], for example, you might have – I don't know – [named contractor], one of the private firms. They've probably got 30 staff in and around

that area and that's it. Their next nearest staffing group might be [fifty or sixty miles away]. We've got thousands of staff in [our local trust] across the [region], thousands of them, so they just do an internal advert and just say, you know... (Commissioner).

The principle here was broadly the same as secondment in other sites; but the scale and reach of secondment sat on an entirely different level.

What was enabled by the funds?

Having noted the barriers to implementation and the measures interviewees took to address them, it is important to recognise much of the planning and vision that the additional funding enabled. As noted in previous sections (e.g. pp.38-48) the funding was seen as exciting – as opening up genuinely decent possibilities for new services and capacities. This section consequently also details what the additional funding enabled, within these categories:

- Renewed focus on harm reduction;
- Renewed focus on crime reduction;
- Gendered and trauma-aware provision;
- New partnerships;
- IPD gains – new beds, and new facilities;
- Residential treatment gains – new funding, new capacity;

Having detailed these plans, a related question is explored:

- What, at the time of interview, was up and running?

This resulted in a mixed bag of replies. Many were getting there – they had recruited to a portion of posts, or filled posts in some areas, but were not quite up to delivering everything yet. Beyond this group, a very small number of commissioners and providers were fully up to speed – they had recruited to all new vacancies, and service delivery was already in place. Finally, at the opposite end of a spectrum, a sizable proportion of sites were still struggling with issues around recruitment and staffing, in particular. As the first quarter of funding ended, a notable proportion of interviewees had no services operational yet.

Renewed focus on harm reduction

Given the focus of the additional funding, it is perhaps unsurprising that one of its main effects was a major resurgence in harm reduction capabilities. Interviewees were excited, seeing clear opportunities for boosting existing services, and bringing in comprehensive, high specification capacities and functions:

We've got a harm reduction nurse that's going to be in the harm min service... We're getting like a proper harm reduction medic to go in there, who can do all the lung testing with smokers, do all the blood, all the bloods, everything, just do all the stuff, all the clinical medical stuff that we need to get done, that we sometimes have to farm out, we've now got the person in there that's going to do all of that. So that's absolutely perfect. (Commissioner).

Several strands of work attracted particular attention or enthusiasm. Amongst these was nasal naloxone – a big priority in a significant number of LAs, with the belief that this was an intervention with a real legacy. Even if funding was not continued, getting the kits out there was likely to save some lives:

We've gone down the nasal Naloxone route, and the idea is that we don't have a problem getting Naloxone out to the people who need it, and the people who are happy to carry it. (Commissioner).

Relatedly, a reasonably large group of interviewees were also interested in Buprenorphine. Buprenorphine was seen to be a more complicated proposition than Naloxone – it came with a significantly higher cost, needed more maintenance, and had the potential to impact on mainstream treatment budgets if the universal grant funding was not renewed. Long-acting buprenorphine – went the thinking – could not simply be withdrawn. For those areas that were willing to invest in it, though, Buprenorphine was seen as a real life-saver – particularly for vulnerable service users at the start of a recovery journey:

We put in for Buprenorphine. Which was again, something that we felt was really a priority, because those people that we've been talking about, who are in and out of treatment and everything, and you lose them quite easily. They can have their treatment for... I know you're not necessarily doing all that harm reduction stuff, but you are keeping them safe and hopefully it's the start of the journey to recovery. So that was a priority, Buprenorphine. (Commissioner).

Medication, then, was a core part of resurgent harm reduction services.

A second key component in harm reduction centred on outreach. Several commissioners noted that, as levels of funding had dwindled, they eventually lost all outreach capabilities. With the arrival of new money specifically targeted at reducing harm, reinstating outreach was often a priority. These posts took traditional forms – offering low-threshold engagement to people on the fringes of structured provision.

We've also brought in an outreach worker to beef up harm minimisation and harm reduction. So helping pharmacists, for instance, by offering sort of a weekly surgery with their needle exchange customers, to sort of start promoting the idea that, you know, actually, we care about you, and we want to do something that is positive for you. And not sort of saying, immediately, you know, it's time you thought about treatment. It's, how are you today what are you doing? And just generating that sort of sense that actually, the motivation comes because, you know, you feel like you're not being stigmatised by your activities. (Commissioner).

Several interviewees described outreach at pharmacies, though a couple also described differing approaches. One had prioritised satellite clinics in local approved premises; a second was targeting homeless services:

But yeah so we've got [a local homeless project]. Anyway, they do a lot of work in the community on this rough sleeper pathway, and they are a presence in [a local city]. They're in the church hall there and they do the meals and such. Anyway so we've got an outreach worker there which we're just recruiting as we speak on that. (Commissioner).

And, finally, one interviewee was looking to set up a mobile outreach offer, to increase reach and coverage:

But we're trying to move towards a broader scope of offer, and having things like outreach with a vehicle. Being able to do more through pharmacies and things like that. (Commissioner).

After medication, then, outreach was a significant harm reduction priority for several LAs.

Thirdly, harm reduction brought with it a strong and renewed focus on injecting opiate users, and with this came a revitalisation of needle exchange provision. Almost every LA had retained some form of needle exchange through all degrees of austerity – though often reduced in scale or in geographical reach. The Universal Grant allowed some of these changes to be mitigated or reversed:

We've utilised the Universal Grant to increase our harm reduction offer. So it had become very much about needle exchange and almost entirely focused on injecting drug users on the opiate side. (Commissioner).

A couple of areas were reaching beyond their historical models of provision to try out new harm reduction approaches. A small – but not insignificant – number were trialling peer-led needle exchanges, with considerable enthusiasm:

But I think, actually, you know, the focus around the Naloxone, the needle exchange, the peer led needle exchanges I think are very exciting as well. So, I think that emphasis is really great. Although, that's not just for criminal justice clients, you know, that's for any kind of opiate client or poly-drug user. (Provider).

One commissioner also described trialling new approaches to needle exchange provision. The pandemic and lockdown had seen a rise in drug-related litter, triggering local concerns; the Universal Grant now offered an opportunity to explore whether this could be reduced by sending out alternative packages:

And then with the Grant and the pandemic, we're trialling in both areas, postal schemes and new equipment. But rather than saying, you have to try the new equipment, we're sending the stuff...the equipment that they're used to, all low, dead space needles, regardless of the sort of new or existing. But as well as the existing stuff that they're used to, sending different equipment. (Commissioner).

Renewed focus on crime reduction

Alongside harm reduction, the main focus of the Universal Grant centred on criminal justice. A small minority of interviewees were reluctant to put significant funding into criminal justice services, preferring to prioritise health-focused and community provision. However, the clear majority were excited about what new funding could bring to their criminal justice caseloads. The Drug Interventions Programme (DIP) provided a benchmark here – an initiative that had once provided support to Class A drug using offenders from the point of arrest to following release from prison set a standard for some of the work that interviewees wanted to deliver.

Because of caseloads of pressures on staff we probably haven't had as strengthened pathways between our criminal justice partners than we may have done in the past, when we were back to DIP days. So certainly from the investment point of view this money is really helping us to do that and additional investment moving forward. (Commissioner).

The excitement at revitalising some of this capacity was clear:

We've got the budget from them, they know straight away, brilliant, right, I've got the amount of senior recovery workers and recovery workers that are working on criminal justice we've had to reduce over the years, straightaway I'm going to put an extra four of those in. Liaison with young persons in the youth offending service is an issue, we put somebody straight in to deal with that, dealing with other... (Commissioner).

Particularly in the context of criminal justice – but also framed by the short timeframes for bids, limiting creative commissioning; and by the strong focus on criminal justice and harm reduction within the Universal Grant – there was a strong sense that 'building back better' was not needed so much as directly replacing what had been lost:

It's very much build back what we used to have. We want to see DIP back, we want to see all those criminal justice roles back, those pathways back. Everyone you talk to, they want it back to the way it was, that's what we need. (PHE).

I don't think [commissioners] were going to build back better. I mean, some were trying to re-capture what was lost. And you saw the menu of interventions and said, oh, we recognise that, been there, done that. So, it was a case of that. But again, because it was all rushed, they just grabbed, pick 'n' mix, grabbed what seemed to work. (PHE).

Reduced, specialised criminal justice caseloads receiving intensive support were widely planned:

Our intention will be to move the criminal justice caseloads on to these new workers. Now that will have I suppose a double impact. I've already met with the director of NPS... we've talked about lots of different things that we can do with that cohort, I'm confident that for those 12 months people will get a really good service. Because the caseloads vary, I think we'll say around about 20 to 25, whereas in mainstream treatment I'm currently on around between 60 and 80. (Commissioner).

Within this, new workers were being taken on to work at every stage of the criminal justice system:

We've principally, brought in new staff to support arrest referral, out of court disposals, linking in with prisons... (Commissioner).

A particular priority in many areas was prison links – ensuring that robust pathway were in place to ensure released drug dependent prisoners were kept safe from overdose, and were able to access robust support to smooth their return to the community:

A bit like the old-fashioned sort of through care workers or DIP worker, or prison coordinator. I had that job in a couple of different places and it is intensive and unforgiving, as you know. You do all the work for someone to come out of prison, or even the gate pickups and turn out and they're gate arrested, and you've been working on it for a month and there's no way no one will know that it's going to...it's a lot of work for not a lot. So, we've got that in place now as well. (Commissioner).

Two of the workers'... remit is about the interface from prison into the community. So picking up people, doing the assessment, engaging them in treatment, before they've been released, supporting them with their community, you know, the benefits, so accommodation, all of that malarkey, working in partnership with Probation. (Commissioner).

Finally, one commissioner had also planned dedicated satellite clinics to extend significantly beyond the point of prison release, ensuring that higher risk ex-prisoners housed in probation hostels had access to treatment support.

But there are also some new things that we haven't done previously, which is additional capacity as well. So, one of those things is the work in approved premises. So, we are genuinely getting, I think, we're getting four-point five staff under the universal grant for this year, and a lot of that is going into enhanced...I suppose, you can call it outreach, it's not really, but it's working in those criminal justice environments that we haven't historically done. (Commissioner).

This was a new initiative within a revitalised sector. Speaking to commissioners and providers, it was clear that criminal justice drugs work was back on the table.

Gendered and trauma aware provision

An additional, unexpected gain centred on a renewed interest in gendered – specifically single-sex, women's – provision. For one commissioner, this was rooted in experiences of supporting sex-working women:

And one of the key elements that we had in there, was vulnerable women. Because particularly in [this city], we have a real cohort of women who are involved in street sex working. And, you know, they just have very, very limited options and opportunities with that cohort. So we wanted to try and do something differently. (Commissioner).

For others, it was rooted in criminal justice work, and a clear awareness of women's distinctive presentation and needs.

So, we're bringing back to having a court worker in court to be able to deal with, you know, stand down requests and assessments, and all that sort of stuff, quickly. Particularly a women's worker again coming in to be able to, you know, specialise in helping, I don't know, women through that journey. (Commissioner).

Strikingly, these were not always long-dormant posts being revitalised; in some areas, they reflected entirely new models of work:

One of those [new] workers is a female worker, because that's been identified as being something again, never had. (Commissioner).

Relatedly, whilst trauma-informed provision was rooted in the women's estate (and treatment for women drug users and offenders in particular), it has since developed a

much broader following within substance misuse and criminal justice services. One area specifically mentioned a new role for a trauma informed practitioner.

And that criminal justice team will also have a trauma informed practitioner, because we just recognise that a lot of people that are in that cohort are quite complex and quite often bounce in and out of custody. So we wanted somebody who could maybe do some short sharp pieces of work where people don't necessarily get the opportunity to engage in therapeutic services much. And a group work practitioner as well within that team. (Commissioner).

These aspects of provision suggested some genuinely imaginative thinking behind universal grant bids. New facilities and new capacities targeted at groups long identified as vulnerable, or as having specific needs, were deployed. New forms of tailored care and support were enabled, reflecting a return to some of the gendered provision that began to be implemented following the Corston Review (2007).

New partnerships

A clear loss from austerity was the loss of partnership work – and a widely-perceived increase in silo working (see pp.31-34). With reduced funds, partners had steadily disengaged. Lockdown had then capped off losses in several areas, with treatment services losing (for example) the ability to carry out drug tests for Drug Rehabilitation Requirements, and so losing their last vestiges of engagement with probation. The Universal Grant brought with it real cash aimed at prioritising support within criminal justice, and there was a near-universal perception that this had supported a rapid return of partners and a swift regrowth of partnership work:

Actually, it's amazing how quickly some of those partnerships with the police and with probation and with some of the third sector organisations and housing, a lot of the work that was done around the rough sleeper and homelessness stuff as part of the COVID response, have come together. I've been very impressed in terms of the pace and the speed at which they've brought that programme together but it's backed up by, you know, [several] million [pounds] which is not an inconsiderable amount of money for two and a half or three years' work. (PHE).

Clearly, the main alliances here were formed with criminal justice – and probation in particular:

I think one of the things that this universal grant will be asking us to do really or trying to do is make sure we've got that link so we're trying to put workers within criminal justice setting in terms of courts, police stations that, sort of, side of

things. And have that criminal justice side within the treatment service that can, you know, get that joined up working where we need it. (Commissioner).

Renewed relationships with Probation were a particularly widespread focus:

Another thing that we've felt to focus on is integrating probation into the service a little bit more, so both the ways that we've done that is through the Naloxone, so the funding's helped us to purchase nasal Naloxone for probation officers, so straightaway that involves them being trained by the addiction service, it builds up that relationship, which I think over the last while has deteriorated a lot. I think because of the reduced capacity of the service. (Commissioner).

Criminal justice might be the main beneficiary, but was not the only new partner around the table. Various interviewees described new partnerships with health, housing and homelessness agencies, in particular:

Within [our] County Council there's a team called the health and wellbeing coaches, and they've got a breadth of experience from housing to probation to addiction et cetera, and we decided that the bulk of that money we would give to a County Council team and basically embed them within the service, so that they could work with people in criminal justice, and because of their breadth of experience, and we could use those posts. (Commissioner).

IPD consortia

A related set of new partnerships centred on the development of consortia for IPD bids. A handful of interviewees stuttered at the need for collaboration, feeling either that the work involved was too much for the perceived benefit, or that they already had local needs covered using existing budgets:

I think the regional commissioning approach is great, but it doesn't take account of what we've already got. (Commissioner).

More broadly, there was a near-universal feeling that one year was nowhere near enough to both build consortia and get them up and running.

It was, "you need to do this in-year, you need to have consortia, and what we want is collaborative commissioning," and it was like, well, that just can't happen, you know, to get sign-off from one local authority takes three months, never mind 23, ten, or nine or five local authorities signing off a tender. (PHE).

Much more time was needed in order to get partnerships to a point of being fully operational, leaving some concerns about what could be realistically achieved within one year.

So the IPD monies came in and said, okay, one, we want to know are you going to have consortia, we need to know that in 14 days' time. Now, all the commissioners went, hold on a minute, to commission inpatient detox will take two or three years, if we wanted to collaboratively commission tier four services, we're looking at two or three years within local authority to get a grip of that, to go out to tender, to...all that kind of stuff, you know that. (Commissioner).

Some consortia had shown considerable progress. Two were developing new units, or new capacity within units (see p.89). Others had come together swiftly, and were mostly block-purchasing additional capacity in existing units – an approach that required relatively little additional planning (but, reliant on existing capacity, was widely thought to have increased waiting lists). However, other consortia were struggling. Within at least one, “the consortium work has just...well, it's just ground to a halt really” (Commissioner).

IPD gains – new beds, new facilities

An additional benefit arising from the one-year funding was the increased – or new – availability of detoxification facilities and, for those who chose it as an aspect of the universal grant, beds in residential treatment. The impact of this new capacity varied, as this commissioner describes – whilst some areas already had ample funding for IPD, for others the availability was a complete game-changer:

So, right, so for [us], because we already had five beds, and we can always fill up beds. But because we had five beds, we were okay. But the other areas, [one neighbouring area] is really struggling, didn't have hardly any budget, hardly any budget for inpatient detox, yeah. So now, it's got a bit of a budget. [Another neighbour], exactly the same. [A third neighbour], exactly the same. So they just didn't send people to inpatient detox. It's all very, very rarely. So this has bolstered their ability to send people to inpatient detox. (Commissioner).

'Bed nights' – the number of funded nights available in supported beds – were seen as a key priority. Some consortia (including a majority of those interviewed) also funded a co-ordinator post, but securing generous IPD provision came above other potential targets for funding:

I think we bought [over one thousand] bed nights...And also, we put all the money into buying space, we didn't put any money into...we didn't top slice it for

commissioning or anything like that, so we've put all of it into buying space. The only bit of that is there's a sort of an admin post to help coordinate all of the spaces, the bed spaces across the consortia, but effectively it's all about buying space. (Commissioner).

For most consortia, moving from spot purchasing capacity to having block contracts represented the main shift. They could now rely on having dedicated capacity; and existing providers could be more confident of secure funding.

So we chose [two IPD providers] because they were in our area and there was an element of safeguarding those providers in the longer term. And what we designed, essentially, was a promise of a block purchase of a number of beds over a twelve-month period. (Commissioner).

Two new services were also in the process of being assembled, to considerable excitement:

We've managed to find a really good partner... They had a central [building] which was being used for COVID homeless housing. And that was likely to come to an end. So it was quite serendipitous, Geoff, I can't claim that we were miraculous as a result of us being amazing people, we were very lucky to find that building at that time. (Commissioner).

For these engaged and proactive consortia, there was a sense that new possibilities were being created – that even in a worst case scenario this one year of funding could save lives and open up possibilities for the future.

We're sort of moaning about the temporary nature of the funding. But government have given us an incredible opportunity to leave a lasting legacy in [our region] of something that is going to take the strain off the hospitals locally, and it is going to save lives and change lives. And we just feel like we can't give up. (IPD provider).

Residential treatment gains – new funding, new capacity

If interviewees had a particular concern about IPD funds, it was that there was little structured support following on from detoxification. Local services may be able to provide a level of support, but traditional residential pathways – from IPD to between three and six months of abstinence-focused residential treatment – were not supported by the IPD funding. Some areas were content with this, seeing no particular need for residential provision. Some others had used part of their Universal Grant allocation to fund residential beds, a proportion of which could be linked to IPD:

So, we've got £400,000 for the residential detox and rehab. (Commissioner).

This was a less structured part of the bid. Areas could opt in or opt out of funding residential treatment from the menu of available options, and some felt they already had more than enough capacity. However, there were some creative uses. One LA had decided to fund dedicated single-sex provision, with an equal allocation for men and women:

We also used that funding to increase residential provision. So we've got five beds for women, five for men. So we're really pleased with that. (Provider).

Others saw residential as a natural follow-on from other forms of detoxification, including prison. In a handful of areas, Universal Grant money was supporting post-release transitions straight into residential provision:

I think it was also residential rehab we were able to bid for, which was good, but that wasn't a separate thing. But that was something that we could bid for as part of the universal grant. And that, for criminal justice clients, that's been really welcomed as well. (Commissioner).

I think it was about ten extra places in residential rehab to enable particularly those that are in prison to have a seamless pathway straight into rehab. (Commissioner).

Up and running?

Having reflected on the plans commissioners and providers had in place, it is potentially useful to explore how much of this was being delivered at the time of interview. Interviews coincided with the end of the first funded quarter, and this was a significant moment for the Universal Grant. Commissioners and providers had five quarters to spend a year of funding; and so, services should ideally be operational by the end of the first quarter if a full year of evenly-spread funding were to be leveraged. A handful of areas had achieved this goal:

And...yeah, so...but apart from that most of the posts have been recruited and most of the people are in post now. And in the last...probably two weeks ago we started taking referrals to the service. So, it's started. (Commissioner).

We're a month late but we're pretty much fully staffed, good to go, well, we've gone! (Provider).

We've managed to then secure the drug and alcohol liaison nurse. So, we got a Band 6 nurse doing that, sitting opposite me now, in fact. And then we've got

advance volunteer coordinator. We've got the harm reduction recovery worker going out and doing needle exchange, working with the pharmacies. Blood borne drug testing, blood borne virus stuff, Hep-C campaign and we have got a criminal justice specific recovery worker doing the prison work, harm reduction. (Commissioner).

Far more common were experiences of 'getting there.' As noted earlier, one of the UK's largest provider had only managed to recruit to a third of posts, and this embodied the general picture. Most LAs were beginning to implement new services – but problems with staffing (in particular) meant that they were not yet fully off the ground. Recruitment might be middling across a full set of interventions; or aspects of provision, or elements of bids, might be struggling to get going:

I think we've got about half of them filled from the last time we had a conversation. So, the big issue appears to be, at the minute, is the ones based within IOM, so there's three posts there, none of those are in post, so that's quite a key bit of the thing, no one's in post at the minute. (Commissioner).

We're not up and running on this universal yet...inpatient detox, we've just made the award... And we are in the process of, sort of, getting it up so these universal beds, sort of, operate, getting into, sort of, setup and getting it operational. We're hoping to go live sometime in August. (IPD consortium lead).

Finally, several commissioners were not yet spending anything at all. As the first quarter approached its end, no staff were in post, and no funding was yet on the ground. This characterised some experiences at a local level:

We're not spending it, and this is a little bit of a problem, hopefully one that we're going to make go away quite soon, is it was quite a lot of money to drop on the system at one point, I suppose... So we're kind of...it hasn't gone off as quick as we would have liked. We've put some money into rehab, we've put 50 grand into res rehab and no-one's been placed yet, so I was hoping we'd get a hit on that, we'd get a bit of spend. (Commissioner).

At the moment, I would say we're in the commissioning phase because we're doing things but we're not yet doing things...you know... At the moment, there's little pilots getting run and there's definitely testbed areas getting done. But no, nothing that I would say, oh, it would be good to feedback on this in a month's time to you or six months' time, no (Commissioner).

And characterised one regional picture, too:

I think almost exclusively, all of our local authorities did their quarter one returns with nil spend. (PHE).

Barriers to implementation were significant, then – and despite considerable effort, in some areas had yet to be substantively addressed.

Provision: limitations of fixed-term funding

The unifying feature of the Universal Grant and IPD funding was that they were fixed-term, one-year pots. The Universal Grant, in particular, was rooted in the Black Review with an implicit message that funding should be not only sustained, but increased. The IPD funding – particularly in areas setting up new facilities – risked becoming very inefficient if services and contracts had to be run down after a year. Within this context, interviewees particularly highlighted limitations of fixed term funding in these areas:

- An inability to secure a full year of delivery from a one-year fund;
- A reluctance to promote time-limited new services.
- The impossibility of achieving – or evaluating – impact within a year;
- Disproportionate impact of other processes – for example, if retendering within the one year

An inability to secure a full year of funding

All interviewees were asked if they expected to get a full year of delivery from the Universal Grant and IPD pots. Very few did:

There's still a bit of a question mark over whether it will actually be 12 months, but the Public Health England guidance said that the funding had to be spent within the first quarter of next year. Now obviously if I've got people that don't start until September that really only takes them to a ten-month post. (Provider).

Built into this were all of the problems described so far – the difficulties of securing recruits, and of getting services to the point where their doors could open. Few areas were approaching a point where they were reasonably staffed.

I think the one-year thing is difficult. And I know that we've kind of been given a bit of grace with quarter one, but still in quarter two I've only got half of the staff recruited – not even half. So it's difficult. (Provider).

Beyond this, however, delivery time was eaten away by other aspects of setting up a new service:

That takes a lot of time, doesn't it, for a service to recruit, build people up, do the training. Then all of a sudden, you've only got a finite window to deliver what you're wanting to deliver. It's not...you know, there's no way that member of staff will deliver that programme within the 12 months, because you've lost so much of it either side anyway. So in reality, that's... (Commissioner).

Inevitably, it was also the case that staff approaching the end of insecure fixed-term contracts would seek secure positions elsewhere as their funding neared its end. Again, this was widely expected to nibble 2-3 months off the end of contracts unless it was clear that sustained funding was coming down the line:

We've recruited a whole load of new people on fixed term contracts, who are all great. My worry is if we don't find out we can keep them then they are all going to start leaving, you know. And by the time, you've trained them up to have an impact the funding has almost gone. (Provider).

For a handful of interviewees, this began to pose existential questions about the value of the one-year pots. Clearly, they were reaching towards significant additions to capacity and competence that few stakeholders would willingly go without. However, if recruitment challenges continued, without some assurance of continued investment there was little value in continuing to recruit:

the other flag is just about the length of the, well obviously, the length of it. It's a big investment. I mean, if I'm still recruiting, if, you know, if we're not allowed to extend contracts beyond June next year and I've still got vacancies in September/October, it will beg the question of is it worth it? Is it worth carrying on? It's putting in a lot of effort trying to recruit people, newbies for six months, I don't know. (Provider).

The same was also true for new services and facilities. Two IPD consortia had commissioned new facilities. Each had built dilapidation costs (money set aside for closing down facilities) into their initial calculations, reducing money available for bed space from the off. If no further funding was forthcoming after the end of year one, they were aware that they would have to both pay for a new service to be dilapidated, and would have to stop detoxification some time in advance.

There will be some dilapidations cost. We're in the process of calculating that at the moment. Some of the changes that we're making to the building will be useful and beneficial to the housing association in the long run. But some of them will have to be reversed. So there's some dilapidations cost. There will also be a period of running down the site which will involve incurring costs but not doing detoxes, which would be horrible. (IPD consortium lead).

This clearly built inefficiencies into the system.

Some interviewees suggested that one-year, rolling funding pots may well be the new norm. The message from commissioners and providers was that this was likely to result

in greatly increased – and potentially unmanageable – workloads, whilst drastically reducing the value proposition that could be bought.

Reluctance to advertise new services

A related inefficiency centred on the deployment and use of new facilities whilst they were operational. This was not a widely shared perspective but did come from a small number of areas. Here, interviewees were wary of informing partners or service users about new treatment offers:

How much time and effort, and energy am I going to be putting in, to really advocate in this, and really promoting this with my partners in our community, in our service user groups, when we know it's short term. How much time, and time is money, are we going to invest in something that might not be here in a few months' time? (Provider).

The risk of IPD disappearing was seen as greater still. IPD offered significant, new, enhanced capacities. Interviewees were deeply worried that an awareness of it could lead to new expectations, which then could not be fulfilled:

I've also got to be honest, you know, sort of thinking before you probably even asked me this question, is, if the money's only for one year, I'm not going to do a big, massive educational advertisement about this brilliant new resource. Because what happens at the end of one year? So we're not going to invest loads of time and effort, and energy into advertising this as a brilliant opportunity, when it might not be there. (Commissioner).

This tapped into a broader awareness of service user cohorts who had been repeatedly let down – often based on years rotating in and out of services, seeing provision that they had once expected or relied upon falling out of favour or coming to an end. In this light, some commissioners saw that what they hoped to deliver had huge potential value – but understood that raising expectations was high-risk.

Evaluating impact within one year

A third limitation centred on a sense that initiatives were being set an unmanageable task – that despite genuine enthusiasm for the programmes that were being developed, and a real desire for them to succeed, the structure of the one-year funding meant that initiatives were being 'set up to fail':

But it's never straightforward because the people that we're thinking about are living really...their lives are just in the moment. So it can be...it takes a bit of time

to get it all lined up and so that it's actually the right moment for that person to go in. I think the other thing is as well is that we...it's hard to really show impact. And so it feels a little bit like we're being set up to fail. Because essentially, we all want to be able to evidence that this is a really good thing. We all really, really want this resource, and we can all think of – off the top of our head – individuals who could really, really benefit and would...we know in the right moment with the right support would really benefit from this. (Commissioner).

All of the barriers to implementation described so far impacted on this, not least the inability to secure a full year's provision from a single one-year pot of money:

And if you want to provide a service that is good, based on peers and volunteers, they need to be properly supported, which is what we're not able to do with ideas from them. And also measuring...by the time you've got them and you've trained them and everything, measuring the success of this money is going to be very tricky. We're not going to be able to say this has made a massive difference because actually we'll probably see that a bit later down the line and not within the year that they want the resource to be. (Commissioner).

Some outcomes were also very hard to manage or predict, particularly if base rates were relatively low and big changes (like emerging from lockdown) had the potential to affect them adversely.

We've got a massive...as we've said, a massive drug related death problems. And one year's funding is not really going to impact on that. It might impact a few people in the next stats that come up, this is not the way to work with people who've got all these complex needs. It's not going to go away in a year. (Commissioner).

Compounding this sense of anxiety and frustration was a belief that services may not even have a year to show an impact. With decisions about sustained funding needing to be made some time in advance, the time available for gathering evidence swiftly dwindled to unachievable timeframes:

There's no way that we're going to make a massive difference in eleven months, well, it'll be shorter than that, won't it, you need to know within six months whether you've made a difference. (Commissioner).

National and regional teams gave no sense that this belief – of being set up to fail, or evaluated on unrealistic or unachievable timeframes – was grounded in actual or intended practice. However, for several commissioners, the fear was real.

Managing one-year contracts through new providers

Finally, a small number of LAs were approaching the end of their commissioning cycle. Indeed, for two, the year of assured funding crossed the window in which contracts could change providers. The technical details of this could be managed; but it meant that yet another layer of uncertainty and complication was introduced to posts that were already seen as insecure and with limited broader appeal.

Just being able to now, the challenge was, we're going through our re tendering right now, so we've already got quite a lot of uncertainty within the workforce and knowing what the model is going to be going forward. The money potentially runs into the new contract year, so we started at June but we've had to put people on fixed term contracts until the end of March, because we don't know whether we're going to have our contract beyond that. So, it's like, well, actually it might be the contract changes hands during the period of this as well. (Provider).

When funding ends... Sustainability

Central to the legacy of the fixed-term funding was whether or not commissioners would be able to build in any elements of sustainability. Clearly, this presented a challenge. Years of cuts had stripped services back to irreducible and core functions. The one year funding had then allowed a resurgence of IPD use and interventions focused on crime and harm reduction. Should the money go again, it was hard for many commissioners to see how they could not be back where they were before the funding arrived. This noted, all commissioners had thoughts about sustainability, and some of these were in the form of structured plans for retaining important aspects of services or funding streams. Perspectives on sustainability included:

- Specific plans for alternative funding streams to retain important work;
- A lasting legacy of some interventions, even if no new funding arrived;

Less encouragingly, many interviewees saw little hope for retaining services without renewed funds. These participants expected:

- A loss of newly-employed staff;
- A loss of newly-established facilities;
- Somewhat bleakly, a loss of all gains arising from the one-year funding;
- A loss of trust from service users, obstructing future engagement.

Sustainability: specific plans for alternative funding streams

Two sites identified plans for alternative funding streams, which they saw as a pathway to retaining important new services. Firstly, the end of the year coincided with a recommissioning process for a couple of areas. Here, commissioners described plans to learn lessons from the Universal Grant and mainstream any particularly promising initiatives arising through it:

We're in the process of starting to write our new spec as well, so if those posts develop the way we think they will, they'll influence what goes into that spec, so again there's a bit of a long term legacy there as well around the funding, which is really useful. (Commissioner)

I: What will you lose when the funding ends?

R: I'm hoping because its ending will coincide with my recommissioning, nothing.

I: So you've built sustainability in.

R: Yes. (Commissioner).

Secondly, an IPD consortium had embedded sustainability within their initial offer. Although IPD funds had gone a long way to support the development and funding of a new unit, commissioners would still be required to pay for approximately 40% of each stay. The consortium hoped that the additional money brought in through this model would both allow more detoxes to be funded; and for the model to have additional life beyond the end of the assured year:

One reason why we developed the mixed funding model of local authorities paying a contribution, is because it increases its sustainability in terms of how long the unit might be able to run for. We think it could generate another six months, another 90 to 130 beds, stays, medically managed detoxes, sorry. Obviously, our main concern is around sustainability, so... we can do what we can to make this more sustainable but ultimately, we will need more...potentially more funding, or we need to work out a way where the commissioners would take on and be able to fund this unit themselves with placements.

As she notes, plans for sustaining the unit longer term were far from certain. Ultimately, either new money would have to be found or the model would have to shift to LAs absorbing 100% of costs.

Some other newly-funded interventions also had alternative funding streams built into their structure. This was clearly the case for areas recruiting to open contracts, which were recognised as a funding risk that would have to be managed or absorbed irrespective of any additional funds. Some decisions had also been made to ensure some specific new posts became permanent fixtures within some teams:

What we've done with the universal is we've actually made the NMP, the nurse, the project manager and the team leader permanent roles so we'll absorb them into the service afterwards. Because we just thought they need to be permanent because otherwise we're not going to get anybody to do it. (Provider).

A subset of funded posts would thus remain. So, indeed, would a small proportion of interventions. Several interviewees were clear that they would not have sought to offer Buvidal unless they could guarantee that it could continue to be funded after the end of the structured year. Just as some staff posts would be absorbed into some mainstream treatment budgets, so would Buvidal in some areas if no new funding were forthcoming:

In terms of the Buvidal I think we're going to have to continue that – we can't just suddenly take somebody off when it comes to June next year (Provider).

Clearly, for both staff posts and retained treatment components, savings would have to be made elsewhere. However, the promise of re-tweaking and refining treatment offers through experience of the one-year funding could be identified in these forms.

Sustainability: the lasting legacy of some funded streams

Even if no new funding could be found and interventions could no longer continue, some elements of work had a natural legacy. Nasal naloxone was a leading contender here, with distributed kits having the potential to save lives for some time to come. Clearly, any lives saved by this or any other newly funded intervention would also be a clear legacy of the funding:

Even if we had 12 months and even if we just gave out hundreds and hundreds of naloxone this year and didn't next year, that's still lives saved, so it's definitely worth it. The same with needle exchange. If we can reduce all of the negatives, [blood borne viruses] and stuff like that, for a year, it's worth doing. (Provider).

Outside of these specifics, some elements of work had a likely legacy through skills training. For example, dedicated harm reduction workers could upskill colleagues, so that even if that post went the skills could still remain in the service:

So for instance, the harm reduction outreach worker, their job will be to upskill other professionals in other areas, so that actually, there's less of a drop off after March 31st (Commissioner).

Peers, too, could benefit from training made available under the one-year funds:

I suppose in terms of the peer role you would imagine that you will be training up lots of peers, they will still be around after the 12-month period, you're investing in their learning and their development, aren't you, so that I think can be sustainable. I think we will have to build something in service to make sure that they're fully supported. (Provider).

Whilst far from a complete response to the skills shortage identified as critical by so many interviewees, there was nonetheless a sense that services would be left in a better place than they had been.

Unsustainability: Staff

Other interviewees saw less hope for the future. They struggled to see clear strands of work that could continue to be developed, or legacies from funded interventions that could somehow be retained. The view here was often significantly bleaker, and in a couple of instances was as straightforward as 'we go back to what we did before'

(Provider). However, interviewees often had particular concerns about what they would lose. One of these, perhaps predictably, was staff. This was a real blow in some services, where interviewees were acutely aware of the lack of skilled workers they were already contending with.

I: Okay, and what will you lose when this one year funding ends?

R2: Four staff.

R1: Four staff. You know, and also...

R2: And quality staff, as well. You know, it's really hard to get good quality staff, really hard. There's not enough people out there with a good level of skills and experience about substance misuse. And also, there's not enough nurses with a good level of knowledge and skills around substance misuse. So we will lose that. (Commissioner then provider).

Moreover, with the loss of staff went the loss of the services they delivered. As this provider elaborates, the end of fixed term posts would mean a very significant loss of capacity for his LA:

Ohh. Well, we'll lose all those staff, won't we, whoever we do manage to recruit into treatment services, if the funding doesn't continue because our services don't have the additional back-up or resource to keep those people in post, and then we'll just... So all the hard work that commissioners and providers will have had to put in place, specifically for the criminal justice stuff as well and the inpatient, it'll just...we'll just revert back to – well, hopefully not, we may build pathways, I'm being positive, some good must...will come out of it in terms of... But at the end of the day, I think we know that it takes resource and people to deliver services to people, and if you haven't got the people, then you can't deliver the services. (Provider).

Recruitment had been hard enough; losing those posts now looked doubly painful.

Unsustainability: facilities will be lost

Secondly, entire facilities could be lost. Two areas were setting up new IPD units. One area was building new capacity within an established unit. All of these knew that dereliction costs had to be built in, and all foresaw the potential loss of a great deal of hard work and invested resources should no new funding become available. As one surmised, 'we've had to put that they'll rip it all down afterwards' (Consortium lead).

The problems here also went deeper – lost facilities meant a loss of much-needed capacity:

Potentially [what will be lost is] the detox unit and the opportunity to, you know, get people that don't always have access to specialist acute treatment. You know, we'll lose that pathway to get people into treatment, to reduce that drug dependence and, you know, we will lose potentially a really valuable provision. (IPD consortium lead).

And in a context where IPD beds and funding were in short supply, this loss of capacity represented a real local – and even national – loss:

Well, I think if they end and there's no additional money coming down, we will lose a new nine bed inpatient detox unit and nationally, there is already a shortage of medically managed inpatient detox units so we'll lose that. (IPD consortium lead).

Unsustainability: almost all gains will be lost

As noted, some interviewees were blunter in their assessments. The fixed term funding had enabled new interventions. Its loss would mean the disappearance of those new interventions:

R1: We need some money from somewhere, because we haven't got the money in our budget, so the money that we've got in our budget is the money that we've got in and we certainly won't be able to put more into it at this moment in time, we won't be looking to put more in. So, we need more money from central government really, to continue these things on.

R2: Absolutely, and decent notice to be able to keep the people on. (Provider, followed by commissioner)

I don't...you know, that's a circle I can't square really, a lot of the time. How do we offer these additional, sometimes very expensive services, when the funding's not there? I don't...I still don't know how we're going to do that.

It was not specific elements of work or specific staff roles that would be lost. Rather, everything that had been gained through the universal funding would be lost, and any temporary gains would disappear into dust:

All those services will disappear again. So, we'll go back to square one. So, any gains that we've made in terms of being able to have access to a specialist in the court setting, you know, that person's not going to be there. So, you know, the

efficiency and being able to recommend people for an ATR or a DRR⁹ it's not going to be... an ATR, it's not going to be a possibility. (Commissioner).

There was a familiar sense here of being reduced, again, to core functions. Just as a series of cuts over the years had left services reduced to core functions, so this reduction would become necessary once again:

But certainly, the fixed term nature of it all, is a huge, huge challenge, there's no getting away from that. And there's only limited amounts that we'll be able...if it does come to that, and all the funding stops, there's only a limited amount that we will be able to sustain. Because we've had to get to a stage with prioritising the sort of...the more reactive stuff. There's no getting away from it, those who are in your old money, Tier Three, sort of treatment interventions. (Commissioner).

Even then, the loss of all new provision – a return to square one – looked like a comparatively rosy picture to a couple of interviewees. This is elaborated more on in the following section, but some thought that introducing then removing services would leave LAs significantly weaker by seriously damaging staff morale:

I think the largest loss is going to be the morale of staff in the sector, yeah, I think the Dame Carol Black review has been really honest and I think the sector have enjoyed that. I think people are completely behind Dame Carol Black in terms of what's happening, but the moment that funding doesn't continue and we're back to the grindstone with the bare resources that we had, I think that'll be quite challenging for the sector as a whole. I mean, other than the loss of opportunities it's creating to work in a more integrated way with criminal justice, supporting local recovery support groups, and lived experience recovery organisations, that'll be a massive impact as well. Yeah, so the work around county lines, I think there's opportunity, especially if some of this funding demonstrates that there are benefits to county lines, I think that would be a real loss to us, so yeah. (Commissioner).

Capacity within treatment systems across the [region] will go back to what they were, possibly even worse because you're going to have a very disgruntled workforce whose caseloads are going to increase. (PHE).

⁹ Alcohol Treatment Requirement or Drug Rehabilitation Requirement – community sentencing options, mandating engagement with a treatment regime.

Raising expectations then failing them has already been noted. The risk that lost trust from staff and service users could cause additional damage and disintegration was relatedly a big concern.

Lost trust from service users

Finally, whilst some areas thought they could keep some benefits from new provision, and some thought that most things would be lost, a handful of interviewees thought that services would be in a significantly worse place than ever before should the funding be withdrawn after a single year. This belief centred on an understanding that new services would drive new demand, and new demand would create new expectations. Going back to how things were was no longer a possibility:

We can't go back to where we were before because the need is still the same. If anything, we've created more demand through this investment of the staff and the offer, that we won't be able to sustain, moving forward, I don't think.
(Commissioner).

In conjunction with this was an understanding that many service users had been repeatedly failed by services, and so the slow development of trust was essential to meaningful engagement. A provider reflects on the awkward fit between this indefinite and long-term need, and fixed, short-term funding:

Particularly people who've been through the criminal justice services who have a mistrust of professionals anyway, to start to get a therapeutic relationship and get them to really open up and start to do some real recovery work, there's a risk that it could actually make things worse for some of those people if they build a relationship and then that person goes and they're back to square one. (Provider).

Consequently, small changes could be unsettling; reductions in the accessibility or convenience of essential services could shake people's faith in providers:

But it is a real concern, and from a client perspective, if you can access needle exchange at convenient times for you and it's really great, and then that disappears or reduces again, that would really shake my experience of a provider.
(Provider).

Concerns became amplified when talking about major interventions. You do not need to speak to many long-term opiate users to hear about historic stints in residential treatment, and the steady dwindling of residential treatment budgets. Indeed, as such budgets have dwindled, so much of the residential sector has diminished or died. The

Universal Grant now brought back some potential for revitalised capacity; if this were to be lost again, the impact on trust – and on equity of treatment – could be substantial:

People might be let down, yeah. And certainly, the rehab thing would be a massive issue, because as [my colleague] already said, there is no budget for that at all. We're going to be promoting and encouraging this, this year. We are going to use those beds; we know we will. And then next year, somebody will say, well, I need rehab, and a worker says, I need rehab, and it's going to be much harder to access. (Commissioner).

What do you still need? Policy and governance

Interviewees welcomed additional funding, and many had decades of experience and strong visions of what gold standard local service provision might entail. All interviewees had views of what they still needed to reach their goals. These answers are broken into two sections: what they needed, in terms of governance and policy arrangements; and what they needed, in terms of additional funded programmes or elements of need.

- Secure, long-term funding;
- A skills and career framework for drug workers;
- Joined up and strategic government thinking;
- Help with the cost of medication. Some interviewees felt that national purchasing could greatly reduce costs.

Reflecting a core theme within the Black Review, across interviews there were conflicting desires for localisation and accountability. Some interviewees – at all levels – saw complete localisation as the only way forward, with commissioners allocating (perhaps ring-fenced) treatment budgets on the basis of local needs assessments. Contrastingly, other interviewees saw significant centralisation – grounded in a new cross-governmental Drugs Unit – as ideal. They saw real benefits arising from centralisation – from established standards, outcomes frameworks, and ring-fenced and dedicated budgets (for example, for crime and opiate treatment). These interviewees welcomed significantly greater accountability within this. There was a sense from some stakeholders that localisation was partly responsible for worsening treatment outcomes. Between these two views, a significant number of interviewees expressed a desire for some increased accountability – maintaining the ability to respond to local needs, but with a degree of new oversight.

Secure, long-term funding

It is hard to emphasise the consistency with which this one, key, overarching message came across. Many pieces of structured coding, exported into word documents, covered a few sides of A4. Perhaps a dozen or so, containing multiple nuances on a topic. This was less the case for the code ‘funding – security, long-term, etc,’ where interviews contained sixteen sides of excerpts and quotations, all essentially resolving to one basic message:

But what’s really difficult, when you... And I was thinking... You asked the question, then, of well what’s still missing, is they all know what’s still missing. They don’t need to fund you to tell you what’s missing. They already know it’s the short-term funding. (Commissioner).

Money was needed. Stability was needed. A degree of reassurance and foreknowledge was needed in order to enable the reasonable planning and delivery of services. Interviewees were well aware of this fact, and often repeated it to the point of apparent tedium:

I feel like I'm a bit boring in that I keep saying sustained funding. It's kind of what we need. (Commissioner).

Longer timeframes would enable greater planning – whether these were over 3, 5 or 10 years:

Just knowing, having a plan for three years would just be amazing, that would get us where we need to get a lot quicker. (Commissioner).

I think, at the very least, if they could say that this is going to be the, say a five year amount, that you're guaranteed to get. And that would fit with longer term commissioning, would give us a little bit more planning time... I mean, five years is essentially, permanent in these times, isn't it. I think that something like that, would give us a far greater chance of making a difference... (Commissioner).

We have to put money into these services. We have to put money into community treatment, into housing, into...just literally we need to start doing this and on a ten-year basis...(Commissioner).

Interviewees widely felt that one year was barely enough to get recruitment working functionally – a point supported by the profound difficulties in every LA and every region, and nearly every provider at every level. Longer timeframes could enable much more considered, planned-out and cost-effective spend:

Five-year money be better because it means...and a bit more flexibility in the criteria so that you could tailor it more to your local needs and then do...you could spend the first year doing like a proof of concept. Where we had no time to do that. I mean, just recruiting, you know, you just really... (Commissioner)

Having begun to form a basis of novel interventions through the Universal Grant, commissioners now felt that they were in a good position to extend and develop this through sustained, longer-term funding models:

The longevity's the one for me, that these pots of money come out, short timeline, you rush it all through and then what's that mean in 12 months? Stability and longevity I think are the only things. I think now the model's there and we know what we're going to do, and once all the staff are in place, it's literally you're not

going to get any really decent outcomes in six months, because that's all we're going to have by the time we go for the operation. (Commissioner).

Often, these views were built on experience. Commissioners talked of rolling out five, eight or ten-year contracts, extending commissioning cycles to give providers a chance to really bed in and work collaboratively with commissioning teams. Change was understood to be long-term at a local level; to see national funding working on short-term frameworks consequently seemed counterintuitive:

Short-term funding's a problem, you know, for a whole plethora of reasons. If I look at where we were... and look at what we've got to, we can prove that long-term funding, well managed and clearly done, works. If you want evidence it works, look at [our] performance over the last three or four years. (Commissioner).

A second commissioner was more direct:

The biggest impact for me is the short-termism has completely bugged us up. (Commissioner).

A skills and career framework for drug workers

This was perhaps the point from the Black Review that resonated most clearly with interviewees. Many of the interviewees' concerns about staff skills were covered in the opening of this report, in descriptions of the deskilling of the substance misuse sector. This showed itself in the difficulties that now existed in the community – in the challenges in finding or recruiting appropriately skilled staff, or progressing staff with reference to clear and consistent benchmarks. Concomitantly, a real priority for many interviewees was to revitalise skills trainings and qualifications within the sector. It is striking that many barriers to operationalising funding identified by interviewees were rooted in a loss of skilled workforce; but none of the solutions addressed this at all. Rather, they moved existing pools of skilled workers around – tackling the core problem was beyond individual services or authorities.

Framed by this context, interviewees saw a need for change. Frontline workers were already managing difficult caseloads, and delivering on complex tasks.

We need massive investment in the sector, we need to start recognising the level of expertise that a recovery worker does, the amount of risk they hold on a daily basis. (Commissioner).

Offering development through structured frameworks had the potential to ensure that they were able to follow through on this with appropriate training – delivering meaningful, evidence-based interventions as a routine part of their work:

Having either better wages or better structures or better time to ensure that when we say that we're delivering motivational interviewing, that we actually are. Or when we say that we're delivering an evidence-based needle exchange, that we actually have the space to do that. Yeah, that's very waffly but that's my passion. (Commissioner).

DANOS was seen as a decent benchmark here – a model of what had been done, that had worked to a decent extent. More broadly, though, there was a sense that drug and alcohol workers were being treated as though they were 'second-class across the board' (Commissioner). A levelling-up process was needed to revitalise the sector, comprising meaningful qualifications akin to those required in other fields:

I would like to see a, for staff, a more...not necessarily like social work, but a formal qualification, something more for our staff, because they are always considered to not be professionals in the way that a social worker is considered to be a professional. Which has problems with resourcing with people disappearing off 'cause they want to then do that, if they're a good worker they'll go and do something else, where they're going to be paid more. (Commissioner).

There was a feeling that this would alleviate many of the problems the sector faced – supporting improved interventions delivered by a better-skilled workforce with higher morale:

Essentially as a sector, if we could employ people at a better rate and we could offer them job security and people can actually make a career out of this, we'd have an amazing system. And actually, imagine what would happen for those people coming into that system. Imagine all that potential that could hopefully come out of that system and actually do something really helpful and productive in society. So it's like no-one wins unless they do this. (Commissioner).

Doing so could also reduce the incentive for many of the best workers to leave for posts in more professionalised roles with clearer career structures:

I do think there needs to be something around like professional training of the workforce and how we make it attractive for people to stay within this sector. And that we're not just doing all the hard work of training up fresh people for them to then go and leave and get a job managing a caseload somewhere else where they'll get paid more. (Provider).

Time and time again, interviewees hinted at the idea of substance misuse as a Cinderella service – all too easy to forget or ignore, and working with a highly stigmatised population. A provider consequently framed the basis of their plea in related terms, asking primarily for equity and respect:

My plea would be, please invest properly and treat people with the respect and equality that they deserve. (Commissioner and provider).

Joined up and strategic government thinking

Just as the rise of siloed provision was seen as one of the great harms of austerity, so a fragmented approach to treatment and governance was seen as one of the core obstacles to addressing complex needs. This point was raised in the Black Review, which called for a cross-governmental Drugs Unit to co-ordinate work and establish targets and objectives for other departments. This need was widely recognised by interviewees, as this commissioner shows:

We need a proper drug strategy and we need some real commitment, basically. We need the political will to be...and we need it to be cross-parliamentary. It cannot be something that is a kneejerk response every four years. It needs to be taken out of the hands of there being a kind of...it needs to be cross-party. It needs to be something...and I think probably a number of areas of social policy and delivery need to be taken out of this realm. I think they need to be just kind of...there needs to be...everybody signs up for it for much longer. Like a ten-year strategy or something. I don't know. But it needs to have real clear investment with uplift and obviously, we need to perform. We don't just get money for nothing. We need to make sure we're performing. But with the proper commitment and proper action across other areas of social policy, like welfare reform. I mean, why we have in-work poverty in this day and age, it beggar's belief. And what about the local housing allowance that means... And why are we not doing something about privately rented landlords? What's happening with social housing? Why are we making all this so difficult? (Commissioner).

Above all, this was rooted in a sense that service users had increasingly complex needs. If ever they had been straightforward, the heroin users in their mid-fifties with multiple morbidities and extensive criminal records certainly were not any more:

there's been a...like I say, it's feast or famine, because there hasn't been so many resources available, there's a certain practice that is quite risk averse. And it's trying to change that practice to be able to understand when we can support somebody that's rough sleeping or with those kinds of intersecting needs, multiple disadvantage, history of trauma, complex physical health needs, how we can say,

actually, we want to put them in for stabilisation and to get them assessed for their different health conditions, and the step down will be a hostel or it might be whatever it is that we can come up with. But that way of thinking hasn't been nurtured if that makes sense? (Commissioner).

These were both the most costly individuals, and those who were the hardest to support towards any form of change. In this context, the importance of joined up thinking and joined up planning became evident:

We don't want to think about tobacco, we don't want to think about alcohol, we don't want to think about drugs, we don't want to think about homelessness. We want to think about complexity and marginalised groups et cetera, et cetera. (PHE).

And beyond this, came a clear need for joined-up and cohesive interdepartmental government planning.

More broadly, interviewees appreciated the idea of a centralised strategy. Many reflected back to the time of the NTA, and the role that it had played in steering and guiding treatment.

I'm expecting Government to set standards that we can all work to. Because when they do that, actually, it makes sense to people. But by diverting it all into the local authority and saying, it's all your issue, it's your issue, you know best, that's fine, but there have to be some standards that we can aspire to, and that we can work with, that enable us to look at our local area and say, yes, we can do that in that particular way. And, you know, again, the National Treatment Agency or the Central Drug Unit, whatever you want to call it, will be an ideal way of doing that. I think that's brilliant. (Commissioner).

I've heard...obviously I've been watching the Dame Carol Black sort of...some of the webinars that they've done so far, and I mean, I think...I still think there's room for, you know, something like the pooled treatment budget, something where there's a funding stream that is absolutely protected, but...you know, careful what you wish for, but comes with some expectation, comes with some national expectation, you know. Agendas have to be driven to a certain extent, and I think that in the last...I don't know, is it the last ten years, I don't know, but it feels as if the lack of national expectation and monitor has caused some systems to drift a little bit. I don't want someone's boot up the back of my neck obviously, but it doesn't hurt having someone locally to ask, whether we have with the NTA, to kind of bounce ideas off and just say, look, is this the way we should be going, is this how we should be working? It's actually quite refreshing having some of the

discussions with PHE colleagues, and some of the language they've used about what their expectations are of local authorities. I found it quite instructive, actually. (Commissioner).

An important theme runs through these last two accounts. They were not uncritical – rather they were from commissioners seeking a balance between localism and centralisation. A handful of interviewees were quite uncritically positive of previous models of work:

there's nothing in there that's surprising to me, I flicked through it again yesterday, but there's nothing in there that's surprising. But what does that mean, have I been...because you know like between you and I, they say one of the departments has come up with this really innovative way of working that we should work collaboratively and criminal justice and whatever and we should have a whole system response to criminal justice, substance misuse and mental health, like, fabulous idea, now who thought of that, we didn't have that 15 years ago, did we? You know, nothing's perfect, is it, it wasn't perfect then and we probably moaned about it, but when it disappeared we were like, whoa, that was actually quite good, why did we get rid of that, and then someone's had a brainwave, oh, let's do this, yeah, brilliant. (Provider).

However, they were a minority. The broader view from stakeholders at all levels was that complete localisation had lost any substantive sense of accountability, and that some re-establishment of standards and expectations could help to revive the sector. This was particularly true in areas such as re-skilling the workforce.

Help with the costs of prescribing

This final suggestion was raised in only one area, but it was nonetheless raised as a particular priority. Here, the commissioner noted that a very significant part of his treatment budget went on opioid substitution medication. He saw a potential role for government in centralising costs, leveraging widespread economies of scale:

Yeah, just one more thing I think would be alleviation on the pharmacy budget, the amount of, how can you say, the growing pharmacy costs, and I really don't know why we can't have a national purchasing organisation that does work on our behalf to set standard prices across the whole of the country for methadone and buprenorphine et cetera, it just seems to me like a loss of an opportunity to lever government purchasing power, yeah. (Commissioner).

What do you still need? Service user needs and support

Cutting across many of interviewee's accounts was the understanding that substance misuse cannot be treated alone. The rise of silo working began to emphasise this, along with the loss of partnership work. The loss of the pooled budget had also been another loss along the way. As funding had reduced, so provision became more thinly stretched and core partners had less reason to be around the table. Framed by this context, interviewees set out the aspects of treatment that they felt were still underserved, and that they felt needed increased attention (and funding) in order to enable treatment services to function effectively. These included:

- Access to enhanced funding for alcohol treatment;
- Prevention and youth work;
- Mental health support;
- Decent, safe and secure housing;
- Education, training and employment support;
- Residential rehab. There must be a follow-on to inpatient detox;
- A holistic offer for long-term drug and alcohol users; and
- Support in accessing primary care.

Alcohol funding

Whilst the available funding was broadly welcome, as one provider reflected...

[The universal grant] fit our priorities to a degree, but we also think our priorities are average, if that makes sense. (Provider).

Less 'average' LAs found the funding reflected their priorities less straightforwardly. Rural and smaller regions, in particular, had relatively small populations of opiate users. Alcohol was a major concern here, and this concern was shared by a good proportion of other LAs. Alcohol was seen as a key local driver of crime:

I understand the focus on heroin and crack, I understand that focus, but the larger population needs around alcohol are massive. In our health assessment, looking at things like driving accidents, violent crime, they are alcohol driven, a significant proportion. (Commissioner).

I don't know how they didn't end up with enough focus on alcohol because I think alcohol is more prevalent [in this LA], isn't it, [provider]? It's not that we've not got opiate use, because we have. And we've got some long-term opiate use, but I think the alcohol...I don't know whether it wasn't seen as important, I don't know. (Commissioner).

And of deaths – some of which were initially reported as drug-related:

We are seeing alcohol-related deaths, and we're also...our drug-related deaths co-ordinator works very closely with the suicide prevention co-ordinator and quite often we're finding that suspected suicides are actually alcohol-related deaths. (Commissioner).

Even in areas where the Universal Grant was hitting key priorities, interviewees often recognised that levels of alcohol provision remained comparatively poor.

Alcohol I would say probably is a big issue, and clearly a lot of the money that comes down, Geoff, is about drugs, because that's where that is, and people cry about it or moan about it, alcohol is a big issue, not just because of the unmet need which I think is obviously in a lot of places really, but the times...the way people come off that is just very different. (Provider).

One PHE interviewee provided the broad context – identifying that just two LAs within their area retained any dedicated alcohol provision.

We have literally two areas in [the region] that have dedicated alcohol services, everything else is integrated so I think, you know, there's not been many winners but the big losers, I think, are around dedicated alcohol provision, particularly. (PHE).

Moreover, COVID had made drinking patterns worse. Whilst more opiate users had been driven into services as accessing both funds and heroin became more challenging, drinking levels within the community had spiralled, creating new concerns:

I think alcohol, I agree with you completely that it...because it's socially acceptable, although when we look at the increasing percentage of liver disease deaths, we look at the impact COVID's had on heavy drinkers in particular, I think we have to find a way to focus more on that. (Commissioner).

The demand for alcohol services also needs to be looked at and it's huge and it's got worse through lockdown. (Provider).

our priorities really, were kind of what the Government told us to do, wasn't it. Because we wanted to do certain things... One of our key things was, well, we need real assistance doing stuff around alcohol. And particularly with COVID-19, a lot of people's experience of alcohol and the effects from it, had been quite adverse in many respects. So of course, the Government says, no, you can only use it for opiates, you can...and crack, you can only use it principally, in Criminal Justice,

because this is a crime, and we've got to stop people being criminals, blah, blah, blah. And it was that, ah, okay. (Commissioner).

This sense – of alcohol as the new Cinderella service in need of additional measures – cut across the board. Perhaps inevitably, because of this alcohol was one of the key missed priorities within the available one-year funding.

I: Had money come along without constraints, without restrictions, what would have been your priority areas?

R1: It definitely would have had an alcohol element, definitely. (Commissioner).

The bit that it misses for me, aside it not being towards the health focus, is around the alcohol clients. (Provider).

Some areas were using IPD money to provide additional support for some alcohol users; but this remained a relatively low-level element of support.

Prevention and youth work

The second biggest priority for interviewees centred on youth work and preventative capacities. This was driven by a sense that very little was currently available:

Young people's services have just disappeared off the face of the earth. (PHE).

And that what was being targeted and delivered focused very much on an entrenched cohort who, realistically, were very hard to support towards substantive change. As such, some commissioners powerfully desired to 'invert the triangle': to find ways of stopping problems early:

When I look at where the addiction service sits at the moment, it sits at the top end of that triangle, and there is very little investment in [this LA] at the moment in the public health messages, in the prevention that stops some of the demand being created, and that would be massive for us, really more funding that's focused on parenting and families and young people. (Commissioner).

This led to a bit of a sense of firefighting – of delivering reactive services to seriously troubled cohorts, whilst missing opportunities for prevention that could alleviate future suffering in today's young people.

But we're all enlightened enough to know and have enough common sense to know that actually, prevention is better than the treatment, so it's young people's services and young persons' and young adult transition services that probably do need the most investment in order just to get to that point in the first place. So if

the investment doesn't come, it's going to be catastrophic for lots of different reasons. (Provider).

There was not a great deal of substantive variation within the coding for this theme – succinctly, as the following quotations suggest, preventative work represented a strong priority in a wide range of areas with a clear feeling that more targeted funding needed to be focused on services:

It would be amazing if we could have it more focused on the younger people and also on families as well and that really. And that seems to be a very different agenda. (Commissioner).

And the other thing that I would like to see, from a Public Health point of view, is I would like more money to be focused on prevention and early intervention. And also, that kind of community cohesion, community capacity building type approaches, I think, would be better. But for those sort of things, we need longer term money. (Commissioner).

It would be amazing if we could have it more focused on the younger people and also on families as well and that really. And that seems to be a very different agenda... So yeah, it would be great to see some families being kept together rather than A or B getting offered a rehabilitation or an inpatient or just a drug and alcohol service per se really, it tends to be one or the other. (Commissioner).

I'm really pleased that Dame Carol has picked up on that and made it a specific recommendation but I don't see any dedicated funding coming down the silo for young people's services. (PHE).

Mental health support

A third priority need centred on mental health. As noted earlier, the profound challenges of engaging substance misusers with complex needs characterised the experience of virtually every commissioner and provider. Mental health needs were a leading part of this:

I: what's still missing that you still need, or what's missing that you still need?
R1: The mental health provision. (Commissioner).

The mental health provision and the joint working with the...you know, that's still not there... To be honest, the working relationship we've got in the mental health service, is probably the closest I've ever seen at the moment. They're really open to working with us which would be really good. But that's the main thing that's

missing from our provision at the moment, I think that would really help us in terms of...and our service users that have got co-occurring conditions that...you know, because they're struggling recruiting nurses. (Commissioner).

The narratives were familiar – interviewees were keen to build stable partnerships with mental health providers:

So locally our mental health NHS trust is looking to...is consulting stakeholders about transforming community mental health services and that's been...a lot of the feedback has been don't work on your own, come and work with us, and lets...exactly that, let's work together and intervene earlier. (Commissioner).

But often found it impossible to develop such partnerships:

it has been a thing for years, is that, you know, so dual diagnosis. Trying to get our clients into mental health services. You know, and then, no, no, no, we can't go with them, they're using. But they're using, because of their mental health. (Commissioner).

Referrals into mental health services, or securing adequate mental health treatment for drug users was widely seen as impossible.

I suppose the one thing which is really prominent now because it's so challenging to get into mental health services, is there appears to be an awful lot of people who have significant mental health issues that actually because of their addictions, they just get bounced between both...yeah, both pathways. Which is really quite challenging at times, yeah. (Provider).

There was a driving sense that money was essential here – that dedicated funding was needed in order to establish partnership work. A large proportion of interviewees would have welcomed some flexibility to use some of the one-year funding for these ends – rooted in a belief that mental health underpinned many of their service users' needs and so drug treatment would (and could) have little impact unless accompanied by meaningful support in this area:

And their mental health, you know, getting their mental health and their mental resilience or their coping strategies with the crap, I can't think of any better word, sorry for my language. But the crap that life throws at you, people need to be able to cope with that and if we can get them before, or even after recovery but soon after recovery and get the coping mechanisms up and, you know, lifelong coping strategies, then I would have rather spent the money there to be honest. (Provider).

Housing

Beyond alcohol, prevention and mental health work, several commissioners flagged housing as a real concern. Perhaps surprisingly, given the prominence of secure and stable housing in people's lives and the significant presence of rough sleepers' money in several areas, this was not a major theme across interviewees. However, a couple noted the significance of housing, alongside a clear sense that housing remained a major problem that had not been effectively addressed:

The other thing that Dame Carol Black did touch upon was housing, and this really slapped me in the face as soon as I started work in our area, and the way that Dame Carol Black described it as you can't recover when you've got people injecting all around you. And different areas have different levels of temporary accommodation. We have a high proportion that just seem to be very close together, which I think makes that even more difficult to work through. And I know that various areas have played around with models like Housing First and I just don't feel that as a country we've got that right and I think that significantly impacts on the group of people that we work with. (Commissioner).

The end of lockdown brought with it a new set of risks and vulnerabilities; housing in other areas was now looking like a real problem for marginalised substance misusers too.

We've got a resumption of no fault evictions. We've got absolutely atrocious housing options here. Even if we have Housing First and various other supported accommodation options, the reality is that the biggest majority of people using drug and alcohol services are living in crappy, you know, private sector stuff. So, we've got a whole load of things that are outside that also impinge on that recovery approach. (Commissioner).

Education, training and employment

A handful of interviewees mentioned the importance of added offers related to skills and employment. When transitions into work were enabled, they were seen as absolutely gold standard work:

I do think we need to put a big emphasis on what does the offer look like? It's got to be more than just focussed on drug treatment, actually, if we want to enable and support people to overcome their addiction or their dependence and get onto the recovery pathway and into employment. The stories that we hear about people who make that transition are really, really inspiring. You think, well, thank God we

are doing something amongst all this other strategic nonsense that we spend our days dealing with. (PHE).

A small number of interviewees described very positive past experiences of employment programmes, including a 2018-19 DWP initiative delivered by Reed in Partnership. Past experiences of dedicated employment support – prominently Progress to Work – were also raised:

So, what's happening, in terms of the employment support, for example. What's happening, in terms of housing support. I mean, years ago there used to be dedicated, sort of, housing support workers that, you know, made a real difference when you spoke to service users about it. (Commissioner).

Other areas had bid for Individual Placement and Support funding, seeing little overall success but reflecting strong interest in potential programmes

was it IPS funding? We put in an expression of interest for that and we weren't successful with that. So I think that's an area, and I've read that they're looking at perhaps increasing that in later years. I think that is definitely an area, because obviously people...we can support people in the system, but then it's what do they do from there. They've got to have lives and they've got to have the ability to get a job or a focus in their life that means that they've got something other than drugs and alcohol. (Commissioner).

Beyond these structured programmes focused on community integration, a small number of commissioners and providers saw potential for improving peers' pathways into structured posts as substance misuse workers.

Residential rehab funding associated with IPD

An additional requirement centred on a desire to ensure that funding for IPD and residential treatment were linked. UG funds could be allocated to residential treatment. The IPD funding was there. However, the two pots existed discretely, and there was no structured link between the two. For quite a few interviewees, this presented a problem – IPD could offer a very promising start, stabilising someone or supporting them away from drug dependence. However, it could not offer the skills people needed to stay drug free:

There's been a disinvestment across the piece in terms of, you know, in line with other, you know, funding reductions, which has impacted people's ability to get detox. So then probably more crucially there's the whole package on to rehab. Because I think sometimes people talk about detox as if it's a panacea to

everything. Well actually detox is just detox. It doesn't solve your life problems. So it needs to be seen in the round. (IPD consortium lead).

Such problems were exacerbated in several big cities, where the proximity of detoxification units to a great deal of temptation made discharge a particularly vulnerable point:

I think it's that journey from inpatient detox into residential rehab is a good transition, and when you have that, you really have to be emphasising your support in communities... And sometimes that's challenging, especially when you're not collecting somebody from the door of an inpatient detox unit, you know, somebody may straightaway, if they discharge from [a local detox], straightaway they're in the town centre of [a large city], and so, you know, some of those pressures haven't been great. (Commissioner).

This led to a sense that the *availability* of follow-on provision was essential. It may not be desired, desirable, or necessary for everyone who went through IPD – but the added value over and above a return to standard housing for those who needed more support was clear:

I would have liked to have seen some kind of parallel investment, I think, in the residential element, you know, the inpatient. We could get people into medically managed inpatient detox but where are they going to go after? These are people with multiple complex needs that we're talking about. They're not going to go and sit in a bedsit so they need that kind of ongoing support coming through this that there isn't the capacity in the system to do because it's been absorbed. (PHE).

Some IPD consortia had begun working these principles into their eligibility criteria – looking to ensure, for example, that those who accessed IPD had a decent prospect of continuing (and possibly residential) care on their release:

it is about that, absolutely about that rounded package and to be honest the inpatient detox bit is just one part of the journey, and it's that much broader piece around sustaining a recovery which is going to be critical. And I'm hoping that this residential rehab element model of the other piece will be useful... But some of the onus will be on the local authority to provide that stepdown care and look at that onward treatment journey. But we will have that in some of the entry criteria, that when a local authority refers somebody in, we will want to see evidence of that ongoing package of care planned for when that individual finishes treatment. (Consortium lead).

However, this still left the solution in the Local Authorities' hands. The broader message was that these were linked residential interventions, with a strong history of routinely being delivered together. Such packages made sense – and linking funding mechanisms and processes for IPD and residential treatment consequently made sense too.

Holistic support

A final set of priorities centred on drawing together discrete support pathways and delivering more wraparound care. As all of the preceding sections suggest, this was seen as essential – and built on an understanding that drug use is not just about drug use. One provider elaborated, based on focus groups he had run with service user:

the main thing that they said was they wanted something...it's all the stuff that I know as a [professional] about recovery – “I want something meaningful to do in the daytime, like get a job, have some money, go to college, have some kind of self-worth. I want to do other meaningful things in the daytime, like, you know, busy, make yourself busy, gym memberships, that kind of thing. I need somewhere to live – that was obviously a big thing. Healthy family relationships,” you know. At no stage did they mention anything to do with drugs. (Provider).

Within this, interviewees expressed a strong belief that substance misuse could not meaningfully be treated alone – that working solutions had to include work with the person who presented, not just with individual aspects of their need.

This idea, you know, what are you treating, when you're treating someone for drug and alcohol use. What are you treating? Are you treating sort of some quite dated model of addiction, where it's just this psychosocial intervention and you're expecting them to either stop or massively reduce their use, yeah. But what about...does that...because there's also pressures about, you know, what about their physical condition? Yeah. And where do you draw the line that that's because of drugs, that's because of alcohol? You know, and just, I feel, not just me, but this came through very strongly yesterday and it has been a thing for years, is that, you know, so dual diagnosis. Trying to get our clients into mental health services. You know, and then, no, no, no, we can't go with them, they're using. But they're using, because of their mental health. (Commissioner).

Three additional perspectives emerged. Firstly, centred on a feeling that some services had become reduced to prescribing – that the 'soft' work that made life worthwhile had been lost.

To me, I think one of the things, Geoff, that we've done, or that we've realised, is over the last few years, the service has become far too clinically orientated, and we

have lost the non-clinical – although that’s definitely not the best word – I would say the holistic support that people need outside of the pharmacological solutions to addiction. (Commissioner).

Secondly, that siloed approaches to funding were actively detrimental here:

It’s the whole system approach and we don’t seem to be doing that, it’s, here’s a pot for detox and here’s a pot for criminal justice, just give us the money and let us say what we’re going to do with it. (Commissioner).

Several people consequently welcomed proposals for a cross-governmental Department for Drugs. Finally, interviewees missed having the capacity to have multi-skilled caseworkers with small caseloads, able to support service users in addressing a plethora of needs – from housing, through mental health, to training, employment and education.

Primary care

Forging links with primary care was a mainstay of many DIP teams’ work. That first point of contact – a link with a GP who could, in turn, link to secondary services where needed – has long been seen as a critical first step in stabilising people’s physical and mental health and supporting their reintegration. Links with GPs were not a huge issue across interviewees, but were raised by several. Concerns here reflected longstanding problems. GPs were reluctant to engage with marginalised drug users:

I think generally GPs don’t want to deal with people that have got severe drug and alcohol issues. They don’t want them in the building. They don’t want them, you know, around the place. So...and they need to take more of a responsibility for looking after their patients the same as the...you know, with any other patient. (Commissioner).

They were often based in contexts that were difficult for marginalised groups to navigate

what about the people that aren’t in treatment, that have been bowling in and out of treatment, that are struggling because their caseworker has got 60 people and hasn’t been able to call them for...or they haven’t been able to get rescripted again, or they actually really need to see their GP because they’re really unwell, but because they can’t navigate that primary care pathway because they don’t necessarily have a stable address and the receptionist isn’t particularly welcoming because they don’t look particularly clean. (Commissioner).

And, finally, there was a sense that many GPs were ill-prepared to work with drug and alcohol using populations. The sense here was familiar – that people needed to stop using drugs or alcohol before their conditions could be diagnosed or treated, a proportion may be using drugs or alcohol to control the symptoms of their illness:

COPD...the physical health needs sometimes are just so challenging for an individual. And if you could get that underway and someone stable, that then gives you a different pathway to being able to say, right, okay, let's try this route or let's try this route. But because the constraint comes when...you need to be drug-free so, therefore, you need to be...confirm that your illness is this and on such a medication. Yeah, it's just...it's the challenges of the system that we're creating rather than taking the individual's needs. (Commissioner).

Discussion

If there is a point that unites the context and findings for this study, it is that commissioners and providers heaped praise upon the Black Review. They fundamentally recognised the picture it presented; in every respect, they thought it identified their key concerns and priorities:

I think a lot of the stuff from the Dame Carol Black stuff to me was music to my ears, Geoff. I went away and when she puts down the challenge services aren't fit for purpose, I think I've got one of the best services in the country, but I go away and think about what do we need to do better... (Provider).

For the first time in years, commissioners and providers felt heard – their voices, their experiences, had been accurately taken forward. And now that they were set out in an independent report, many had high hopes that their lived experiences of austerity and disjointed services were finally beginning to steer policy change:

I guess Dame Carol Black's Review, didn't tell us who were commissioning and providing services, anything we didn't already know. I think that's the first thing. I think, what it did do, was actually put it fairly and squarely in black and white, in front of the Government. And said, if you are serious about what you say, about wanting to do stuff to help people, then actually, this is a key area, key cohorts of individuals that you are letting down time and time again. And the systems that we had in place previously, were good systems that you now need to reintroduce to ensure that actually, we can re...well, even as one service manager said to me, he said, some people haven't been integrated, never mind being reintegrated into society (Commissioner).

For some, this was a tenet of faith: Black was the future; Black had to happen; and a future without additional funding and the implementation of recommendations was almost unthinkable:

What happens when this funding ends is, the government approves all of Dame Carol Black's recommendations and the funding is effectively continued and increased year on year for the next five years. That's what needs to happen, isn't it. That's my short answer there. (Provider).

However, this existed within a context. A handful of providers pointed out the important convergence of points within the Black Review. Additional funding alone will not be enough:

I think it's really important that those recommendations, we need to have them all, not just some of them. I know she described the system as just not being fit for purpose and for it to be fit for purpose we need that cross-government unit and we need all of those recommendations to come to light (Commissioner).

Systemic change needs to happen in order for services to begin working effectively.

In many ways, this reflects the core message of this study. Interviewees recognised the troubling picture presented by the Black Review, had seen profound damage arising from years of funding constraints and decentralisation, and were aware of a retreat to working in silos. They were hugely relieved by the arrival of new funds, and often described deep aspirations to use it creatively to maximise local impact. To find ways of drawing on wider evidence bases, on service user voices, on other elements of local skills and knowledge that could help them meaningfully leverage best value. However, they persistently found themselves unable to make the most of the funding. Compressed timeframes meant that they were restricted to a subset of off-the-shelf solutions, almost invariably from their existing providers. A national shortage of skilled staff meant that almost no areas were able to find the people needed to deliver the interventions they wanted to bring to their areas. In consequence, by the end of the first quarter, very few areas had managed to deploy much of the additional funding. One entire region had nil spend across its LAs.

This reflects an underlying problem. The problems facing the sector are structural. A process of deskilling and undervaluing has been going on for years, and the prospect of reviving full teams of criminal justice workers staffed by retired police officers, trainee social workers and third sector warhorses with decades of experience across multiple high-skilled roles is now unrealistic. Contrastingly, most of the recruitment solutions that commissioners and providers put in place were very far from structural. They relied on poaching existing staff from their own services, in the form of secondment; or attracting them from neighbouring LAs or rival services through enhanced offers of pay and conditions. Some areas saw a longer-term goal of upskilling peers and volunteers, but these were solutions that provided a poor fit for one-year fixed-term funding. By definition, mid-term funding could not adequately or amply address short-term need.

The deeper need that interviewees kept on coming back to was the need for a valued workforce. This recommendation is clearly established in the Black Review; and the Government response notes an intention to action it. However, this must be seen as perhaps the most essential long-term change that is needed if more funding is to be usefully spent. If one of the largest contractors in the country, acting with significant notice and months of preparation, had not managed to recruit two-thirds of the posts it needed by the end of quarter one, this is a troubling indicator for providers elsewhere.

Short-termism also presents a structural threat to delivery. There was a sense from some interviewees that one-year funding pots may be the new normal; that a succession of funds allocated to siloed elements of need, available for one year or for a series of one-year cycles, may continue. The message from this study is that this, very clearly, will not work. Fixed-term funding creates a wealth of additional complications and substantial inefficiencies. It mandates a great deal of additional time and effort in recruiting, particularly when posts are much less appealing because they are fixed-term. It requires considerable planning for managing the end of contracts, with the likelihood that people on fixed term contracts will leave before their funding ends, and potential dereliction costs for any new facilities or services. It leaves commissioners and providers reluctant to advertise new services, aware that service users needed access to long-term, stable support – not liable to end after a few months. Short-termism also created a sense of perpetual crisis and panic for interviewees – with small pot after small pot adding to their workload, and adding complications to governance structures that were just not designed to allow very significant sums to be added to an existing provider’s contract. The need to retender services was fast approaching in a couple of areas, which had benefitted from multiple small pots consecutively.

The Black Review notes the harm that short-term commissioning cycles can cause. Many interviewees had similarly offered five, eight or ten year contracts to their providers. To see very large one-year funding pots arrive consequently appeared perverse, and against all understandings of long-term best practice.

The final point perhaps centres on a related need for coherent governance and planning. This extends across all of these preceding points. Money was being wasted, because it was only available for one year. Best value was not being achieved, because commissioners had no time to develop a needs assessment, to secure service user input, to talk to colleagues in neighbouring LAs about efficiency savings, or to explore the evidence base for proposed interventions. Inefficiencies were entering the system because work was carried out for small pot after small pot, often focused on supporting the same small cluster of drug-involved, multiply-marginalised offenders. Some LAs were choosing not to bid for some funding because they straightforwardly no longer had the time or energy. Powerfully, commissioners and providers wanted to do better; but they felt unable to within the limitations they found themselves facing. The money that they could access was unbelievably welcome; but the conditions around it made them unable to deploy it effectively – or in some cases, where recruitment proved too much of a barrier, at all. Within this context, it appeared that changes in governance could yield a step change in the value achieved by working to long-term, strategic, clearly defined goals within a measured and realistic timeframe. The broader aspects of capacity building appeared essential here; looking towards longer-term upskilling of the workforce and accepting that some solutions might take time. There was also a clear sense that cross-governmental work was essential for marginalised offenders, as their

needs were very far from discrete. Substance misusers needed access to better housing, alcohol provision, and mental health care, as well as employment opportunities. However, with cross-governmental collaboration and planning, there was a real sense that very real and very substantive impact on measures of concern could be achieved. As several interviewees noted, it has been done before; it could be done again – and, potentially, done better.

Conclusion

The arrival of significant new funding was welcomed by interviewees, who described a significant loss of capacity over the preceding decade. It enabled a great deal – including the development of new inpatient detoxification facilities, an increase in bed capacity, and enhanced harm reduction and criminal justice support pathways in nearly every area.

However, significant barriers existed to getting the funding operational. The main challenge here was staffing, as the skills base simply did not exist within the community. Skilled recruits could rarely be found to any extent, and when they could be this was usually by poaching them from neighbouring LAs or local competitors. The skills shortage was consequently passed on to other services instead of being meaningfully addressed.

A second set of challenges centred on the short-term nature of the funding, which triggered significant cost inefficiencies and meant many interviewees had to advertise new posts on unappealing fixed-term contracts, thereby exacerbating the challenges of recruitment. The one-year funding also triggered a range of other additional workloads, costs, inefficiencies, and governance difficulties.

Interviewees identified that a shift towards longer-term funding is needed, alongside significantly more long-term and strategic government thinking. Developing a long-term strategy for professionalizing the sector was a particularly important point here, as was the need to adequately fund services for a range of needs prominent within substance misusing populations. This, it was felt, could help drive significant new efficiencies and impact within the sector.

Overall, following the publication of the Black Review, interviewees were hopeful. They recognized serious difficulties in operationalizing new funds, but felt – for the first time in years – that they were being heard. With a long-term, joined up view and sustained additional funding, they believed that a radical transformation of crime and substance misuse outcomes was possible.

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Appendices

Appendix A. Funded proposal

(a) Request:

We are looking to commission a short piece of research on the implementation of the universal grant and joint commissioning of inpatient detoxification beds. The aim is to investigate:

What factors influenced the priority setting and the delivery plans of LAs (e.g. how did the uncertainty of additional funding beyond 21/22 affect their approach)?

What were the barriers to scaling up drug treatment services in the coming financial year?

- What barriers did LAs anticipate? What were their mitigating actions?
- What additional challenges did LAs face in planning and commissioning services?

The methodology would involve interviews with stakeholders and LA case studies

(b) Aims:

- To develop an understanding of the factors influencing priority-setting and the delivery plans of LAs in planning use of the universal grant and inpatient detoxification grant (with particular regard to the short-term nature of the money available).
- To identify barriers identified by LAs in scaling up treatment services.
- To identify actions taken and plans made to mitigate the impact of any such barriers.
- To explore, where available, the role and impact of local experience and resources in scaling up to utilise additional funding. For example, planning and implementation in some areas may benefit from significant pools of drug workers made redundant over previous years; other areas may have core stakeholders with significant prior experience of rapidly scaling up treatment provision in the early 2000s.
- To map the associated barriers expected, and mitigation strategies deployed, by broader stakeholders – with a particular focus on commissioned service providers.

- To assess how key stakeholders (primarily commissioners and service providers) believed LAs were coping prior to the introduction of additional funding.

(c) Research plans:

- To identify, with the support of Public Health England, Local Authorities for substantive case studies utilising a ‘maximum variation’ approach to sampling.
- To secure c.25 semi-structured interviews with commissioners from Local Authorities with a range of approaches to funding – including those with a range of successful treatment completion rates, and those prioritising a range of different interventions. Variation in Local Authority characteristics (e.g. rural / urban; large / small; North / South; affluent / deprived) and interventions (particularly residential provision / dedicated criminal justice workers / naloxone) will guide the choice of interviewees here too.
- To secure c.15 semi-structured interviews with providers of commissioned drug treatment and detoxification services to identify associated barriers to scaling up for practitioners.
- To secure c.8 interviews with PHE regional teams, and national staff.
- To secure full transcripts of all interviews.
- To analyse these transcripts, and provide an interim report detailing barriers, mitigating strategies, and key case studies by late August 2021.
- To submit a full and final report by October 2021.

(d) Research rationale

The proposed study seeks to establish an understanding of the recent rollout of the universal and inpatient detox grants and to understand barriers to scaling up treatment responses for funding that is only guaranteed for one year. Semi-structured qualitative interviews form the backbone of the proposed methods, offering rich and detailed accounts of key stakeholders’ experiences. Drawing on established qualitative principles, we propose maximum variation sampling – looking to capture insights from stakeholders adopting a range of approaches to the universal and inpatient

detox grants, seeking to fund a range of interventions chosen from the interventions ‘menu’, and from regions across England.

The significant number of proposed interviews with commissioners gives us some room to develop a broad picture of commissioning experiences before focusing down on selected LAs for full case studies. In conjunction with our proposed ‘maximum variation’ approach to sampling, this will enable a thoroughly informed selection of sites for detailed analysis. Beyond this broad picture, 6-8 full case studies will draw on additional semi-structured interviews with key stakeholders – primarily leaders and managers within commissioned services, and PHE regional teams and national staff. Based on initial discussions, we expect access to interviewees to be straightforward as there is a strong expectation that stakeholders at all levels will want to contribute to this study. This assumption – of ready access to prospective interviewees – underpins a proposal for an ambitious number of semi-structured interviews within a short research timescale.

(d) Timetable and outputs

The study will be conducted over a five-month period from June to October 2021. Reports will be submitted to practitioners and funders by end August 2021 (interim) and mid-October 2021 (full report). We expect to regularly feedback findings to funders as useful.

(e) Project timeline

	June			July				August					September				October			
	14	21	28	5	12	19	26	2	9	16	23	30	6	13	20	27	4	11	18	25
Ethical approval																				
Developing research tools																				
Identifying interviewees																				
Interviews																				
Transcription																				
Analysis																				
Interim report																				
Final report																				

Appendix B. Topic guide for interviews.

Pre-existing situation, and level of grant

- Can you describe your experience of / role within drug treatment over the last ten years?
- Challenges faced before the universal grant?
 - heroin / crack cocaine / offending populations?
 - other populations?
 - Deaths / numbers disengaged from treatment?
 - impact of austerity?
 - impact of treatment ethos (e.g. harm reduction c.1997-2010; abstinence focused 2010-2016)
 - impact of Dame Carol Black's independent review of drugs
- Can you describe harm reduction services and your use of detoxification beds before the arrival of the grant?
- What did your LA receive, in terms of the universal grant / funding for detoxification beds?
 - Prompt: and how does this fit with local needs / what you would have asked for?

Use of grant

- How were local decisions made regarding the use of the grant?
 - Prompt: key local discussions / local decision points / local stakeholders?
 - Prompt: how were discussions taken forward, and decisions reached?
- Goal: to build back what was lost, or to build back better?
- What shaped your decisions in how to deploy the grant?
 - Prompt: Which kinds of services were a priority?
 - Prompt: How do they fit with an emphasis on heroin / crack using populations?
- Which did you see as the most important aspects of the grant (universal / menu of treatment options / detoxification beds), and why?
- Can you describe the barriers that you expected to face in scaling up treatment for one year?
 - Prompt: staffing
 - Prompt: resources
 - Prompt: organisational change
 - Procurement
- If you managed to overcome these barriers, can you describe how you did so?

Broader lessons

- What is missing, that you still feel you need?
 - Prompt: black, partnership, loss of skills and capacity
 - Psychiatrists, housing, education, ringfenced \$\$\$, non heroin provision
- What do you wish you had known at the outset of this process, that you know now?
- What lessons have you learned from other areas, or other local authorities, in scaling up to use these grants?

- What will happen in your local authority when the grants end next year?
 - Prompt: universal grant
 - Prompt: funding for detoxification beds
 - Residential
 - Sustainability

P **R** **↙** **Partnership for**
E **P** **A** **REsponsive**
L **R** **E** **Policy**
Analysis and
REsearch