



## ***Healthy Lives, Healthy People: Our strategy for public health in England***

### **And supplementary consultation documents:**

- 'Transparency in outcomes – proposals for a public health outcomes framework'
- 'Consultation on the funding and commissioning routes for public health'

### **Response from DrugScope – April 2011**

DrugScope is the UK's leading independent centre of expertise on drugs and drug use and the national membership organisation for the drugs field. DrugScope is a registered charity (charity number: 255030).

DrugScope's objectives are:

- To provide a national voice for the drug sector
- To inform policy development drawing on the experience and expertise of our members
- To work with others to develop 'joined up' responses to drug and alcohol problems
- To support drug services and promote good practice
- To improve public understanding of drugs and drug policy.

DrugScope believes in drug policy that:

- minimises drug-related harms and supports recovery
- promotes health, well-being, inclusion and integration
- recognises and protects individual rights
- recognises and respects diversity.

DrugScope is committed to:

- promoting rational drug policy debate that is informed by evidence
- involving our membership in all our policy work
- ensuring our policy interventions are informed by front-line experience
- speaking independently, and free from any sectoral interests
- highlighting the unique contribution of the voluntary and community sector.

DrugScope incorporates the London Drug and Alcohol Network (LDAN), which works in London

- to provide independent and expert advice to member agencies, commissioners and other stakeholders
- to support member agencies in providing cost-effective, high quality services that are user focussed
- to engage with policy and decision-makers on behalf of its membership.

## 1. Introduction

1.1 Drugscope welcomes the opportunity to respond to the White Paper *Healthy lives, healthy people: Our strategy for public health in England* (30 November 2010). Our response will also address the proposals set out in the supplementary Healthy Lives, Healthy People (HLHP) consultation documents on *Transparency in outcomes – proposals for a public health outcomes framework* (20 December 2010) and *Consultation on the funding and commissioning routes for public health* (21 December 2010). The key issues for us are broadly the same across the suite of HLHP documents. We have not structured our response directly around the consultation questions, but we hope that it will be clear how it addresses them.

1.2 We would like to express our appreciation for the access that we have had to the relevant officials at the Department of Health (as well as other Government departments and the National Treatment Agency), to discuss the potential impact of the health reforms on drug and alcohol services and to shape policy development. We are also grateful to the Head of Drugs and Alcohol at the Department of Health for his presentation on public health reform to DrugScope's Drug Treatment Chief Executives' Forum on 1 March 2011, and his engagement with the issues raised at the meeting.

1.3 This response is informed by the discussion at the Drug Treatment Chief Executives' Forum, and other consultation events facilitated by DrugScope. These include the London Drug and Alcohol Network (LDAN) Senior Managers Group, the NTA/LDAN Service Providers Forum, and consultation events on the recovery agenda in London (26 November 2010) and Manchester (21 February 2011) that we hosted for the funded 'Drug Sector Partnership' of Adfam, DrugScope, eATA and The Alliance.

1.4 It is informed by our involvement in relevant policy initiatives and advisory groups. DrugScope is a partner (with Clinks, Homeless Link and Mind) in the Making Every Adult Matter initiative that is improving outcomes for adults with multiple needs, with funding from the Calouste Gulbenkian Foundation. We were represented on the advisory group for the Royal Society of Arts (RSA) 'Whole Person Recovery' project and had an active role in helping to facilitate the RSA's consultation event with service users. LDAN is currently running three major projects to support front line services to implement the recovery agenda, respectively on homelessness (in partnership with Homeless Link and Shelter) and domestic violence (both funded by London Councils) and pathways to employment (funded by Trust for London).

1.5 We have had an active role in alcohol policy in London, and were funded by the Regional Public Health Group in London to support the Greater London Alcohol and Drug Alliance's Joint Action Group on Alcohol in 2010-11. We are currently funded by the London Voluntary Sector Council (LVSC) to help develop a database of alcohol services in London to assist public health commissioners.

1.6 Our Chief Executive, Martin Barnes sits on the Advisory Council on the Misuse of Drugs (ACMD) (in a personal capacity), the Ministry of Justice's Criminal Justice Council and the Association of Chief Police Officers (ACPO) Drugs Committee. Our Director of Policy and Membership, Marcus Roberts, is currently a member of the Department of Health's Expert Group on Payment by Results, and chairs the sub-group on Health and Well-Being. He wrote a report on payment by results for the UK Drug Policy Commission (*By their Fruits*, 2011). He also sits on the Department of Health's National Advisory Group for the Health and Criminal Justice Programme.

1.7 Our response reflects our status as a charity and our role as a leading independent centre of expertise on drugs and drug use and as the national membership organisation for the drug field, representing around 600 organisations across the country. We have a particular role in providing a voice for voluntary and community sector organisations. The response has a specific focus on drug and alcohol service within the HLHP proposals.

## 2. DrugScope's response – the importance of drug and alcohol issues

2.1 The proposals in the HLHP consultation documents are of critical importance for the future of drug and alcohol policy and treatment in England, and the delivery of preventative and early intervention initiatives to reduce the harms caused by drugs and alcohol. **The success of the public health reforms will be crucial to the delivery of the outcomes in the Drug Strategy 2010 (*Reducing demand, restricting supply, building recovery*), and to other key areas of Government policy – for example, crime reduction and reducing re-offending (including the reforms set out in the Green Paper *Breaking the Cycle*) and the DWP's Work Programme and its success in supporting the long-term unemployed (including benefit claimants affected by drug and alcohol problems) into education, training and work.**

### Public Health England

2.2 The abolition of the National Treatment Agency for Substance Misuse (NTA), and the transfer of its key functions to the public health service, was announced in *Liberating the NHS: Report of the arms length bodies review* in July 2010. The NTA has overseen a significant expansion in drug treatment since its creation as a special health authority in 2001. In 2009-10 there were estimated to be over one thousand drug treatment services in England, employing a workforce of over 11,000, and providing services to 206,000 adults with serious drug problems and nearly 25,000 under 18s. Taking over responsibility for drug and alcohol treatment will be one of *the* principal challenges for Public Health England (PHE), Directors of Public Health (DoPHs) and Health and Wellbeing Boards (HWBBs) from April 2012.

2.3 DrugScope believes that bringing drug and alcohol policy into the broader public health remit will create real opportunities for innovative local approaches that will help to support the delivery of the drug strategy and other Government policy objectives. These benefits include the opportunity for an increased focus on prevention and early intervention (which many Drugscope members felt had been neglected when we consulted on our response to the drug strategy consultation), flexibility to respond to local needs and priorities, and opportunities for engagement with a range of drug-related health problems, including poly-drug use and improved integration of drug and alcohol policy.

2.4 Drug and alcohol treatment includes many services that will present challenges for a 'public health' approach as traditionally understood, because they are closer to NHS health services, including acute and crisis services, and will need to be developed to the same clinical standards and in compliance with the same evidential standards (for example, compliance with guidance from the National Institute for Clinical Excellence). These include needle exchange, prescribing services, psycho-therapeutic interventions and structured programmes (community-based and residential). **Equally, the public health service's responsibilities for drug and alcohol treatment will have a vital role to play in delivering the step-change in the quality and effectiveness of drug service delivery set out in the 2010 Drug Strategy, with a greater emphasis on recovery and social reintegration.** This will depend on the effectiveness with which Public Health England engages with other Government department's nationally, and the ability of local DoPH to

work with other local services, such as housing, family support, adult and children's services and employment (for example, through Health and Wellbeing Boards).

#### Funding for drug and alcohol treatment

2.5 The significance of the public health reforms for drug and alcohol policy is apparent from the (anticipated) composition of the public health budget. DrugScope understands that around £1 billion of current drug and alcohol investment will be rolled into the new ring fenced public health budget from 2012. It has been estimated that this will account for as much as a quarter of the overall budget for public health nationally, and that it could be 40% to 50% of the public health budgets that are controlled by local authorities and DoPHs at local level.

2.6 The allocation of £570 million of central government funding for community and prison-based drug treatment by the Department of Health for 2011-12 was an extremely welcome signal to the sector of the Government's commitment to maintain funding in drug treatment during a period of financial austerity. This confirmed the Government's commitment to delivering the agenda set out in the 2010 Drug Strategy, and a recognition of the 'value for money' of this investment in helping to address a wide range of policy issues – including crime, poor health and mental health, family breakdown and unemployment (see DrugScope's response to the Spending Review). **However, the removal of the specific 'ring fence' from the pooled drug treatment budget and its incorporation into a ring fenced public health budget creates a risk of disinvestment.** DrugScope is committed to working with its membership to ensure investment is maintained, both nationally and locally.

2.7 In twelve months time, the public health service will be assuming responsibility for a public health budget including £1 billion of the current drug and alcohol spend. **There is concern among DrugScope's membership about the limited reference to drug and alcohol services in the HLHP consultation documents. The White Paper *Our strategy for public health in England* contains only a handful of references to drugs and alcohol.** These include a welcome recognition of the contribution of substance misuse problems to health inequalities and social exclusion and the need to address these issues, with a strong emphasis on the public health role in prevention. The only direct reference to drug and alcohol treatment in the White Paper concerns the transfer of the prison treatment budget from the Ministry of Justice to the DoH to align funding for substance misuse treatment services in prisons and the community (which DrugScope supports).

#### Implementation and operational challenges

2.8 The key passage on drug policy states that 'Public health professionals will work locally to prevent people from taking harmful drugs, to reduce the drug use of those already taking drugs, and to help people to be drug free, recover fully and contribute to society. Details of our approach will be set out in a forthcoming cross-government drugs strategy. It will seek to prevent people taking illicit drugs at all ages, and arrest the slide into dependency'. We recognise that the public health service's role depends on the approach in the Drug Strategy 2010, but the strategy does not seek to address the implementational and operational challenges of the transition of responsibility for drug and alcohol services to public health – this would naturally be a matter for consideration as part of the wider HLHP consultation and development process.

2.9 The separate HLHP consultation paper covering 'funding and commissioning routes for public health' includes one paragraph on alcohol and drug misuse (and elsewhere acknowledges the impact on mental health). It explains that 'Public Health England and local authorities will play a key role in tackling the harms caused by alcohol and drugs. Local authorities will be responsible for commissioning treatment, harm reduction and prevention

services for their local population, providing an opportunity to more comprehensively join up the commissioning of drug and alcohol intervention and recovery services locally. At a national level this will be supported by Public Health England, which will provide evidence of effectiveness, guidance and comparative analyses to support local areas in their task. To ensure this support is immediately available, the core functions of the National Treatment Agency for Substance Misuse (NTA) will transfer to Public Health England’.

2.10 This does not, however, seek to address a number of issues about funding and commissioning that have been raised by DrugScope members, including any future role for Drug (and Alcohol) Action Teams (DATs and DAATs) and Crime and Disorder Reduction Partnerships (CDRPs); the role of GP Consortia (if any) in drug and alcohol commissioning; and the commissioning routes for prison drug services, given that the NHS Commissioning Board will assume the overall responsibility for prison health care.

2.11 We recognise that a lot of work is being undertaken in the Department of Health to address and clarify these and other issues, and look forward to continuing to work with officials and ministers to support policy development and implementation in this area. **We believe that there is a strong case for a separate HLHP consultation on drug and alcohol services. This would cover issues such as transitional arrangements, the future role of local drug partnerships, workforce development, accountability frameworks for the DoPH, the role of Health and Well-Being Boards, and the integration of public health, criminal justice (including the new Police and Crime Commissioners) and recovery (from recovery champions and mutual aid to housing, training and employment).** We also believe that there is further potential to add value by bringing more closely together a range of drug policy developments across Government – for example, the NTA’s *Building Recovery in Communities* consultation and establishment of a Substance Misuse Skills Consortium.

2.12 Drug Action Teams (DATs), Drug and Alcohol Action Teams (DAATs) and Crime and Disorder Reduction Pilots (CDRPs) currently play a critical role in local commissioning of services. We would welcome clarification of the intended approach to existing local partnerships (and their staff) in the transition to the new public health system. For example, is it envisaged that DATs and DAATs will be absorbed in some way into local public health teams?

#### Substance misuse and mental health problems

2.13 DrugScope has a particular concern about services for people with co-occurring substance misuse and mental health problems (so-called ‘dual diagnosis’). Health reform provides an opportunity to improve integration of substance misuse and mental health strategies and services, but also creates a risk of the unintended emergence of new ‘gaps’ between services. We note, in particular, that the HLHP consultation paper on funding and commissioning states that ‘treatment of mental ill-health, including Improving Access to Psychological Therapies (IAPT) will not be a responsibility of Public Health England but will be funded and commissioned by the NHS’. **It would be advisable to ‘trouble-shoot’ the plans for health reform set out in HLHP (and in the Health and Social Care Bill) to assess the impact on people with ‘dual diagnosis’, at both the ‘mild to moderate’ and ‘severe ends’ of the mental health spectrum.** This should also consider the impact on people with multiple needs. DrugScope endorses and has contributed to the submission to the HLHP consultation that has been made by the Making Every Adult Matter (MEAM) partnership.

### **3. The outcomes framework**

3.1 The HLHP *Transparency in outcomes* (TiO) proposals raise similar issues. There is one proposed outcome indicator apiece for drugs and alcohol. The TiO indicator for drug services is the numbers leaving treatment free of drug dependency (i.e. successful completions as recorded by the National Drug Treatment Monitoring System, who do not re-present for treatment within 12 months). The TiO proposed alcohol indicator is rate of hospital admissions per 100,000 for alcohol related harms.

**3.2 DrugScope does have concerns that only two of over 60 proposed indicators in TiO are directly concerned with drug and alcohol services.** We understand that the final public health outcomes framework will consist of around 15-20 indicators. Even so, two drug and alcohol outcomes does not seem proportionate to either their contribution to the overall PHE budget or the importance of service provision in this area for individuals, families, neighbourhoods and society as a whole.

3.3 We note that both these outcomes are included in Domain 3 'Health improvement: Helping people to live healthy lifestyles and make healthy choices'. There is an issue about the 'fit' – in particular - of the indicator 'number leaving drug treatment free of drug(s) of dependence' in a domain described in this way. While drug treatment does help people to 'live healthy lifestyles and make healthy choices', this is not a natural descriptor for those services providing acute and crisis interventions for people experiencing chronic drug problems. **It is important that the conceptual frameworks for HLHP reflect the responsibilities of PHE and DoPH to provide the sorts of highly specialised health interventions that are currently overseen by a special health authority within the National Health Service with a clear and specific responsibility for improving the availability, capacity and efficiency of drug treatment in England.** We would welcome consideration of the merits of including a separate 'recovery and treatment' domain in the public health outcomes framework.

3.4 There are a number of other proposed indicators where drug and alcohol interventions will be important factors in successful delivery and/or that will contribute to improved outcomes for people affected by drug and alcohol problems. These include the mortality rate from chronic liver disease in persons less than 75 years of age, hospital admissions as a result of self harm, under 18 conception rates, incidents of domestic violence, statutory homelessness households, employment of people with long-term conditions and rates of violent crime. **It will be important to ensure that the role of drug and alcohol services in delivering these outcomes is recognised by PHE and DoPH.** For example, LDAN's London Council's funded domestic violence project is working with drug and alcohol services in the capital to support them to work more effectively with both victims and perpetrators of domestic violence, and LDAN's homelessness project is addressing the links between drugs, alcohol and homelessness. Alcohol, in particular, is a significant factor in violent crime and substance use will be a key factor in under 18 conception rates.

3.5 The importance of alcohol treatment (and of interventions to prevent the transmission of hepatitis in drug services) for reducing mortality from chronic liver disease is clear. However, there can be a significant time lapse between investment in drug and alcohol services and impact on chronic liver disease. **In developing the outcome framework it would be helpful to give further consideration to the approach to incentivising decision-makers (notably DoPH and HWBB) to give appropriate weighting to outcomes that are realisable only over longer time periods.** It is also unclear how the commissioning frameworks proposed in HLHP will take sufficient account of the substantial crime reduction dividend from continued investment in drug treatment.

## Employment

3.6 DrugScope welcomes the inclusion of the proposed indicator to improve employment rates among people with long-term conditions. We know that training and employment can play a critical role in recovery from drug and alcohol problems, but also that there are formidable barriers to accessing work for people who use (or have used) drug and alcohol services. Since 2009, LDAN has been funded by Trust for London to develop a project in the capital to support services to improve pathways to employment for people in treatment (or leaving treatment) for substance misuse problems. We are currently planning the second phase of this project, which will run to 2013, with a particular focus on working with employers. We have welcomed the recent focus from the Department of Work and Pensions on improving education and employment opportunities to support recovery from drug and alcohol problems. **It is important that any public health indicator on employment for people with long-term conditions is developed with a clear and explicit requirement that this should include a specific outcome for substance misuse service users (and former service users).** Otherwise there will be a tendency to ignore or exclude this group, particularly as they are not covered by the legal protections of the Equalities Act 2010.

#### Supporting recovery and stigma

3.7 There is a particular challenge in ensuring that provision for people affected by drug and alcohol problems is given sufficient priority at local level given the levels of stigma they (and their families) can experience. Serious drug or alcohol dependency often develops in response to problems in people's lives, such as, childhood neglect and abuse, trauma, mental health issues and experience of social exclusion (for example, homelessness or loss of employment). But drug problems may be viewed as self-inflicted. **There is a broader challenge for Government in an age of localism of ensuring that services for the most marginalised sections of the community receive sufficient investment, particularly at a time of significant pressure on local budgets.** Withdrawal of support is not only devastating for the individuals concerned, but will tend to result in problems for communities and economic and social costs to society. In our response to the 2010 Drug Strategy consultation we suggested that Government introduces a requirement for 'community impact assessments' where local decision makers and funders are proposing to refocus, significantly reduce or withdraw funding, where there may be an impact on the most vulnerable and/or the voluntary and community sectors.

## 4. An integrated and recovery-orientated system

4.1 A key challenge in developing the HLHP proposals will be to ensure that the new public health structures support the delivery of the Drug Strategy 2010 and are informed by the guidance (or other resources) that emerge from the NTA's *Building Recovery in Communities* consultation. It would be helpful – for example - if Government could make more transparent the relationship between the HLHP outcomes framework and the 'best practice outcomes' for 'successful delivery in a recovery-orientated system' set out in the 2010 Drug Strategy (p. 20):

- Freedom from dependence on drugs or alcohol;
- Prevention of drug related deaths and blood borne viruses;
- A reduction in crime and re-offending;
- Sustained employment;
- The ability to access and sustain suitable accommodation;
- Improvement in mental and physical health and wellbeing;
- Improved relationships with family members, partners and friends; and
- The capacity to be an effective and caring parent.

## Reducing drug-related harms

4.2 We note that the outcomes framework in HLHP does not include a proposed indicator on 'prevention of drug related deaths and blood borne viruses'. DrugScope has strongly supported the focus on recovery and social reintegration in the 2010 Drug Strategy, but it is important not to lose sight of the role of drug services in reducing drug-related harms. The introduction of public health services in the UK in the 1980s and 1990s resulted in one of the lowest rates of HIV infection among injecting drug users anywhere in the world. HIV prevalence among injecting drug users has stabilised at around one per cent (although Hepatitis B and C infection is more widespread). **We would welcome further clarification on what requirement (if any) it is envisaged there will be for DoPH to provided services such as needle exchange, screening and testing for blood borne viruses and vaccination and treatment for hepatitis and other health problems associated with the use and administration of drugs.**

## Role of GP Consortia

4.3 There is some confusion about the anticipated role of GP Consortia. DrugScope has supported the decision to give the public health service the lead responsibility for drug and alcohol services. We note, however, that many GPs in England provide 'shared care'/GP prescribing schemes. It might therefore be an expectation in some local areas that GP Consortia will take a lead role in commissioning health promotion and prescribing services, or – at least – will contribute to local provision from their budgets. It is our understanding that Consortia may agree to commission drug and alcohol services jointly with local authorities, but there is no requirement or expectation that they will necessarily do so. The engagement of GPs in drug and alcohol work will tend to vary between localities, and it is therefore likely that if investment from GP budgets is discretionary there will be significant variation in the levels of investment (if any) across the country. **It is therefore important to ensure that the role of GP Consortia in drug and alcohol service commissioning is fully understood by all the key local decision-making bodies (as well as by local providers and other stakeholders), and that there is no ambiguity as to where the lead responsibility for provision of these services rests.**

## The NHS Constitution

4.4 In this context, we welcome the statement on p. 66 of HLHP that the NHS Constitution will continue to apply to the whole health service, whether the NHS or Public Health England. It is our assumption that this means that DoPHs will be required to comply with the NHS Constitution in all local authority areas, which will help ensure provision of drug and alcohol services is consistently meeting an acceptable minimum standard. If the NHS Constitution applies to local public health structures, then patients (including drug and alcohol service users) will have a right, for example, to expect DoPH to assess 'the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary', to keep waiting times down and to provide access to drugs and other treatments recommended by the National Institute for Clinical Excellence. The NHS Constitution also includes pledges to provide all staff (including, by implication, staff in drug and alcohol services) 'with clear roles and responsibilities' and 'personal development, access to appropriate training for their jobs and line management support to succeed'. **We would welcome further clarification of the responsibilities of DoPH – and other local decision-making bodies, particularly Health and Wellbeing Boards – under the NHS Constitution.** In particular, we understand that DoPHs will be employed by the local authority rather than PHE and would appreciate assurances that this will not affect their responsibilities under the Constitution. **It would be helpful for the Department of Health/Public Health England to produce clear guidance for DoPHs, HWBBs and other local decision makers on their responsibilities.**



## Recovery orientated approaches and collaboration

4.5 The development of recovery-orientated drug and alcohol treatment systems will depend on effective collaboration between public health and other key services – including mental health, housing, employment, family support and social services. We agree that the proposed local statutory Health and Wellbeing Boards (HWBB) have the potential to play a critical role in ‘joining up’ local services to deliver the ‘best practice outcomes’ in the 2010 Drug Strategy, as argued in HLHP. For example, HWBBs will bring together DoPH, GP Commissioners, Directors of Adult Services and Directors of Children’s Services, and are therefore ideally placed to develop local young people’s substance misuse services, support for families and carers, and to improve the capacity of service users to be effective and caring parents.

4.6 The effective integration of the public health service with other local services to develop recovery-orientated approaches to drug and alcohol problems will be further supported by the opportunities to bring different budgets together to address the multiple needs of many people with drug and alcohol dependency problems, and the social causes and contexts of substance misuse. We would urge the Government to build on the learning from innovative approaches to co-commissioning and budget pooling that were introduced by the previous administration, notably the Drug System Change Pilots and Total Places. The 2010 Drug Strategy states that public health grants can be brought together with the new single Early Intervention Grant from 2014-15 to support ‘local areas to take a strategic approach to tackling drug and alcohol misuse as part of wider support for vulnerable young people and families’. We welcomed the announcement in the Spending Review that Community Budgets will be available in 16 local areas to enable local pooling of resources to meet the needs of the most vulnerable families, with the intention to roll this out from 2013-14.

## Health and Wellbeing Boards

4.7 The HLHP White Paper says that the proposed ‘minimum membership’ of HWBB will comprise elected representatives, GP Consortia, DoPH, Directors of Adult Social Services, Directors of Children’s Services, local HealthWatch and, where appropriate, the National Health Service Commissioning Board. Local areas will be able to expand membership to include other key services, as well as representation for the local voluntary and community sector. We note that the Drug Strategy 2010 suggested that the HWBB might also include Police and Crime Commissioners (PCCs), employment and housing services, and prison and probation services to provide local leadership on recovery. How far it is practicable to expand HWBB membership in this way is questionable, but getting the relationship between public health and these other local structures right will be critical for drug and alcohol provision (for discussion of criminal justice and PCCs see paras 4.9 and 4.10) . We note that HWBB need not be confined to a single local authority area, and could work over a wider geographical area. This could potentially provide a more strategic focus for commissioning (for example, where commissioning a full range of services makes more sense with a wider target population), but there may also be a risk of weakening ties to the local community.

**4.8 We believe that the statutorily required minimum membership of HWBB should include appropriate representation for the voluntary and community sector, which has a critical role in the delivery of drug and alcohol services.** It would be inconsistent with the vision of the Big Society and the Government’s commitment to the third sector not to ensure that the VCS is represented on a local strategic body that will ‘establish a shared local view about the needs of the community and support joint commissioning of NHS, social care and public health services in order to meet the needs of the whole local population effectively’. **It is also important that patient representation (including through HealthWatch) provides a voice for the views and experiences of drug and alcohol service users, which may be different from those of patients of ‘mainstream’ health**

**services. This could involve local service-user ‘recovery champions’ and communities.**

#### Prisons and criminal justice

4.9 DrugScope welcomed the decision to transfer the budget for prison drug and alcohol services from the Ministry of Justice to the Department of Health. As the Drug Strategy 2010 explains this change in responsibility should ‘support the Government’s ambition for a greater emphasis on shared outcomes and provide an opportunity to promote the co-commissioning of drug services in England’, with the potential ‘to facilitate more coordinated support to help individuals recover from drug dependence, including those in contact with the criminal justice system’. The HLHP consultation on funding and commissioning routes for public health explains that public health care for those in prison and custody will be commissioned by the NHS Commissioning Board. Our assumption is that this will include drug and alcohol treatment. **There is a risk that a different approach to prison treatment may work against the broader commitment to shared outcomes and co-commissioning. It would be helpful to have further clarification of how public health reforms will ensure co-ordinated support across the community and criminal justice system.** In particular, we would welcome further details of the public health role in developing proposals in the Ministry of Justice’s *Breaking the Cycle* Green Paper – for example, the residential treatment capacity for offenders placed on the ‘high’ intensity community orders, if these proposals are adopted.

#### Police and Crime Commissioners

4.10 Police and Crime Commissioners (PCCs) will be introduced in England from May 2012. The 2010 Drug Strategy states that PCCs will be democratically accountable ‘to local people for reducing crime and disorder, including drug-related crime’. The PCC’s role in the strategic, oversight and commissioning structures for drug and alcohol services is not clear, and they are not directly referred to in the HLHP White Paper. The 2010 Drug Strategy says that they might participate in HWBB, but they are not among the required membership for HWBB set out in HLHP, nor discussed as potential discretionary members. It could be argued that full membership of HWBB is not realistic or appropriate for PCCs in the light of their wider responsibilities (and those of the Board). In addition, some PCCs could be responsible for up to 28 local areas, which would place clear limitations on their ability to participate in HWBBs (although this could also provide a rationale for organising HWBBs at a sub-regional level). Our understanding, however, is that PCCs will assume responsibility for the budgets for the Drug Intervention Programme and for core Community Safety Funding (including Young People’s Substance Misuse Funding), although with the current ring-fencing around these budgets removed. **It is appropriate therefore that PCCs are involved in any budget pooling or sharing arrangements developed through HWBBs.** Decisions made by local DoPH and HWBB could have a significant impact on drug and alcohol-related crime, given that PCCs will be democratically accountable for crime rates they must be empowered to influence decisions on public health investment. **We would welcome further clarification on the relationship between PCCs, DoPHs and HWBBs.**

#### Payment by results

4.11 We also note that payment by results (PbR) is not discussed in the HLHP documents. **We would welcome further clarification of how the relationship between payment by results and these reforms will work.** The Drug Recovery PbR Pilots that are currently being developed by Government will reward services for their success in delivering outcomes across four domains - free of drug(s) of dependence, reduced offending or continued non-offending, employment and health and well-being. It is unclear whether this is intended to link to the TiO outcomes framework, and if so how they would be related. There

are similar questions concerning a number of other payment by results initiatives, particularly the separate PbR for alcohol treatment, PbR for prisons and criminal justice and the DWP's 'work programme'.

## 5. Prevention and early intervention

5.1 When DrugScope consulted its members as part of the Drug Strategy consultation the importance of prevention and early intervention emerged as one of the key messages. DrugScope is a member of the Drugs Education Forum and facilitates the Drug Education Practitioners Forum. LDAN facilitates and supports a London-wide network for young people's drug and alcohol workers. Our 2010 report *Young People's Drug and Alcohol Treatment at the Crossroads* highlighted the need for a broad conception of 'prevention' and 'early intervention' that would include a lot of the work done in 'specialist' young people's drug and alcohol services.

### Public health campaigns

5.2 A greater 'public health' focus in the allocation of resources for drug and alcohol services could encourage increased local investment in prevention. This is welcome, but it is important that investment is evidence-based in an area where approaches that may have a high degree of intuitive appeal from a public health perspective are not well-supported by research. In particular, it would be concerning if public health money was disproportionately invested in high visibility public health campaigns. All the evidence suggests that 'shock tactic' public campaigns are ineffective and a poor use of public money unless they address a particular public health issue and are consistent with the everyday experiences of their target audience (as applied to the more successful drink driving and HIV/AIDs campaigns). Similarly, there is no evidence that 'just say no' approaches to drug education are effective for prevention. **Public Health England should issue clear guidance to help to ensure that local discussions and decisions on prevention and early intervention are evidence-based and informed.**

### Young people's treatment

5.3 There is abundant evidence for the value of early intervention with those young people who are most at risk from drug and alcohol problems, and a lot of the work currently undertaken by specialist young people's drug and alcohol services fall into this category. The majority of young people in specialist services have issues with alcohol and/or cannabis, and do not require 'treatment' in the narrow medical sense. As our *Young People's Drug and Alcohol Treatment at the Crossroads* report argued 'working with young people in treatment is not only about problem drug or alcohol use, but multiple needs' – including mental health issues, involvement with the criminal justice system, social exclusion and lack of education, training or employment opportunities. A holistic approach is therefore critical. Currently local Drug Action Team chairs and Directors of Children's services are expected to meet together, agree priorities, ensure an integrated and holistic response and share responsibility for delivery. **DrugScope members have reported a lack of consistency across the country in the effectiveness of these commissioning and service structures.**

5.4 The public health reforms provide opportunities to improve the provision for early intervention with the most at risk young people – for example, given the opportunities for pooling of public health, early intervention and community budgets and the composition of HWBB (which brings together DoPH and Directors of Children's Services). However, the outcome framework in ToI would provide only limited incentives for PHE and DoPHs to invest in prevention and early intervention. **It will be important to ensure there are**

**appropriate mechanisms to protect and promote investment in services for the most vulnerable young people.** There is currently real concern among DrugScope members about local disinvestment in children's and young people's services in many areas as Local Authorities reduce their expenditure to manage the cuts to their funding. A telephone survey conducted by DrugScope in London for our LDAN Newsletter (January/February 2011) reported that out of 18 young people's drug and alcohol treatment providers contacted in the capital, only three saw their service's current funding situation as 'safe'. Of those respondents who had been informed of definite cuts in their funding, most expected reductions of around 40 per cent, although one service was facing cuts of up to 75 per cent.

## 6. Budgets and resources

**6.1 The principal concern of DrugScope members is that the transfer of £1 billion of drug and alcohol money into the public health service, with the removal of the ring-fence from the pooled treatment budget, could lead to disinvestment, with money being allocated to other public health priorities. This would have a negative impact on some of the most vulnerable individuals, families and communities, as well as imposing substantial costs on the taxpayer over the longer term.** The National Audit Office's *Tackling Problem Drug Use* (2010) found that the 'most significant and costly objectives in the drug strategy were supported by robust evidence' (and specifically the spend on drug treatment), stating that every £1 invested in drug treatment resulted in savings of £2.50 from reduced criminal justice, health and social costs.

6.2 DrugScope believes that people with serious drug and alcohol problems have an entitlement to evidence-based treatment, operating to the same clinical, ethical and evidential standards as other NHS funded health care provision, and we therefore are delighted that HLHP includes a clear and explicit commitment that the public health service will be covered by the NHS Constitution (see above). This view is supported by the public. A DrugScope/ICM public opinion poll reported in February 2009 that nine out of ten respondents (88 per cent) agreed with the statement that drug treatment should be available to anyone with an addiction to drugs who is prepared to address it.

### Local investment and disinvestment

6.3 DrugScope notes the potential additional strains on local drug and alcohol spend as responsibility is transferred to the public health service. Currently, over £200 million of local investment is made in drug and alcohol treatment. In some areas, as much as 50 per cent of the total treatment spend is from local mainstream funding. We note that the NTA's Chief Executive, Paul Hayes, has expressed serious concerns about local disinvestment and the impact on the public health reforms in a letter announcing the central allocations for 2011-12 (11 February 2011): 'The biggest threat to those ambitions [i.e. for a recovery-orientated drug and alcohol treatment system] is the potential for local disinvestment. With the impending abolition of PCTs and severe budgetary pressures on local authorities, there is legitimate concern across the treatment field that the vital funding provided from local sources will be squeezed. I believe this would be a grave mistake, and is clearly not what the Government's Drugs Strategy aims for, nor what local Health and Wellbeing boards and Police and Crime Commissioners would wish to inherit.' To the extent that there is local disinvestment this will place additional strains on the ring fenced public health budget to 'plug the gaps'. **DoPHs (and HWBBs) will need to provide effective local leadership to ensure that local stakeholders are aware of the benefits of drug and alcohol investment for their own priorities and objectives and to encourage other investors (including GP Consortia).**

### Alcohol treatment

6.4 It is also likely that there will be a significant reallocation within the available drug and alcohol budget in some areas – for example, we would anticipate an increased investment in alcohol treatment that could be accompanied by a reduction in funding for some current services for people with drug problems. This, of course, is consistent with the shift to localism. Improved access to alcohol services would be welcomed by our members, and this does not have to be a ‘zero-sum game’ – if local strategic planning, commissioning and delivery of drug and alcohol services are more effectively integrated there is potential to add value within current capacity. **However, if local reallocations of budgets are to deliver the desired results for local communities, and Government is to ensure that core services are provided in all areas, this process will require a degree of central management and facilitation.** For example, DrugScope would welcome a programme of national and regional events for public health and other local partners – including opportunities for scenario and contingency planning to explore the possible consequences of alternative allocations of drug and alcohol budgets.

#### Ring-fencing and disinvestment

6.5 In our response to the 2010 Drug Strategy consultation we welcomed the ring-fencing of the budget for public health announced in the Spending Review, but added that we ‘would like to see a specific reassurance that budgets for drug and alcohol treatment will be protected, and a clear recognition of the contribution of drug and alcohol treatment to pursuing the Government’s public health, criminal justice and social policy objectives. **Our concern is that the removal of ring-fencing at a time when there is significant pressure on public spending could result in disinvestment from drug and alcohol services, with devastating consequences for some of the most vulnerable people in the community, and a negative impact on the whole community, that may not be anticipated (for example, increases in acquisitive crime)’.**

6.6 We recognise the Government’s strong commitment to supporting drug and alcohol treatment and prevention/early intervention. We accept that the Government is unlikely to ring fence drug and alcohol budgets within the public health budget, and understand that the benefits of localism require scope for local decision-makers to set their own priorities, and to shift resources to meet these priorities, which may require some disinvestment in other areas. **However, we urge Government to ensure that there is a sufficiently robust national framework of accountability for drug and alcohol services to ensure that the levels of investment that will be needed to deliver the outcomes in the 2010 Drug Strategy are available in every area.** One option would be a specific allocation within the public health budget for the drug and alcohol outcomes. This need not be inconsistent with increased flexibility to enable local authorities to respond to local needs and priorities.

## 7. Conclusion

7.1 DrugScope knows that there is a real commitment in the drug and alcohol sectors to work with Government to build on the achievements of the last decade while developing the recovery-orientated approaches described in the 2010 drug strategy. We want to ensure that the transfer of responsibility from the NTA to the public health service is successful, and to engage constructively with Government to develop an appropriate balance between the flexibility of localism and the need to ensure that people experiencing the most serious substance misuse problems have timely access to a range of evidence-based services of good quality across the country.

7.2 The future of drug and alcohol services is only one component in a much wider programme of health reform, but it is vitally important for the whole community that we get it right. The proposals in HLHP present opportunities to improve the effectiveness of local

interventions and responsiveness to the issues of greatest concern to local communities, but there are risks too – particularly of disinvestment. DrugScope would welcome further opportunities to work with the Department of Health to develop more detailed models and proposals. We would welcome opportunities to support a further and more detailed HLHP consultation strand with a specific focus on the commissioning and delivery of drug and alcohol services. We believe that Public Health England will have an important role in providing training, guidance and other resources to support DoPH and other local stakeholders (including GP Consortia) as they assume responsibility for a £1 billion drug and alcohol budget. Our members have identified a particular need to provide training and support to improve the quality of commissioning. DrugScope will be monitoring the impact of funding changes on our sector (including evidence of local disinvestment) through our Funding Watch initiative and will share this information with Government.

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