

State of the Sector 2014 – 15



on behalf of



About DrugScope and the Recovery Partnership

DrugScope is the national membership organisation for the drug and alcohol field and is the UK's leading independent centre of expertise on drugs and drug use. We represent around 400 member organisations involved in drug and alcohol treatment, supporting recovery, young people's services, drug education, prison and offender services, as well as related services such as mental health and homelessness. DrugScope is a registered charity (number 255030). Further information is available at: <http://www.drugscope.org.uk/>

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

Acknowledgements

We would like to thank the Department of Health for funding this project. We would also like to thank the organisations and individuals who supported the development of the questionnaires, including the Department of Health, Public Health England, the Home Office, the Department for Work and Pensions as well as stakeholders from the drug/alcohol treatment sector.

We would also like to thank Ryan Campbell of KCA, Brian Dudley of Broadway Lodge, Steve Jones of ARCH Initiatives, Monty Moncrieff of London Friend and Mike Trace of RAPt for participating in on the record interviews, and to 6 service managers who took part on the condition of anonymity. The service managers were selected from among the respondents to the online survey, the primary criteria being to ensure that we were able to reflect a range of locations, types of service and to include interviewees from the public, private and voluntary sectors.

We would like to express our gratitude to those who participated in the online survey. The questionnaire was substantial and required respondents to provide, in some cases, quite detailed and potentially sensitive information. We are conscious that in participating in this survey, service managers will have donated a significant amount of their limited time; we hope that this report is a fair and accurate reflection of their contribution.

Finally, we would like to thank colleagues from across the Recovery Partnership for their support in designing and promoting the survey and, in particular, Rachael Evans of Adfam for her assistance in conducting and transcribing a number of interviews and Richard Clifton for transcribing other interviews and for early analysis of the survey responses.

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Foreword

The first State of the Sector report was published early in 2014 and provided a snapshot of the drug and alcohol treatment sector as it entered into new and uncharted territories. 2013 had seen some of the biggest system changes for over a decade. These included the abolition of the National Treatment Agency and the transfer of its functions to Public Health England, the absorption of a 'ring fenced' drug treatment budget into the wider public health funding pot and increased discretion for new local decision makers and bodies (including Directors of Public Health, Health and Wellbeing Boards and Police and Crime Commissioners) to decide how much they spend and on what.

The drug and alcohol treatment sector benefits from some exceptionally good data about its clients, outcomes and impact – notably the National Drug Treatment Monitoring System (NDTMS), and, more recently, an equivalent for alcohol (NATMS). Our annual survey has a different purpose: to provide a 'health check' of the sector itself during a period of change and upheaval, and to 'hold a mirror up' to local and national government on the impact of reforms. It is an attempt to paint a picture of a changing landscape by capturing the experiences of those directly involved in managing and providing services in our communities.

Last year we found many signs of innovation, resilience and adaptation. There were also anxieties about the ability to sustain the necessary investment to deliver the ambitions of the Drug Strategy, particularly as reductions in local government funding were requiring councillors and their officials to take difficult decisions about priorities. How will services for an often marginalised and stigmatised group fare in this environment?

We found no evidence of deep and widespread disinvestment at this early point, although 35 per cent of respondents reported a decrease in funding, and there were other grounds for concern. These included increased caseloads, a reduction in front-line staff and difficulties in accessing 'recovery capital' in some local areas (in particular, housing and housing support, mental health services, support for complex needs and employment). A subsequent study of commissioners by Public Health England found that at least a third of local authorities were expecting to reduce funding for drug and alcohol services in the years 2014-15 and 2015-16, with considerable uncertainty beyond that.

In the period that we asked people to consider for this State of the Sector report - September 2013 to September 2014 – the impact of earlier reforms has continued to work through, but with no new policy changes of the sort that we saw between 2010 and 2013 (although we are seeing big public service changes, notably the Transforming Rehabilitation reforms of probation and offender management).

Reductions in funding for local councils have also continued in this period, and are ultimately expected to lead to a reduction in overall funding of around 25% by 2015-16.

The theme of innovation and resilience comes through again in State of the Sector 2014, but so does a clear message that service managers are experiencing or anticipating significant reductions in funding. It is in the nature of localism that this will vary between local areas. And the trends we picked up last year continue to be in evidence, with over half of respondents reporting reductions in front line staffing, for example, and many reporting challenges – particularly – in accessing housing and housing support, mental health services and support for dual diagnosis and complex needs. Also in evidence again is the impact of the constant cycle and churn of local commissioning and recommissioning, with over half of services responding to the survey saying that they'd been through a tendering or contract renegotiation process in this period.

This remains a time of opportunity, challenge, uncertainty and risk for drug and alcohol services – and it is important that policy and decision makers maintain a 'clear line of sight' through to what is actually happening on the ground. State of the Sector provides a voice for nearly 200 services. But it is also important that reliable and timely data on local spending is publicly available, and we would welcome clarity, for example, on how Public Health England will be following up on last year's review of commissioning intentions going forward. This is particularly important with the introduction of a 'health premium', along with new grant conditions, to protect drug and alcohol investment. These services work with some of the most marginalised and vulnerable individuals, families and communities. The impact that they have on people's lives, and the wider economic and social benefits they bring, have been clearly demonstrated over many years. It is vital to sustain the investment to 'build recovery' in every local community.

Vivienne Evans OBE, Chair, Skills Consortium
Noreen Oliver MBE, Chair, Recovery Group UK
Dr Marcus Roberts, Chief Executive, DrugScope

Executive summary and key findings

In 2013, DrugScope conducted the first State of the Sector survey, as part of the work done with the Recovery Partnership, the findings of which were reported in January 2014. This second report is based on a survey and interviews conducted 12 months later in September and October 2014.

The systems and structures focused on in the 2013 survey, such as the creation of local Health and Wellbeing Boards and Police and Crime Commissioners, are now more than 18 months old, although some of the interviews suggest that they are still 'bedding in'.

There is also the broader matter of public service reform and the external environment, which remains challenging. Local authorities are continuing to make efficiencies across the full range of services they offer. Councils are part way through a process of reductions of funding that will ultimately lead to a reduction in overall funding of around 25% by 2015-16.

The drug and alcohol budget sits within the broader ring-fenced public health allocation, although without separate protection in this period.

Key points

- The State of the Sector survey includes responses from 189 services from across England.
- 54% of community services had been through tendering or contract renegotiation since September 2013. Half (49%) were expecting this to happen between September 2014 and September 2015.
- 60 community services and 11 residential services reported a reduction in funding compared to increases for 17 and 6 services respectively. The average net change of funding to services appears to be a reduction of 16.5%.
- 53% of respondents reported a reduction in front line staff and 40% a reduction in back office staff and managers.
- 62% reported an increase in the involvement of volunteer recovery champions, and 47% an increase in the use of other volunteers.
- 16% of services reported an increase of 10% or more in people accessing services and 14% a decrease of the same size.
- The biggest gaps in provision were housing/ housing support, support for dual diagnosis/ complex needs and services for older clients.
- 22% of respondents thought that access to mental health services had worsened over the last year.

This year's survey continues to show that local decision makers are reordering their priorities for public health. And, like last year, the majority of respondents have been through or are about to go through recommissioning or, more rarely, contract renegotiation.

With a sizeable proportion of local authority resources (and around 29% of local authority public health budgets) effectively reserved for mandated or prescribed services, it seems likely that all non-mandated services are potentially vulnerable, including drug and alcohol treatment.

The survey reinforces the understanding that the drug and alcohol sector does not work in isolation and that other services face their own distinct challenges. As a member of the Making Every Adult Matter (MEAM) coalition, DrugScope has an understanding of the way that key partner sectors are being affected by the changing environment and how they in turn are adapting and responding.

Methodology

State of the Sector 2014-15 is based on three components: a large online survey using a convenience sample; a series of anonymised interviews with service managers and attributed interviews with the Chief Executives of Arch Initiatives, Broadway Lodge, KCA, London Friend and RAPt.

168 respondents completed or mostly completed the community and residential questionnaire with a further 21 responses from prison services.

Amongst the community and residential responses 19% were residential services, 77% community services with the remainder being a mixture of mutual aid and other services. 24% were NHS services, 62% provided by charities, with the remainder from elsewhere in the public sector, the private sector, social enterprises and partnerships between sectors. Around a quarter participated in State of the Sector 2013.

State of the Sector 2014-15 – four key themes

The commissioning cycle

There was a consensus that commissioning and testing the market has a place in ensuring effective and affordable drug and alcohol treatment. However, many respondents were concerned that, although difficult to quantify, rapid commissioning cycles had a harmful and disruptive effect on service provision.

As in 2013, a majority of participating services had been through contract negotiation (12%) or competitive tendering (42%) in the preceding 12 months, with more (49%) expecting to go through one or other process in the following 12 months.

"Commissioners are in, if anything, a more difficult process of change than providers. They're expected to work in different and new ways within different, new organisations with reduced budgets, which is to my mind a virtually impossible task."

Ryan Campbell, KCA

"The negative impact has been that the workforce are disconnected from their employers, in many cases they are on their third or fourth employer in ten years."

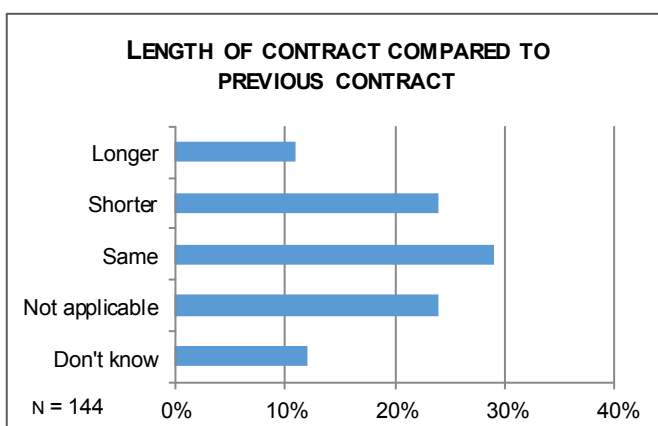
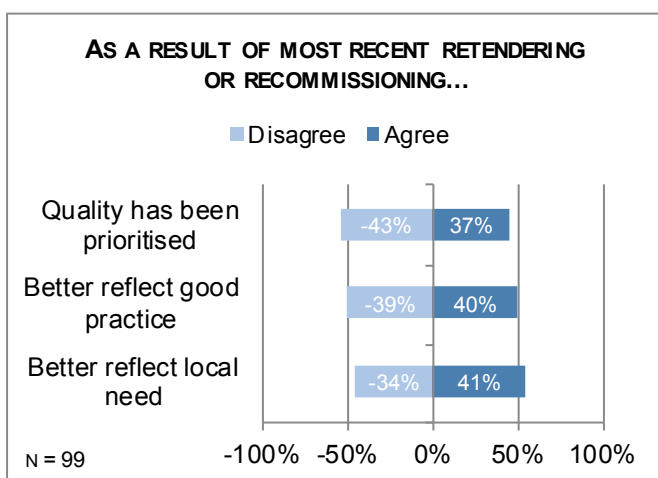
Service manager

Respondents and interviewees expressed a number of concerns about this process, which can broadly be categorised in the following ways.

Disruption to services. Many respondents emphasised the destabilising and demotivating effect of uncertainty about jobs, employers and in some cases the future of entire services. Respondents were keen to emphasise that their concern was related to the potential impact on their workforce and the potential implications for service provision and clients.

Provider diversity. Several respondents acknowledged the need to make economies but cautioned that one of the consequences of an increased emphasis on cost could be reduced provider diversity. Small and medium-sized organisations were felt to be particularly disadvantaged in this process, while the residential sector faces distinct and complex challenges of its own.

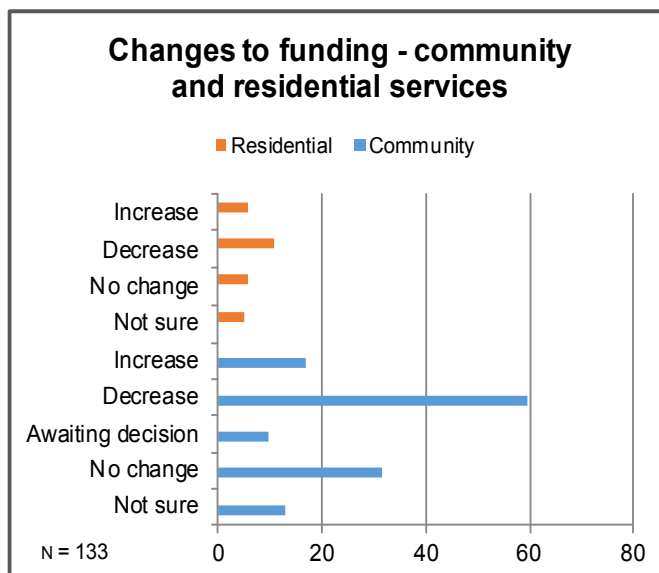
New systems, new challenges. Many respondents saw the value in testing the market and acknowledged the contribution commissioners make to an effective and successful treatment system. There was a desire to see more support offered to commissioners, who may themselves have taken on new roles, potentially within a new setting. Several expressed the hope that future commissioning can lead to closer



partnership working between sectors and more seamless services to individuals, even in the face of a challenging climate.

Funding for the sector

The funding picture seems increasingly clear. While there are clear limits to what can be inferred from the findings of our survey, service manager and chief executive interviews give cause to believe that over the period 2014 to 2016, substantial disinvestment is expected and being planned for, although this will vary from place to place. We identified an average net reduction of 16.5% in funding to services, this masks what appears to be considerable volatility, with many respondents reporting substantial increases or decreases.



Some of the chief executives interviewed acknowledged that the sector has been relatively well funded over the last decade and has enjoyed a considerable degree of budgetary protection in more recent years. That this period may be drawing to a close has not come as a surprise to them or to others, but it raises questions of how England's world class treatment system can be maintained.

"There has been a decrease in staffing at all levels with an expectation that volunteers and peer mentors will compensate."

Service manager

Some answers to this question may lie in the survey responses and interviews; respondents indicated eagerness to innovate, to make efficiencies and to forge new partnerships. Respondents also indicated an enthusiasm to market their services – commercially to commissioners, but also to new clients, people they may otherwise

not have reached. Chief executives in particular acknowledged the need to take a whole person approach based around social inclusion and recovery capital, while emphasising that specialist treatment for substance misuse and dependency has a distinct place that must be maintained.

Again, the residential sector may face a separate set of challenges relating to the way it is funded and places purchased. The possibility of block loss of capacity – where many

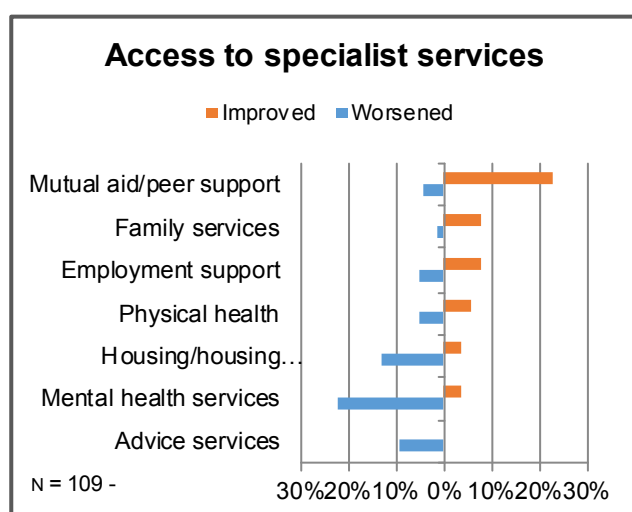
services become financially unviable simultaneously – was raised as a concern, along with the likely difficulties of reinstating that capacity should it be lost.

Gaps in provision

Gaps in provision have been highlighted by respondents and interviewees. A minority of these gaps are largely or entirely external to the treatment system and the other services it works with. While people with histories of drug and/or alcohol misuse are likely to be particularly disadvantaged, problems such as access to appropriate, secure and affordable housing and access to paid employment are by no means unique to this cohort. Several respondents and interviewees articulated in some detail the steps they are undertaking to address these gaps.

"I still think it's a nightmare trying to join up mental health and addiction. It's down to funding. There's often a complete lack of joined up working between mental health services and rehabs."

Brian Dudley, Broadway Lodge



Whereas the above might be described as external challenges, others are more particular to the sector. Access to mental health treatment and support for complex needs again features very highly, with the 22% of respondents indicating that access has deteriorated over the 12 months to September 2014.

In addition to the barriers to mental health treatment often reported by agencies working with people with coexisting mental health and substance

use problems, respondents suggested that there is a growing gap in provision in the mental health sector. A relatively recent introduction, Improving Access to Psychological Therapies (IAPT), is seen as offering provision at the mild to moderate end of the spectrum and community mental health teams (CMHTs) at the more severe end, with the suggestion of a growing gap between the two, leaving a portion of clients unserved.

While mental health, housing and employment - direct contributors to recovery capital – featured prominently among gaps identified in State of the Sector 2013, access to support for older clients was indicated as a gap by a far larger proportion of people in 2014-15. It is not obvious why this is the case – although the average age of the

population in specialist treatment is ageing, that alone seems unlikely to account for the proportion of respondents mentioning services for older clients changing so substantially over just 12 months.

The ageing population in treatment may be reflected in another gap identified – access to services for transition age adults. Providers are increasingly aware that a different service offer may need to be made for younger people coming into adult services. An ageing adult population in treatment and the changing profiles of younger people moving into treatment may require commissioners and providers to work together to develop new models of provision.

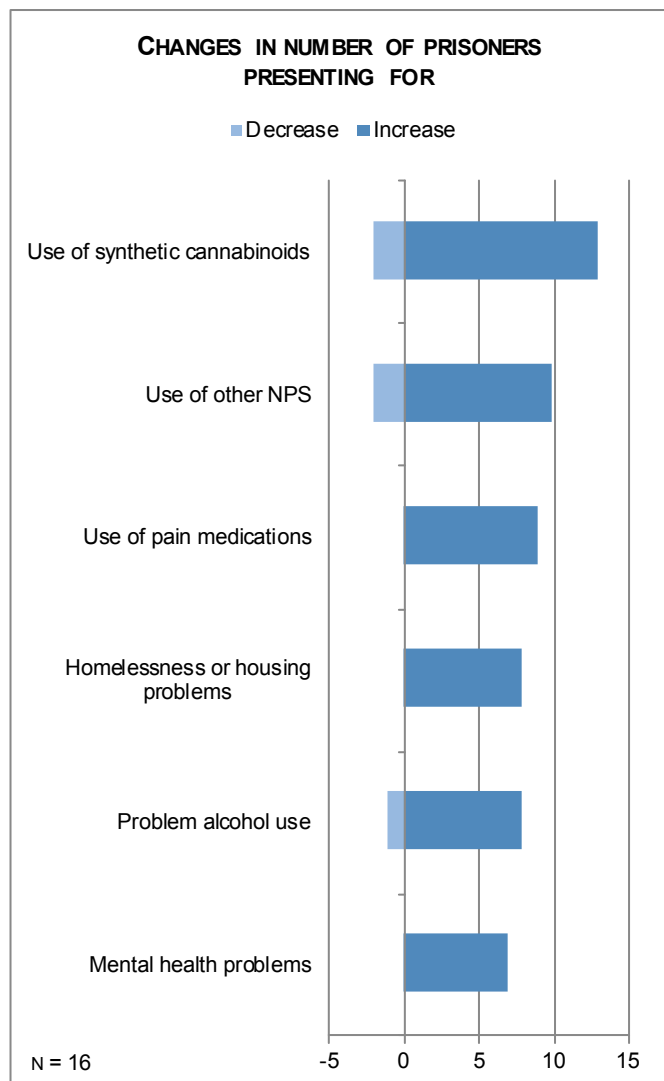
What support is available often suffers from saturation causing threshold problems, which result in only the most severe cases receiving attention, and problems escalating out of control. Even very severe cases are often turned away - particularly noticeable in seeking crisis or respite care for clients with complex needs.

Service manager

Prison services

Services in prisons were generally more optimistic, acknowledging that treatment in prisons has made significant progress over a relatively short space of time. With a caveat around the survey sample, there are more signs of stability than in the community and residential parts of the sector. There was also optimism that some aspects of the reforms, either in hand or planned, could yield positive results. For example, an increased focus on ‘through the gates’ work and the extension of probation support to short sentence prisoners under Transforming Rehabilitation, if implemented as planned, was seen by many as offering the potential to reduce reoffending and improve outcomes.

Less positively, the reduction in prison officer and support staff headcount



was seen as adversely affecting the delivery of substance misuse treatment and related support in prisons, and the role of novel psychoactive substances – particularly synthetic cannabinoids – as well as prescription medication was seen as being extremely harmful. Perhaps unsurprisingly, resettlement support and access to accommodation appear as the biggest gaps - although here again, the situation may be improved by more through the gates activity.

"We know exactly what we're meant to be doing in prisons [but] it's a constant battle because of staff shortages or lockdowns or because somebody has taken away the meeting rooms."

Mike Trace, RAPt

Key Points - Community and Residential Services

- 168 respondents from the community and residential sectors completed or mostly completed the questionnaire with a further 21 responses from prison services.
- Of the 168, 19% were residential services, 77% community services with the remainder being a mixture of mutual aid and other services. 24% were NHS services, 62% provided by charities, with the remainder from elsewhere in the public sector, the private sector, social enterprises and partnerships between sectors. Around a quarter definitely participated in State of the Sector 2013.

Scale and impact of recommissioning

- 54% of services had been through tendering or contract renegotiation since September 2013, with only slightly fewer expecting to go through either process between September 2014 and September 2015. Where tendering or negotiation had taken place, a narrow majority felt that services better reflected local need. However, narrow majorities also felt that commissioning or renegotiation had failed to reflect good practice and that quality of service had not been prioritised.
- While anecdotal reports suggest a move to longer contracts, either now or as new commissioning and funding structures mature this has not yet been reflected in the survey findings. Compared to their previous contract, 11% of respondents report a longer contract compared to 24% shorter. Overall, 77% were working to a contract of three years' duration or shorter.
- Relatively few services were commissioned on a payment by results (PbR) basis: 7% as part of the formal PbR pilots, and 12% elsewhere. A further 9% were anticipating the introduction of PbR before September 2015.

Changes to funding for adult community and residential treatment services

- 17 community services had received an increase in funding compared to 60 reporting a decrease. From information provided by respondents, the average net change appears to be a reduction of 16.5%. Of residential services, 6 reported increased revenue compared to 11 reporting a reduction. This figure is only representative of the services that took part in the online survey and should not be interpreted as being more generally representative.
- While there were improvements in opening hours and family support, the consequences of changed funding were reported as being mostly negative, with caseload per worker and workforce development indicated as being particularly adversely affected.
- 53% of respondents reported a reduction in front line staff and 40% a reduction in back office staff and managers. Conversely, 62% reported an increase in the use of volunteer recovery champions, and 47% an increase in the use of volunteers. Some respondents indicated that recovery champions were undertaking responsibilities that were formerly those of paid staff. Some respondents emphasised the additionality of recovery champions or the role that volunteering can play as a stepping stone to paid employment. Others were keen to emphasise that while they were proud of and welcomed the additional support offered by volunteers, they were keen to ensure that the involvement of volunteers was not at the expense of other forms of professional support.
- At least 90% of respondents employ people with personal experience of drug and/or alcohol use and treatment, with 37% having a programme in place to support recruitment from this group.
- Taking all respondents into consideration, there appears to be little change in the number of people accessing services. However, 16% of services reported an increase of 10% or more and 14% a decrease of the same size. Demand for alcohol treatment, changed patterns of drug use, changing numbers of referrals from other agencies and the role played by novel psychoactive substances (NPS) were most often cited as the reasons for changed demand.

Gaps in provision

- Services are funded to meet a range of needs and client groups or can at least otherwise work with them. There appear to be gaps in funding to undertake several activities including smoking cessation; one of Public Health England's seven priorities.
- Other than addressing substance use itself, self-esteem and motivation, health improvement, social networks and employment support all rated as significant

support needs presented. Of changing support needs, problem alcohol use, financial and/or social security problems and the use of NPS were the most significant.

- For other locally accessible provision, the most available were mutual aid/peer support, harm minimisation advice/services and alcohol support. The biggest gaps in provision were housing/housing support, support for dual diagnosis/complex needs and services for older clients.
- While access to mental health services were nearly universal, with only 4% stating their clients were unable to access them, 22% of respondents thought that it had worsened over the last year, with several developing in-house provision to compensate for difficulty and/or delays in accessing specialist mental health support. Most often citing as problematic mental health services' reluctance to provide treatment for people misusing substances and a developing gap between Improving Access to Psychological Therapies (IAPT) provision at the less severe end of the mental health spectrum and NHS community mental health teams (CMHTs) for people with more severe mental ill health.
- Up to 76% of services had some form of partnership working with Jobcentre Plus (with 3% reporting funded partnerships), but no more than 56% of respondents had partnerships with Work Programme providers. A similar number were working around the Troubled Families agenda.
- While access to advice services was widespread, many respondents reported a lack of capacity in specialist advice agencies they were partnered with or made referrals to.
- Access to housing, housing support and resettlement was seen as problematic, with survey respondents and interviewees mentioning the difficulties accessing suitable accommodation can present.
- Access to family support and recovery networks/ peer support was reported as being widespread and improving.
- There was little movement in links with the criminal justice sector, although respondents reported a reduction in custody suite/arrest referral work (possibly accounted for by the end of the national Drug Interventions Programme) and in through the gates work, which is perhaps surprising given the emphasis on this as part of Transforming Rehabilitation.
- Most services were confident or very confident that they could or would in future be able to respond to equalities issues, NPS, wider availability of naloxone and image and performance enhancing drugs.

- There was little confidence that Police and Crime Plans and Joint Strategic Needs Assessments/Joint Health and Wellbeing Strategies reflected local need, with in both cases only 19% of respondents being confident or very confident that they did.
- The impact of welfare reform was seen as being negative, although some respondents reported that some reforms had had a positive impact. The Work Capability Assessment was reported as affecting the largest proportion of clients, and the post-2012 Jobseeker's Allowance (JSA) and Employment and Support Allowance (ESA) sanctions regime as having the most strongly adverse consequences.
- Services saw a number of opportunities in the current environment, including diversifying their offer (a broader approach)/reaching new clients (a deeper one), increased partnership working and diversifying their funding streams.
- Challenges included revenue funding, caseloads and the need to reform services.
- Innovations included offering new services, making efficiencies and the role of recovery champions. Providing support to staff was mentioned by a small number of respondents. This was raised in the context of staff morale and team stability being adversely affected by frequent changes of provider, recommissioning and general uncertainty some teams might be experiencing.

Prison services

- Respondents and interviewees from prison services were rather more positive than their community and residential-based counterparts, with signs of more stable contracts (although still subject to retendering and recommissioning) and funding. Developments towards integration of drug and alcohol treatment and wider health services, including mental health, were welcomed.
- Access to accommodation, employment support, specialist substance use treatment and related services on release was identified as being a major obstacle to the achievement of post-release positive outcomes. There was optimism that increased use of 'through the gate' services and (somewhat cautious) optimism that the extension of probation to short sentence prisoners as part of the Transforming Rehabilitation reforms may help to address this.
- Many interviewees expressed concern about the resourcing of prisons and prison staff (excluding specialist treatment services), believing that frequent shortages of prison officers were adversely affecting their ability to provide an effective and appropriate service.

- Respondents pointed to the presence of illicit substances and abuse of prescribed medication within prisons as being highly problematic.

About services and systems

To gain an understanding of the effect of funding changes in particular, it is important to consider not just changes to funding to services, but also funding to local substance use treatment systems, which may consist of a network of providers drawn from the public, private and voluntary sectors.

While a reduction of funding to a single provider within a system may be unpleasant for those who work in it and disruptive to those who use its services, arguably the more important considerations (all other things being equal) is the ability of local systems to provide a proportionate service and deliver robust outcomes, which may be dictated more by the level of resource allocated to the local system rather than any one service within it. There is evidence that some localities have chosen to take the path to larger contract lots with fewer providers in the quest for efficiencies, so a scenario in which individual services are adversely affected while investment overall is largely maintained is plausible, as is a scenario in which both efficiencies – doing more; and savings – doing it with less; are sought.

There is currently some information in the public domain that sheds some light on this. The PHE Commissioning Review focuses on commissioner intentions in the next 12 months. The review suggests that a substantial minority of councils were planning cuts in either 2013-14 or 14-15, with a larger number being unsure, presumably as that survey was conducted before either the 2015-16 public health allocations or the provisional local government settlement had been released. It should be noted that PHE's review does not attempt to indicate the scale of any changes to the funding of services.

Based on survey responses, we found a net average reduction among participants of 16.5% (community services only). This average masks some volatility as it includes both increases in funding (the largest being 100%) and reductions (the largest being 88%). We have taken a cautious approach by excluding reductions of 100% on the basis that it is impossible to tell whether or not the resource has simply been moved to elsewhere in the local system.

The figure of 16.5% should be viewed with some caution. In addition to being based upon a limited sample, it tells us nothing about investment nationally or locally. However, seen in the context of some areas that have already confirmed plans to reduce funding this figure seems significant enough to warrant further investigation.

The Freedom of Information Act 2000 requires, with a number of exemptions, public bodies to respond to requests for information. DrugScope will, in due course, explore the viability of this route as a means to obtain more detailed information about local authority decisions and resource allocations.

Methodology and data

State of the Adult Sector 2014-15 is comprised of several elements. These are:

- An online survey promoted to managers of adult community and residential drug and alcohol services - 189 participated;
- An online survey promoted to managers of prison drug and alcohol services (21 respondents started);
- Interviews with 5 chief executives of drug and alcohol treatment providers. These interviews are included in the report and identified by interviewee.
 - Ryan Campbell, Chief Executive of KCA, a voluntary sector service provider operating in London and the South East. It provides a range of adult and young people's specialist substance use treatment services, family intervention programme services and mental health services, including Improving Access to Psychological Therapies (IAPT) services;
 - Brian Dudley, Chief Executive of Broadway Lodge, a voluntary sector residential service in Weston Super Mare. Founded in 1974, Broadway Lodge offers a range of services including detoxification, residential rehabilitation, second and third stage housing with support, separate provision for men and women as well as community treatment and recovery support programmes;
 - Steve Jones, Chief Executive of ARCH Initiatives, a voluntary sector provider operating in the North West of England and in North Wales. ARCH, which stands for Advice, Rehabilitation, Counselling and Health, runs a range of community services including family services, services for young adults and criminal justice services. ARCH also offers residential detoxification;
 - Monty Moncrieff, Chief Executive of London Friend, London's oldest lesbian, gay, bisexual and trans charity. London Friend offers a range of services including sexual health, counselling and social support, in addition to Antidote, the UK's only LGB&T run and targeted drug and alcohol support service;
 - Mike Trace, Chief Executive of RAPt; a voluntary sector organisation that in 1992 set up the first specialist drug treatment service inside a UK prison at HMP Downview in Surrey. RAPt now offers a range of prison based services, community based services and recovery support services, including family support at locations around England.

- Interviews with 5 managers of drug and alcohol services, selected from respondents to the online surveys with the aim of enabling, as far as practicable, a reasonable geographical spread, representation of the voluntary, public and private sectors. We were also keen to include services with a particular speciality or focus, for example, family support or accommodation. These anonymised interviews are included in the body text of the report along with additional comments provided in response to the online questionnaire.

The online surveys were promoted to DrugScope's membership, but were open to any relevant service manager. They were also promoted by Recovery Partnership members, via PHE regional networks and through DrugScope's social media channels.

However, it should be noted that the survey in effect uses convenience sampling; to participate, a respondent must be aware of the survey as well as having the time and inclination to take part. It is also open to sample bias, in that participants are entirely self-selecting. There are a number of scenarios in which service managers may be more or less inclined to participate. This might include:

- A service going through a period of rapid expansion due to assuming new services post commissioning. This would potentially result in positive responses being under-represented;
- A service going through recommissioning where project management do not have the time to participate. This would potentially result in mixed responses being under-represented;
- A service that has unsuccessfully been through commissioning or through a difficult process of contract renegotiation. This would potentially result in negative responses being under-represented.

From conversations between DrugScope and its members, each of these scenarios seems likely, although it is difficult to quantify the relative probability. Consequently, no assumptions or adjustments have been made to the responses received. At various points responses to the questionnaire can be compared to known data points (such as the number of councils intending to retender services or renegotiate contracts and the number of services participating in the Work Programme); doing this suggests that our sample is reasonably representative.

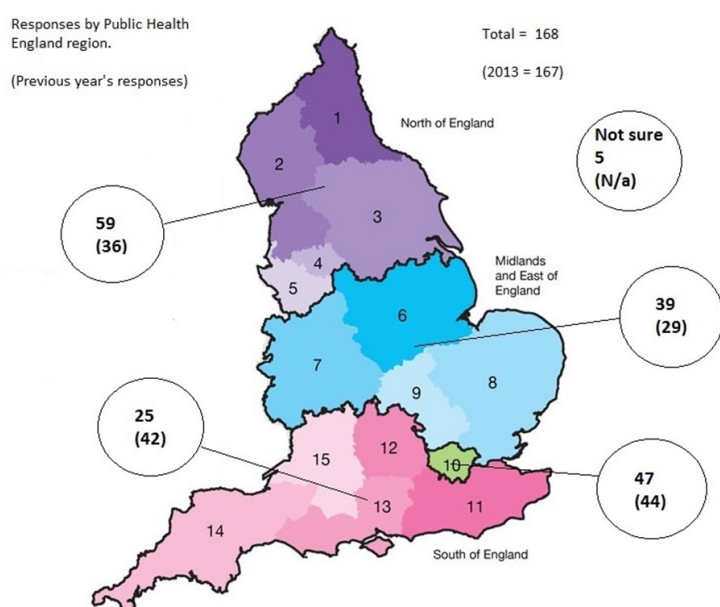
Similarly, 26% (48) respondents indicated that they or someone else from their service had participated last year, with a further 50% or 92 respondents being unsure. While we offer participants the opportunity to leave their contact details for a follow-up telephone interview, the otherwise anonymous nature of the survey makes it impossible to make connections between *State of the Adult Sector 2014-15* and *State of the Sector 2013*. Consequently, responses relating to recommissioning, contract renegotiation and, in

particular, funding, should be taken as relating only to the period in question and no inferences can be made with respect to the previous 12 months.

190 respondents started the survey with most completing all or most of it. However, the responses to individual questions varies; the number of respondents is indicated for each question. Charts use either actual numbers or percentages; whichever is more suitable to aid easy comprehension of the chart in question. In the case where percentages have been used, data labels are clearly identified as percentages.

The online surveys and interviews generated a significant amount of narrative content, which we have endeavoured to reflect in a balanced way in this report. Opinions expressed by survey participants or interviewees do not necessarily reflect those of DrugScope or the wider Recovery Partnership.

Respondents by region, type and sector



This year saw substantial increases in participation in services based in the North of England, Midlands and East of England, a small increase in those from London, and a big fall in the number from the South of England. There is no immediately obvious explanation for either substantial movement.

Three in four services (77%) that participated in the survey this year described themselves as community services. We had 32

(19%) responses from residential services, and a smaller number (7) from mutual aid organisations. One in ten who took the survey were not drug and alcohol treatment providers, examples include: a day centre, a Work Programme provider, liaison psychiatry within an acute hospital, the law enforcement and criminal justice sector, probation and primary care.

One in four participants said that they had participated in the State of the Sector survey in 2013, with a further 50% being uncertain whether their service had participated.

The largest proportion of respondents came from the charitable sector (62%), followed by the NHS (24%) and other public sector organisations (8%). We also had respondents from the private sector (7%) and social enterprises (7%).

Contract length, recommissioning and funding

- 54% of services had been through tendering or contract renegotiation since September 2013, with only slightly fewer expecting to go through either process between September 2014 and September 2015. Where tendering or negotiation had taken place, a narrow majority felt that services better reflected local need. However, narrow majorities also felt that commissioning or renegotiation had failed to reflect good practice and that quality of service had not been prioritised.

“Four years into this I still have not seen any commissioning that RAPt has been involved in where the issue of what results can you achieve has really dictated the decision of who gets the contract. It’s always price, always system measures. Outcomes don’t seem to play any part at all. There’s always a section about what outcomes you think you can achieve but it never swings the decision.”

Mike Trace, RAPt
- While anecdotal reports suggest a move to longer contracts, either now or as new commissioning and funding structures mature this has not yet been reflected in the survey findings. Compared to their previous contract, 11% of respondents report a longer contract compared to 24% shorter. Overall, 77% were working to a contract of three years’ duration or shorter.
- Relatively few services were commissioned on a payment by results (PbR) basis: 7% as part of the formal PbR pilots, and 12% elsewhere. A further 9% were anticipating the introduction of PbR before September 2015.
- 17 community services had received an increase in funding compared to 60 reporting a decrease. From information provided by respondents, the average net change of funding appears to be a reduction of 16.5%. Of residential services, 6 reported increased revenue compared to 11 reporting a reduction. This figure is only representative of the services that took part in the online survey and should not be interpreted as being more generally representative.

Over half (54%) of respondents had been through either a tendering process or contract renegotiation in the preceding 12 months. Some participants questioned what they perceived as a preference for tendering over negotiation:

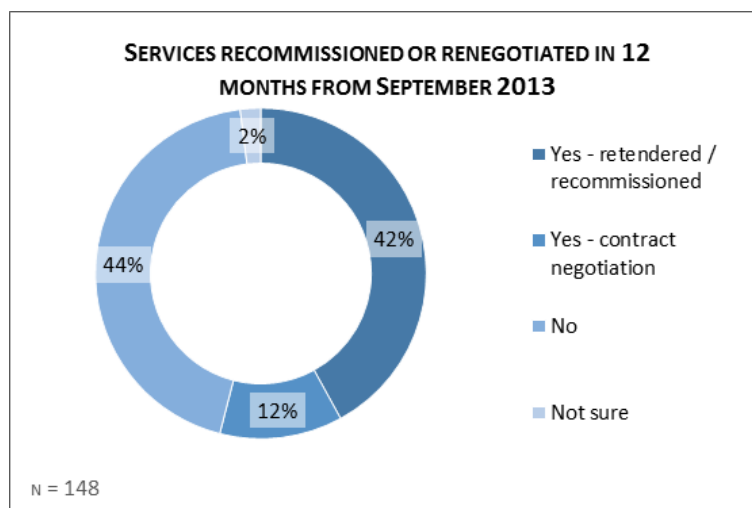
We were led to believe that there was a standing financial instruction that

local authorities must market test on a regular basis, but the reasons that are now being given are that they felt the treatment system was not performing adequately for a period of time - something we dispute highly - and that they wanted closer integration for drugs and alcohol and more emphasis on recovery. We felt we

"Providers in our sector (and in other social care sectors) are being pretty much forced into partnerships to win contracts. The contracts are getting bigger and more multi-faceted. You're not going to win any of those unless you're in a partnership.

"The ideal partnership is moral and ethical. We have some partnerships and we try to behave this way. We're very much 'cards on the table.' We've had experiences of partnerships where the other partners had the same approach and whatever problems are hit - and there are always problems in partnerships - are dealt with by grownups chatting it through in a trusting way. We have other partnerships where you feel like the other partner is your biggest enemy. It's a human thing and organisational cultures take their cue from the top."

Mike Trace, CEO, RAPt



already had that, so we tried to challenge the reasons around the tender and tried to query why it wasn't just a contract negotiation. We understand there's less money, but we were able to meet the demands of the specification adequately.

There was a broad consensus that the process was often demotivating and destabilising for teams and consequently (and importantly) potentially disruptive for clients.

This was generally the case regardless of whether the participant was located in the voluntary or public sector:

The one thing I would see an improvement in is if we did away with competitive tendering because it is complete waste of time and money; you lose a lot of resource

and skill. It destabilises the system and service users always come out of it worse off. It's massively destabilising.

All the treatment in this area as we know now and as we have known for over 20 years will cease and change. Our staff and our 2,500 clients will have to move. We are about to send a letter to our clients to ask whether we can transfer their NHS patient data to this new provider. If they decline, they will be told that there will be no service available beyond the 1st of February because the incoming provider can't treat them without the information. A section of our client group, who are often brown-envelope phobic, may not want to open the letter, might open the letter and not fully understand the consequences of it so will not reply, will wait and will not do anything about it no matter how urgently we make the request to them.

"We seem to be in an environment where retendering at an arbitrary time period whether the service is working well or developing well or whether it isn't is the norm. So the first thing I would like to do is stop that. If something's working well don't throw it all up in the air. The second thing I would do is to have a form of tendering that isn't virtually 100% reliant on the great big wads of paper that everybody puts into the tender. Too many tenders are won and lost on the quality of the writing and I think too many tenders are won on the basis of writing into them things that are unachievable, sometimes because the specification which has been put out is unachievable... There needs to be a much more sophisticated process of handing over services because we're talking about millions of pounds of public money and we're talking about life or death issues in terms of the services that people receive."

Ryan Campbell, KCA

Staff are already worried and leaving, clients are worried about whether their prescription will be safe, will they be maintained, will they be forced to detox?

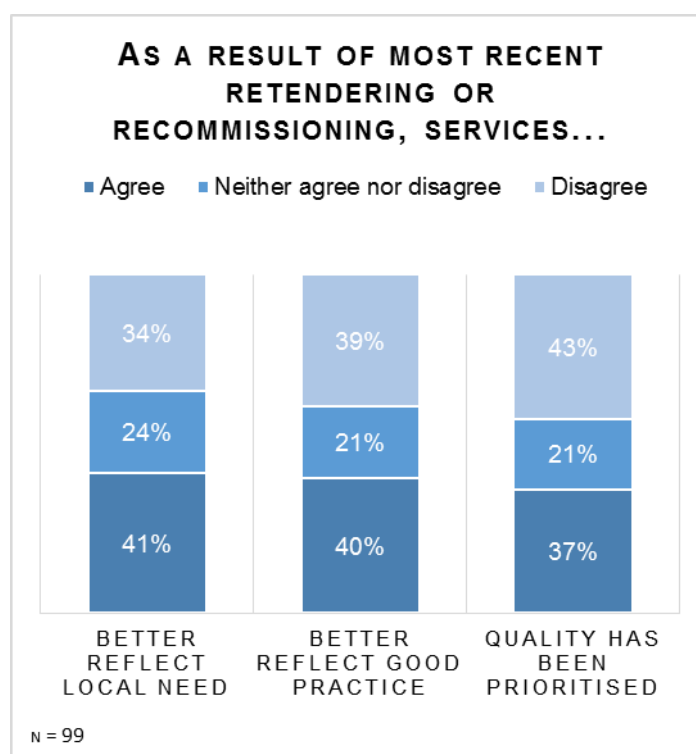
Some comments highlighted the increasingly complex world of sub-contracts and supply chains that services now exist within:

We were subcontracted to another voluntary sector provider. [Their contract] has been renegotiated, which affects us, even though there was no negotiation with us.

The recommissioning went out to competitive tender. They asked for tenders to come from consortia and we went in as part of one and our consortium is the

preferred provider. It's going to be very much changed because we were directly funded and now we will be funded through the lead agency in the consortium, which is not us.

Where a view was expressed there was a sense that for many, recommissioning and retendering had led to a better focus on local need (41%), but this wasn't universally true and a substantial minority (33%) thought it had reduced local focus. More respondents strongly disagreed with the statement (18%) than strongly agreed (12%).



The proportions thinking that the process had ensured better practice (39%) was almost equal to those disagreeing (43%). But again those expressing a strong view tended to believe that it had made things worse (20%) rather than better (14%).

When reflecting on quality of provision, marginally fewer believed that commissioning had prioritised this aspect of service provision (43%) than those who agreed that this had been prioritised (36%). Unlike other questions in this section the proportions that felt strongly were broadly equal (20% strongly disagreed and 18% strongly agreed).

Respondents indicated a number of potential issues – not all perceived as negative or detrimental to services – and often differentiated between financial drivers and policy ones:

I believe there may be a trend across the country where NHS services who operate drug and alcohol services are being put out to tender now that the funding comes under the local authority. However, there doesn't seem to be a corporate memory within the new public health. From the dissolution of the PCTs, and the drug and alcohol action teams, where there would be a wealth of knowledge, the funding now falls under the local authority, who are strapped for cash. They're now looking to juggle budgets between needing to keep the lights on and empty the bins and provide treatment to drug and alcohol patients as well.

Before 2012 - recommissioning to get more 'recovery-orientated'. Now recommissioning as budget envelopes are shrinking.

There is still too much emphasis on the hard substances (heroin / crack). 'Recreational' drugs users who find themselves in trouble are poorly catered for.

It is too early to state the actual impact but changes needed to happen and having one lead organisation should aid this.

The negative impact has been that the workforce are disconnected from their employers because of TUPE. In many cases they are on their third or fourth employer in ten years.

Some pointed to increased difficulty accessing services or to gaps in local provision:

There are fewer locations for clients to be seen, forcing people to travel further to access appointments.

Ryan Campbell of KCA put it this way:

There are pros and cons to our inclusion in public health. Inclusion in the public health agenda isn't the problem at all. We use it in our own way to improve the general health prospects, mortality indicators of the population. We're comfortable with that. The downside is that in commissioning terms substance misuse doesn't yet comfortably fit within public health.

I respect the quality and contribution of the commissioners that we work with, and commissioners in general. There are absolutely superb commissioners who are entirely focused on the welfare of the service users and the welfare of the communities they work in more broadly.

"With the contract we have lost, we need to ensure a smooth transition for staff, for service users and for partners so that service users still get a quality service. We've been helpful, supportive, as much as it's gutting to be losing this contract and handing over to another provider.

"It's an anxious time for everybody; you need to be grown up about it and professional about it and enable a smooth transition. I think that is a lesson that small providers and larger statutory providers who lose contracts absolutely need to hold on to because it's very telling how our workforce is still getting on with the job, still seeing service users, still meeting their needs... But naturally people are anxious, they've heard there are fewer jobs in the new system, albeit, only by a margin."

Steve Jones, CEO ARCH Initiatives

The problem is that they're in, if anything, a more difficult process of change than providers are. They're being expected to work in different and new ways within different, new organisations with reduced budgets, which is to my mind a virtually impossible task. And some of the commissioners are achieving it really well.

There are two big problems in commissioning, neither of which is the fault of commissioners. The first is that there isn't to my knowledge an established framework that commissioners should work within when commissioning substance misuse services. The expectations aren't clear, it seems that the tools commissioners are given to work with arise purely at local level. There's no way of benchmarking commissioning properly. There's no way of working out what is good and poor commissioning nationally. Commissioners are operating in this vacuum where it's down to the local level about what good practice and what bad practice is. I would support the government introducing a national framework for commissioning where it could be supported and developed and not just left to local authorities and local commissioners to work out for themselves what they think it is.

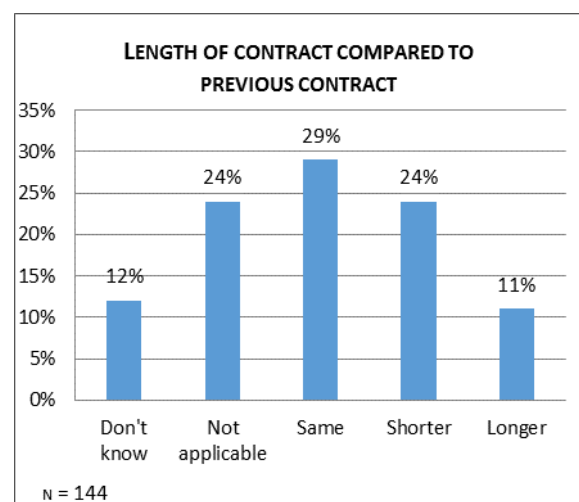
The second area of difficulty in commissioning is a skills and competency issue. Commissioners tend to go into their roles because they have knowledge of how to manage and provide services. More and more, they're expected to develop a functioning market and deliver value for money in a very competitive environment.

For those sorts of management competencies, there doesn't seem to be a national framework of skills development, of guidance to support commissioners in what is effectively quite a new area. The economics of the public commissioning quasi-market are not a generally held skillset and I would be urging government, if they want to have a properly functioning, competitive, quasi-market, they need to be able to support commissioners.

Respondents suggested that where contracts had changed they tended to be shorter rather than longer by a proportion of 2:1.

Most of the services indicating that contract length did not apply were either NHS services that had not been out to tender or otherwise incoming providers.

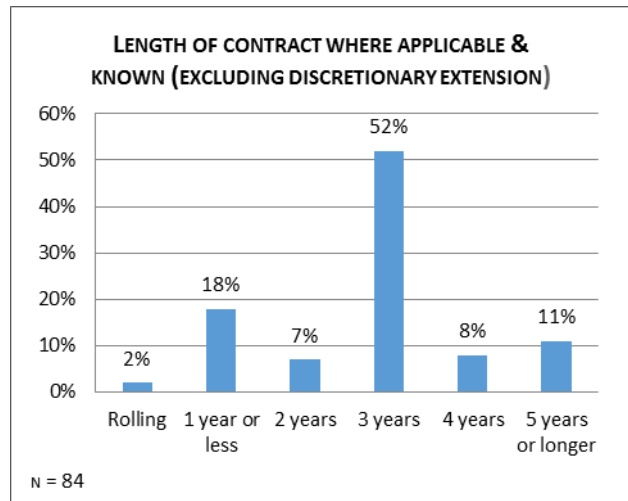
Most (52%) respondents told us that they were working to a 3 year contract, although with a minority of longer contracts (21%) and a significant number of shorter ones (25%), some of which appear to be on an interim basis. As one service manager put it:



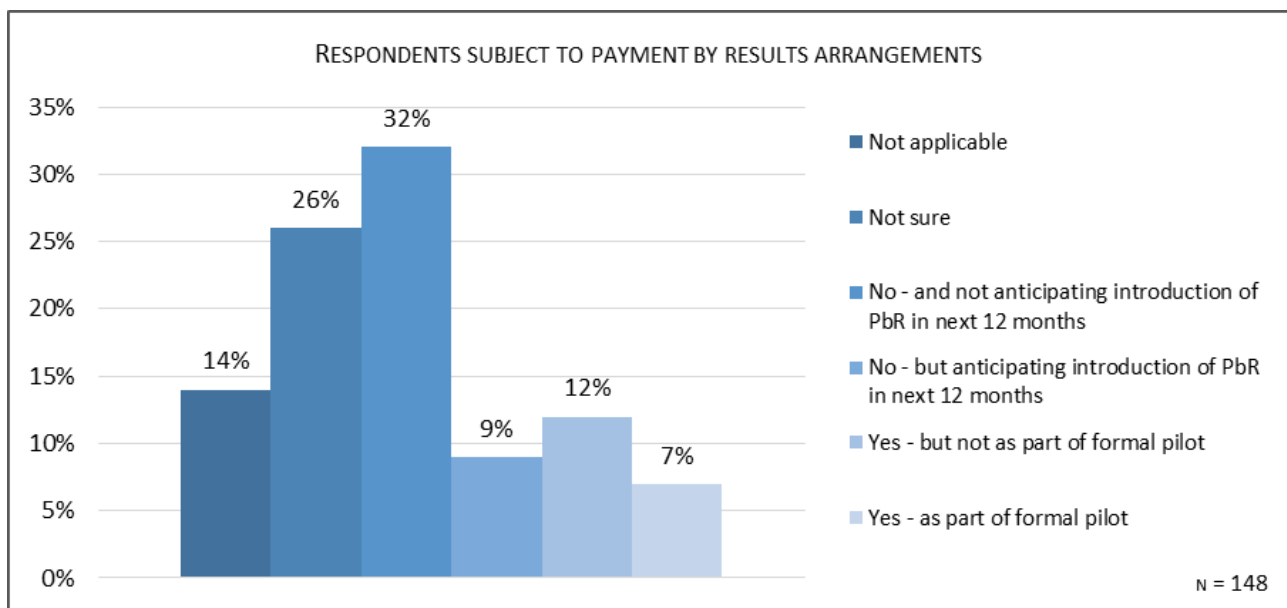
It's just a rolling year, year upon year. The commissioning landscape is entirely unstable.

By contrast Mike Trace, the Chief Executive of the Rehabilitation of Prisoners Trust (RAPt), said:

When you get new commissioners, and remember they're only just setting their structures up, people want to retender and reshape their services. The idea or the theory is that once all that is bedded in, the contracts will be longer. There is a trend towards that, so once a commissioning institution has a long view, it has its own strategy, it has its own structures in place, there's no benefit in those services being retendered every couple of years. So that's how it should happen.



Ten respondents were participants in the formal drug and alcohol payment by result (PbR) pilot. Overall, a minority of services were currently subject to PbR funding arrangement or were expecting to be in the next 12 months, although some respondents made references to arrangements that appear to be somewhere between PbR and outcomes-based commissioning incentivised with a performance component.



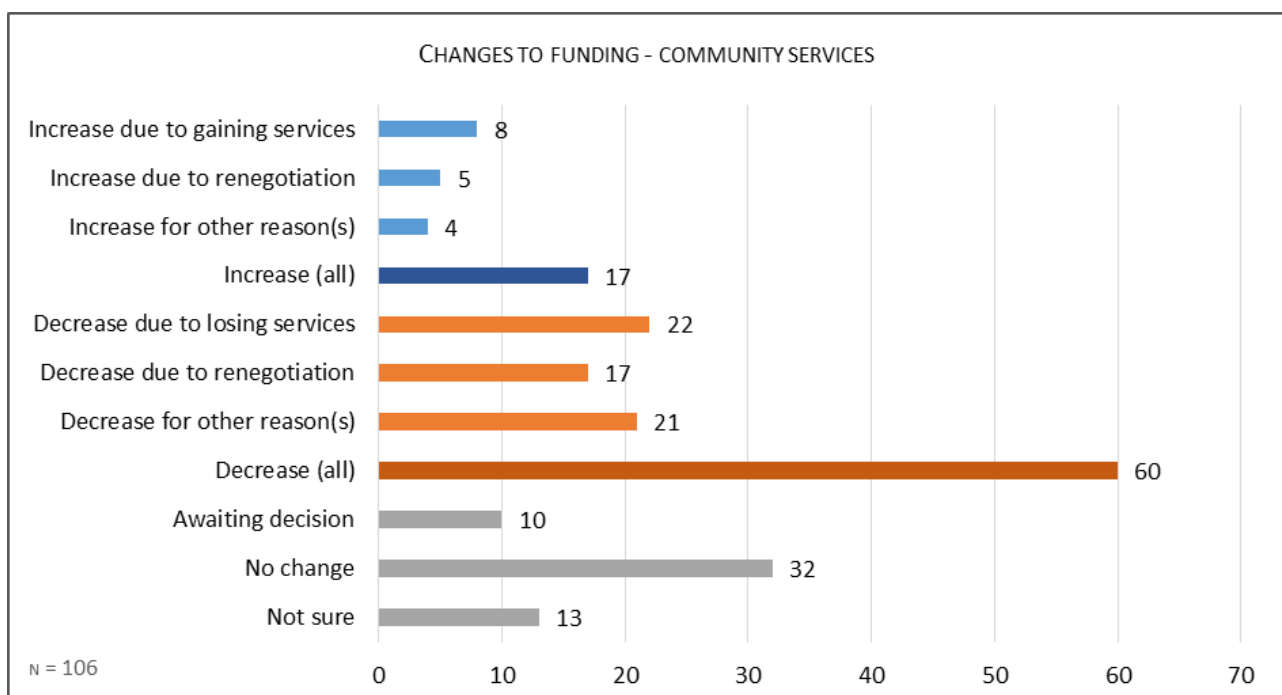
"The idea that you reward providers and award contracts to those most likely to achieve outcomes - absolutely. I just don't see much of it happening. PbR as defined by government and as piloted in our sector is a mess. It's down to a flawed conception that PbR, once again, is all about systems and bureaucracy.

"Civil servants operationalise things by obsessing over the details of accounting mechanisms, over the detail of data reporting mechanisms. Of course you've got to have all those things but then the tail is wagging the dog. With the PbR pilots, there was an obsession with defining outcomes and with how you count them, how you make sure that reporting doesn't create perverse incentives. As soon as you go down that line you are going to end up with massively bureaucratic commissioning and reporting systems which don't really tell you in the end who's doing a good job and who's not."

Mike Trace, RAPt

Sixty community services reported a decrease in funding, compared to a 32 reporting no change and a much smaller number saying they'd seen an increase (17).

Twenty-two respondents reported that they had lost a service, 8 that they had seen an increase because they had been appointed to deliver a service, and 10 were awaiting the outcome of a bid.



As many services benefit from more than one funding stream, respondents were asked to select all the options that applied to their situation.

In addition to asking for an indication of the direction of change, for the first time respondents were also asked to indicate the size of any change of funding. After excluding services that reported a 100% funding cut (as it was in most cases impossible to identify whether that funding had been transferred to a different provider or had been lost from the system entirely) we averaged the remaining responses. By this measure, the net average change to funding was a reduction of 16.5%.

Other than those who reported a 100% reduction the largest cut reported by any respondent was 88%; the largest increase was 100%.

Some respondents and interviewees provided considerable detail concerning changes to funding:

"Money was spent in a hurry in the late 90s. In a way we expected the quadrupling of budgets and pushing money out really quick to end up with a not particularly tightly planned, efficient system.

"When you get towards the end of the noughties, the NTA and others are focussing more on outcomes, more on recovery and on realigning the systems, the commissioning, to get the best results. A lot of the rhetoric said that but what's happened on the ground and has happened since the 2010 election is that a lot of restructuring has happened and the restructuring seems to me to be to a large degree missing the point.

"There's a strong urge to rationalise - some rationalisation was reasonable - but that rationalisation cost coupled with cost pressures is leading to a style of commissioning which is looking for whole system partnerships, consortia, and is looking for cost efficiency measured against activity levels."

Mike Trace, RAPt

For this year, 2014-15, we've not experienced any cuts. We have no indication as yet for funding next year. We're in a partnership, so the funding is split. At the moment, we are in negotiations with commissioners, but because it's all tied in to the local council and the health and wellbeing board and PHE, there's no clear picture emerging. We were told to be prepared to experience cuts, but the level of cuts could be anything between 10% and 40%.

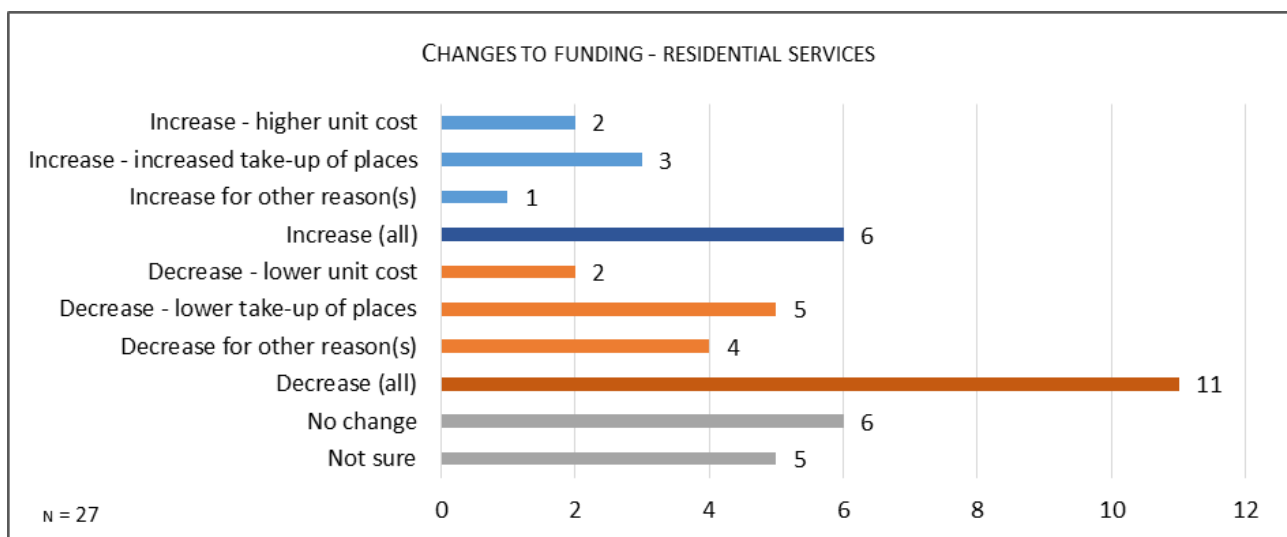
Funding increased by approximately 10% due to agency fundraising activities, new grants and donations.

"We're aware that envelopes are smaller than they were previously; it was reduced by at least a third. But for a borough that has had an awful lot of investment in drug and alcohol treatment services, that's probably not before time. There's been a lot of money in this system and there have been some excellent services for years. But you cannot continue to deliver by just simply sucking more and more money out of the local authority and the commissioning pot. We were all expecting to have to seriously consider how we cut costs, save money and work better together."

Steve Jones, ARCH Initiatives

A further scenario was described, in which rather than funding changing, it had been held static for a number of years, with or without a change in demand:

Same level of funding but for combined alcohol and drugs service rather than two/three separate services.



As with community services respondents from the residential sector were more likely to report losing income (11) than seeing an increase (6).

Due to the substantially lower number of responses and less additional information offered, it has not been possible to calculate an average net change for respondents from the residential sector.

Almost half of respondents (49%) were anticipating either recommissioning or renegotiation of their contract in the next year, with a further one in ten saying they were uncertain about the position. As with the preceding 12 months, retendering and recommissioning was expected to be the preferred route (44%) over renegotiation (5%).

"Around half of local authorities [we deal with] are reducing funding for residential rehabs. The majority of our funding is on a spot-purchase basis and it's very uncertain. We don't know from week to week how many clients we'll have. With residential rehab things are a little different, because Broadway Lodge covers 50 different areas rather than having a close relationship with one commissioning team.

"If the state commissioned all my beds, I could guarantee I'd exceed all their outcomes and I'd provide all the wraparounds for nothing, like the family services, the aftercare programme, education programme, they'd all be provided as well, if we had more certainty over our income.

"I've never had a 3 year contract – and I don't think any residential rehab has. At best, I've had a one year contract. But what do you do at the end of that if they say they're not sure they'll commission you again? Birmingham is a classic example of how one area can have a massive impact on the residential market: Birmingham is the biggest commissioner in the UK and we used to get 50-60 people a year from Birmingham. They then made the decision they weren't sending anyone to rehab out of area, so we lost that business overnight.

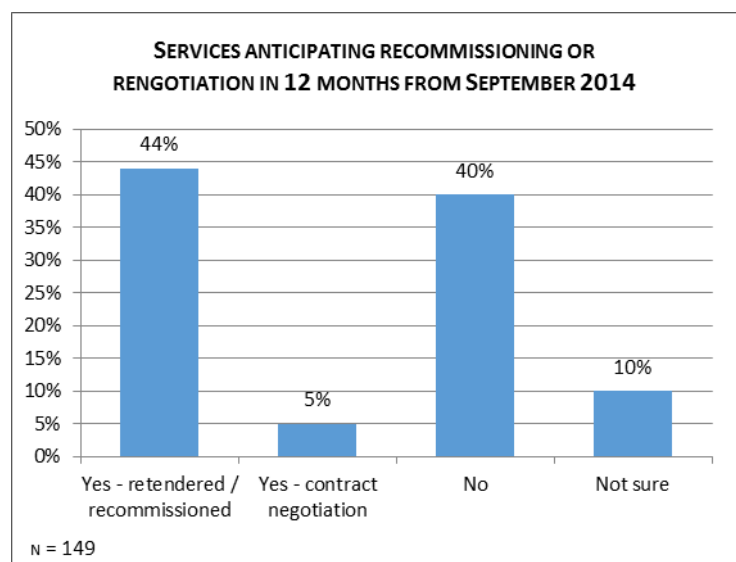
"Now, how, when we are only getting spot purchases, can we replace that sort of loss of income? And that is the major issue. For me, if someone asked how residential rehab can be protected, it would be two things: commission nationally or commission for 2-3 years, like the community providers. Let us have some security of income so we can provide our services, rather than not knowing week to week."

Brian Dudley, Broadway Lodge

Some responses suggest that that may be due to systemic change of a sort that would make negotiation impracticable:

The commissioning process was so badly done it now has to be repeated.

It is possible that retendering of the service due in April 2015 will be deferred. But



there have been strong hints of a separation of services away from our integrated model.

"There's a level of commercial and business maturity required in commissioning. Commissioners need to understand what happens between providers who are bidding. Clearly they don't always understand that large providers often talk in terms of exclusivity and they often build no fair competition safeguards in to the tender."

Steve Jones, ARCH Initiatives

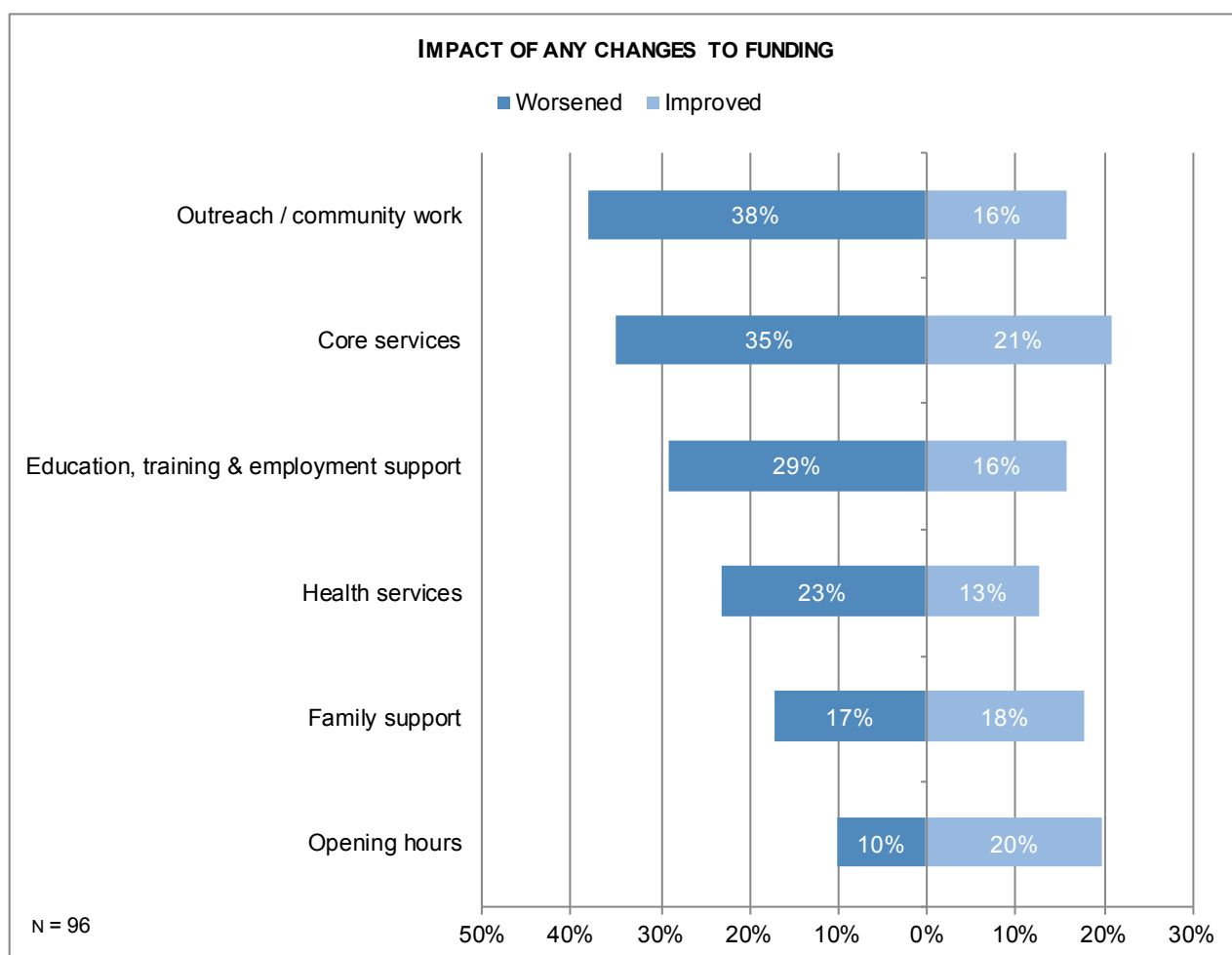
"The crucial thing is local commissioners that are properly trained, knowledgeable and commissioning according to the needs of the locality. We've never had that and now the vast majority of commissioners are less specialist, less focussed, less steeped in the moods of the sector. I can't see that changing but if it could be made to change then you could get a more planned sector. Public Health England and NHS England could establish a community of commissioners, run workshops about things like outcome commissioning or about size vs quality."

Mike Trace, RAPt

Impact on services of changes to funding

- While there were improvements in opening hours and family support, the consequences of changed funding were reported as being mostly negative, with caseload per worker and workforce development indicated as being particularly adversely affected.
- 53% of respondents reported a reduction in front line staff and 40% a reduction in back office staff and managers. Conversely, 62% reported an increase in the use of volunteer recovery champions, and 47% an increase in the use of other volunteers. Some respondents emphasised the additionality of recovery champions or the role that volunteering can play as a stepping stone to paid employment. Others were keen to emphasise that while they were proud of and welcomed the additional support offered by volunteers, they were keen to ensure that the involvement of volunteers was not at the expense of other forms of professional support.

With the exception of opening hours and family support which showed a net improvement, there was a net deterioration across every other aspect of service



considered. The majority of respondents reported a significant increase in case load with the risk of a deterioration in the quality of service as the time pressure on staff increase - for example, of face-to-face time with service users. Also noteworthy is the effect on services' ability to support people with complex needs – a subject prominent at other points in the survey, and also the negative impact on workforce development.

Respondents commented on changes to service provision:

In particular the harm reduction services have been reduced.

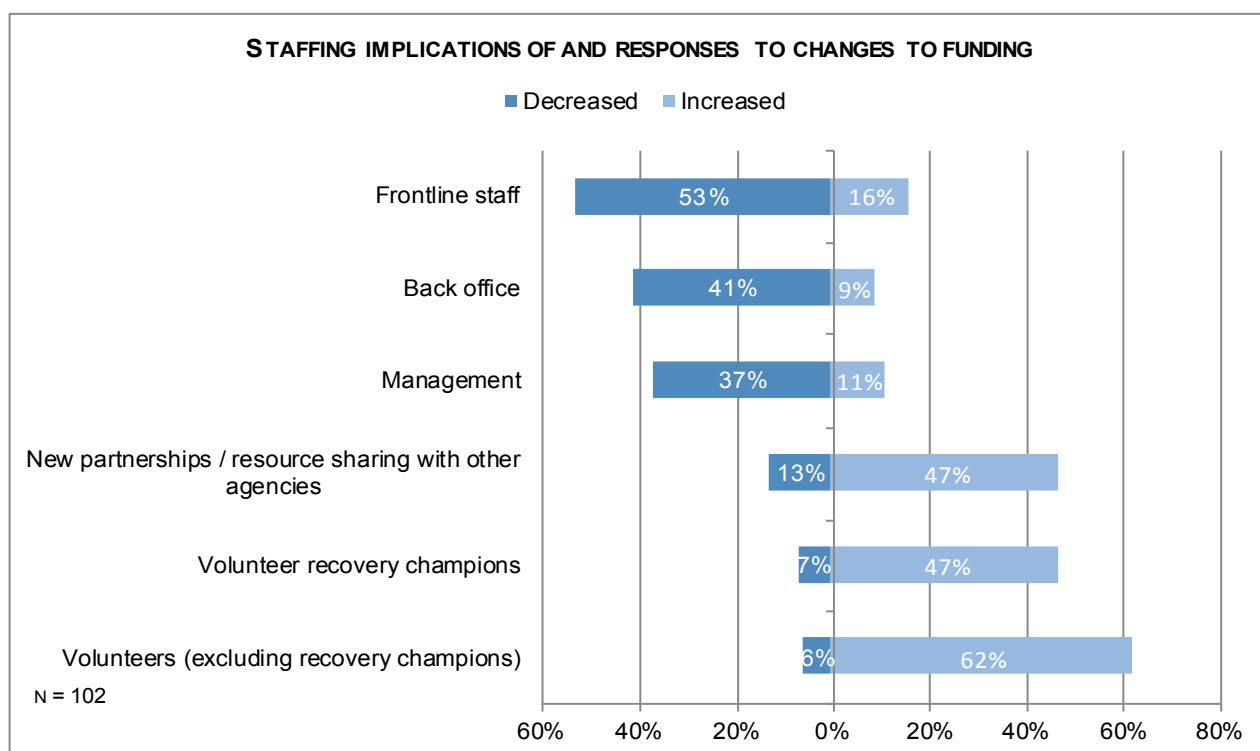
More locations for delivery of services; increased staff.

Now investing in more family based interventions through employing specialist qualified social workers.

Improved working conditions and staff development. Improved service for patients now service is in the NHS rather than a charity.

Overall the effects have been to impair services, reduce resources available for multi-agency coordination and restrict the creativity of practitioners and service managers.

Seemingly consistent with the responses indicating increasing caseloads as being problematic, responses suggest a reduction in staffing levels, with reductions in frontline staff, back-office staff and management. Like last year, there were substantial increases in the use of volunteers (62%) and recovery champions (47%). The use of



and potential reliance on volunteers was raised by respondents elsewhere in the survey variously as an opportunity, an area of innovation, and in one case, as a threat.

Also similarly to last year, partnerships and resource sharing have increased, which may indicate the ways in which the sector is adapting to the changing environment and ecosystem of services.

Respondents primarily focused on changes to staffing levels and skill mixes:

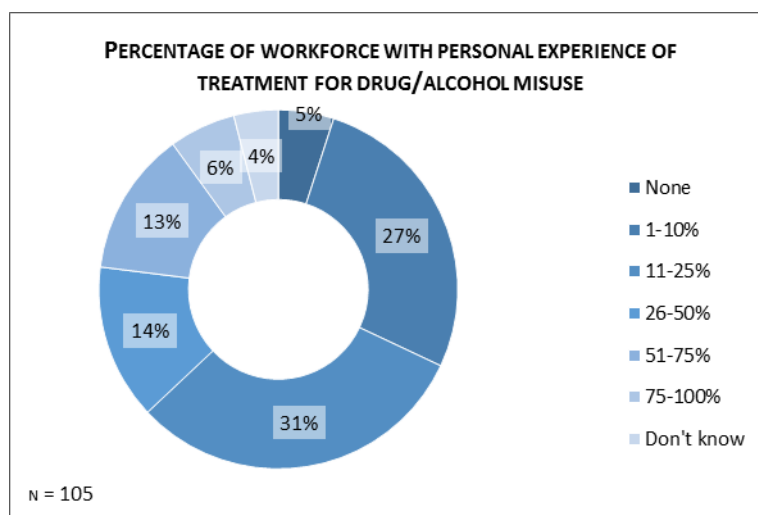
There has been a severe decrease in staffing at all levels with an expectation that volunteers and peer mentors will compensate.

Increased use of non-medical prescribers. Increased skill mix, with workers downgraded to support roles.

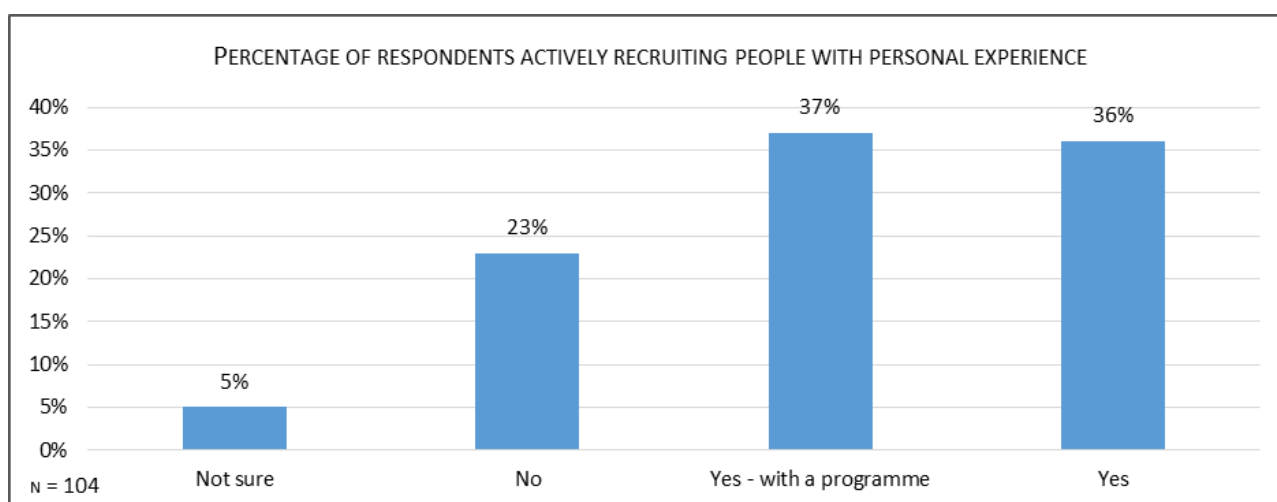
Staff, recovery champions and volunteers

- At least 90% of respondents employ people with people with personal experience of drug and/or alcohol use and treatment, with 37% having a programme in place to support recruitment from this group.

Compared to 2013, more services appear to employ people with personal experience of treatment for drug and/or alcohol use. Most of the respondents with workforces composed mostly or entirely of people with personal experience of treatment continue to mostly be mutual aid and peer support organisations. However, more organisations appear to see people with personal experience of substance use and treatment as their potential future workforce.

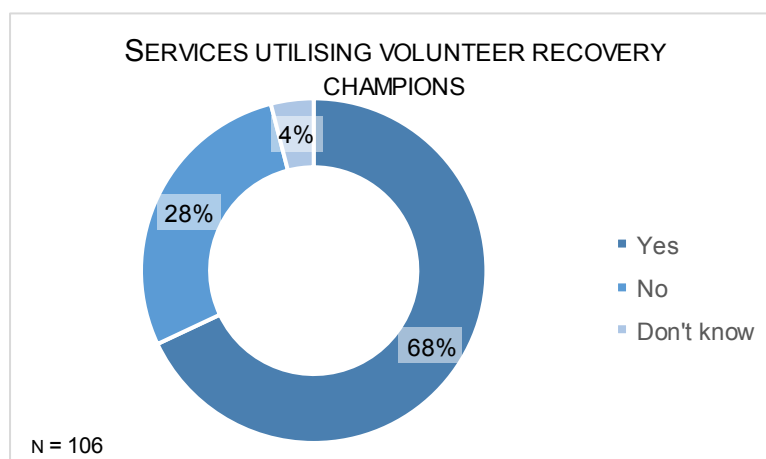


We were also keen to learn how people with experience of treatment for substance use were recruited; for example, whether or not services (or organisations) had formal strategies or provision to support this.



Compared to 2013, slightly more respondents actively recruited people with experience of treatment via a structured recruitment and development programme, although the proportion of respondents actively recruiting with or without a structured programme was roughly the same at just over 70%.

As in 2013, most services that do not actively recruit people with experience were keen to emphasise that their recruitment policies and procedures were non-discriminatory and intended to identify and recruit the best candidates regardless of personal circumstances. The only exceptions to this were services that work in a setting that could, in some circumstances, make recruiting people with a criminal record (where applicable) problematic, such as those working in a police station:



We select people, both paid and volunteer, based on what is considered the best person for the job at all times. We find that there is always a balance of those with historical substance/alcohol misuses issues and those without, without the need to actively select, purely on this basis.

We work within the hospital and the police custody suite so are limited in terms of taking a worker with a criminal record.

Roughly the same proportion of services employ recovery champions as in 2013, at around two thirds of all respondents (68%). The roles described vary significantly in both scope, activities, profile, purpose and potential for organisational contribution. Some services appear to be using recovery champions to carry out tasks that might previously have been carried out by paid staff:

Filling in for staff who have been made redundant, to be honest.

High level responsibilities - including case management, delivering training, facilitating groups/meetings, strategic involvement, 1-2-1s.

Supporting clients in one to one assessments, groups, escorting and co-facilitating groups.

They support current service users by being around the service and giving the benefit of their personal experience. Anything more they refer to the staff team.

Opportunities, challenges and innovation

"The difference between the residential and community providers is that we all know there are only 3 or 4 big community providers in the UK. All the residential rehabs are small. So, they have no influence or power and part of the choice is, because there are two completely different markets... obviously very small individual players are very vulnerable to any disinvestment and this is what people haven't quite worked out yet. One of the participants at the DrugScope Chief Executive's forum pointed out that as a large provider they 'can afford to carry losses, to bid low,' and others do the same... We can't.

"We work with a couple of the big national providers and are forming relationships with some of the people who have the big contracts in the areas, because a lot of the tenders are for one provider. We are having to become a sub-contractor to big national providers. What we've also done over the last few months is we've now got a group of 23 rehabs together to share information and talk.

"Funding for rehab is really tight so if people have made a mistake, rather than being discharged back into the community and probably never getting the chance of rehab again, we are working with commissioners now to move them to another rehab rather than discharge them and them losing their funding. Once they've dropped out, their chances of getting into rehab again are virtually nil. So it's like a safety net really. It's started to work really well."

Brian Dudley, Broadway Lodge

Survey participants were asked to indicate what they saw as being the most significant opportunities and challenges in respect of the service(s) they manage, and also to provide information about any innovation that have been able to introduce or are currently planning. As this resulted in roughly 300 individual responses from 104 survey respondents, these have been coded and categorised thematically.

- Services saw a number of opportunities in the current environment, including diversifying their offer (a broader approach)/reaching new clients (a deeper one), increased partnership working and diversifying their funding streams.

- Challenges included revenue funding, caseloads and the need to reform services.
- Innovations included offering new services, making efficiencies and the role of recovery champions. Providing support to staff was mentioned by a small number of respondents. This was raised in the context of staff morale and team stability being adversely affected by frequent changes of provider, recommissioning and general uncertainty some teams might be experiencing.

Opportunities

One participant spoke of the mixture of opportunities and challenges posed by the current environment:

We see ourselves as a true charity in every sense. We are here simply for our beneficiaries and we concentrate our efforts in that. We know the usual issues that exist alongside substance use – social exclusion, housing problems, poverty, unemployment, but also

Hepatitis C is a big one. We are promoting advice and interventions to our clients, as well as campaigning around Naloxone because of the high level of people overdosing and dying.

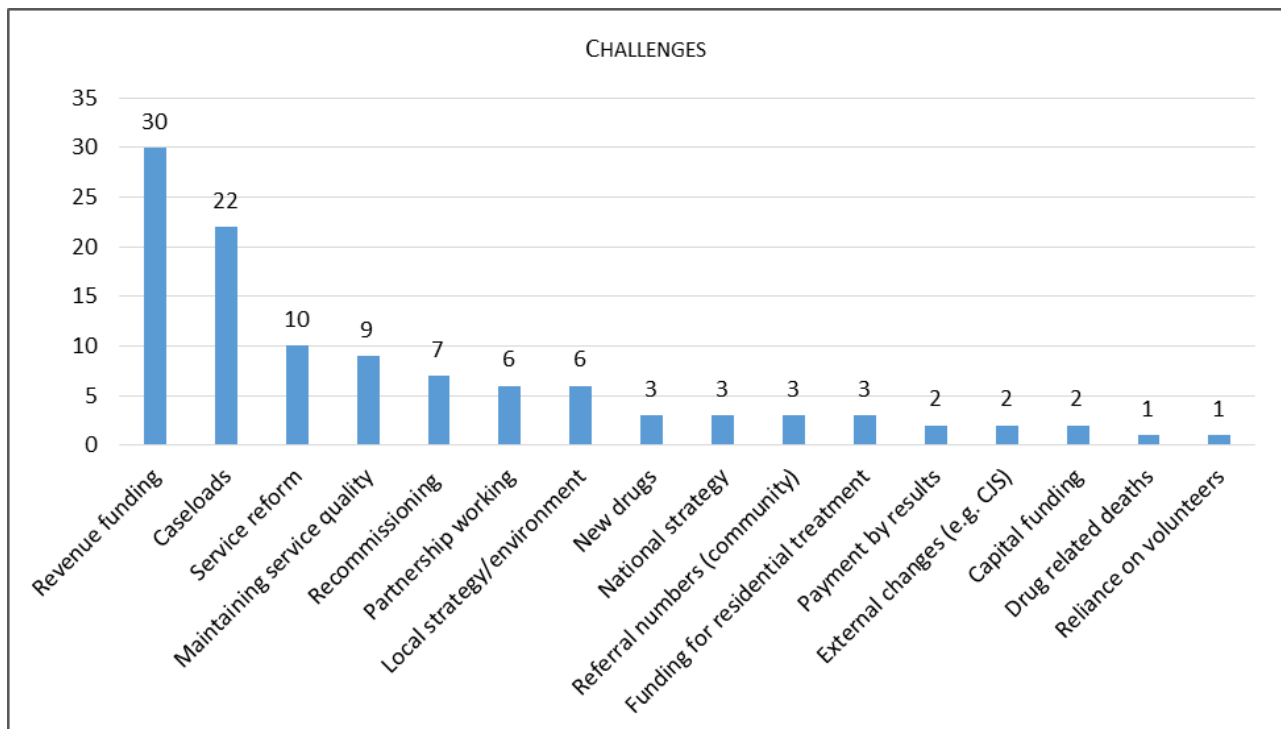
I think there potentially will be opportunities – it's not all doom and gloom - but I think there will be acquisitions and mergers and we have to become a bigger player to have a bigger influence in what we do.



"A better outcome in future would be a more sensible approach to bringing together all the providers in the area, including the smaller providers, and working with those providers to redesign the system so that all providers know collectively how we would make the efficiency savings, the quality improvements etc. for the people of the borough."

Steve Jones, ARCH Initiatives

Challenges



"We're expected and need to work in partnership because we're delivering larger and larger contracts that are expected to cover larger and larger areas. It feels like quite a naïve marketplace at the minute though in terms of developing consortia.

"There are two forms of partnership and sometimes you don't know which you're getting into until it's up and running. The first is when you have organisations who genuinely come together, who share provision, share a set of values and bring things that are quite distinct, fit together well and deliver an improved offer. Then there's the other form of partnership where you get together really just for the sake of a single tender and actually find that it's very difficult to provide an integrated service because something about the two organisations don't quite fit together.

"Either way, there's quite a lot of additional resource that needs to be put into consulting and partnership managing if you're going to win a contract with 3 or 4 other people. That translates into a lot of management time and quite a bit of time looking at how the partnership is working rather than looking at the quality of service delivered."

Ryan Campbell, KCA

"We recognise our position in the market as being one of where our size is no longer sufficient to compete, which creates some real challenges because at best we can only be a subcontractor now as opposed to lead contractor and with that comes inherent risk.

"For organisations of our size what I've seen in the sector is that we will end up at a point where most drug and alcohol treatment services are delivered by a small handful of very large contractors. The risk of that is that lose is the flexibility that you get with smaller providers sometimes. The quality, eventually, could be at risk and the contract packages that are delivered are dictated by cost and not necessarily by what is needed in a local area.

"So for organisations like ours we have to respond in a different way, accept that part of the business will be sub-contracting and to look at alternative ways, very quickly, of reorganising our areas of business and looking at different areas to branch out and diversify because the drug and alcohol sector itself has now become too small and too crowded for smaller providers.

"I understand why that is and it's not a criticism but it is a recognition of the challenge for smaller organisations who don't have the infrastructure to be ahead of the curve or have the funding available to invest in growth and development. You've got to do a lot of work now as an organisation in order to get ready for the future. And that comes at a cost that we'll just have to live with."

Steve Jones, ARCH Initiatives

Given the findings from the rest of the survey it is perhaps not surprising that many service managers identified the environment that services were being delivered in as amongst the most pressing challenges these included revenue funding (30 responses), the caseloads of staff (22), and in delivering service reform (10).

One participant emphasised the characteristics of NHS services as treatment providers:

Because we're the NHS we have links with primary, secondary health services, GPs and so on. We know how to work with and what GPs need to provide the best care for the patient. You lose all of that when you lose the NHS link in the system. What people are just starting to come around to is that the NHS take on

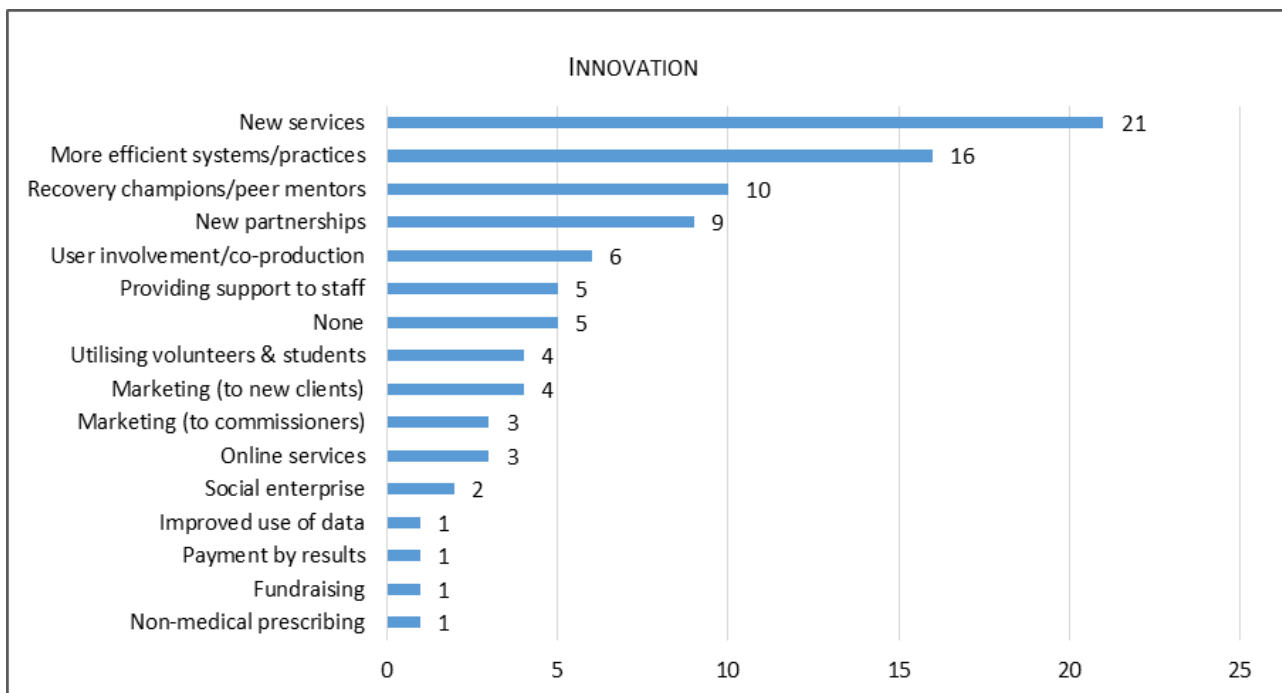
governance for their patients is very robust -in that we have probably delivered a lot of wrap-around services which have never been in any service specification, but we've done them for our patients because they make good common sense and good clinical governance. All those extras will go unless the local authority is prepared to pay extra for them. We just did them because they made good sense. There's a bit of a run on where local authorities are almost saying that the NHS is too expensive. Nurses will cost an arm and a leg but a recovery worker will cost half the price. You get what you pay for, basically.

This was echoed by another participant:

I regret the demise of the health service contribution to the addiction field with competitive tendering. The health service is losing contracts up and down the country. I think it's putting the addiction field back by more than 50 years. I think it's not possible to pursue a health agenda unless you have a health service looking after people with a problem.

Innovation

Very few (5) respondents said that there was no new innovation being undertaken by their services. Where innovation is taking place, much is in the development of new services (21), and greater efficiencies (16). There was also a theme about the use of volunteers, including those with lived experience (16), developing user involvement and coproduction (6) and other volunteers (4).



"We have a number of partnerships with sexual health clinics, where we are taking our drug and alcohol service - and through that, we've been able to identify people much earlier in their drug use, because, as a drugs service, people tend to present once they are in a crisis position. We're finding that people are coming to have their sexual health needs checked, because they've got an STI that needs treatment, or they're coming in to access PEP if they've had a HIV risk, which of course has to be done in a timely manner, certainly within 72 hours.

"By taking the service out there, it allows us to access people much, much earlier than they would ever come in to a drugs service - if they would ever come in at all. It allows us to do a bit more preventative work and motivational work, where we identify potential problems and then refer into our more structured service or to another local service. It's an innovative way of working for us, it's changed the picture of what we do quite a lot."

Monty Moncrieff, London Friend

Clients – support needs and services

- Taking all respondents into consideration, there appears to be little change in the number of people accessing services. However, 16% of services reported an increase of 10% or more and 14% a decrease of the same size, so at a service level there is some volatility. Demand for alcohol treatment, changed patterns of drug use, changing numbers of referrals from other agencies and the role played by novel psychoactive substances (NPS) were most often cited as the reasons for changed demand.

"I don't think there's a difficulty in reconciling harm minimisation with the wider recovery agenda. We provide information and advice to people to try and keep people safer. Our harm minimisation approach would include their drug or alcohol use, but it would also include things like personal and sexual safety, HIV. I don't think there's too much of a conflict between harm minimisation and the recovery approach."

Monty Moncrieff, London Friend

- Services are funded to meet a range of needs and client groups or can at least otherwise work with them. There appear to be gaps in funding to undertake several activities including smoking cessation; one of Public Health England's seven priorities.
- Other than addressing substance use itself, self-esteem and motivation, health improvement, social networks and employment support all rated as significant support needs presented. Of changing support needs, problem alcohol use, financial and/or social security problems and the use of NPS were the most significant.
- For other locally accessible provision, the most available were mutual aid/peer support, harm minimisation advice/services and alcohol support. The biggest gaps in provision were housing/housing support, support for dual diagnosis/complex needs and services for older clients.

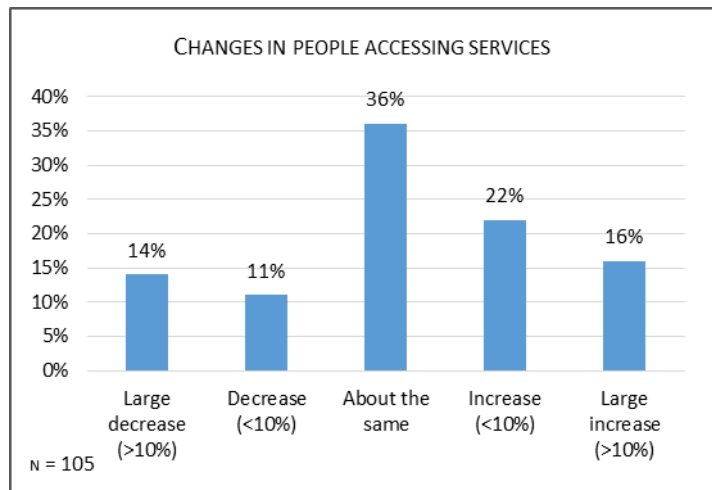
Seen overall the picture appears relatively stable, although there appears to be considerable volatility on a service by service basis, with almost a third of respondents reporting a large increase (16%) or decrease (14%).

Attracting more alcohol users and also people who misuse over the counter medication. The number of traditional opiate or crack users has decreased.

Seeing more females accessing service and more younger people.

Mainly via alcohol as we have increased capacity to engage with GPs.

Demand has increased but often the service limit results in the well-known "threshold" problem particularly for people with multiple and/or long term conditions.



Changed – and generally increased – demand for alcohol treatment was the most significant change reported, although some respondents made reference to complexity of need as well as changing levels:

Welfare reform and poverty. Loss of jobs. All driving individuals to seek help earlier than they may have had before.

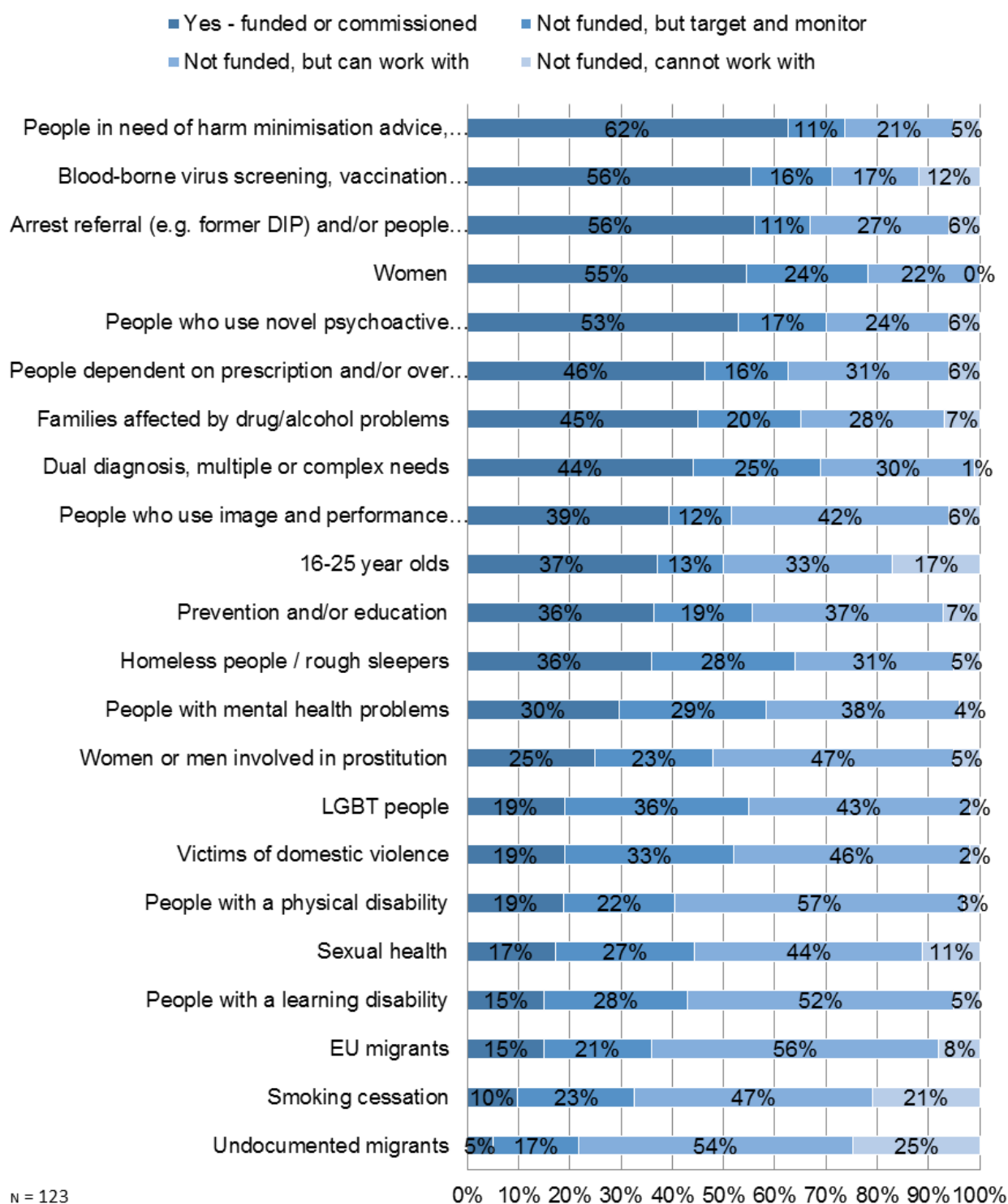
A small increase but clients' problems have increased mainly due to benefit changes; this exacerbates mental health problems as well; therefore our complex needs clients have increased and the legal advocacy service we provide is inundated.

Older people with alcohol problems which the local charity provider does not work with. The charity was historically a drug service and sees alcohol as a bolt on service. Patients with alcohol problems do not wish to go to a service provided for drug users. The majority of persons we are seeing in the NHS have alcohol problems combined with physical health problems. The local community service is for those aged 18 to 65. The majority of the patients we see are aged 30 to 95 years of age. Those older have difficulty receiving a service in the community. This leads to more demand on the acute NHS trust provider.

Alcohol remains the biggest issue that is not being properly addressed at a strategic level, with a massively under-resourced overlap into mental health.

Change in the residential placement timescales we offer - we now offer 12 week assessment of parenting and substance misuse recovery work which fits with the 26 week timescales of the family courts as introduced in April 14.

Services funded/commissioned to meet the needs of:



The above have been ranked from top to bottom, with the services most frequently formally funded and commissioned at the top. Given considerations around recourse to public funds and an occasionally confusing picture about migrant access to healthcare, it is perhaps unsurprising that undocumented migrants and EU migrants come low in the ranking of commissioned services.

On the other hand, given the prevalence of smoking among the drug and alcohol misusing population, it is notable that few respondents appear to be formally commissioned to provide smoking cessation. Discussions elsewhere with DrugScope members suggest that smoking cessation is, in fact, seen as a significant contribution that the sector is well placed to make.

Finally, some consideration should be given to responses indicating that services are unable to work with particular cohorts. For example, being unable or unwilling to work with LGBT clients would (in addition to being ethically problematic) probably contravene the Equality Act 2010. It may be that respondents are subjectively considering whether or not they are equipped to offer an effective and appropriate response to some groups, rather than indicating that they would exclude or decline access to their service in a discriminatory manner.

Some participants made a distinction between core and contingent activity:

We do the harm reduction work that is required but we don't do it as a first port of call. We try and encourage people to give up drugs and give up drinking, so we do harm reduction work that is a part of the process of giving up but it wouldn't be an end in itself. It's a means to keeping people safe while we help them to give up. For some of us, the recovery agenda was always there. Methadone was just a harm reduction measure for people who were not ready to give up, but we would always place huge emphasis on changing people's

"I think anybody in our sector would say that if you're only looking at substance misuse treatment needs, that may work for some clients when they've got low level needs and high levels of social capital, but the majority of people we work with have higher levels of need and tend to have low levels of social capital. To only address substance misuse needs, the evidence base suggests that that's going to be pretty pointless.

"To be able to really help people in recovery we have to be skilled in working in areas like employment, housing, particularly around mental health. Services are coming to terms with that and trying very hard to be able to do it. The problem is of course that we're commissioned as substance misuse services. We're not commissioned to provide employment services. However, we are sometimes monitored on those things.

"That leaves us with two choices. We either develop the skillset internally to be able to give proper, specialist support in those areas or we develop partnerships with specialist organisations."

Ryan Campbell, KCA

motivation and getting them to want to give up and do better than be stuck on methadone.

One interviewee pointed to difficulties in trying to work across multiple funding streams, in this case adult and young people:

The other side, with the young people's services we run, over the last 2-3 years we've taken a 60% cut in funding and now we've just been told that it's likely that adult substance misuse will not be funding the transitional side of that work because it's for 13-25 year olds. So, it looks like we have to now go to children's services to negotiate with them and see if they are

willing to take over funding for that service. We've had meetings around it, but we don't know what the picture is yet. We've managed to shore up with fundraising. We've been very successful.

"It's a truism ever since drug treatment started that what we're really trying to do is reintegration of people marginalised from society. And so reintegration has always got to include family work, help with accommodation and employment support. I do feel sometimes that the field gets aspects of that wrong, so if we do some work on employment that is somehow a substitute for recovery or treatment for addiction. I do feel some of the resources that are meant to be about treatment for addiction are being diverted into what are effectively housing and employment projects."

Mike Trace, RAPt

Some respondents indicated that their contracts make general requirements without specifying particular characteristics, groups or support needs:

Very few of our contracts specifically mention many of these groups so that targeted work can take place, but there is 'general' expectation that we do. There is less opportunity and resource to provide specific interventions to smaller minority groups of people within larger single borough systems.

Some respondents pointed to the challenges of responding to complex needs interacting with complex and changing systems:

Too little attention is given to alcohol and to smoking cessation as features of clients' attempts to cope with underlying mental health problems. Homelessness problems are getting worse. Efforts in the CJS to integrate health developments are under way but on top of a wave of retendering and service change may be overwhelming to practitioners even though they are now taking a more positive direction.

Respondents were asked to consider what proportion of their clients typically presented with 14 needs, and separately, the level of that need. These responses were then assigned a numerical weighting and plotted on the chart (right) as a means of providing an indication of the range and level of support needs clients typically present with. Addressing drug and/or alcohol use was excluded from the list of support needs as it seemed likely to be the most common support need that clients of drug and alcohol services present with.

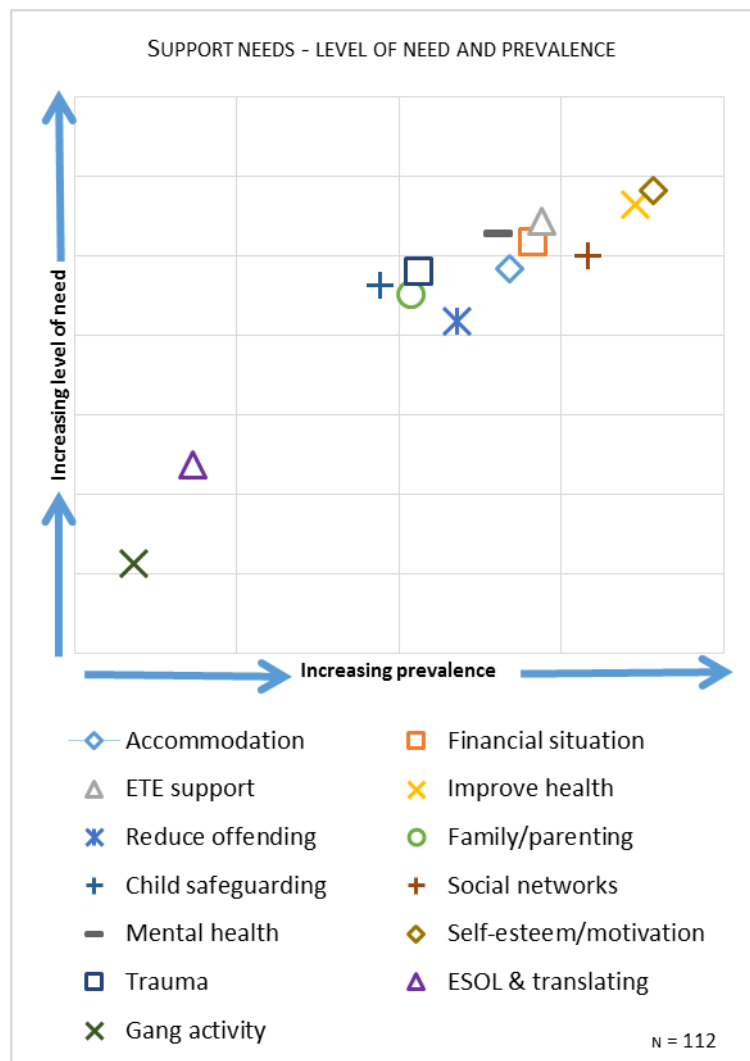
Many individual needs cluster together as significant in both degree of severity and prevalence. These include self-esteem and motivation, health improvement, social networks, employment support and accommodation, the last two also featuring prominently last year.

At the other end of the spectrum, English for speakers of other languages (ESOL) and translation as well as gang related activity are low outliers in both the number of people presenting with those needs and the individual extent of the needs.

Respondents were offered the opportunity of mentioning other support needs they encounter. These include:

End stage liver disease related to excess alcohol consumption.

There is a high prevalence of complex and multiple needs among people facing diversity and equality issues. Minorities are over-represented in the client group.

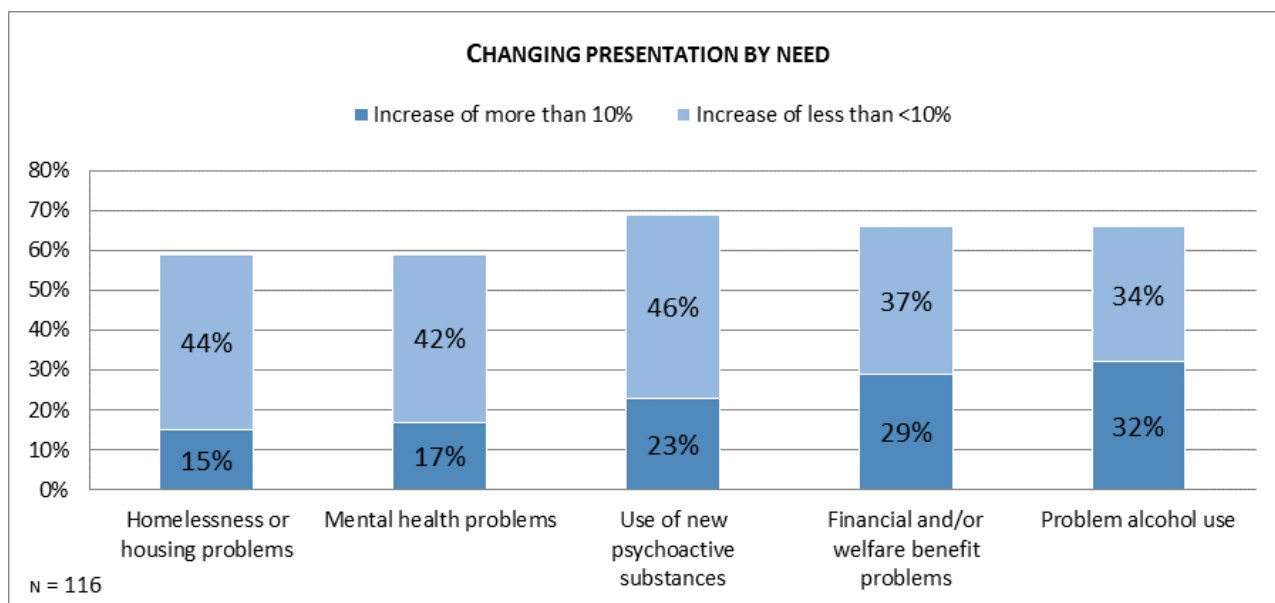


"A concern for us is that we are seeing higher levels of mental health problems, particularly around drug-induced psychosis. It's the strong stimulants being used, like crystal meth and long-term use of mephedrone over a period of days."

Monty Moncrieff, London Friend

We provide specialist LGBT support. This covers drug/alcohol use, mental health & wellbeing, sexual health etc. but also very specific issues around identity and self-esteem related to sexual orientation and/or gender identity.

The majority of respondents described increasing numbers of people in service with a range of needs, with almost no respondents describing a decrease.



A small number of respondents volunteered additional information, including:

Seeing more and more people with no income due to sanctions.

More specifically the bedroom tax led to increase in homelessness and increased presentation.

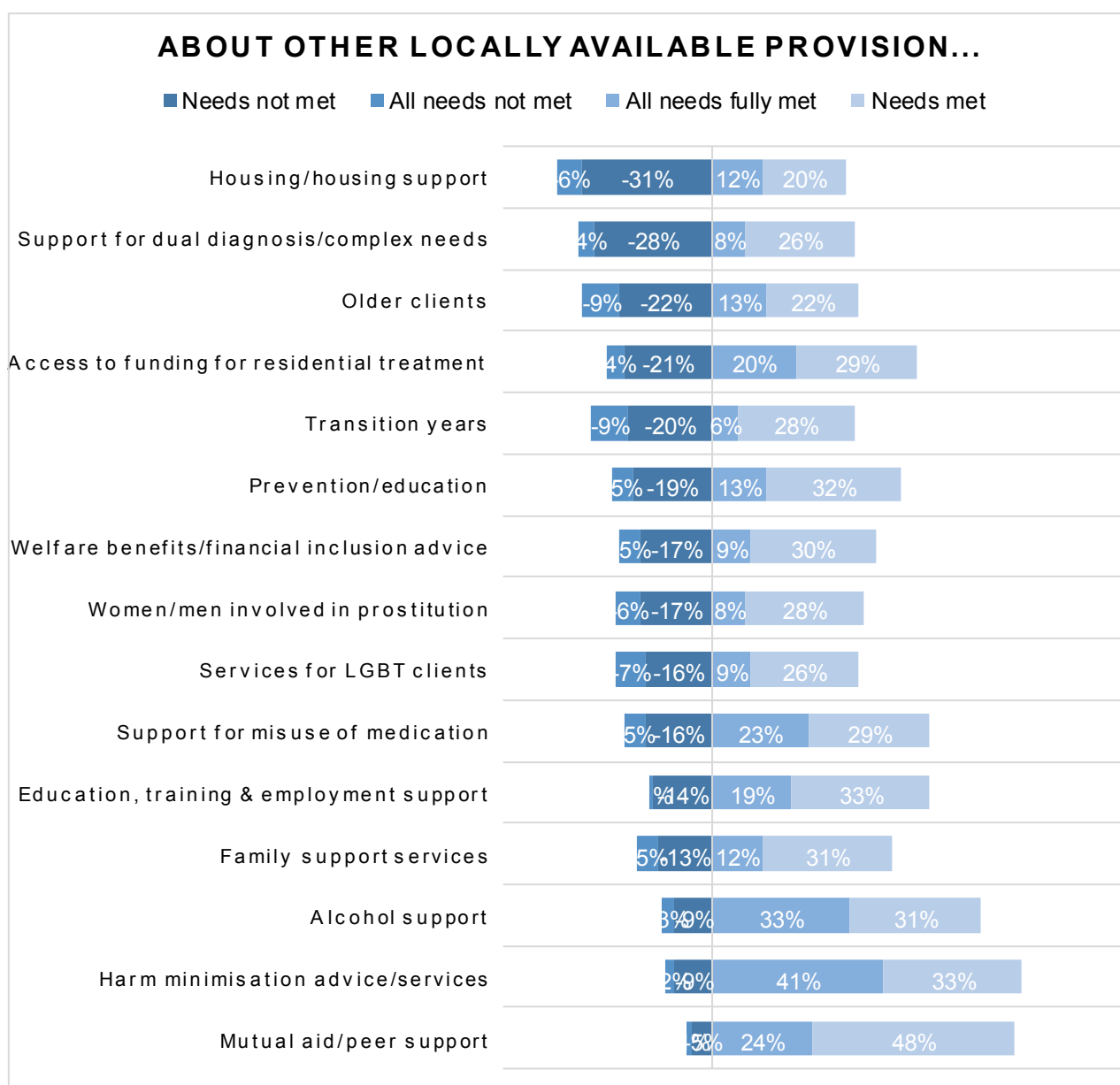
Needs of people using performance and image enhancing drugs has increased.

The largest gaps in provision identified by the sector are in housing (37%), mental health and complex needs (32%) and for older people (31%).

While the responses suggest that many localities have treatment systems and related services that

"One of the silver linings around financial constraints could be that it forces commissioners, providers and other stakeholders to look at how they can provide services differently - because we can't afford to provide services in the way that we do. Looking at how we add value for less money does mean that people might be more flexible across boundaries and a bit less competitive with agencies in other sectors. We can at least look at ways where we can work together more seamlessly."

Ryan Campbell, KCA



are, to a greater or lesser extent, able meet a wide range of needs, some respondents referred to capacity as well as general availability:

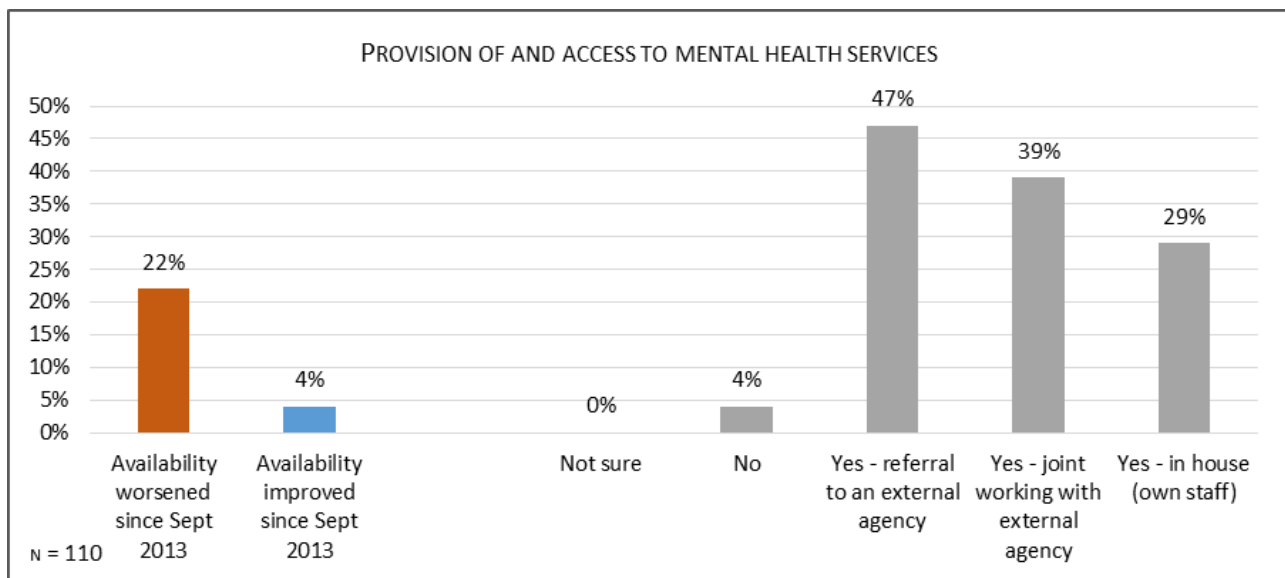
Overall, there is not enough support for any of these needs, and what support is available often suffers from saturation causing threshold problems, which result in only the most severe cases receiving attention, and problems escalating out of control. Even very severe cases are often turned away - particularly noticeable in seeking crisis or respite care for clients with complex needs. Another area is "place of safety" which is totally unsuitable for clients in crisis.

Partnership working and access to specialist services

- While access to mental health services were nearly universal, with only 4% stating their clients were unable to access it, 22% of respondents thought that it had worsened over the last year, with several developing in-house provision to compensate for difficulty and/or delays in accessing specialist mental health support. Most often citing as problematic mental health services' reluctance to provide treatment for people misusing substances and a developing gap between Improving Access to Psychological Therapies (IAPT) provision at the less severe end of the mental health spectrum and NHS community mental health teams (CMHTs) for people with more severe mental ill health.
- Up to 76% of services had some form of partnership working with Jobcentre Plus (with 3% reporting funded partnerships), but no more than 56% of respondents had partnerships with Work Programme providers. A similar number were working around the Troubled Families agenda.
- While access to advice services was widespread, many respondents reported a lack of capacity in specialist advice agencies they were partnered with or made referrals to.
- Access to housing, housing support and resettlement was seen as problematic, with survey respondents and interviewees mentioning the difficulties accessing suitable accommodation can present.
- Access to family support and recovery networks/ peer support was reported as being widespread and improving.
- There was little movement in links with the criminal justice sector, although respondents reported a reduction in custody suite/arrest referral work (possibly accounted for by the end of the national Drug Interventions Programme) and in through the gates work, which is perhaps surprising given the emphasis on this as part of Transforming Rehabilitation.

Mental Health

- While responses indicate general availability of mental health services or support, one in five (22%) said that it had worsened in the last year, with only 4% saying access had improved.



Several participants made reference to raised clinical thresholds preventing access to community mental health team (CMHT) services and the consequent gap that has, in some places, opened up between Improving Access to Psychological Therapies (IAPT) at one end of the scale and CMHTs at the other:

We are the CMHT, so all that [client] information is available on one system. An example would be: our drugs workers will come in and be able to access the system and see that one of our patients was admitted to hospital the night before, or was in liaison psychiatry for 3 hours having a mental health assessment the night before. Likewise, people in psychiatry can access the drugs and alcohol episodes. That's valuable information. That will cease on the 1st

"We continue persistently to struggle with the whole debate over: 'is it drugs, is it mental health, is it alcohol, is it mental health?'

Access to low level primary care mental health services is good in that for low level anxiety, depression, type disorders, there seem to be plenty of services that respond well to those needs in our client group.

"Slightly more complex mental health clients we do tend to struggle with; they're sort of everybody's problem and nobody's responsibility. Where it's worked particularly well is when we've had the mental health lead within our team as opposed to being in another organisation. Where we've hosted a post within our services that's a mental health specific post. Accessibility has been better but also education and understanding on both sides of the fence has been better. Specialist liaison teams have been quite useful for us as well in other areas: criminal justice being one."

Steve Jones, ARCH Initiatives

February. The new provider will not have access to any of that – risks or associative information for other episodes. Our drugs and alcohol workers going over will not have access to any of the mental health stuff. That's a major concern.

Mental health has become a nightmare for us, trying to get our clients access to services. They either shut off the referral pathway completely, or they tell us, 'Your client is using drugs. He's unstable. We can't accept him. He needs to be stabilised by you before we take him on.' Even if they are clients who have a

diagnosis of mental health problems. The complex needs part is really tricky. There's one hospital which caters for complex needs. Mental health services may be under pressure but that's not really our problem, it's theirs. Our problem is getting our service users access to the services they need. Even with consultant psychiatrists available to our service, we still find that incredibly difficult. We have to paper over the cracks as much as we can, deal with it ourselves, in-house. We have access to a dual diagnosis team, which is brilliant, but it's a small team that can only do so much work, but they do work their socks off. Otherwise, we have to use services like Mind and other smaller, voluntary sector services which cater for mental health as well.

Changes to mental health services have increased the difficulty of successful referrals. There is poor service provision for those above moderate anxiety and depression and below a diagnosed psychiatric condition.

Pressures have increased, and services have become increasingly difficult to access, even for people with severe needs. Clients are often inappropriately discharged from hospital without any care plans or support. Pressure on in house staff is intense and growing.

"We deal a lot with dual diagnosis and mental health conditions because we are a fully medical model. I still think it's a nightmare trying to join up mental health and addiction. It's down to funding. There's often a complete lack of joined up working between mental health services and rehabs. The same as if we get someone into rehab who does get psychotic for any reason, we try and link with the mental health services. It is incredibly difficult and I think there's got to be more joined up working between mental health and addiction services to give people the right place to get well."

Brian Dudley, Broadway Lodge

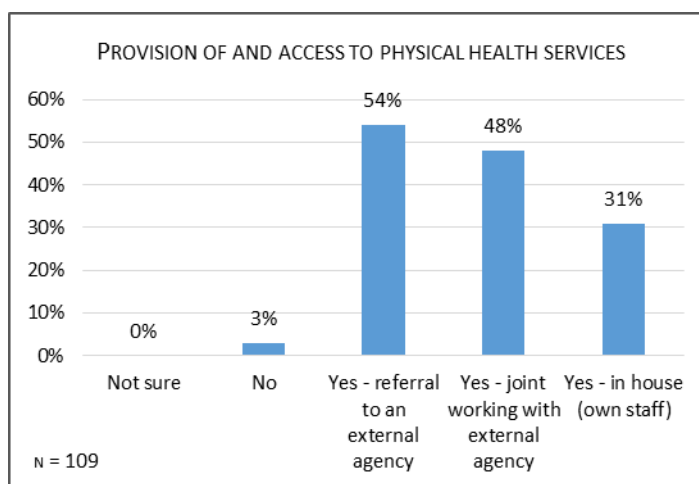
Some respondents made the case that some client groups, including some with protected characteristics, may be under-served:

We provide LGBT specialist counselling in house. Higher need would require referral to local mental health services. However we do not know how well such a large range of possible providers would meet the needs of LGBT clients, although we know LGBT people's experience of mental health services is often poor.

Physical Health

While the question responses between this question and the one on mental health partnership appear similar, responses from participants suggest that access to physical health services appears less problematic.

Sexual health and blood-borne viruses featured in many responses:



We work in partnership with the local NHS Trust. They take care of all the prescribing needs, vaccinations, testing. They supply us with speciality doctors 2.5 days a week, consultants 2.5 days a week and 2 nurses. It works reasonably well but the problem is line management, because we don't have any management responsibility for them. We can't tell them what to do, we can only point out when things aren't working effectively, which is often the case, with vaccinations for example. Sometimes the line of communication just gets closed off. Having said that, we do have monthly care quality meetings where we all meet up as a partnership, including the substance use team as well as social services. We iron out as many issues as possible. We've agreed on standard operating procedures, which is good. But, ultimately, we are reliant on the staff doing their job and if some people fail to do their job, it causes problems.

We secured funding for a new pilot, health coordination for people with complex needs leaving hospital. This changed designation from general to specific needs rather than creating new facilities, but provides for some extra staffing for people with intense physical health needs.

We incorporate HIV prevention and psycho-sexual interventions into our drug and alcohol interventions due to the links between substance use and sexual risk behaviour we see in parts of our target client group (LGBT). We work in

partnership with two GUM clinics to run targeted specialist services (for gay/bi men using drugs, and transgender people), and refer to other GUM services.

As well as healthcare, some respondents mentioned interventions intended to improve and actively promote health:

Working in partnership with the NHS. They provide circuit training on site.

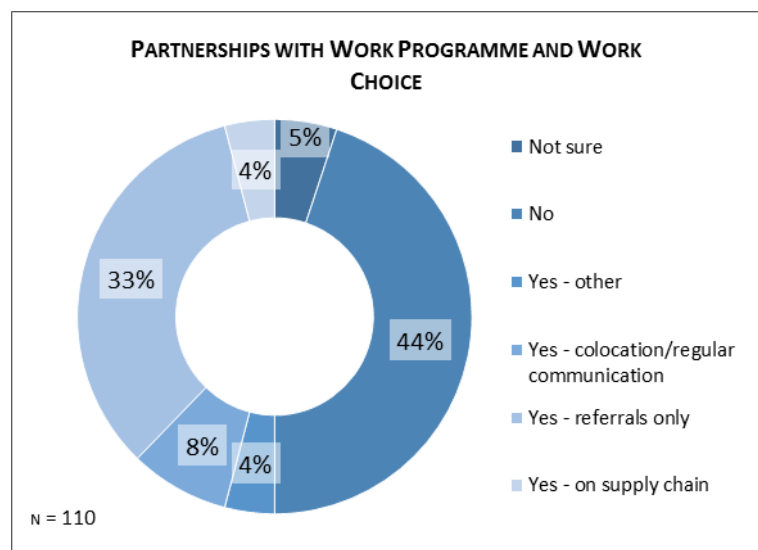
We have an NHS Health Trainer who visits and provides advice and support with general health.

Work Programme and Work Choice

Half of services (49%) reported that they have a partnership with the Work Programme and Work Choice.

Roughly equal proportions of respondents reported the relationship improving (7%) as those who believed it had worsened (8%).

Like last year, the most common form of engagement or partnership activity was via referrals only, with limited examples of colocation and very few instances of organisations on supply chains.



Very poor levels of referrals and they have consistently refused our offer of delivering training and awareness to their workers.

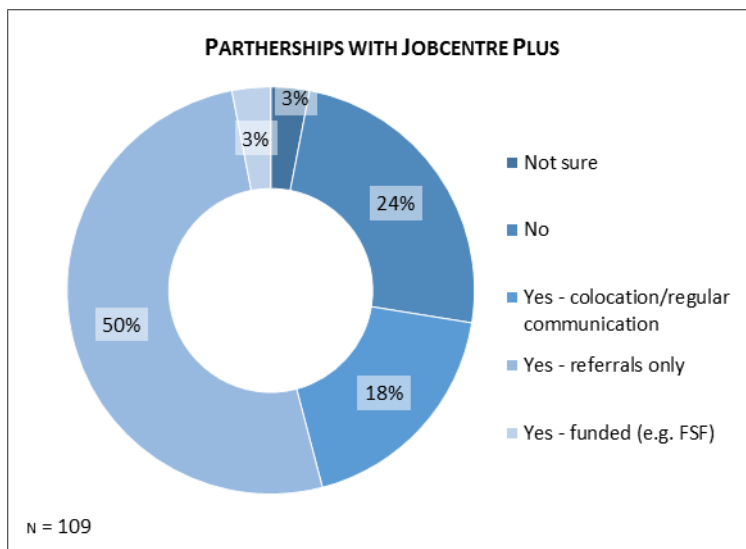
We have local providers present to service users and have some communication. One provider puts on certificated training at our centres.

Some respondents made reference to some of the perceived difficulty Work Programme providers have had in working with voluntary sector agencies and providing effective support to the 'hardest to help':

I was a founder member of a service created with clients and volunteers to deliver positive experiences of learning across health and wellbeing, personal development, creativity etc which was connected to the Open College network. Our overall experience is that the Work Programme did not work for our clients,

and although our work with clients was successful in many cases in moving them towards and into work, that was not remunerated or recognised by the Work Programme contractors. Our work with clients with complex needs was far more successful on a percentage basis than any Work Programme. We made great efforts to cultivate relationships with prime contractors and their sub-contractors. The main contractors took vast contracts and failed to deliver, whereas local charities who did excellent work with clients to help them towards employability went unrewarded.

Jobcentre Plus



Like last year, around three quarters (71%) of respondents had some sort of partnership or relationship with Jobcentre Plus, although primarily based around referrals only. Unlike 2013, some services were in receipt of funding from Jobcentre Plus (3%).

However, more than twice as many responses said that partnership working had worsened (18%) than suggested it had improved (8%).

Comments suggest a mixed picture:

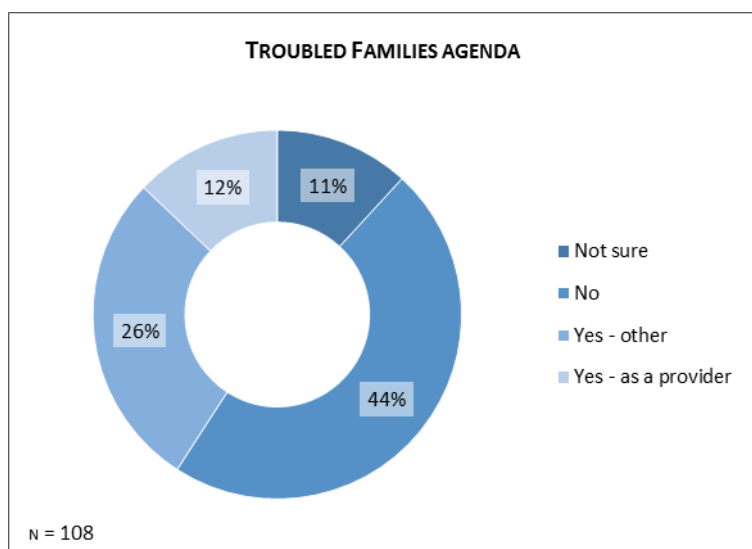
We may be able to get some funding from them. They have a funding pot that can be drawn on; we have to submit a bid, and we'll see where it goes. It's for about £50,000, but whether we get it or not is a different matter. I think our bid is strong enough, we have a good chance, and they will help us. It's not just a case of submitting a bid, it's a case of them feeding back and telling us areas we need to improve upon for the bid to be successful. They're good that way.

JCP still are not really aware of what the drug services do and they appear to create "drug champions" without training those champions. Some JCP managers are not even aware of the [treatment provider's] programme.

I have regular contact with Jobcentre Plus dealing with sanctions and changes to service users' benefits.

Have notional referral pathways but never really taken up, and JCP seem to do less partnership working.

Troubled Families



A minority of respondents were engaged in working alongside the troubled families agenda (38%), with equal numbers saying they had seen partnership working improve (7%) as described it as having deteriorated (7%).

Some respondents provided additional information:

Family service in [London borough]. Data sharing with Troubled Families to ensure

shared service users are accessing all relevant services.

Through Multi Agency Safeguarding Hub (MASH) only, would like to develop better links.

We deliver Strengthening Families Programme in partnership with our local Supporting Families Team.

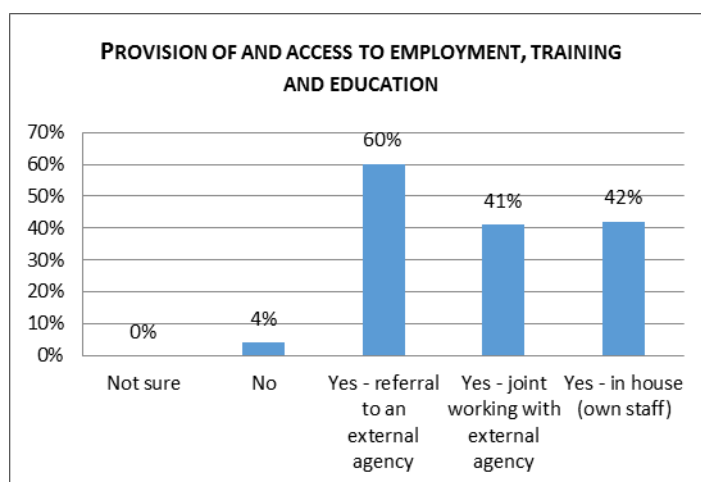
Employment Training and Education

While Jobcentre Plus provides an effectively near universal service, some respondents provided information about more specialist services they deliver:

Dedicated training worker/ accredited IT training.

NVQ delivered to clients that come back for voluntary work. External computer courses.

ETE funded through grants and fundraised money offered centrally and also locally within and external links.



As well as healthcare, some respondents mentioned interventions intended to improve and actively promote health:

Working in partnership with the NHS. They provide circuit training on site.

We have an NHS Health Trainer who visits and provides advice and support with general health.

Advice Services

Many respondents pointed to a lack of capacity in external advice services covering subjects including debt, social security, legal and housing advice:

Good relationships with local CAB although their resources are currently very stretched.

Have two organisations who offer advice on site 3 times per week plus a volunteer offering this. They are run off their feet.

Staff have knowledge in the welfare benefit system and what residents can claim, we also act as an advocate when dealing with residents' debt problems e.g. court, bailiff etc we can also refer to CAB or for legal advice, we refer to specific agencies that deal with this.

Benefits cases have continued to trouble practitioners who report a variety of issues, mainly benefits being stopped without adequate reasons or consultations, for clients who have a variety of disabilities that present obstacles to their engagement with systems.

"Of course, it's best if [housing and employment support] is done in a seamless way rather than one organisation dealing with the drug treatment, another organisation dealing with housing and so forth. Integrating that work is the way we should be looking at it but we shouldn't get confused that finding somebody a house or doing employment workshops or training workshops with them is the same as treatment for addiction. And the reason why the distinction is so important is something we very strongly believe at RAPt. A lot of money is wasted trying to sort out housing and employment needs when their dependence or dual diagnosis issues are unresolved."

Mike Trace, RAPt

Housing and housing support

Responses suggest that some provision is relatively 'light touch', including provision of or access to rent deposit schemes. Some respondents and interviewees also indicated increasing difficulty in accessing accommodation, particularly social housing:

We have workers that sit on the housing priority panel and work with the local authority housing partnership and housing associations. We have reps working in those locations and they have in-house surgeries here. We are able to support our clients with housing and tenancy issues and tenancy bonds, making the right referrals, advocating on their behalf, transferring information where they've given us consent. We have fairly robust relationships around that.

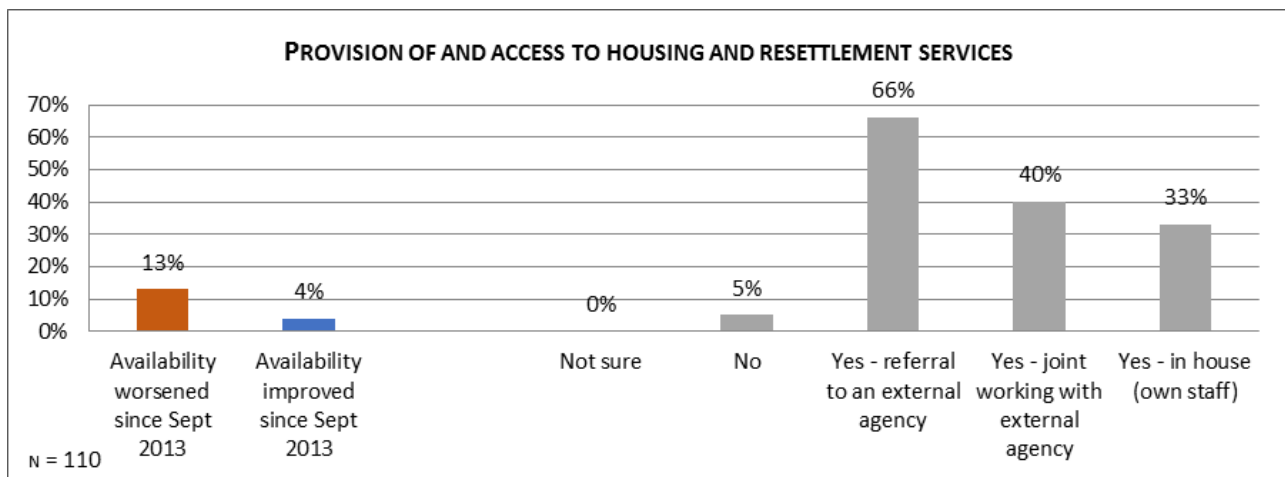
Housing is a nightmare. It really is. Like a lot of the country, each borough is approaching it from their own direction. Our borough has changed their policy on social housing. If you want access to social housing now, you have to meet very specific criteria. And you cannot be using drugs or alcohol, not problematically, that automatically stops you from getting access to housing.

"I think we're quite blessed really in the areas we operate in, in the sense that we've got good relationships with housing providers. We provide quite a lot of support to clients once they've been placed in accommodation. Albeit, it's not a commissioned Supporting People service but we provide the same sort of wrap around tenancy support that we would provide if we were a Supporting People provider. That gives comfort to some of the housing providers we work with but placing "difficult to manage" clients remains a challenge to everybody.

"We also work with a pool of private landlords and that works well. We provide a floating support service, particularly for hard to place offenders, and actually work really closely with no more than 6 landlords who we have a strong relationship with. They trust us, they know what we deliver, we communicate with them on a weekly basis, they understand how their property is managed. We also support the landlord when there's an issue with a particular tenant, so it's much more collaborative than: 'well you're the landlord and we're providing and we're just going to stand up for our clients.' We do stand up for the clients but it's done in a much more: 'let's all get together and sort this problem out' sort of way."

Steve Jones, ARCH Initiatives

We are part of a strategic partnership with a number of LGBT organisations, including Stonewall Housing, which is an LGBT housing advice provider. They also have a small number of supported accommodation provision for younger LGBT people. If we have someone with a housing need, we would tend to refer



them to there to get specialist advice. Although there is no special treatment, because they are an LGBT provider, they might have more confidence in their ability to empathise with the client's situation and understand the nuances of being LGBT.

"With regards to housing, we're quite fortunate – we have a couple of third stage houses where people go post-treatment and can stay for 12-18 months, engaging with employment, education and volunteering support. The success rate of those is absolutely incredible. Last year we had 27 people through and 23 got into employment or education and only 4 relapsed.

"We know it works but the problem is that funding is an issue with housing benefit, so it's almost like funding is given in the primary and secondary stages of treatment but then it drops off a cliff and, again, it's about working with potential housing providers and associations or having the capital to invest in these properties.

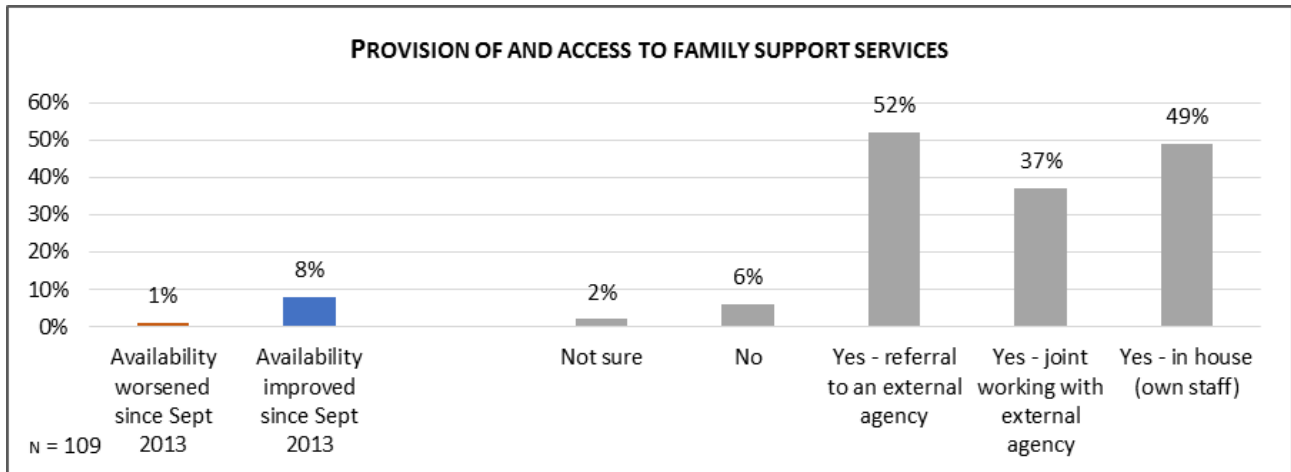
"We all know that if we can get people through, give them a house and a job or education, the likelihood of them entering the treatment system again reduces dramatically, and that is being borne out in the figures that we've shown in the last few years from our third stage properties."

Brian Dudley, Broadway Lodge

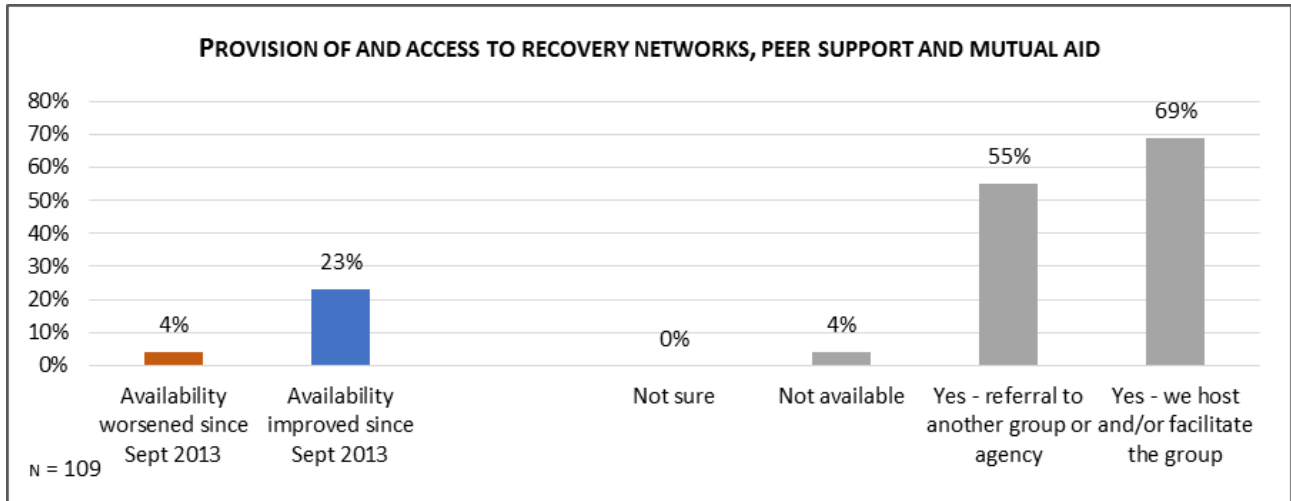
Family Support

Like 2013, there was considerable provision of in-house family support, and more respondents thought that provision and access had improved rather than deteriorated. Some provision was Big Lottery funded:

We provide a comprehensive family support service in line with We Count Too guidelines. We have delegated authority from [local authority] for carer assessments for families of substance users and are the only specialist provider of family support in the county. We are funded by Big Lottery with a small £20k grant from [local authority] for carer involvement. We have improved provision through securing more charitable funds.



Mutual Aid and Peer Support



Respondents indicated a broad range of approaches and generally widespread provision:

Peer mentor led abstinence oriented aftercare programme; we train and support volunteers.

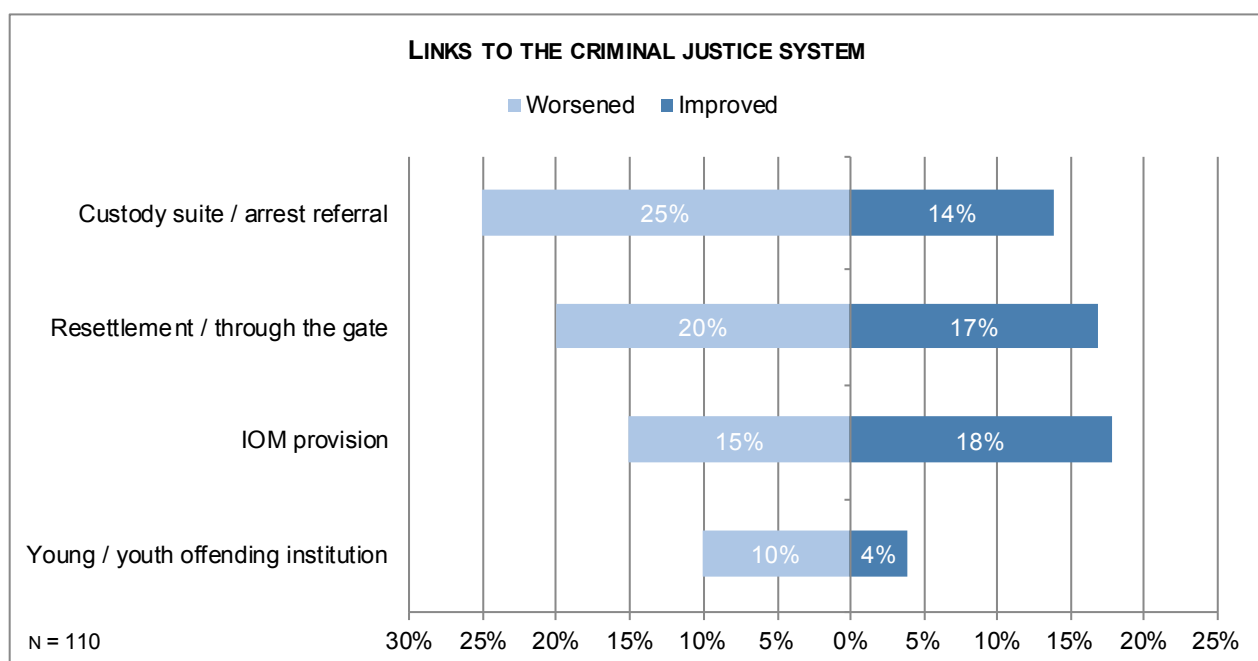
Locally sponsored SMART groups have stopped in all areas with one newly started in [place].

Staff trained to provide SMART groups in the centres. 12 step groups setting up across the county.

We actively encourage clients to attend fellowship meetings and our clients have been involved in establishing new groups.

We currently signpost to external groups such as LGBT AA/NA. We hope to launch an LGBT SMART Recovery group soon.

Criminal Justice



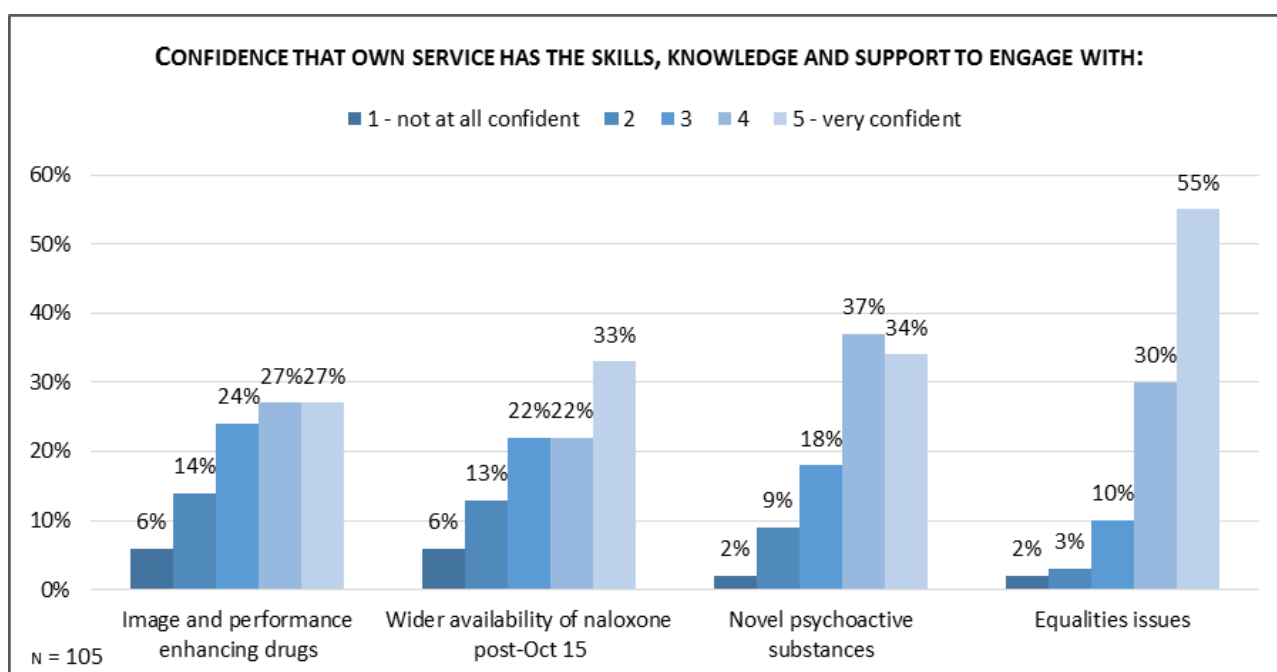
While for many the overall picture appears relatively stable, the apparent reduction in custody suite and/or arrest referral work could be a consequence of the withdrawal of the Drug Interventions Programme as a national initiative. Similarly, it is perhaps surprising that respondents indicated little movement on ‘through the gates’ provision at a time when the Ministry of Justice has been increasing the emphasis on this aspect of service, partly in preparation for Transforming Rehabilitation.

NHS England's [redacted] region has started on some good health for justice developments but overall the changes in probation and the retendering (that has already happened and which is yet to happen for 2015) has hampered positive developments. Practitioners are saturated with uncoordinated or badly managed change and holding our breath waiting for the next surprise.

Probation services are very hard to work with at the moment due to the structural changes, disjointed approach between the National Probation Service, courts and others.

Recent developments and post-2013 structures & systems

- Most services were confident or very confident that they could or would in future be able to respond to equalities issues, NPS, wider availability of naloxone and image and performance enhancing drugs.
- There was little confidence that Police and Crime Plans and Joint Strategic Needs Assessments/Joint Health and Wellbeing Strategies reflected local need, with in both cases only 19% of respondents being confident or very confident that they did.



Although the proportion varied, most service managers responding felt their services were well equipped to address some key current challenges. Comments from survey respondents indicate varying degrees of understanding and preparedness and provide an indication of some of the steps being taken.

[We are] working towards up skilling our team in order to be better equipped in dealing with and understanding NPS as with other new substance misuse trends.

We have an image and performance enhancing drug (IPED) specialist and also work at festivals in the summer season providing drug and alcohol welfare which gives us good intelligence and exposure to new on the scene legal highs.

The number presenting with NPS is small and are usually using other drugs alongside. Harm reduction messages are clear although knowledge of specific NPS's is probably basic. IPED is virtually non-existent in Tier 3 psychosocial and naloxone is provided elsewhere.

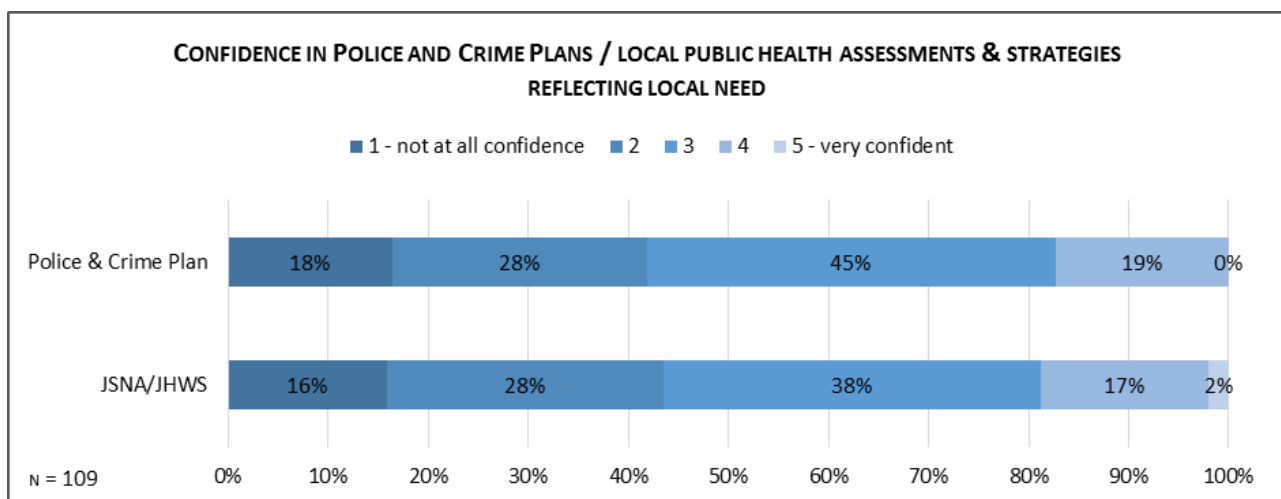
Have done a lot with naloxone over last 6 years including pilots, planning, preparation and co-delivery of training.

Our confidence reflects our experience as a targeted LGBT service that sees NPS and club drugs as the main issue presented. We are more confident in club drugs than the various and new legal highs due to more evidence, even though there's not that much.

Post-2013 structures – Health & wellbeing boards and Police & Crime Commissioners

As part of the April 2013 public health reforms, health and wellbeing boards (HWBs) now play a crucial role assessing need and setting local public health strategies, including local work around drugs and alcohol.

Police and Crime Commissioners (PCCs) were also introduced in 2013. They are responsible for policing and community safety within individual police force areas, and are accountable to Police and Crime Panels. In London, the Mayor has overall responsibility for the Metropolitan Police while (appointed) Deputy Mayor for Police and Crime carries out the executive elements of the PCC role.



There were mixed degrees of confidence in HWB joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (JHWSs) compared to PCC and police and crime plans (PCPs), with slightly more confidence in the former and less in the latter.

Some concerns were expressed, broadly falling into the categories of structural or procedural concerns, resources available or allocated, or the exclusion of particular groups from the respective documents:

Because of competing demands I do not feel that the JHWS will be able to meet the needs because there is too much to do and funding is not ring fenced [for drug/alcohol treatment within the public health budget] and is therefore being diverted away from prevention and treatment into other initiatives. As a senior nurse I am very concerned about this approach.

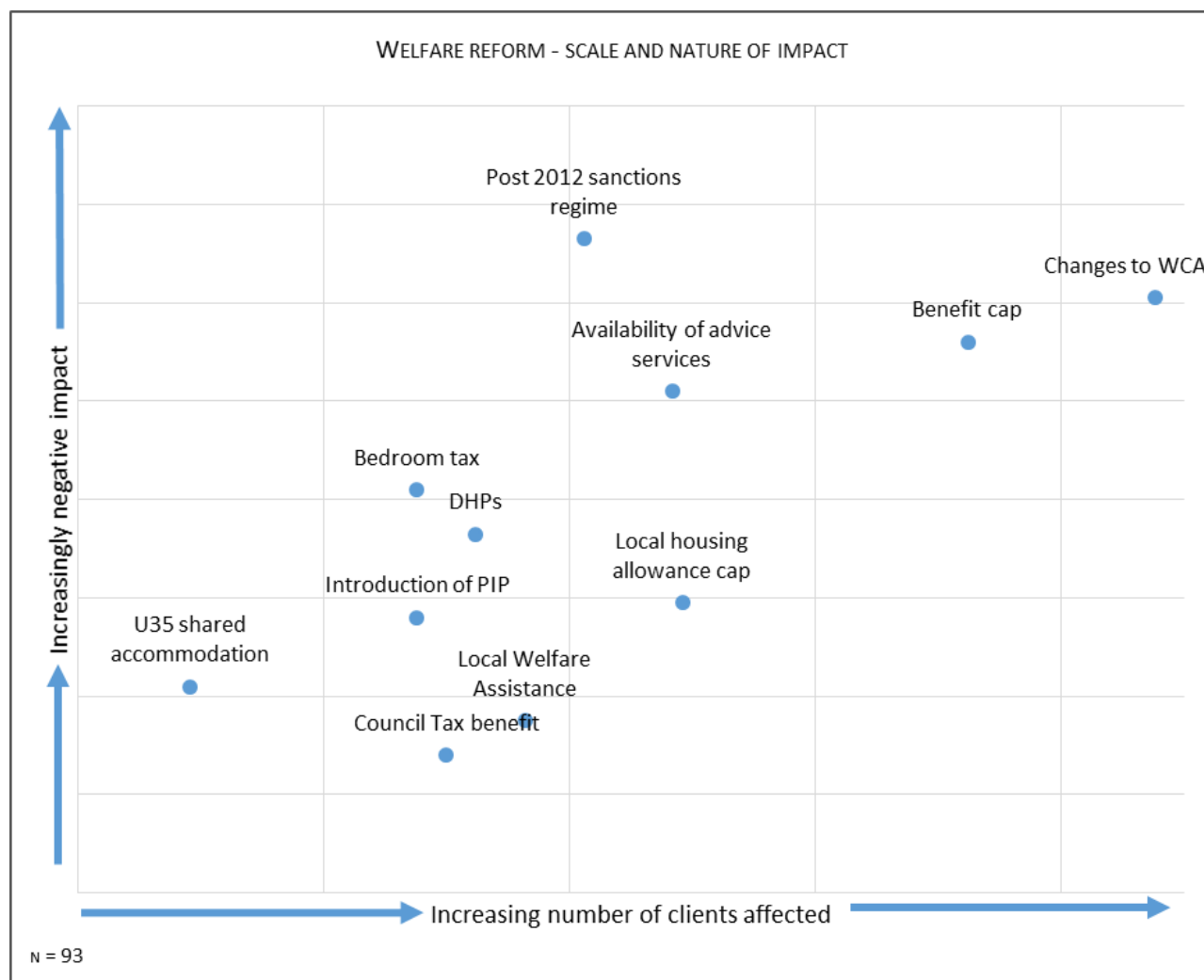
Police and Crime Planning was closed in my opinion; we were never given an option to engage. The JSNA was not much better and hardly makes reference to drug or alcohol misuse.

Impact of welfare reform

- The impact of welfare reform was seen as being negative, although some respondents reported that some reforms had had a positive impact. The Work Capability Assessment was reported as affecting the largest proportion of clients, and the post-2012 Jobseeker's Allowance (JSA) and Employment and Support Allowance (ESA) sanctions regime as having the most strongly adverse consequences.

Respondents were asked to indicate the proportion of their clients who had been affected by 11 different aspects of welfare reform and also what the consequences had been, ranging from strongly positive to strongly negative. These were then assigned a numerical weighting and plotted on a scatter chart as a means of providing a top-level picture of the scale and nature of the impact.

While a very small minority of respondents felt that some of the reforms had had positive consequences for their clients (ranging from 1.3% for the Work Capability Assessment/WCA to 6.8% for the removal of the spare room subsidy/'bedroom tax') the net effect of each reform was negative or detrimental to their services' clients.



The reform affecting the largest proportion of clients was the WCA, while the most negative individual aspect of welfare reform was the post-2012 JSA and ESA sanctions regime. Conversely, while still perceived as having a negative impact on clients, the move to the shared accommodation rate for under 35s and the reforms to Council Tax benefit appear to be less problematic and affect fewer people. Respondents and interviewees volunteered additional information:

"The feeling on the ground is that issues like changes to housing benefit where people are potentially even having to move house are obviously going to affect peoples' stability, their social capital, their ability to be able to move into recovery. As anyone who's ever been in financial hardship knows, it's very difficult to make progress on anything positively when there's financial hardship and debt."

Ryan Campbell, KCA

Our battle is not so much housing, but more the DWP. Though they deny it, they say people don't get sanctioned automatically or there are no targets for sanctions... the reality for us is that our clients get hit very hard and get sanctioned for the smallest indiscretion. It's a constant battle of wills between us and them. We have a good working relationship with DWP, so luckily enough, I am able to speak directly to people to try and address the situation. These people are being sanctioned – benefit sanctions or their health benefits get stopped or something like their council tax benefit stopped and then it's a battle with the DWP to get their benefits back. There's no doubt – and we do have to examine the figures this year – but our suicide rates are shooting up and the board is very concerned. They're getting more serious and untoward incident reports than they've ever had. It's probably the highest ever volume, this year.

The welfare reform agenda has hit our service users very hard. The biggest issues are the length of time to process and change benefits, sanctions, capability assessments, appeals etc. People have been left without money for weeks. The demand for food parcels completely outstrips supply.

The impact of these multiple changes has been very negative for clients and staff. A lot of effort to support recovery has been undermined and situations made worse because benefits staff do not co-operate or liaise with other agencies. Inappropriate sanctions have been instituted for little or no reason. These have been repeated 3, 4 or 5 times in a year even in cases where the decision has been reviewed and overturned by the courts. This has a disproportionately severe effect on clients with complex needs. Attempts at suicide have increased, depression and anxiety have increased and efforts to

support recovery are undermined. The cost to the public overall has increased, savings from cuts have been wiped out several times over because the cuts have proven to be the final straw and clients have collapsed into crisis requiring complex and long term support to recover.

"The online element causes some practical challenges for some of our chaotic clients, who are just not IT savvy. It's meant that we've had to respond and react to that by bringing in additional IT equipment and make sure we've got people around that can sit down with somebody and go through the process online.

"We see some real issues with repayment of people who have been underpaid welfare benefits and then receive a big amount of money in one go. That exercises our workforce a lot because we see some really dangerous behaviour as a result. And also the risk of other people targeting those individuals when they know they've had a big pay-out. We see quite vulnerable clients getting a very large back payment and before you know it, you've got three or four others on the doorstep, so that can be a challenge from a safeguarding perspective.

"Universal Credit could be risky for our clients. I mean anything in a lump sum as opposed to a weekly payment is risky. Risky because sometimes a lot of our focus is around budgeting and money management with clients and they find that difficult to do. Particularly where there's poor or low educational attainment, where numeracy and literacy just aren't their strong point.

"When it comes to saying: 'look, you're going to get £2000, how are you going to manage that?' It's gone on day 3. And when you've got complex addictions going on then it's very easy to get rid of two grand and just blow your brains out and that's dangerous stuff."

Steve Jones, ARCH Initiatives

Annex – prison services

This year, State of the Sector has been extended to prison services with a separate questionnaire, designed in consultation with stakeholders. While the issues facing community treatment services and prison based ones are often similar, the major reforms affecting both public health and offender health made us believe that a separate questionnaire would be valuable.

While we have had a smaller number of responses than in our community survey, what we are reporting is a comparable response rate to the community sector. Nevertheless, the survey findings are subject to the risk of noise. Consequently, we are only publishing selected responses.

This annexe is also informed by discussions with senior stakeholders from NHS England and Public Health England, as well as service managers and senior voluntary sector managers. These discussions have been summarised rather than reported verbatim, with the exception of the interview conducted with Mike Trace of RAPt, an organisation with considerable experience of and expertise in delivering substance use services in a criminal justice setting.

Substance use treatment in prisons – background

Substance use within the prison population poses a significant challenge to prisons and related services, as well as to the health, wellbeing and future prospects of prisoners themselves. Novel psychoactive substances pose a new test, and in turn are being met with new policy responses. There were almost 4,500 seizures of illicit drugs in prisons in 2013-14, an increase of over 200 on the preceding year. It is not clear what the variable might be – more effective methods of finding and intercepting drugs, more drugs within the prison estate, or a mixture of both.

Contact between drug users and the criminal justice system is widespread and significant. People who misuse substances are reported to engage in much higher levels of criminal activity than non-drug users, and studies have found that drug use may intensify, motivate and perpetuate offending behaviour; the highest levels of drug use are found among the most prolific offenders. A longitudinal study published in 2013 found that 64% of prisoners had used illicit drugs in the month before arrest, with lifetime use being higher, at around 70% for women and 80% for men. Research also indicates high levels of pre-arrest hazardous drinking in the prison population, of just over 60% for men and just under 40% for women.

More broadly, prisons face challenges around deaths in custody, which are at a recent high, self-harm incidents involving assault and other forms of disorder. Novel

psychoactive substances (NPS), particularly synthetic cannabinoids, appear to be behind an increasing number of incidents and other problems in prisons.

Summary of discussions with stakeholders

While the scale of the challenge is significant, discussions with stakeholders, service managers and senior managers paints a picture that is far from negative, particularly when contrasted with some of the sentiments expressed by managers and chief executives of community and residential drug and alcohol services.

Seen over the course of several years, stakeholders expressed the opinion that there had been a step change in the provision of treatment in prisons following the introduction of the Integrated Drug Treatment System (IDTS), driven in part by a mixture of high-level political interest and class actions brought by prisoners.

The role of specialist substance use agencies from the voluntary sector was welcomed. One service manager who had previously been employed by Her Majesty's Prison Service (HMPS) but now worked for a charitable provider indicated that as well as a change in ethos, she had been offered increased opportunities for training and professional development.

Changes within the prison estate have been broadly welcomed, including the availability of recovery and drug-free wings in prisons and the reclassification of some prisons as resettlement prisons. However, given the relatively lesser numbers of female prisons, it is less clear that the intention behind local resettlement prisons will be met to the same extent for women as for men.

The introduction of the National Drug Treatment Monitoring System (NDTMS) into prisons was seen as an unambiguously positive development, supporting the improvement of the offer to the individual as well as enabling a deeper systemic understanding of the treatment journeys of offenders between different settings.

Other changes include the restructuring of the prison estate as part of the Transforming Rehabilitation reforms. Among other things, this has led to some prisons being reclassified as resettlement prisons, creating enhanced opportunities for links between prison and community-based services. Some stakeholders did however express the concern that due to the lower number of female prisoners and correspondingly smaller number of women's prisons, there may be more of a disconnect between community and prison services for women compared to men.

Also connected to Transforming Rehabilitation, the increased use of 'through the gate' services was seen as a positive development, as was Transforming Rehabilitation itself, although with the very major caveat that the reform must work as intended. Some

early problems with information technology and client information in the new interim system have not offered much reassurance.

New drug testing products will soon be in place that will enable testing for a number of substances contained in and metabolites of many common NPS.

Less positively, a reduction in staff headcount in many prisons was seen as a negative development, including a lack of non-clinical staff who, nevertheless, made a valuable contribution to prisoner wellbeing and safety by engaging with them more informally.

‘Retoxification’ - the process whereby steps are taken to increase tolerance to opioids prior to release - was discussed as it is a matter of some public interest. Stakeholders engaged were keen to emphasise that it is extremely rare, to the extent that none were aware of it having taken place in their prisons or services during their time of employment.

“Prison-based substance misuse treatment, is relatively stable. But, if you look outside substance misuse within prisons, everything you hear is about prisons regressing. I’ve worked in prisons for 30 years and I’ve seen them develop from being absolute hell holes to being relatively humanely managed places.

“Everything you hear about the benchmarking and cost cutting going on in prisons is true and what we’re witnessing now is everything done in prisons is more dangerous, more done on a wing and a prayer and done for less quality now. So morale at RAPt is more affected by that reality. One of the impacts of moving the budget from NOMS to health, which I think generally has gone better than we thought it would, is that governors are now no longer personally responsible for the substance misuse service. Among those daily, tricky decisions governors have got to make about priorities, about what happens within the walls, substance misuse is less in their minds.

“That has the knock on effect of making the general prison problems worse for us. Trying to maintain what we know is a good service - we know exactly what we’re meant to be doing in the prisons - it’s a constant battle because of staff shortages or lockdowns or because somebody has taken away the meeting rooms, or somebody else has moved a load of drug dealers onto the drug free wing. So all of those day-to-day battles are harder than they have been for many years.”

Mike Trace, RAPt

Prison services – selected responses to the survey

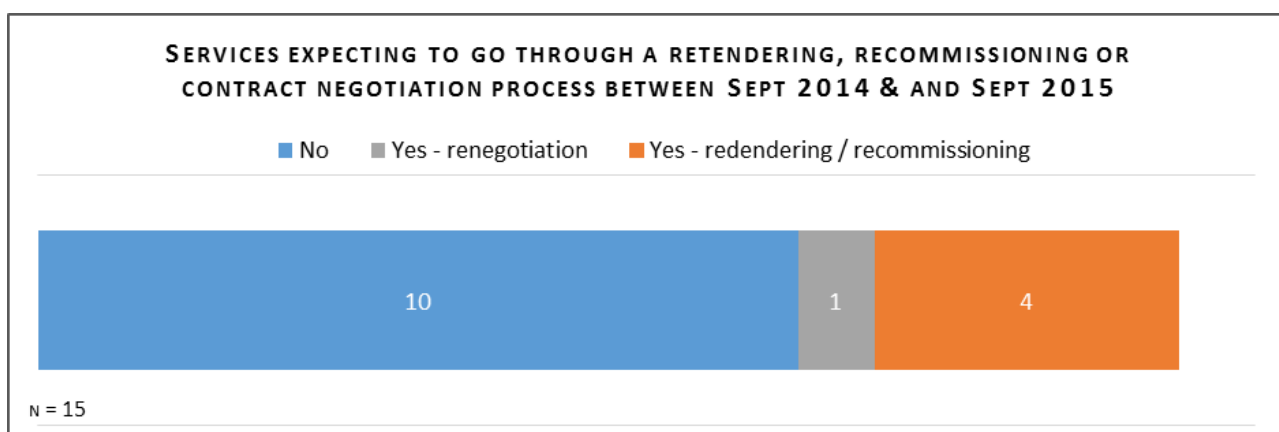
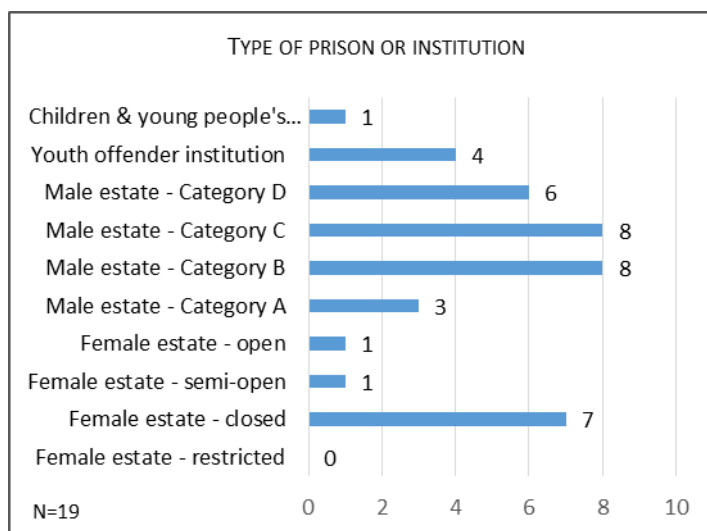
With prison services in particular, you really have to want to do it, to work there. People don't stay in a prison service if they don't like it. They're dedicated people who want to be there.

The majority of respondents in this year's survey came from the Midlands and East of England (11) followed by the North (3) and South (3) and fewest came from London (2).

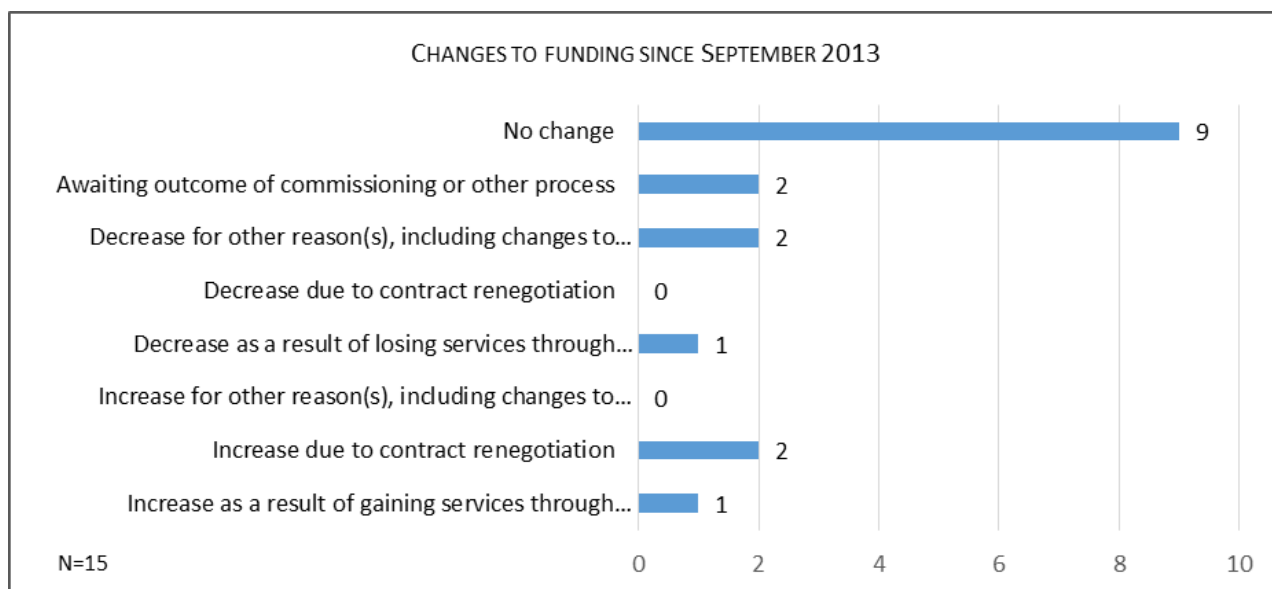
Respondents came from a range of different types of prison – see right.

Compared to the community sector there seemed to be much more stability when it came to funding and the commissioning cycle. Nine out of 15 respondents said they had seen no change in funding.

Similarly, 10 out of 15 said they were not expecting to go through a retendering, recommissioning or contract negotiation in the next year.

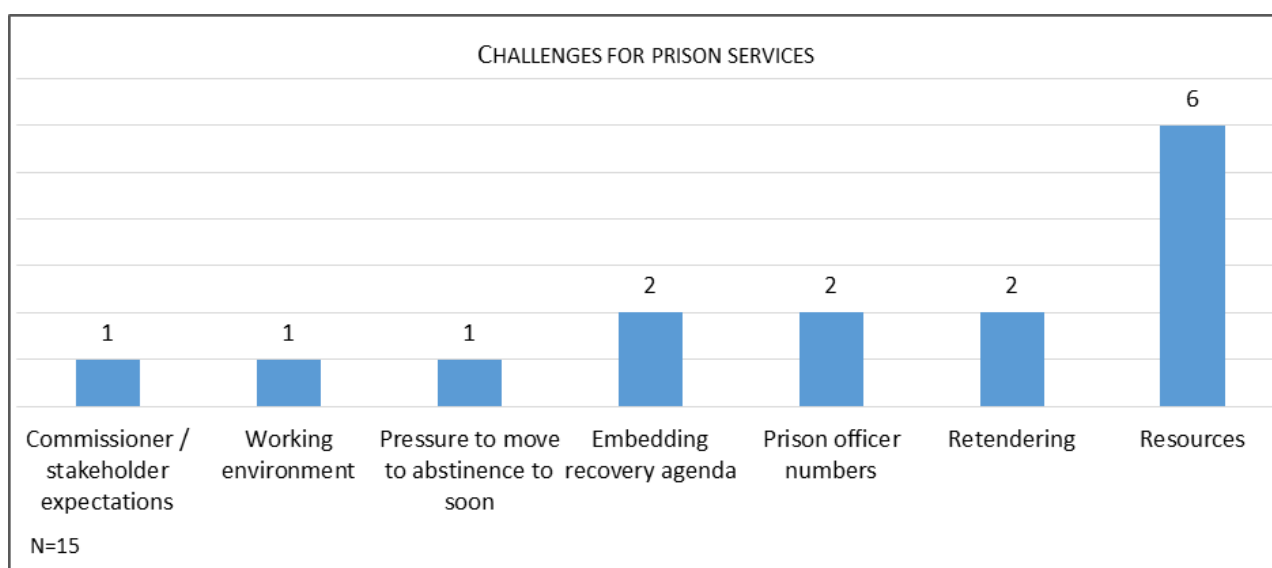


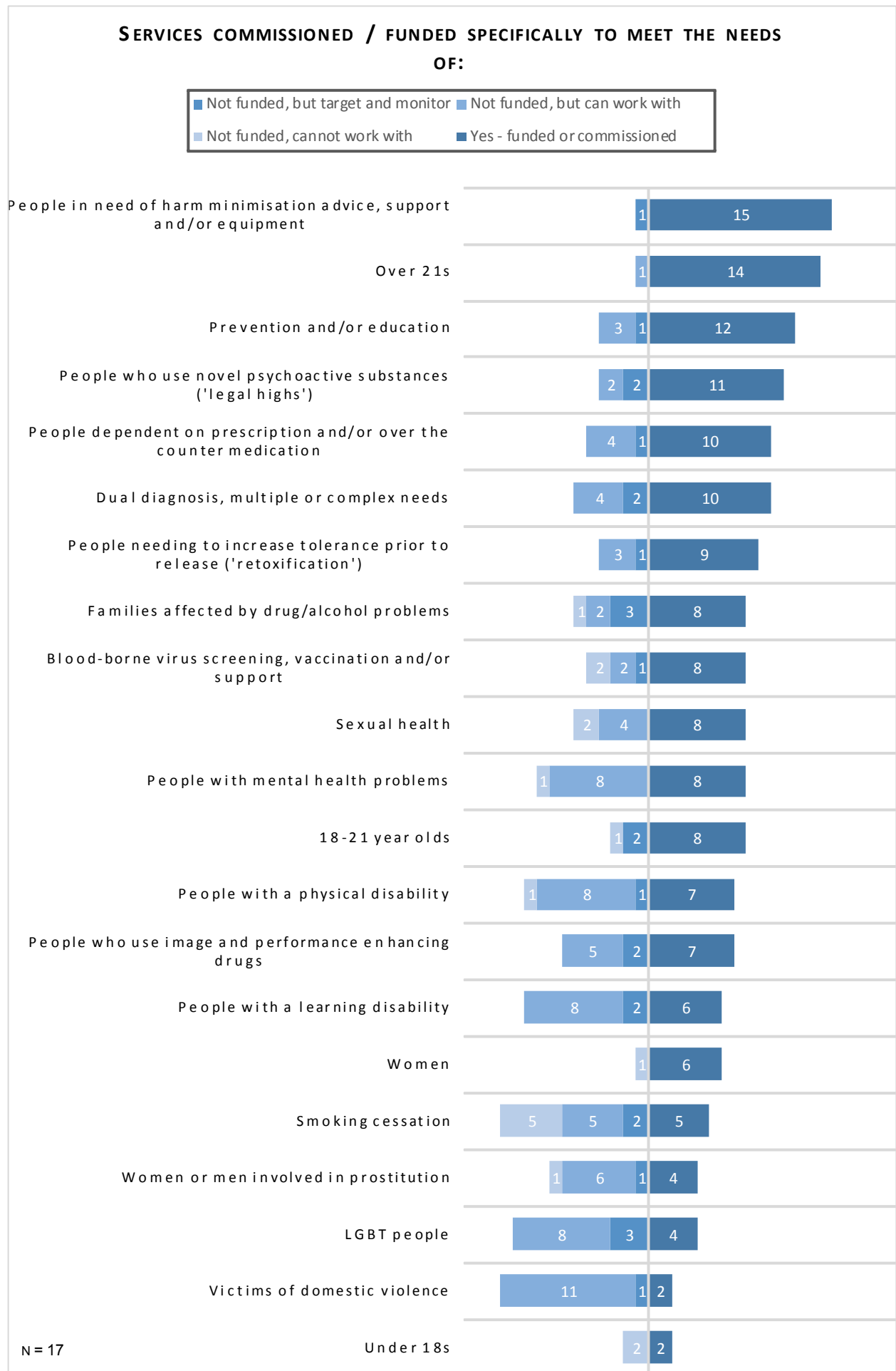
We haven't seen much evidence of contracts getting longer – although that doesn't mean it's not happening – but it doesn't feel like things are turning round any less quickly than they have been in the last few years. Most contracts are still 3 to 5 years, although possibly more towards the 5 year end and less towards the 3.



Based simply on the financial side, things aren't bad, services aren't underfunded in the way that some of the community services feel like they are. But our teams are finding it more difficult when prison officer posts are underfunded and where there are staff shortages; while we may have enough staff in our office, there might not be enough officers to escort prisoners or to supervise a group session. It feels like the morale among the prison staff is low; that has an effect in addition to the questions of numbers. It's quite frustrating for our practitioners.

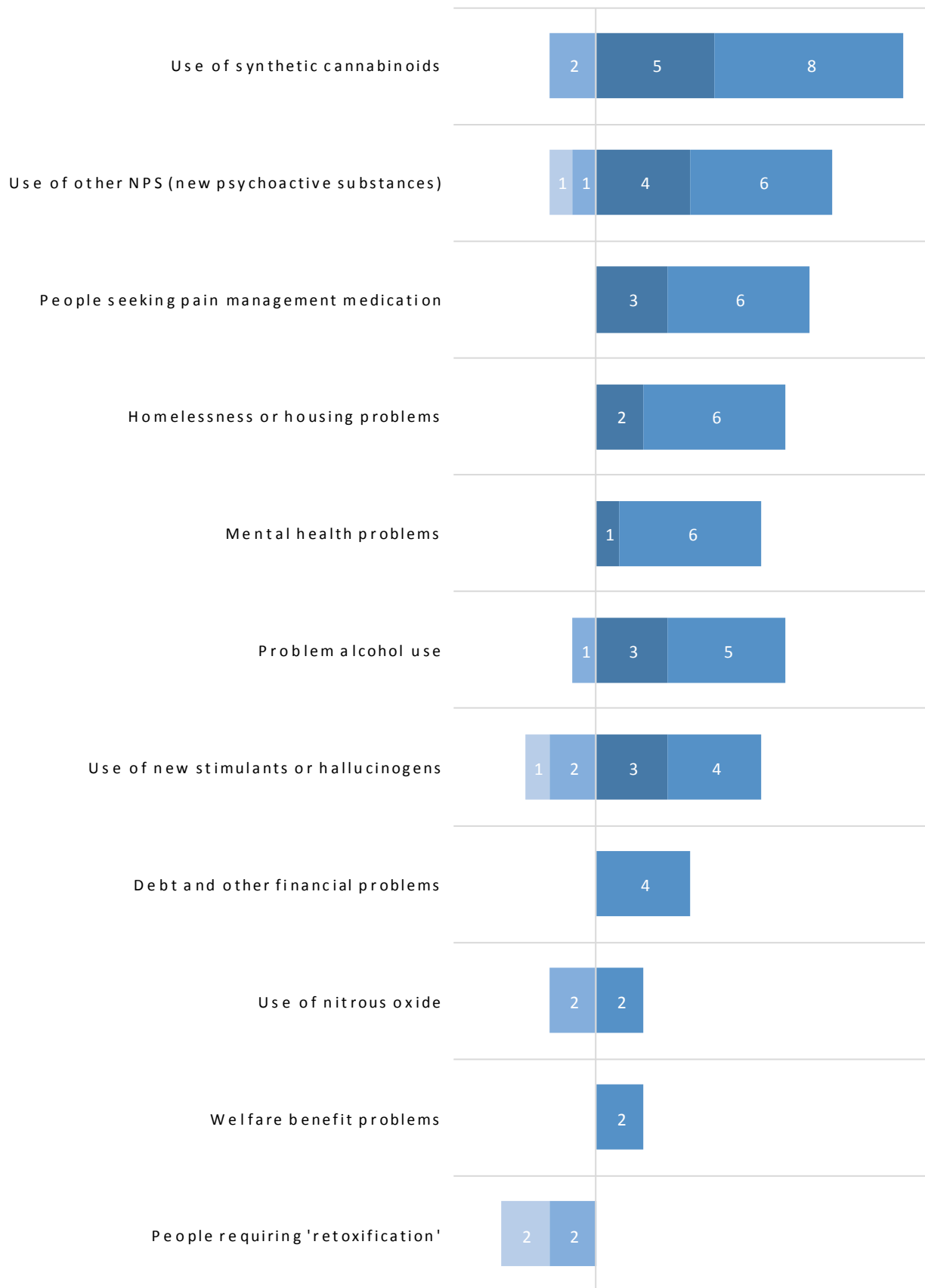
As in the adult and community questionnaire, respondents were asked to disclose the most significant challenges their service faces, the biggest opportunity presenting and also how they may have been able to innovate. As in the larger survey, these responses have been categorised by type. 15 participants provided information with respect to at least one of these three factors.





CHANGES IN THE NUMBER OF PRISONERS COMING FORWARD WITH THE FOLLOWING NEEDS SINCE SEPTEMBER 2013

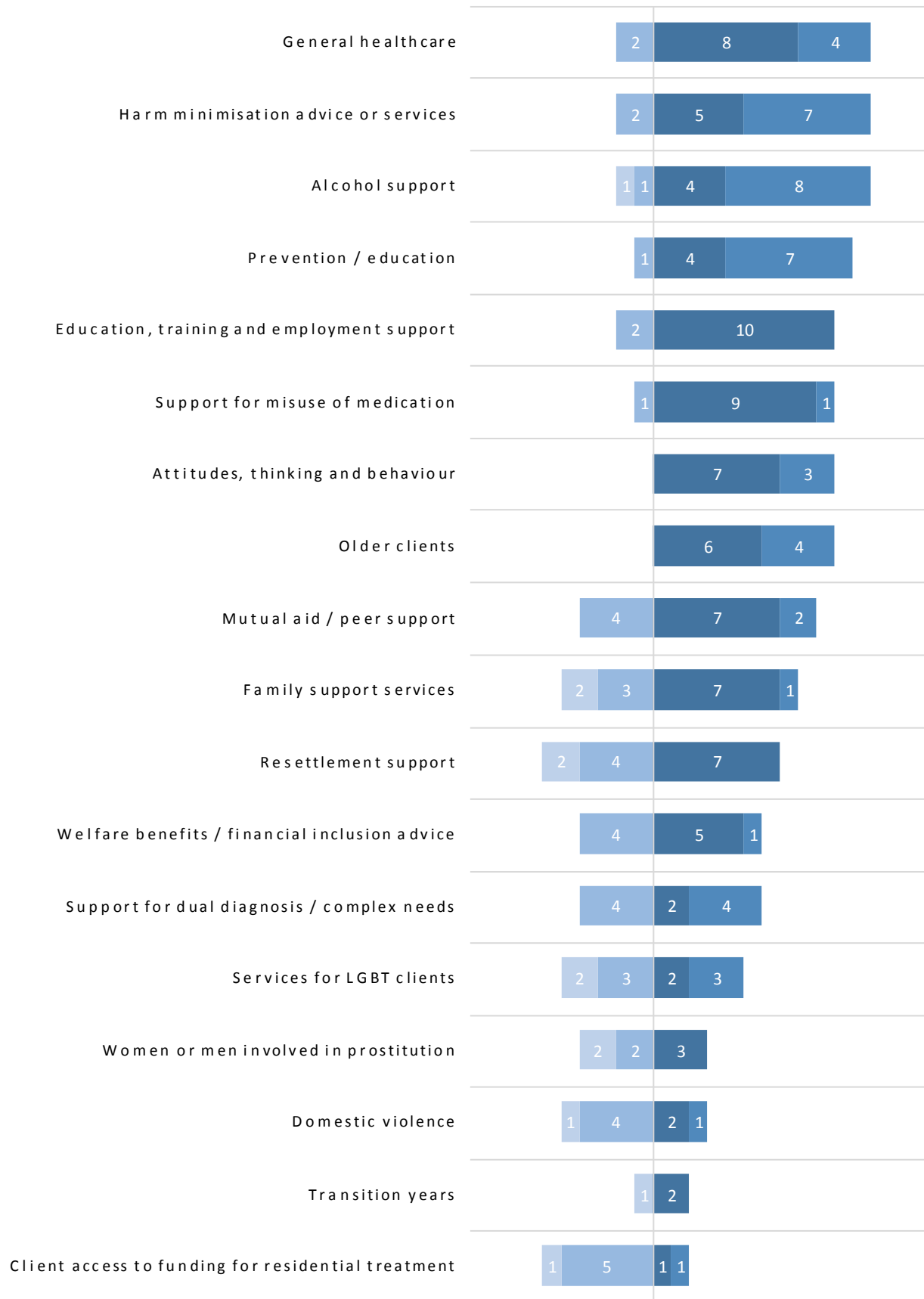
■ Significant increase ■ Increase ■ Decrease ■ Significant decrease



N = 16

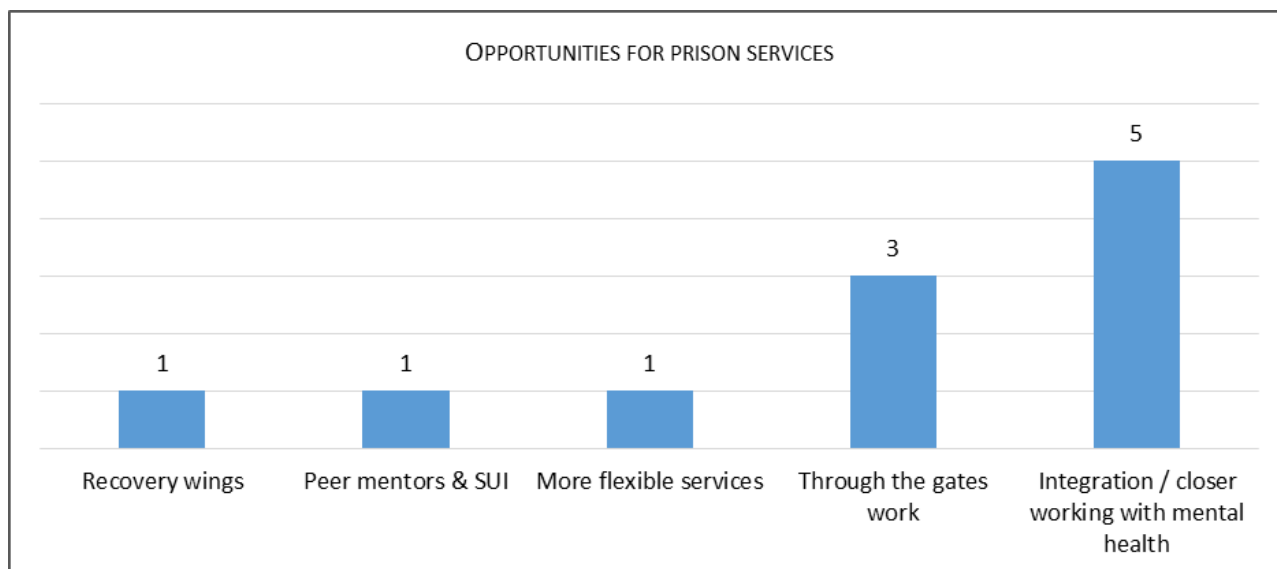
ARE PRISON SERVICES SUFFICIENT TO ADDRESS THE FOLLOWING NEEDS:

■ Needs unmet ■ Needs not met at all ■ Needs met ■ All needs fully met

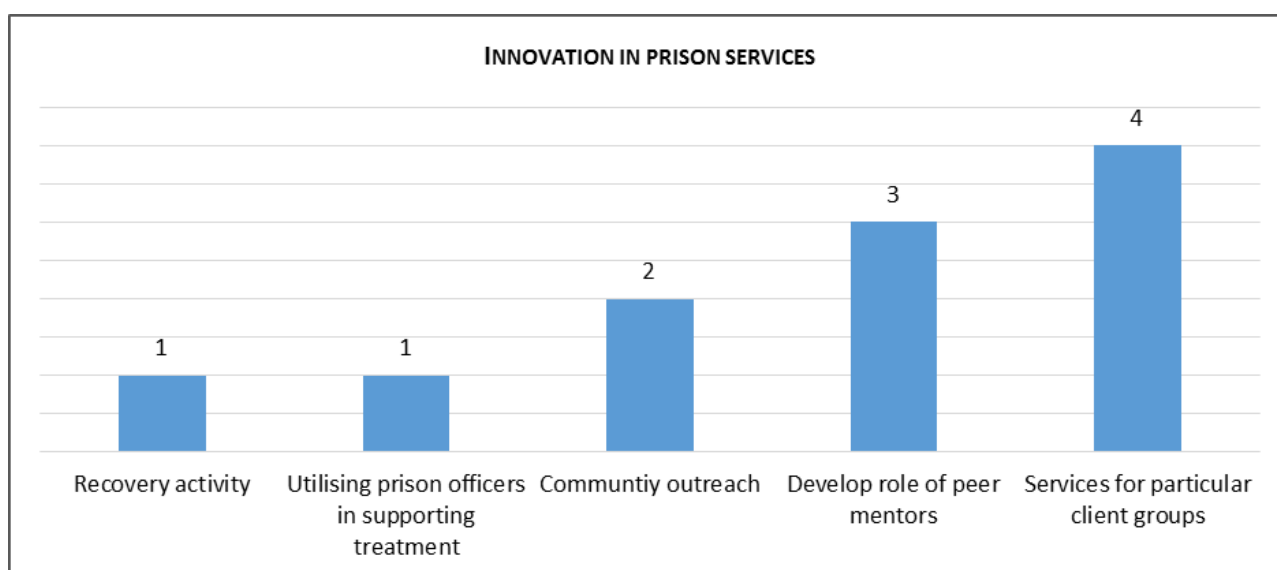


N = 16

NPS is a massive issue. It's a big issue in every prison. Pregabalin and gabapentin are big issues in pretty much every prison, and my understanding is that it's medication that's being prescribed in the prisons and then misused, it's not medication coming in from outside. We need to get prescribing and pathways nailed down. It's a key priority.

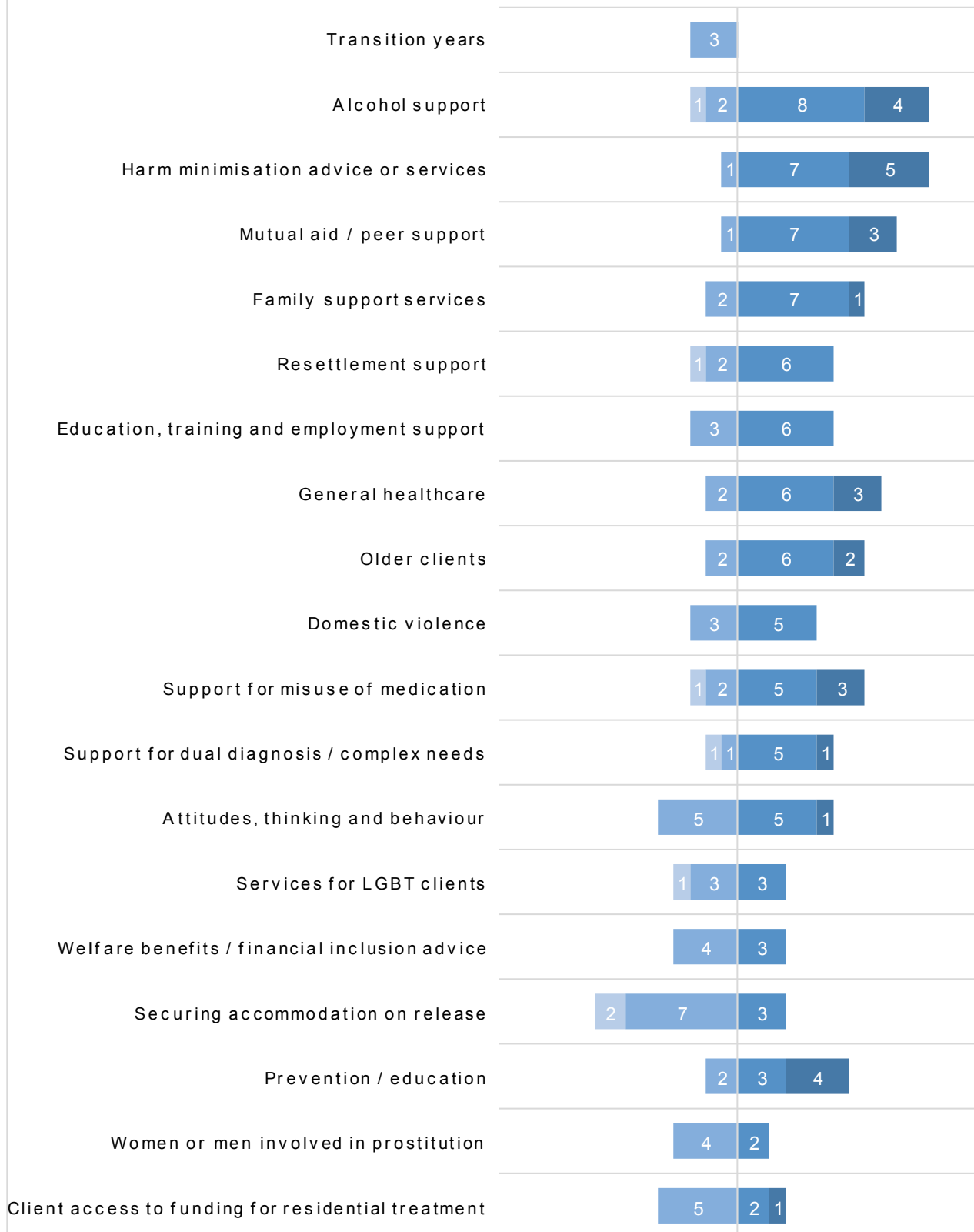


The big recent development has been around the commissioning of large, integrated healthcare services. There are still a few drug-specific tenders, but most of the ones we've been involved in have been large, regional healthcare contracts. For an organisation like ours, the only realistic way of doing that is by going in as a subcontractor with a larger organisation, usually an NHS trust or a big private organisation. It feels as though whether or not you're successful depends on backing the right horse; the treatment provider input feels pretty minimal in terms of how the decision is made. You need to identify who will write the best tender, which may not be who you think will be the best partner from your point of view. It's a different way of doing things.



SERVICES ACCESSIBLE ON RELEASE FROM PRISON

■ Some needs unmet ■ Needs not met at all ■ Some needs met ■ All needs fully met



N = 16

Commissioning of integrated services probably does improve things, the clinical teams and the psychosocial teams working more closely together, having shared objectives at the client level so the client receives a single programme of treatment, getting different intensities of each intervention at the right stage. It definitely happens in practice, but it's something that could be further developed. We're only just seeing integration with mental health services. In theory, it must lead to an improvement because it's clear there are gaps, but it's too early to say what the impact will be.

I'd like to think where people have moved into specialist treatment providers from the prison service, that they've seen a difference in training and the ability to provide an effective, professional service. One the things I see when I walk around prisons is that staff from agencies such as ours have a different way of relating to prisoners. You build a case about therapeutic value and services doing better because staff get on with people. It's sometimes as simple as prisoners feeling they have someone they can talk to, someone who isn't going to judge them. Specialism and dedication to one area helps, but it's more about the way that people relate.

Lead contractors don't so much require exclusivity as the tender process makes it difficult. There seems to be a tacit understanding that you go with one main provider. It'd weaken the bid if you're emphasising partnership and shared values but also saying the same about three or four different providers. It might be more straightforward for smaller providers – like a local, service user-led organisation. It wouldn't be so dependent on who the lead provider was.

I'm optimistic about Transforming Rehabilitation, although it has to actually work as intended. I'm slightly disappointed with who the contracts have been awarded; the big private sector providers have got the biggest slice of the pie even though there are voluntary sector agencies involved in many of the contracts. We didn't go in for it – we want to see how it goes, first. We're concerned that the involvement of substance use treatment providers isn't going to have that big an impact on how successful the consortium is.

There's still work to do on the transition from prison into the community. A lot of the time, the good work that happens in a prison is undone when someone is released into the community. It's nothing to do with the quality of the community service, it's just how difficult that transition is. The potential for things to go wrong increases. Sadly, we still get involved in investigations into deaths of released prisoners who've, while inside, done really well, been abstinent, engaged in the programme but have been released and in a couple of days injected heroin and overdosed. It's one of the saddest things in my job and it doesn't seem to be happening any less frequently, despite all the improvements in prison services and in community services.

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