



The 2010 Drug Strategy Consultation

Response from DrugScope

30 September 2010

DrugScope is the UK's leading independent centre of expertise on drugs and drug use and the national membership organisation for the drugs field. DrugScope's objectives are:

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

DrugScope believes in drug policy that:

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

DrugScope is committed to:

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

DrugScope works to achieve our objectives by:

- Informing policy and developing innovative approaches to substance misuse, for example, in our Drug Treatment at the Crossroads (2009) and Young People's Drug and Alcohol Treatment at the Crossroads (2010) reports and bi-monthly magazine, Druglink;
- Building partnerships to develop holistic approaches to recovery – for example, the 'Drug Sector Partnership' (with Adfam, the Alliance and eATA), the 'Making Every Adult Matter' initiative (with Clinks, Homeless Link and Mind) and projects in London on homelessness, domestic violence and employment;

- Providing administrative support for forums including the Needle Exchange Forum and Drug Education Practitioners Forum, and involvement in a number of cross-sectoral 'third sector' alliances, including the Criminal Justice Alliance and Third Sector Forum on Mental Health and Criminal Justice;
- Representing our members through regular communication and consultation and our participation in advisory groups, such as the Home Office's Voluntary and Community Sector Drugs Forum, the ACPO Drugs Committee, Criminal Justice Council and National Advisory Group on Health and Criminal Justice (DrugScope's Chief Executive sits on the Advisory Council on the Misuse of Drugs in a personal capacity).

DrugScope incorporates the London Drug and Alcohol Network (LDAN), which works in London to provide independent and expert advice to member agencies, commissioners and other stakeholders; to support member agencies in providing cost-effective, high quality services that are user focussed; and to engage with policy and decision-makers on behalf of its membership.

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1. Drug strategy review: an overview

This section draws together and summarises some of the key issues, messages and themes in DrugScope’s response to the drug strategy consultation.

DrugScope is the UK’s leading independent centre of expertise on drugs and drug use and the national membership organisation for the drugs sector. Our response draws on consultation events in London (6 September), Birmingham (7 September) and Newcastle (10 September), attended by around 150 delegates. It reports on the findings of a DrugScope survey - prepared specifically for this consultation – which was completed by 231 respondents.

DrugScope welcomes the Government’s determination to ‘give the voice of the “Big Society” the power to influence the development of the new drug strategy’. Our role as a membership organisation has enabled us to support hundreds of frontline organisations to have their voice in the policy process. We have a particular role in providing representation for the voluntary and community sector.

Our members support the overarching aims set out in the drug strategy consultation document. They welcome the focus on recovery and social (re)integration and applaud the recognition that delivering on this recovery vision requires a holistic approach, continuing to break down silos and bringing together a range of professionals and agencies, both nationally and locally. They want to see the promise of continued improvements to drug and alcohol treatment matched by a commitment of energy and resources to a genuinely ‘joined up’ approach to prevention and early intervention. While this overview and much of our response to the consultation focuses in particular on treatment and recovery, there was clear and strong support for more emphasis on prevention.

The challenge is to identify and develop policy and practice that will deliver on this vision. The Government’s priority is to reduce the public spending deficit but, as we set out in our submission to the Spending Review, it is important that drug policy continues to be allocated significant public spending, and to ensure that well-resourced drug and alcohol treatment is a priority for public health. This is not only consistent with the commitment to minimise the impact of spending cuts on the worst off in society, it is also a cost-effective investment in the medium to long-term. It is important that policy continues to be shaped by the best available evidence and by the practical experiences of people involved in services on the ‘frontline’ (including prevention, education, treatment and rehabilitation services). The key theme that has emerged from our discussions with our members is that they are supportive of change and the broad ‘direction of travel’, but do have concerns about its pace, assumptions and implementation.

Informed by the responses of our membership, this submission sets out the case for a (re)balanced approach to drug policy.

1. **A balance between consolidation and change.** DrugScope welcomes the determination to address the limitations of past drug policy, but we also believe that the new drug strategy will be building on solid achievements, to

which our membership have contributed. The availability and quality of drug treatment services has taken a leap forward. There is recognition of the need to address the inter-relationships with other health and social problems (for example, in the National Treatment Agency's 'Commissioning for Recovery' and the Bradley Review), as well as recent piloting of some potentially innovative approaches to achieving this (for example, Total Places and the Drug System Change Pilots). There has been progress on social (re)integration – for example, the creation of drug co-ordinators in JobCentre Plus, the Think Family and Every Child Matters initiatives, Supporting People and the Adults Facing Chronic Exclusion programme.

However, there is plenty still to do. For example, our 2009 report 'Drug Treatment at the Crossroads' concluded that too many people were 'warehoused' in treatment, receiving long-term substitute prescriptions and little else. Our joint report with Adfam – 'A New Deal for Families' – concluded that there was a need to improve support for families and carers affected by drug and alcohol problems. The Making Every Adult Matter (MEAM) coalition – DrugScope, Clinks, Homeless Link and Mind – produced a 'Four point manifesto for tackling multiple needs and exclusions', which concluded that 'we can build on progress, but it is also clear that we have a long way to go'.

DrugScope welcomes the Government's responsiveness to these (and other) issues that are of concern to DrugScope members, and we recognise that moving forward will require change. Equally, it is important that there is continuity where we have been making good progress, and a commitment to build on the foundations that have been laid down.

DrugScope calls on Government

- **To ensure that the key functions of the National Treatment Agency are successfully incorporated into the new public health service**
- **To develop the drug strategy based on evidence of 'what works'**
- **To consider the conclusions and recommendations of the DrugScope/Adfam report 'A new deal for families' and the MEAM coalition's 'Four point manifesto for tackling multiple needs and exclusions'.**

2. A balance between policy momentum and stakeholder engagement.

Drugscope believes that the development of effective drug and alcohol policy is significantly strengthened by ongoing constructive consultation with people who are directly involved in developing, delivering and using drug and alcohol services. We recognise that the Government wishes to see ambitious reforms to public services, which are central to its vision and programme. We look forward to working with Government to ensure that this policy agenda is shaped and informed by the views and experiences of our membership and other stakeholders, across a range of issues, including NHS, welfare and criminal justice reform.

We urge the Government to ensure that processes for policy development permit time for meaningful engagement, taking account of the range of

consultations that different departments may be planning to conduct during a particular time. DrugScope has expressed concern that the consultation on the drug strategy was launched by the Home Office on the 20 August with a deadline of 30 September. There is a high level of speculation, uncertainty and anxiety in the drug and alcohol fields at the present time. We acknowledge therefore the importance of the Government articulating its aims and aspirations for drug policy. The current review of the drug strategy is taking place, and will conclude, before the completion of other significant reviews and consultations across government – e.g., welfare reform, the NHS White Paper and criminal justice reform. In recognition of the relevance of other policies and strategies, we hope the Government will commit to consulting on developments in drug policy and the drug strategy as the broader programme of reform takes shape.

DrugScope calls on Government:

- **To commit to the Code of Practice on consultations and to review and promote ‘The Compact on Relations between Government and the Third Sector in England’**
- **To develop effective engagement mechanisms to ensure that the voice of the ‘Big Society’ continues to shape and inform all aspects of the drug strategy**
- **To invest to support the infrastructure for ‘third sector’ engagement in public debate and policy formation, recognising the value that is added by involving people on the ‘frontline’.**

3. **A balance between respect for evidence and support for innovation.** With our partners in the Drug Sector Partnership - Adfam, the Alliance and eATA – we have produced a ‘drug treatment consensus statement’ So far over 40 drug and alcohol treatment providers and service user groups have signed in support. It argues for ‘an evidence-based and non-partisan approach to drug and alcohol policy, which respects the advice of independent experts, such as the Advisory Council on the Misuse of Drugs and the National Institute for Clinical Excellence’.

At the same time, we understand that there are concerns that too narrow an interpretation of ‘evidence’ may stifle innovation and place excessive restrictions on service user choice. An ‘evidence-based’ approach commits to funding those services which *the best available evidence* suggests are effective in achieving policy and/or clinical objectives. But resources should also be available for innovative work, evaluated using appropriate methods. An approach anchored by evidence is particularly important in a policy area that merits and requires significant public investment and which has important implications for the well-being of the whole community. The debate on drugs and drugs policy can be emotive and misperceptions are not uncommon – including reporting by sections of the media.

DrugScope calls on Government:

- **To make a clear commitment to an evidence-based approach to drug policy**

- **To ensure that drug and alcohol services are supported by the same clinical and evidential standards as all other NHS provision, including implementing appropriate NICE guidance**
- **To work constructively and transparently with the Advisory Council on the Misuse of Drugs and other independent advisory bodies.**

4. **A balance between accountability and adaptability.** DrugScope welcomes the Government's review of the role of national targets in drug and alcohol policy, and shares the desire to empower communities to enable them to respond to local patterns of need and local priorities. We believe, however, that the opportunities for more devolved decision-making need to be balanced against the risks of underinvestment or disinvestment and creating 'postcode lotteries'. The design of these decision-making, commissioning and purchasing systems will be critical to the delivery of a new drug strategy. There needs to be a balance between devolving decision making and responsibility and achieving accountability and quality standards. DrugScope would urge Government to examine options for change with particular care, and would welcome opportunities to engage constructively with Government in the light of concerns raised by our members.

Over half of respondents to DrugScope's consultation survey believe that 'localism' will increase the responsiveness of drug and alcohol services to local needs. However, a large majority also say it will result in greater variation in the availability and quality of services. We also asked about 'payment by results'. One in five felt that payment by results could improve outcomes for service users, but more than half 'disagreed' or 'strongly disagreed' that outcomes would improve, and there were particular concerns that payment by results would exclude small, locally-based services. The survey findings are in line with the messages from our face-to-face consultations in London, Birmingham and Newcastle.

We recognise that it is early days for this debate and that support for both 'localism' and 'payment by results' could increase as the details become clearer. We would, however, welcome assurances from Government that a ring-fenced budget will be allocated specifically for drug and alcohol services, and that national Government will continue to have a clear responsibility for ensuring that an acceptable level and consistency of evidence-based service provision is available in every community (for example, by retaining national targets for waiting times). DrugScope suggests that where a local authority or partnership is proposing to refocus, significantly reduce or withdraw funding there should be a requirement to conduct a "community impact assessment", with a particular focus on the impact on the most vulnerable and socially excluded individuals, families and communities.

DrugScope calls on Government

- **To maintain a ring fenced budget for drug and alcohol treatment**
- **To ensure that there is an acceptable level of consistency in the quality and availability of drug and alcohol services across the country**

- To develop the ‘localism’ agenda and ‘payment by results’ on the basis of a careful assessment of potential risks and benefits, involving both service providers and service users.
- To introduce a requirement for ‘community impact assessments’ where local decision makers and funders are proposing to refocus, significantly reduce or withdraw funding, where there may be an impact on the most vulnerable and/or the third sector.

5. A balanced approach to treatment, encompassing reintegration, recovery and harm reduction. DrugScope welcomes the focus in the drug strategy consultation on ‘recovery’ and the commitment to developing ‘a more holistic approach with drug issues being assessed and tackled alongside other issues’. One of the biggest challenges is accessing the social capital – such as housing and employment – that is critical to sustained recovery from drug and alcohol problems. The most frequently identified barrier to social (re)integration among respondents to DrugScope’s consultation survey was ‘lack of available opportunities, for example, employment or training options for people recovering from substance misuse problems’. The development of new approaches that encourage multi-agency work and incentivise services to focus on (re)integration outcomes for service users is welcome. DrugScope would like to see the drug strategy operating within a broader cross-governmental ‘recovery strategy’ or ‘programme’. Tackling negative attitudes and ‘stigma’ is a key challenge.

There has been insufficient engagement with equality and diversity issues in recent drug policy - a recent report from the UK Drug Policy Commission concluded that drug services have 'little relevance' for many of Britain's diverse communities.

It is vital not to lose sight of the importance of a range of interventions that have proven to be effective in reducing some of the most serious harms from drug misuse (including death, chronic and acute disease and acquisitive crime). It is not acceptable simply to ‘park’ people on substitute drugs like methadone, but equally this is a NICE recommended treatment for opiate dependency, which can provide a ‘base camp’ for recovery and can be effective in reducing crime and the impact of illegal drug markets in our communities. The introduction of needle exchange provision in the 1980s helped to avert a feared HIV epidemic. DrugScope has welcomed other recent harm reduction initiatives, including a pilot scheme that has trained the families and carers of opiate users in drug overdose management and the administration of naxalone. Harm reduction work improves health, saves lives, and can provide ‘gateways’ to engaging problem drug users and commencing them on the path to recovery.

DrugScope believes that the welfare system can play an important role in supporting recovery. For example, we strongly supported work to integrate drug treatment and training and employment support through the creation of drug co-ordinators (now Integrated Partnership Managers) in JobCentres. We do have serious concerns about the possible use of benefit sanctions, however. We note that the Social Security Advisory Committee recently

concluded that ‘coercive measures directed against extremely marginalised and stigmatised people risk reinforcing negative attitudes to them, entrenching their disengagement from statutory services and mainstream society, causing hardship and damaging communities’.

DrugScope calls on Government:

- **To develop an integrated, cross-governmental ‘recovery programme’**
- **To support workforce development and consider a cross-sectoral workforce support and development strategy**
- **To address stigma and discrimination**
- **To raise the profile of equality and diversity issues within drug policy**
- **To ensure adequate housing provision for people in contact with drug services**
- **To develop the benefit system to work more effectively with problem drug users, but to reject the use of benefit sanctions**
- **To develop a clear strategy on harm reduction.**

6. **A balanced vision of problematic drug and alcohol use, focusing on the most harmful drugs but responsive to new problems.** While the previous Government’s drug strategy implicitly covered all drugs (and alcohol, as relevant), there was a strong focus on ‘problem drug use’ defined as use of opiates (particularly heroin) and/or crack cocaine. It is reasonable to target resources on the most serious problems, and this focus should not be lost. However, there needs to be a review of the concept of problem drug use and ‘the drug problem’ in light of changing patterns of use and misuse (including poly drug use) and the emergence of new drug markets and so called ‘legal highs’.

Young people’s drug and alcohol treatment services work effectively with under 18s who will very rarely be using heroin or crack cocaine. For 90 per cent of under 18s in treatment the ‘primary substance’ causing them problems is either alcohol or cannabis. These services are often working with substance misuse issues because they contribute to other problems, like disengagement from education, unemployment and offending, which are at the core of the ‘recovery’ agenda for adult treatment too.

There is strong support among DrugScope members for a more integrated approach to illegal drugs and alcohol, including a combined drug and alcohol strategy. However, it is important to ensure that where there are opportunities to develop and expand treatment provision for alcohol misuse and harms, this is not at the cost of reducing necessary investment in drug treatment.

DrugScope calls on Government:

- **To review the basic assumptions and frameworks of the drug treatment system to take account of changing patterns of substance misuse**
- **To establish a national ‘radar’ service to provide early warning of new drug trends**

- **To review the effectiveness of provision of drug treatment for young adults (18 to 25)**
- **To give consideration to the development of a joint drug and alcohol strategy.**

7. **A balance between adults, young adults and young people.** In 2009, DrugScope published 'Young People's Drug and Alcohol Treatment at the Crossroads'. It concluded that there had been significant advances in provision of drug and alcohol services for young people, but there were fears of disinvestment and a number of outstanding issues. A key challenge is the gap between young people and adult services, which can leave people stranded at 18, as they are unable to access help from the adult system that is appropriate to their drug use and needs. A number of our members argued for a separate young people's drug and alcohol strategy, because they felt that young people had tended to be marginalised by previous drug strategies and required a distinctive approach.

DrugScope members seek reassurance that a perceived 're-focusing' of the Department for Education will not result in a reduced emphasis within the department and across government on addressing young people's substance misuse (and related) issues. It was commented by DrugScope members that the 'dual key' approach based on the 'Memorandum of Understanding' between the National Treatment Agency and Department for Children, Schools and Families (DCSF) had helped to raise the profile of young people's treatment.

The most vulnerable young people should continue to be a priority in developing interventions to prevent problematic substance misuse. As the National Institute for Clinical Excellence (NICE) concluded in guidance published in March 2007, this requires an integrated approach that brings together local drug partnerships and children's services locally, and a cross-governmental approach nationally (as evinced, for example, in the Memorandum of Understanding agreed between the NTA and the DCSF in 2008). The 'Every Child Matters' strategy has provided a good framework for developing integrated approaches to young people. The document 'Every Child Matters – Change for Children: Young People and Drugs' (2005) highlighted the links between substance misuse and other problems - for example, truancy and school exclusion, sexual exploitation, contact with the criminal justice system and not being in employment, education or training.

DrugScope calls on Government:

- **To develop a national policy framework for young adult services, including substance misuse, mental health, housing and criminal justice**
- **To consider the development of 'high visibility, low threshold' services in local communities, that can engage young people not suitable for more specialist treatment**
- **To monitor the availability and quality of young people's treatment services during a period of funding restraint and policy change, and ensure a basic consistency in availability and quality**

- **To commit to developing key policy initiatives which build on the achievements of Every Child Matters, Think Family and the ‘Hidden Harm’ agenda.**

8. **A balance between crisis management and early intervention.** A strong message from DrugScope members is the wish to see a focus on specialist treatment balanced with a strong commitment to early intervention and support for families and communities.

‘Prevention’ requires a wider set of activities than drug education, information and public health campaigns – all of which do have an important role to play. It includes work done by young people’s treatment services, support for parents and families and investment in communities (and avoiding any disinvestment in the most vulnerable communities and the services that support them). Investment in ‘social capital’ – e.g., employment and training - has a key role as a preventative intervention, as well as in supporting recovery and preventing relapse.

In 2009, DrugScope and Adfam published 'Recovery and drug dependency: a new deal for families', arguing that support for families of drug users needed to be improved and increased. The UK Drug Policy Commission has since estimated that the minimum cost borne by families of problem drug users is £1.8 billion per annum in the UK and the minimum level of annual savings to statutory services from family support is £750 million. There is also a need to address child welfare and protection issues – for example, DrugScope members consistently raise concerns about a lack of training for social workers on drug and alcohol issues.

DrugScope calls on Government:

- **To adopt a strong presumption in favour of protecting the most vulnerable individuals, families and communities in making spending decisions (as pledged in the Treasury’s Spending Review Framework)**
- **To commit to an ambitious programme of community regeneration, with a particular focus on housing, service accessibility, education and employment**
- **To put the contribution of families and carers at the centre of its approach, with improved support for families and carers.**

9. **A balanced approach within the criminal justice system.** DrugScope welcomes the increased investment in drug treatment in prisons - the Integrated Drug Treatment System has been a positive step. There is still, however, a shortage of treatment availability for prisoners, particularly those with alcohol dependency and ‘dual diagnosis’. Criticism that prison drug treatment has been over-reliant on the prescription of methadone, partly reflects conditions within the prison system that make it difficult to engage prisoners in more structured interventions. Our members continue to report frustration about poor links between prison and community services in some localities, and there is still a shockingly high level of death from overdose

among recently released prisoners – we can and should be acting to address this problem as a matter of urgency.

DrugScope has a particular policy interest in woman prisoners, as they have high rates of substance misuse, only a small minority are in prison for violent offences, and many are in prison for drug offences often committed within the context of a history of abuse and violent and exploitative relationships with men (including sex work). We need a new approach, building on DrugScope's 'Using Women' report (2004)¹ and the Corston Report (2009).

We applaud the recent observation by the Secretary of State for Justice that 'it is virtually impossible to do anything productive with offenders on short sentences. And in the short time they are in prison many end up losing their jobs, their homes and their families'. We look forward to working with Government to explore the options for the further development of alternatives to imprisonment for offenders with drug and alcohol problems - including community sentencing and the potential role of new forms of secure accommodation for offenders with substance misuse and/or mental health issues.

We have a particular interest in offenders with both substance misuse and mental health problems and note that the Bradley Report (2009) concluded that 'no approach to diverting offenders with mental health problems from prison and/or the criminal justice system would be effective unless it addressed drug and alcohol misuse' and that 'services are currently organised in such a way as to positively disadvantage those needing access to services for both mental health and substance misuse/alcohol problems'.

DrugScope calls on Government:

- **To continue to invest in drug and alcohol treatment in prisons on a principle of equivalence between the quality and range of treatment provision in the community or criminal justice system**
- **To implement the findings of the Bradley Report on the diversion of people with mental health problems and learning difficulties, with a particular focus on 'dual diagnosis'**
- **To implement the findings of Baroness Corston's report on women in prisons and the criminal justice system**
- **To reduce the number of offenders sentenced to short sentences, and to develop effective alternatives**
- **To support and build on the work of voluntary and community sector organisations to improve the links between prison and the community and support transition**
- **To set a clear and ambitious target for reducing the rates of drug related deaths following release from prison.**

10. **A balance between law enforcement and law reform.** This is an area where there is a lack of clear consensus among DrugScope members. DrugScope has consistently supported a cautious and piecemeal approach to

¹ <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/UWreport.pdf>

drug law reform. We support criminal penalties for people who produce and supply harmful psychoactive substances. However, we are also supporting calls for a review of the Misuse of Drugs Act 1971, as promised by the previous Government in January 2006.

The key questions for this review would include what approaches to law and its enforcement would be best suited to limit availability and reduce drug-related harms, while minimising the negative impact of the system of enforcement itself. DrugScope is not convinced that it is necessary or cost effective to deal with the majority of low level drug offences – specifically possession of small amounts of illegal drugs for personal use – through the criminal justice system.

DrugScope calls on Government:

- **To review the Misuse of Drugs Act 1971**
- **To deal with the majority of low level drug offences (particularly possession for personal use) outside of the criminal justice system.**

2. Introduction

1.1 DrugScope welcomes the opportunity to contribute to the development of the new Drug Strategy, in response to the Government consultation that was launched on 20 August 2010.

Who we represent

1.2 DrugScope is responding on behalf of its 600 plus members, who are involved in a variety of ways in reducing drug and alcohol-related harms in communities across the United Kingdom. DrugScope has a particular role in providing a voice for the voluntary and community sectors in drug policy, although a significant proportion of our membership work in statutory services, and we have also engaged with them in developing this response. While DrugScope is active throughout the UK, this response has a particular focus on the policy and institutional structures for England, and our consultation events were all held in English cities – this reflects the tight time-constraints and the primary focus of the strategy itself given devolution of some of the key policy responsibilities. We would emphasise that most of our comments are equally pertinent to the other nations of the UK.

1.3 DrugScope looks forward to working with Government to deliver the aims set out in the Drug Strategy Consultation Paper. We welcome the strong focus on outcomes, on greater ambition for individual recovery, and the recognition of the important inter-relationship between substance misuse and other health and social problems and the need for a cross-governmental approach. Our members are passionate in their commitment to delivering better outcomes for the individuals they work with, and for often highly vulnerable and marginalised families, neighbourhoods and communities. They have considerable experience and expertise to contribute to the development of practical approaches to delivering on these objectives. At the same time, as Government will appreciate, there is a degree of uncertainty in the sector about the overall vision and approach (for example, the understanding of recovery), how some key policies could work in practice (for example, payment by results), as well as concerns about the potential impact of reduced public spending on services.

The Big Society

1.4 DrugScope welcomes the statement in the introduction to the Drug Strategy Consultation document that the purpose of the consultation is ‘to give the voice of the “Big Society” the power to influence the development of the new drug strategy’, and ‘to provide an early engagement opportunity for a wide range of partners, from charities to enforcement partners, drug workers and voluntary and community sector organisations’. We are concerned, however, that a comparatively short consultation period may have excluded some of these stakeholders from being able to fully engage with the consultation process.

The consultation process

1.5 DrugScope has written to the Home Office to express our concerns about a six week consultation period for such a critical policy initiative, particularly as it is running in parallel with a number of other consultations of importance for our sector (including the Spending Review and health and welfare reforms). We note that the introduction to the consultation document describes this as a ‘targeted consultation’ and ‘an early engagement opportunity’, but it is not clear what future opportunities

there will be for DrugScope members and others to help to shape the further development of the strategy.

1.6 The current Code of Practice on Consultations states that they should normally be for at least 12 weeks 'with consideration given to longer timescales where feasible and sensible'. The Code (para 2.2) specifically refers to consideration being given to the feasibility of a longer period for consultation when, for example, it takes place over the summer 'when consultees are less able to respond'. The commitment to conducting 12 week formal written consultations is included in 'The Compact on Relations between Government and the Third Sector in England' (December 2009), which states that an explanation will be given for shorter time frames (para 3.7). Para 4.7 of the Compact refers to consultations needing to take place in shorter time frames than 12 weeks 'in rare cases'.

1.7 Despite the shorter than normal time frames for consultation, DrugScope has been struck by the interest of our membership, and their desire to have a voice in policy development at a critical time. In preparing our response, DrugScope has hosted consultation events with our membership and other partners in London, Birmingham and Newcastle, working closely with our colleagues in the 'Drug Sector Partnership': Adfam, eATA and the Alliance. These meetings were attended by nearly 150 delegates in total, representing drug and alcohol service commissioners, providers and managers (adult and young people), drug education professionals, related sectors (for example, homelessness and criminal justice – including prisons) and policy specialists. Over 100 different agencies and organisations were represented at DrugScope's events. We also distributed a tailored questionnaire through DrugScope's networks, receiving 231 responses, which have informed this response. Finally, our approach has been shaped by smaller 'Chatham House' style events and one-to-one meetings with chief executives and senior managers of over 30 drug and alcohol services.

1.8 While the comparatively short consultation period has been challenging, there is a great deal of uncertainty about the future at the moment, and we therefore welcome the clear statement of aims, aspirations and 'direction of travel' that a drug strategy, due to be published in December, could provide, particularly at a time of wide-ranging policy changes (for example, NHS reform, the creation of the Public Health Service, welfare reform and the development of 'payment by results').

1.9 Uncertainties and anxieties have also been fuelled by different interpretations of Government comments on drug and alcohol policy. For example, senior members of government have said that they wish to see a greater abstinence focus, this has been articulated in the consultation document as a 'rebalancing of treatment', which we support in broad terms. At the same time – in the words of one service user at our consultation event in Newcastle - there are 'huge amounts of anxiety' about what this could mean for people who need other forms of intervention, which have been heightened, for example, by a reference in the National Treatment Agency's new business plan to 'strict time limits' for methadone prescribing. DrugScope also heard that some commissioners and service managers are adapting their behaviour and approach to fit what they *assume* to be the Government's policy intentions, particularly towards service users receiving methadone – which may not be in line with the Government's actual approach.

1.10 DrugScope therefore welcomes the commitment to publish a strategy by the end of the year, and urge Government to ensure it has sufficient clarity and detail to provide a clear vision and framework for moving forward. Because of the relevance of other policy developments, reviews and consultations (e.g., the NHS White Paper, the establishment of the Public Health Service, welfare reform and the criminal justice changes) we suggest that consideration should be given to publishing an *initial* drug strategy framework document, with a clear commitment to further consultation on key aspects of drug policy and practice as other Government reforms “fall into place”.

1.11 DrugScope’s response (particularly to the questions in section E on ‘Supporting recovery to break the cycle of drug addiction’) has been influenced by our participation in the Making Every Adult Matter (MEAM) coalition, which brings together Clinks, DrugScope, Homeless Link and Mind to develop effective and practical solutions to improving outcomes for people with multiple needs.

1.12 It is our intention that our response to the Drug Strategy Consultation should provide a strong, clear and representative voice for DrugScope members and other key stakeholders. This does not mean, of course, that there is necessarily a consensus on all the issues raised by the Consultation Paper.

1.13 The response includes statements and quotes from people who took part in our consultation events or who completed our consultation survey. This is only a small sample of their comments. We anticipate publishing a separate summary of the messages and findings from our consultation work, which we will send to relevant Government officials.

What does the Big Society mean to you?

DrugScope consultation responses

‘The Big Society for drug policy could mean moving to a situation at the genus of drug services when they were community orientated. For families, the stage of development that family support is currently at is often at a community orientated level. However, many seem to believe that community groups can “combust” on their own – and that’s simply untrue. Community development often plays a hidden role in supporting and enabling the people in the group to organise themselves to become self-sufficient and grow. In many circumstances, it takes a paid professional to help to develop the group’.

‘Doing more for less – using unpaid “volunteers” and relying on communities to support problem drug users into treatment and into throughcare and aftercare. More use of the voluntary and community sector would assist this – but funding is needed to build that capacity.’

‘It would mean community involvement and social enterprise – but it needs to be co-ordinated and jointly commissioned, with local authority and NHS treatment provision and have dedicated funding.’

‘Everyone taking responsibility for providing resources, help and support in the local community and to destigmatise substance use, preventing problems being hidden’.

'The Big Society is a compelling dream, but I fear we are unlikely to find sufficient shift in public attitudes for this Big Society to provide the non-judgemental and inclusive care that substance misusers require'.

'Should and must involve the contribution of big business, which should be offered incentives to do more locally'.

'Could give more room to innovation within the drugs field if it allows the development of new routes to recovery to be harnessed by drug users themselves.'

'It's not been made clear so far – I take it to mean local residents, communities and the voluntary sector addressing problems themselves, not relying on the state'.

3. DrugScope's response to Consultation Questions

A. Vision for the new drug strategy

Question A1: Are there other key aspects of reducing drug use that you would like to see addressed?

The scope of the strategy

A1.1 DrugScope welcomes the aims set out for the new drug strategy, although we raise some questions in this response about their implementation. In particular, while we welcome the aim of flexibility to respond to local problems and priorities by devolving budgets, we believe that central oversight and 'ring fencing' will be needed to ensure there is sufficient service provision of an acceptable quality and availability throughout the country. Drug and alcohol problems are highly stigmatised, and may not be a priority for many local authorities and communities in a tighter funding environment. All the evidence suggests that disinvestment in these services will have a potentially devastating impact not only on often highly vulnerable individuals and families who are directly affected, but on the wider community too (including offending, family breakdown, social exclusion and worklessness). Similarly, while we welcome the principle of a simplified and more outcome-based approach to budgets and funding, there are significant challenges in developing a fair and effective 'payment by results' approach for drug and alcohol services. It is particularly important that the Government maintains a direct responsibility for ensuring a minimum standard of service provision across the country, not least at a time of spending cuts and wider policy change (for example, with the abolition of the NTA, and the transfer of its main functions into a new Public Health Service, and the move to GP commissioning).

A1.2 A number of points were raised at our consultation events in London, Birmingham and Newcastle that concern the appropriate scope of the new drug strategy. First, there was support for the clear statement in the consultation document that 'the strategy will take a broader approach to preventing and reducing substance misuse of whatever type', and will cover alcohol where this is appropriate. Some participants favoured taking this a stage further, and producing an integrated drug and alcohol strategy. Second, and related, the strategic focus of previous strategies on opiate (predominantly heroin) and/or crack cocaine use was challenged by some participants, who favoured a broader conception of problem substance misuse (for example, one group wrote 'provide a holistic treatment system – end to end, for *all* drug use, providing access to a range of evidence-based interventions'). Finally, there was some support for the production of a separate drug and alcohol strategy for young people. All these points are discussed in more detail in response to the relevant consultation questions.

A1.3 The aims set out in the consultation document are broadly in line with the previous drug strategy. An evidence-based approach to future drug policy should be informed by a balanced and objective analysis of the limitations and strengths of work undertaken within the framework of previous strategies. For example, DrugScope agrees that joined up approaches to drug and alcohol problems are needed, and that progress towards this goal has been limited. Several participants at our consultation events talked about 'ensuing that previous mistakes aren't

replicated'. At the same time, many initiatives developed by the previous Government have the potential to contribute to 'a more holistic approach'. These include good practice guidance on 'dual diagnosis' (in the community and in prisons), the Adults Facing Chronic Exclusion pilots and the Total Place and Drug System Change pilots. We recognise that the new Government wants to take a fresh and arguably more ambitious approach to drug and alcohol problems, but would urge it to build on work that was initiated by the previous administration as and where appropriate.

An evidence-based approach

A1.4 It may be useful to clarify what is meant by an 'evidence based approach' as we understand there are concerns in Government that too narrow an interpretation of 'evidence' has tended to stifle innovation, including the creativity of the voluntary and community sector. This point was forcefully made by a participant in a DrugScope roundtable on young people's treatment, who commented: 'The worry is that treatment ceases to be about working creatively with people and its all about balance sheets and targets and tick boxes and proving your evidence base, and what you can do creatively in your own work gets narrower and narrower. So you say 'I want to take this group of kids up to the Welsh mountains rather than sit with them in a room for hours', and the answer is 'well you can't, there is no evidence base for it!'²

A1.5 DrugScope would distinguish between clinical (and other) interventions which involve significant expense and/or risk of harm and a wider range of social and pastoral interventions. Designated resources should be available for innovative work where the evidence base may be thin or weak, which should be evaluated using appropriate methods (for example, random control trials probably are not necessary for adventure holidays). As a minimum standard, there should not be investment in any approach if there is evidence that it may be positively harmful or is likely to be ineffective. While innovation and creativity are important, the need for an evidence based approach is particularly important for drug policy, where the issues can be highly emotive, potentially controversial and where policy has sometimes appeared to be driven by political considerations or concern about how it "may play in the media".

Question A2: Which areas would you like to see prioritised?

Priorities identified at DrugScope consultation events

A2.1 DrugScope invited participants at our consultation events to discuss their priorities for the drug strategy. A number of the points made echoed the aims identified in the consultation document, or were relevant to the debate about how the aims can be most effectively realised. A recurring theme was the importance of maintaining an 'evidence based' approach to reducing drug use and drug-related harm, without stifling innovation and creativity.

A2.2 Other priorities identified included:

- A clear and explicit commitment to ensuring that users of drug and alcohol treatment services receive 'the highest quality of care and support' in accordance with the same principles as apply to other NHS patients and

² 'Adapt and survive', Druglink Vol 25, Issue 2, March/April 2010

recipients of social care services, including informed choice between treatment options and modalities;

- A strategy for addressing the stigmatising and negative attitudes that can prevent often vulnerable individuals from being given a fair chance to get their lives on track once they have made the commitment to change;
- Involvement of service users in policy development and the design and delivery of drug and alcohol services – including involvement in commissioning and community partnerships, and peer support, mutual aid, mentoring and other peer-led services;
- A workforce development strategy to support the skilled workforce that is needed to deliver a more recovery-orientated and holistic approach (and better training in substance misuse for other key services and sectors, such as social work, children’s services and mental health);
- Recognition that drug and alcohol problems flourish where people feel marginalised and disenfranchised, and that an effective strategy will require investment in developing social capital, opportunities and aspirations in more deprived communities;
- A clearer recognition of the role of ‘families, carers and significant others’, with improved support and a commitment to involvement in treatment where appropriate;
- More weight placed on the role of prevention and early intervention in the strategy, at a time when debate is dominated by approaches to treatment and to recovery from addiction.

Question A3: What do you think has worked well in previous approaches to tackling drug misuse?

Reductions in illegal drug use

A3.1 The Home Office’s ‘Drug Misuse Declared: Findings from the 2009/2010 British Crime Survey’ (2010) concluded that last year overall use of illicit drugs by 16 to 59 year olds was at its lowest since measurement began, falling from 11.1 per cent in 1996 to 8.6 per cent in 2009-10. This was primarily due to successive declines in cannabis use. The trends in last year use of Class A drugs are less encouraging, but levels of use have remained similar to 1996. There have been significant falls in last year drug use among young people. For example, according to the British Crime Survey (BCS) figures, around one in three (31.6 per cent) of 16 to 19 year olds had used an illicit drug in the last year in 1996 compared with around one in five (22.3 per cent) in 2009-10. The BCS has some limitations. For example, it only captures information about people in ‘households’ and therefore does not include some of the most socially excluded populations (e.g., the homeless, people in temporary accommodation and people in prison) or some groups of young people (e.g., those living in college or university accommodation). While additional research is necessary to supplement the BCS, it nonetheless provides the best available evidence on overall drug trends, and provides some meaningful comparisons over time.

A3.2 There are no grounds for complacency (for example, use of powder cocaine has increased), but it is important to note that the evidence suggests that measures to control and contain illegal drug use since 1998 have had some positive impact. The impact of specific policies (and other factors) on levels of drug use is less clear.

Drug classification and drug use trends

A3.3 DrugScope would note that the previous Government's decision to downgrade cannabis from a Class B to a Class C drug in January 2004, as recommended by the Advisory Council on the Misuse of Drugs – subsequently reversed in 2008, against the advice of the ACMD - did not result in an increase in use. On the contrary, the proportion of 16 to 59 year olds who told the BCS that they had used cannabis in the last year fell from 10.8 per cent in 2003-04 to 7.9 per cent in 2008-09. For the 16 to 24 year old age group, last year use fell from 25.3 per cent in 2003-04 to 18.7 per cent in 2008-09. The Joseph Rowntree Foundation's report 'Policing cannabis as a Class C drug' (2007) estimated that in the first year following re-classification the change in the police's approach was 'likely to have saved just over three and a half million pounds or 269,327 officer hours across the 43 forces of England and Wales'.

Availability and quality of drug treatment

A3.4 The availability and quality of drug treatment services has taken a major leap forward since the early 2000s. According to the National Drug Treatment Monitoring System (NDTMS), 85,000 people were in contact with specialist services in 1998-99, compared to 210,815 in 2008-09, of whom the majority are categorised by the National Treatment Agency as in 'effective treatment' (engaged with drug services for 12 weeks or more). The use of this measure of 'effective treatment' has been challenged for its focus on keeping people in the treatment system rather than 'moving them on', for insufficient attention to the quality of support for recovery and re-integration received, and for potentially creating perverse incentives. These criticisms have validity and have helped to drive recent improvements in outcome monitoring, but retention does have legitimacy as a proxy for effective engagement. There has also been an expansion in treatment services for young people, with good progress on the integration of substance misuse issues into a more comprehensive children's strategy and mainstreaming within children's services locally. Our response considers these treatment developments in more detail in Section D below.

Criminal justice and prisons

A3.5 There is an exceptionally high prevalence of drug and alcohol problems among offenders. For example, sixty three per cent of sentenced male prisoners and 39 per cent of female sentenced prisoners admit to hazardous drinking prior to entering prison, with half of these having a severe alcohol dependency, and up to 55 per cent of people entering prison are problematic drug users.³ We have supported the improvement in availability of drug treatment in prisons, with the development of the Integrated Drug Treatment System. We have supported the development of community sentences such as drug rehabilitation requirements, as an alternative to custodial sentences. These issues are considered in more detail in Section C below.

Multiple needs

A3.6 DrugScope welcomed the increased recognition under the previous Government of the inter-relationships between substance misuse and other health and social problems. For example, the need for integrated approaches to service users with co-morbid substance misuse and mental health problems was identified as a priority within the National Service Framework for Mental Health (1999), the

³ Figures cited in Criminal Justice Alliance (2010), Criminal Justice – Areas for Action.

New Horizons strategy for mental health (2009) and Lord Bradley's report on People with Mental Health Problems or Learning Difficulties in the Criminal Justice System (2009). There has also been progress in supporting the social (re)integration of people affected by drug and alcohol problems – for example, with the creation of 'drug co-ordinators' in Jobcentre Plus from 2009 intended to provide a bridge between benefit, training and employment agencies and drug services.

Investment and cost effectiveness

A3.7 DrugScope would highlight two overarching developments that have been critical to the most positive developments of the last decade or so.

A3.8 First, has been the recognition of substance misuse as a greater policy priority, and the commitment to invest in tackling drug and alcohol problems. As well as helping to transform the lives of some of the most vulnerable and marginalised people, families and communities in our society, much of this investment has been highly cost effective. As the National Audit Office's report 'Tackling Problem Drug Use' (2010) highlights, the Home Office's Drug Treatment Outcomes Research Survey (DTORS) estimates a cost benefit ratio for drug treatment of 2.5:1 (i.e., each £1 invested in drug treatment saved £2.50 in crime, health and social costs).

A3.9 DrugScope notes that while the National Audit Office (2010) highlighted the effectiveness of the £581 million investment for drug treatment in 2008-09, it was unable to reach any overall conclusion on the value for money of the 2008 drug strategy, because it was not accompanied by an 'overall framework for evaluation'. Specifically, the NAO commented on the lack of evaluation of the effectiveness of the £13 million invested by the Department of Work and Pensions to support drug users into employment and the £30 million investment from the Department for Communities and Local Government on placing problem drug users in stable accommodation. DrugScope would urge the Government to develop an evaluation framework for the new drug strategy, with dedicated resource for assessing the effectiveness of investment in support for re-integration and recovery, so we can build a more robust evidence-base for what works in areas like employment, training and housing.

A3.10 Second, has been the development under successive Governments since the 1970s of a more evidence-based approach to drug policy (see above). This is particularly important in a policy area which requires significant public investment and has important implications for the well-being of the whole community, but where the debate can be highly emotive (often for understandable reasons) and myths and misperceptions are common – not least, in reporting by some sections of the media. One of the key messages from DrugScope members is the importance of evidence-based and non-partisan approaches, which are guided by or responsive to the advice of independent experts, including the Advisory Council on the Misuse of Drugs (ACMD) and the National Institute for Clinical Excellence (NICE). However, the application of the evidence base was not always consistent (as described in para A4.7).

Public opinion

A3.11 DrugScope agrees with the Home Affairs Science and Technology Committee that 'it is perfectly reasonable for the Government to seek to take into account public opinion in determining its policy'. However, the Committee went on to observe (in the

context of decisions on drug classification) that ‘in the absence of any research or empirical data on the subject ... we can only assume that the Government is using the media response as a proxy’, and urged a more ‘empirical approach’ to assessing public opinion.

A3.12 The Committee’s focus was on drug classification, but recent work by DrugScope on public opinion on drug treatment produced results that may be surprising in the light of common assumptions about public attitudes. Nineteen per cent of respondents to a 2009 DrugScope/ICM poll said they had direct or indirect experience of drug addiction; 77 per cent agreed that investment in drug treatment is a sensible use of government money; 80 per cent agreed that people can get addicted to drugs because of other problems in their lives; and 88 per cent agreed that ‘drug treatment should be available to anyone with an addiction to drugs who is prepared to address it’.⁴ A YouGov poll for the Fabian Society pamphlet ‘Hardest to reach: the politics of multiple needs and exclusions’ (2010) – which was developed in partnership with the Making Every Adult Matter coalition – concluded, in the words of YouGov Director Peter Kellner that ‘There is ... a strong view that government and local services currently have a disjointed approach for this group [people with the most serious and complex needs] and that a stronger focus would help improve situations for people with multiple needs and exclusions. Overall, it is clear that voters are far more likely to welcome than resist any plans to address multiple needs and exclusions more ambitiously’.⁵

A3.13 As well as responding to public opinion, DrugScope believes the Government has a role in shaping a mature and informed public debate on drug policy.

Question A4: What do you think has not worked so well in previous approaches to drug misuse?

A4.1 DrugScope believes that significant progress has been made in developing evidence-based drug treatment services, but more work is now needed to integrate health and social care services to support recovery, and to achieve a balanced treatment system with a greater focus on recovery, quality of outcomes and re-integration. In 2009, DrugScope published ‘Drug Treatment at the Crossroads – what it’s for, where it’s at and how to make it even better’, following consultation events with our members and others. A key conclusion was that ‘we should all be aiming higher’, with strong support for a greater emphasis on ‘recovery’ and ‘reintegration’. Many DrugScope members share the view that while central targets have helped to drive an expansion in the availability of drug services, they have had some perverse effects by focusing on the numbers of people in drug treatment and retention in the system at the expense of supporting people through treatment. While the initial focus was on reducing treatment waiting times, building treatment capacity and increasing the number of people accessing treatment, the more recent focus on treatment effectiveness, reintegration and recovery should have come much sooner. Government set targets (e.g., on the numbers accessing treatment), were a driver for specific improvement, change and accountability, but arguably also had some perverse consequences. (Our response considers these treatment issues in more detail in Section D below.)

⁴ <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/MarcusreportICM.pdf>

⁵ <http://www.meam.org.uk/wp-content/uploads/2010/04/Hardest-to-Reach.pdf>

Young people's services

A4.2 In 2009, DrugScope published 'Young people's drug and alcohol treatment at the Crossroads', following a similar process of consultation with our membership and other stakeholders, as for our adult treatment report, as well as young people in treatment services. It concluded that there had been significant advances in provision of drug and alcohol services for young people, but that there were a number of outstanding problems. A key challenge is the gap between young people's and adults services and the issues of transition it raises. Currently, the adult and young people's treatment systems work in different ways and focus on different forms of drug and alcohol misuse. So, what happens to people in young people's specialist services when they reach 18? Our response considers young people's treatment in more detail in Section D below.

Criminal justice

A4.3 DrugScope believes that more needs to be done to develop effective responses to drug and alcohol misuse within the criminal justice system (see section D below). We currently sit on the Government's National Advisory Group for the Health and Criminal Justice Programme, chaired by Sir Keith Pearson.

Multiple needs

A4.4 In 2009, the Making Every Adult Matter coalition launched a 'Four point manifesto for tackling multiple needs and exclusions', concluding that 'we can build on progress, but it is also clear that we have a long way to go', and set out a strategy for improving outcomes for this group. (This is discussed in Section E below.)

Support for families and carers

A4.5 DrugScope's 'Drug Treatment at the Crossroads' report concluded that 'families, friends, neighbourhoods and communities are a vital source of recovery capital but have often been at the margins of debate about drug policy and drug treatment'. In 2008, DrugScope hosted an 'expert' seminar in partnership with Adfam (the national umbrella organisation working to improve the quality of life for families affected by drug and alcohol problems), and in 2009 we jointly published 'Recovery and drug dependency: a new deal for families'.⁶ It argued that support for families of drug users needed to be improved and increased. It called for cost-benefit analysis of the economic value of family support. This recommendation was subsequently taken up by the UK Drug Policy Commission which has estimated that the minimum cost borne by families of problem drug users is £1.8 billion per annum in the UK and the minimum level of annual savings to statutory services from family support is £750 million.⁷ DrugScope endorses Adfam's submission to this consultation.

Evidence and the law

A4.6 The legal frameworks and policy structures for the regulation and control of drugs established over forty years ago by the Misuse of Drugs Act 1971 have been placed under increasing strain by changes in drug markets and patterns of consumption, in particular, and more recently, with the emergence of new psychoactive drugs (so-called 'legal highs') and an increase in poly-drug use.

A4.7 DrugScope would note that the former government did not always take an evidence-based approach. For example, key provisions within the Drugs Act 2005

⁶ http://www.adfam.org.uk/docs/recovery_dependency.pdf

⁷ UK Drug Policy Commission (2009), 'Supporting the supporters: Families of Drug Misusers'.

were arguably driven more by political considerations than policy ones, and there have been widespread concerns about the former government's response to ACMD recommendations on drug classification (and the dismissal of David Nutt as Chair of the ACMD). Some concerns were highlighted by the House of Commons Science and Technology Committee's Report 'Drug Classification: Making a Hash of it?' (2006) – for example, in its suggestion that the decision by the Home Secretary to ask the ACMD to review cannabis classification in 2006 - with a view to returning cannabis from Class C to Class B - was a response to 'intense media hype' and 'gave the impression that media outcry was sufficient to trigger a review'. In other areas potentially effective interventions to reduce drug-related harms appear to have been rejected on political grounds – for example, the Joseph Rowntree Foundation's proposal to pilot 'safe injecting' facilities.

A4.8 DrugScope was unable to support the decision to reject the ACMD's advice and return cannabis from Class C to Class B in 2008, and we supported the ACMD's recommendation that ecstasy should be made a Class B drug in 2009.

A4.9 DrugScope believes it is time for a review of the Misuse of Drugs Act, as initially promised by the previous Government in January 2006. In particular, and as we argued in our submission to the Spending Review, DrugScope is not convinced that it is necessary or cost effective to deal with the majority of low level drug offences through the criminal justice system, and we would welcome a full review of the law and/or approaches to policing in this area. The key questions for such a review would include what approaches to law and its enforcement would be best able to limit availability and to reduce drug-related harms, while minimising negative impacts, on individuals, families and communities. We note that the 2010 Liberal Democrat manifesto spoke of ensuring that financial resources, and police and court time, are not 'wasted on the unnecessary prosecution and imprisonment of drug users and addicts' and that 'the focus instead should be on getting addicts the treatment they need' while 'police should concentrate their energies on organised drug pushers and gangs'.

Diversity and equality

A4.10 DrugScope would also highlight the limited engagement with equality and diversity issues within recent drug policy. In 2010 the UK Drug Policy Commission published 'The impact of drugs on different minority groups', which concluded that drug services were of 'little relevance' to many of Britain's diverse communities, including LGBT groups, disabled people and BME communities.⁸ DrugScope hosted a joint seminar with the Equality and Human Rights Commission in 2009 to identify and address areas where drug and alcohol policy raises equality and diversity issues, but it has proven quite challenging to take this work forward, particularly given the exclusion of drug and alcohol dependency from the Disability Discrimination Act and the Equalities Act. It is also striking that there is a lack of supported representation for key equalities groups on drug and alcohol policy, equivalent, for example, to the National BME Mental Health Network or the Race for Justice campaign on criminal justice. Government could have a role in supporting more effective representation.

⁸ http://www.ukdpc.org.uk/resources/UKDPC_treatment_ethnicity_report.pdf

Tackling alcohol misuse and harm

A4.11 DrugScope is concerned that progress on addressing alcohol misuse and harms has been limited. Over one million people in the UK are described as alcohol dependent; it is estimated that alcohol misuse costs the NHS £2.7 billion per year and the UK economy £25.1 billion.⁹ Cost benefit analysis shows that every £1 invested in alcohol treatment saves £5 later on.¹⁰ Despite this, it has been estimated that only 1 in 18 people with alcohol dependencies enter specialist treatment each year¹¹; half of PCTs (52 per cent) have not assessed the numbers of hazardous, harmful or dependent drinkers in their localities and there are wide regional variations in the availability of alcohol treatment services.¹² DrugScope urges the Government to balance its initiatives on pricing, taxation and licensing laws with a review of alcohol treatment availability. One of the most constant and insistent messages from our members is that the distinction between illegal drug and alcohol dependency is unhelpful in delivering services on the ground – and increasingly so given the growing importance of poly-drug use.

Postcard to the Prime Minister:

Principles and vision

As part of our consultation we asked respondents to write a short 'Postcard to the Prime Minister' on the future of drug policy. A small sample of the responses are quoted in this submission.

'Keep the drug strategy evidence based. Please don't fall in to an old rhetoric of a dichotomy between harm reduction and abstinence - both must work together. True recovery is hindered by the stigmatisation of drug users'.

'The drugs field has made huge commendable progress over recent years. There is much to be retained and developed further. The organisations involved (voluntary and statutory) recognise the value of working together to improve outcomes for individuals and communities. This should be encouraged and built on, not discarded or unravelled'.

'Please remember that the active, often voluntary drug using community has developed years of experience in how to engage effectively with drug services, strategies, policy implementation, etc. Don't forget there are thousands of highly experienced and committed users who aim to be part of the solution to the drugs issue – not framed as the problem.'

'If we are to deliver holistic approaches to drug treatment we need coordination from central government and no mixed messages.'

'Please take into account the complexities – personal history, socio-economic circumstances, housing, health, education, criminality, illicit drug use, problematic alcohol use, welfare benefits, relationships in the family – are all factors in recovery. Recovery is not the same as abstinence.'

⁹ National Audit Office (2008), Reducing Alcohol harm: Health services in England for Alcohol Misuse, p. 4.

¹⁰ UKATT Research Team (2005), cost effectiveness of treatment for alcohol problems: findings on the randomised UK Alcohol Treatment Trial (UKATT), BMJ 2005; 331: 544-7.

¹¹ All Party Parliamentary Group on Alcohol Misuse (2009), The future of alcohol treatment services.

¹² National Audit Office (2008), Reducing alcohol harm: Health services in England for alcohol misuse, p. 20.

B. Prevent drug use

Question B1: What are the most effective ways of preventing drug or alcohol misuse?

A sense of perspective

B1.1 The media can give the impression that illegal drug use is an everyday part of young people's lives. It is important to emphasise that most young people do not use illegal drugs and only a small minority of young people will take the most harmful drugs or go on to develop serious drug problems. Fewer young people appear to be using drugs now than in the mid-1990s. It is important to recognise that most people who do experiment with drugs will not do so frequently or for a long period and will tend to 'mature out' of drug use. The picture on alcohol is less clear and less positive. There is evidence that fewer young people have used alcohol, but they may be drinking more. The percentage of pupils between 11 and 15 who say that they have *never* drunk alcohol has risen in recent years from 39 per cent in 2003 to 49 per cent in 2009. The proportion of pupils who drank alcohol in the last week has fallen from a peak of 26 per cent in 2001 to 18 per cent in 2009. However, those young people who are drinking appear to be consuming more alcohol. A recent survey estimated that 360,000 children aged 11 to 15 had been drunk in the last week, and that the average number of units consumed by 11 to 15 year olds doubled between 1990 and 2000.¹³

B1.2 The importance of prevention and early intervention was highlighted at DrugScope's consultation events. In Birmingham there was support for 'giving equal weight to prevention and education as to treatment and recovery'. In Newcastle, one group emphasised the need to 'realise the importance of prevention, early intervention and harm reduction', and 'exploring brief interventions for early drug misuse to prevent decline into more problematic use'.

The scope of 'prevention'

B1.3 DrugScope would emphasise that 'prevention' refers to a much wider set of activities than simply drug education, information and public health campaigns. A range of interventions can help to prevent drug and alcohol problems occurring in the first place and escalating where they do. These include investment in communities; work with those young people who are most at risk; support for parents and families (including early years support); and much of the activity that is currently going on in young people's specialist treatment (and other) services with young people at the early stages of substance misuse to prevent them from going on to develop more serious problems (and to minimise the impact on other areas of their life – for example, 'preventing' educational underachievement or school exclusion).

Drug education

B1.4 The evidence-base on the effectiveness of different educational approaches to preventing drug or alcohol misuse is incomplete, and not particularly encouraging. The ACMD's Pathways to Problems report (2006) noted that 'most schools in the UK provide drug education programmes', but continued that 'research indicates that

¹³ These key facts are included on the Every Child Matters website at <http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/commonhealthissues/substancemisuse/alcohol/alcohol/>

these probably have little impact on future drug use'. It argued for a reassessment of the role of schools in drug misuse prevention, with an emphasis on 'providing all pupils with accurate, credible and consistent information about the hazards of tobacco, alcohol and other drugs, including volatile substances'. (The ACMD concluded, incidentally, that drug testing and sniffer dogs should have no place in schools.) The National Institute for Clinical Excellence (NICE) has also commented on the 'lack of rigorously tested studies' and the difficulty of determining the effectiveness of particular approaches' to drug prevention.¹⁴ It is important, however, to take a wider view of both the role of education and the scope of prevention activity (see B1.3 above). Prevention is also about targeting risk factors for drug and alcohol problems, such as deprivation and marginalisation, and the aims of prevention may be wide ranging, covering areas including mental health, educational attainment, offending and employment.

B1.5 DrugScope is a member of the Drug Education Forum (DEF) and supports its 'Statement of Belief' on drug education (<http://www.drugeducationforum.com/beliefs/>) and its submission to the drug strategy consultation. Drug education should be an entitlement for all children, with the emphasis on using appropriate methods that are subject to evaluation, providing information, exploring attitudes and beliefs and promoting communication, decision-making and life skills. In 2008, we welcomed the report of the Advisory Group convened by the Department for Children, Schools and Families to examine the effectiveness of information and education on drugs and alcohol. Its key recommendations were: to improve support for parents and carers; make Personal, Social and Health Education (PSHE) a statutory subject and enhance training for teachers; and improve the identification and support for vulnerable young people in schools, colleges and other settings.

B1.6 DrugScope would also emphasise the importance of wider social and emotional development if children are to be supported to make good decisions about risky behaviours, including drug use. We would therefore urge the Department for Education to continue to support initiatives such as the Social and Emotional Aspects of Learning (SEAL) programme.

B1.7 DrugScope facilitates the Drug Education Practitioners' Forum (DEPF) for professionals involved in delivering drug education. In April 2009, the DEPF welcomed the findings and recommendations of Sir Alasdair MacDonald's Independent Review of Personal, Social, Health and Economic (PSHE) education. It recommended that PSHE education - including lessons on drugs and alcohol - should be a statutory part of the National Curriculum for primary and secondary school pupils. DrugScope would urge the Government to place PSHE on a statutory footing. We are concerned that, in the absence of statutory provision, this could result in inadequate or inappropriate drug and alcohol education in some schools. We also note that the Government has expressed a desire to reduce the volume of guidance documents in schools. We would note that training for teachers (and other educationalists) on drugs and alcohol issues has been limited; schools welcome

¹⁴The 'Blueprint' programme piloted an 'evidence-based' and 'multi-component' approach to drug education in 23 schools in England in the Spring Term of the 2004-05 year. The evaluation of Blueprint (September 2009) concluded that the pilot design 'was not sufficiently robust to allow an evaluation of impact and outcomes', and consequently could not draw 'any conclusions on the efficacy of Blueprint in comparison to existing drug education programmes'.

guidance on effective practice, and provision of appropriate resources that they can use in the classroom. We welcomed the Department for Education and Skills 'Drugs: Guidance in Schools' (2004), which drew upon a number of DrugScope policy documents.¹⁵ (We also seek assurances that 'free schools' will be required to take an evidence-based approach to drug and alcohol education.)

The role of the Department for Education

B1.8 We welcome the launch of the Prime Minister's Childhood and Families Task Force and the commitment to helping families with multiple problems. Although the Government has given an assurance that the renaming of the Department for Education does not represent a shift in priority away from families and children, a number of DrugScope members have expressed concerns about a possible change in the Department's priorities resulting in less focus on policy and practice issues affecting the health, wellbeing and wider educational opportunities of children and young people. Some members said they had found it difficult to engage the former Department for Education in the past, but that this had improved significantly when the Department for Children, Schools and Families was given a 'dual key' role (in partnership with the National Treatment Agency) for young people's drug and alcohol issues, within the context of the Every Child Matters and Think Family initiatives. Past problems in how departments worked together on children and young people's issues - for example, in agreeing the contributions of departments towards the pooled young people's substance misuse grant - need to be avoided.

Public information campaigns

B1.9 There is limited evidence for the effectiveness of general public information campaigns in reducing drug use, but there is evidence that more targeted campaigns can be effective. There are risks of perverse effects too, particularly where campaigns employ 'shock tactics', which may conflict with the everyday experiences of their target audience. For example, an early review of the FRANK campaign found that the number of young people who agreed with the proposition 'The people who work there [i.e. at Frank] really know what they are talking about' fell from 51 per cent in 2004 to 40 per cent in 2006. One possible explanation was that 'more explicitly negative messages' in public information work by Frank did not correspond to the experiences of young people. This would mirror the findings of research conducted on the impact of anti-cannabis campaigns in the United States. At the same time, parental support for Frank may have increased in response to these same campaigning activities, although parents were not the target audience. The research suggests that such campaigns can impact on attitudes and behaviour where the target audience already accepts the riskiness of the behaviour, and the negative consequences are more immediate (for example, drink driving, wearing seat belts, HIV/AIDS infection and sharing needles).

¹⁵ The Drugscope documents include: 'The right choice - Guidance on selecting drug education materials for schools' (1998), 'The right response - Managing and making policy for drug-related incidents in schools' (1999) and 'First steps in identifying young people's substance related needs' (2003).

Young people and prevention

Consultation responses

'Young people's services need to be treated in their own special and appropriate way and not as an added extra onto adult services'.

'If you don't start looking at strategies for young people at risk of problematic drug use then you are just creating a massive problem for adult services later on.'

Question B2: Who (which agencies, organisations and individuals) are best able to prevent drug or alcohol misuse?

B2.1 It is, again, important to have the broadest conception of prevention. Those with a potential role in preventing drug or alcohol misuse include a wide range of agencies, organisations and individuals, including parents, teachers, family support workers, midwives, mental health services, social care, social workers, employers and criminal justice workers. Not everyone has to be an 'expert', but a broad range of agencies, professions and groups have a contribution to make.

Drug educators

B2.2 On education, the DEF emphasises the importance of drug educators having sound subject knowledge and confidence in using suitable methodologies. In 2008, the DEF carried out a survey of 350 professionals - including teachers, members of drug action teams and independent providers. Over two thirds of respondents (67 per cent) said that a lack of specialist staff was the biggest barrier to improving drug education.¹⁶ DrugScope would like to see a greater emphasis on drug and alcohol issues in teacher training and continuing professional development, and for others working with young people in educational settings.

Other agencies

B2.3 A range of agencies and organisations working with young people outside formal educational settings have a role in providing guidance, information and supporting attitudes and life skills that can prevent drug or alcohol misuse - including youth services, youth justice workers, people involved in the 'looked after system', social workers and leisure and recreational services (for example, local sports clubs). DrugScope members argue that voluntary and community sector organisations can often engage young people more effectively than statutory services, particularly the most vulnerable young people, who may have had negative experiences in education or through contact with the youth justice system, for example. (DrugScope and Alcohol Concern produced 'Drugs: Guidance for the Youth Service' in 2006, which advised that all youth services should have a written policy on drug related-incidents and that young people should be involved in its development.)

¹⁶ Available at

<http://www.drugscope.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=68494D16-9D3A-441C-AF41-7E1E539F1250&mode=link&guid=af8ce4aec8ae4fbda053a62245a3cb3f>

Question B3: Which groups (in terms of age, location or vulnerability) should prevention programmes particularly focus on?

Targeting the most vulnerable

B3.1 The ACMD's Pathways to Problems report (2006) stated that 'from the late teens onwards, heavy smoking and problem drinking or drug use are strongly linked to socio-economic disadvantage, often with disastrous results. Multiple drug use and drug injecting are common in disadvantaged communities, in many of which problem drug use has become an inescapable feature of life'. A 2009 report for the Department of Children, Schools and Families on the *Impact of Alcohol Consumption on Young People* concluded that risk factors associated with alcohol misuse in children and young people include physical and sexual abuse, early behavioural problems, anti-social behaviour and interpersonal problems and family history of alcohol problems.

B3.2 Vulnerable young people should be a priority in developing interventions to prevent problematic substance misuse. As the National Institute for Clinical Excellence (NICE) concluded in guidance published in March 2007, this requires an integrated approach that brings together local drug partnerships and children's services locally, and a cross-governmental approach nationally (as evinced, for example, in the Memorandum of Understanding on Young People's Specialist Substance Misuse Treatment agreed between the NTA and the DCSF in 2008). The *Every Child Matters* strategy has provided a good framework for developing integrated approaches to young people. The document *Every Child Matters – Change for Children: Young People and Drugs* (2005) highlighted the links between substance misuse and other problems - for example, truancy and school exclusion, sexual exploitation, contact with the criminal justice system and not being in employment, education or training. We urge the new Government to build on the work done through *Every Child Matters*.

Workforce development

B3.3 All professionals working with children and young people should be trained to address substance use and misuse confidently, focusing on identifying potential problems, reducing harm and promoting well-being. Improving the training and competency of professionals and carers working with the most vulnerable young people – for example residential social workers, staff in the young people's secure estate and YOT workers – should continue to be a priority.

Family and child protection

B3.4 DrugScope would also highlight the issue of drug and alcohol misuse in the family, and its impact on child wellbeing and child protection. The ACMD report *Hidden Harm* (2003) estimated that there were between 250,000 and 350,000 children of problem drug users in the UK. While people with drug and alcohol problems can be good and effective parents, the ACMD concluded that parental problem drug use can and does cause serious harm to children at every age from childhood to adulthood, including increased risk of developing drug and alcohol problems later in life. There has been progress in implementing *Hidden Harm*, but there is still much to do, and DrugScope members report that practice is variable and inconsistent. In November 2009, the Department for Children, Schools and Families, Department of Health and the NTA jointly published 'Think Family' to provide guidance on 'the development of local protocols between drug and alcohol treatment

services and local safeguarding and family services to secure better outcomes for the children of parents with substance misuse problems'. DrugScope members working with children and families have expressed concerns about whether the Think Family initiative is to continue.

B3.5 The recommendation that social workers working with families should be required to have substance misuse training as part of their professional development was one of the few recommendations in the 'Hidden Harm' report which was rejected. A lack of training for social workers on drug and alcohol issues is a continuing concern for many of our members, not least because of the high proportion of child protection cases where drug and/or alcohol misuse is a factor.

Question B4: Which drugs (including alcohol) should prevention programmes focus on?

- Those that cause the most harm
- Those that are most widely used
- All drugs

B4.1 The drugs that cause the most harm – particularly heroin and crack cocaine – are remote from the experiences of most young people, and there is wide recognition among young people of the risks and harms associated with them.¹⁷

B4.2 Prevention programmes should provide information on all drugs. In September 2009, Druglink, DrugScope's bi-monthly magazine, published its annual street drug trends survey, concluding that 'younger, recreational users are now swapping or combining cocaine, ketamine, GHB, ecstasy, cannabis and alcohol on a night out'. Drug prevention programmes should have a greater focus on the risks of poly-drug use, and of more rapidly evolving drug markets.

Question B5: How can parents best be supported to prevent young people from misusing drugs or alcohol?

B5.1 A number of reports have stressed the important role that parents play in influencing young people's attitudes to and relationship with drugs and alcohol. For example, the ACMD's 'Pathways to Problems' report concluded that the type and quality of parental supervision appeared to have a stronger influence on young people's drug use than 'living arrangements or economic factors'.

Providing information

B5.2 Parents need clear and accurate information about the properties and risks of drugs if they are to engage with their children in a confident, credible, informed and

¹⁷ The 2008-09 British Crime Survey found that one in five young people aged 16-24 had used cannabis in the last year, accounting for 84 per cent of past drug use for this age group. By comparison, less than 0.1 per cent said that they had used opiates in the last year, and around 0.2 per cent said that they had used crack. Cannabis and alcohol problems are also predominant among the comparatively small numbers of young people involved with specialist drug and alcohol treatment services. An NTA report on young people's substance misuse treatment for 2008-09 concluded that for 90 per cent of under 18s in treatment the 'primary substance' causing them problems is either alcohol (36 per cent) or cannabis (53 per cent). In 2008-09, 657 under 18 year olds were treated for heroin or crack use, representing three per cent of the total number of young people receiving help. Evidence suggests that young people have a high degree of awareness of the risks associated with heroin and crack cocaine.

proportionate way. One way of building the skills and knowledge of parents is to involve them in drug education in schools, and in the development of whole school approaches to substance misuse issues. However, we recognise that it can be difficult to engage parents who may not recognise the relevance of drug and alcohol specific education for their children, and that schools may be reluctant to promote their work on drug education and policy, not least if there are concerns that this may be perceived as implying that there is a 'drug problem' at the school.

Skills development

B5.3 International research suggests that programmes that develop parenting skills will have a greater impact to those than only provide information about drugs. According to the UNODC these include the skills required to build and maintain positive family relationships, family supervision and monitoring and communication of family values and expectations.¹⁸ The ACMD's 'Pathways to Problems' states that there is an increased risk of drug and alcohol problems where parental supervision is lax, parents misuse drugs and/or alcohol, there is 'family conflict or inconsistent parenting' and/or 'low parental supervision'. There is also evidence that drug and alcohol problems are more prevalent among young people who are living with a single parent or step parent (although the overwhelming majority of young people living in these families do not have substance misuse problems).

B5.4 A range of policies to support families and parents can contribute to preventing young people from misusing drugs or alcohol. The ACMD's 'Pathways to Problems' concluded that 'a social and economic climate that supports stable families and enables parents to be engaged with their children and aware of their whereabouts would ... seem likely to favour less hazardous drug use by children and young people who are still living at home'. The ACMD noted the impact of high levels of divorce and the demands of work on family life. It called for public discussion of these societal trends, informed by the evidence that stable family life can reduce the risks of hazardous tobacco, alcohol and other drug use by young people. (A number of projects to support families and parents are discussed below in B7.)

B5.5 DrugScope strongly supports the continuation of a cross-government strategy for supporting families, with a particular focus on the most vulnerable, building on the 'Think Family' programme.

Question B6: How can communities play a more effective role in preventing drug or alcohol misuse?

B6.1 A clear message from DrugScope's consultation for our report 'Young People's Drug and Alcohol Treatment at the Crossroads' was the need for a broader conception of 'prevention' that recognises the need for investment in communities, developing community resources and building social capital. The young people we spoke to said that youth clubs and accessible leisure facilities, access to safe and secure housing and – particularly – education, training and employment would have the biggest impact in preventing problem drug and alcohol use through early intervention.

¹⁸ UNODC (2009), Guide to implementing family skills training programmes for drug abuse prevention.

B6.2 Disinvestment in disadvantaged communities at a time of tight public spending restraints will undermine their ability to prevent drug or alcohol misuse and related problems. We note that the Spending Review document states that the Government will 'not only live within its means but also ... ensure that expenditure is focused on protecting the quality of services that are important to the public and provide support for the worst off in society'. Elsewhere it pledges to 'limit as far as possible the impact of reductions in spending on the most vulnerable in society, and on those regions heavily dependent on the public sector'.

Proposal for community impact assessments

B6.3 DrugScope would like the Government to commit to conducting impact assessments of relevant policy initiatives to determine the probable impact on vulnerable groups and communities, including the potential impact on substance misuse. In addition, we believe that a responsible and effective devolution of budgets and responsibility to local decision-makers must provide them with information, training, tools and systems that enable them to assess the probable impact of spending decisions across the local policy spectrum (for example, of the impact of a disinvestment in youth services on levels of substance misuse).

The Big Society

B6.4 DrugScope recognises the contribution that small, local groups can make to addressing drug and alcohol issues in their communities, including faith-based projects, mutual aid groups, local service user organisations and family support networks. We welcome the Government's commitment to supporting these community-based initiatives (often supported by volunteers) through its 'Big Society' agenda. The challenge will be to develop a framework for funding and developing drug and alcohol services that ensures quality of delivery and is evidence and outcome-based, while providing a fertile and supportive environment for the emergence of smaller projects with strong links to the local community. (This will, for example, be a challenge for the design of a payment by results approach.)

Question B7: Are there any particular examples of prevention activity that you would like to see used more widely?

Specialist services

B7.1 DrugScope would highlight the innovative work on prevention and early intervention being done by our members in specialist services, often working with some of the most vulnerable and marginalised young people, discussed in our report 'Young People's Drug and Alcohol Services at the Crossroads' (2010). We met, for example, with staff and young people in Newham's Young People's Substance Misuse Prevention service, Spark, which offers drug education, information and training for young people aged between 5 and 25, as well as access to professionals from the areas of social work, youth work, statutory and children's services and the criminal justice sector. Similar work was being done by Compass in Brixton, which we were able to discuss with staff and service users. We would also draw attention to Addaction's 2009 report on its three year 'Breaking The Cycle' pilot project, which worked with families to reduce their substance use, improve their parenting skills, help establish boundaries and structures within the home, put children's needs first and encourage the adults to improve their economic situation by claiming appropriate benefits, enrolling on training courses and finding paid or unpaid work outside the home.

Working with families

B7.2 Innovative approaches have included Family Intervention Projects – launched in 2006 in a drive to tackle anti-social behaviour – where families receive intensive support from a key worker. There may also be a role for ‘multi-systemic therapy’, which was piloted in ten areas by the Social Exclusion Task Force. Supported by a significant body of international evidence, multi-systemic therapy has targeted children and young people in contact with or at risk of falling into the criminal justice system. Again, it focuses on mobilising existing resources and social capital, working in close partnership with family and community to strengthen protective factors known to reduce the risk of future offending and anti-social behaviour.

B7.3 DrugScope has taken a particular interest in the Family Drug and Alcohol Court, launched in 2007 by Camden, Islington and Westminster Councils, with a focus on care proceedings involving parental substance misuse. Families involved with the court can access intensive help and support for parental drug and/or alcohol use, as well as links to other services. We understand that this pilot was due to run until January 2011, with an analysis by Brunel University, with funding from the Home Office and Nuffield Foundation. We would urge the Government to carefully consider the findings.

Sport and leisure

B7.4 We would also highlight projects that use sport and leisure activity to incentivise and support change and development. These include ‘Positive Futures’, which worked with young people in contact with the criminal justice system or at risk of offending¹⁹, and the Prince’s Trusts ‘Team’ programme, which works with unemployed 16 to 25 year olds.

Question B8: What barriers are there to improving drug and alcohol prevention?

B8.1 The principal ‘barriers’ to improving drug and alcohol prevention have been identified above. Prevention and early intervention must be given sufficient profile and priority within the new strategy. While it is important to develop an evidence-based approach, there are gaps in our knowledge of what works on substance misuse prevention. Wider social and cultural factors - over which Government may have limited control - can impact on the ability of parents to prevent young people misusing drugs and alcohol. Cuts in public spending need to be carefully managed to ensure they do not impact on vulnerable communities in ways that undermine their ability to prevent drug and alcohol misuse (for example, if they lead to the closure of local leisure facilities – boredom and “having nothing to do” are often described by young people as a factor influencing their drug use - or to higher youth unemployment).

¹⁹ Description and assessment of individual ‘positive futures’ projects was provided in a 2002 report published by the Home Office, Positive Futures, Sport England, Football Foundation and the Youth Justice Board, called ‘Positive futures – A review of impact and good practice – Individual project reports’.

Postcards to the Prime Minister:

Prevention and early intervention

As part of our consultation we asked respondents to write a short 'Postcard to the Prime Minister' on the future of drug policy.

'Drug and alcohol are major challenges for health, welfare, crime, families and society. We need to meet those challenges head on and ensure we invest in young people to create the positive changes needed to reduce the impact of drugs and alcohol. We have only begun to have an impact through the current strategy, this needs to be broadened out and investment increased if we are to continue to ensure young people receive the access and support of quality services.'

'Prevention and early intervention are key to making lasting changes in substance use but as soon as budgets are cut they are always the first to suffer. Prevention is better than cure - invest in our young people and save money and lives in the long term.'

'Please bring out a separate young person's drug strategy with targets that are appropriate to young people's needs. It is very difficult to work with young people with a strategy that has been written with adults in mind. Young people have very different needs from adults and this should be recognised.'

'Importance of supporting young people in an integrated holistic way – to prevent vulnerable young people becoming problematic drug users in the future.'

'Make sure there is support for drugs education in schools, especially secondary schools. Educate young people to make the right decisions.'

C. Strengthening enforcement, criminal justice and legal framework

Question C1: When does drug use become problematic?

Heroin and crack cocaine

C1.1 While the previous Government's drug strategies covered all drugs (and alcohol, as relevant), there was in practice a very strong focus on 'problem drug use' defined as use of opiates (especially heroin) and/or crack cocaine. This was particularly so in the development of adult drug treatment services. This was justified on the grounds that these are the most harmful drugs. A 2002 Home Office study of Class A drug use in England and Wales concluded that the economic and social costs of problem drug use were between £10.1 billion and £17.4 billion, accounting for 99 per cent of the total economic and social costs of drug use, of which 88 per cent were estimated costs of drug-related crime. The National Audit Office's 'Tackling Problem Drug Use' (2010) states that central and local government spend around £1.2 billion a year tackling drug use in England alone, and estimates the cost to society of problem drug use at around £15.3 billion a year (based on a 2003-04 estimate). It adds that 90 per cent of this cost is attributable to drug-related offences (mainly acquisitive crimes such as theft and burglary, committed by 'problem drug users').

C1.2 While the use of the most harmful drugs and patterns of drug misuse must be a key focus for a new drug strategy, there is a strong case for reviewing our conception of problem drug use and 'the drug problem'. Drug and alcohol services are increasingly dealing with other forms and patterns of substance misuse, and there is concern about 'poly-drug use'.

A broader conception

C1.3 DrugScope would suggest that all drug use is 'problematic' – to a greater or lesser degree - where it causes harm to the individual, family or wider community, including crime and anti-social behaviour, drug-related deaths, health and mental health problems, family breakdown and risk to children, and where it contributes to social exclusion and marginalisation. It is, however, reasonable to target resources on preventing the most serious harms.

C1.4 DrugScope members are aware that they will need to demonstrate the potential contribution of drug and alcohol services to a wide range of local policy priorities and objectives in a new and difficult funding environment. This will require a more flexible and more nuanced understanding of the circumstances in which drug and alcohol use can become 'problematic' within different policy domains – for example, drug and alcohol issues contribute to the pressures on Accident and Emergency Departments with knock on effects for the health services available to the whole community, to both unemployment and performance in the work place and to anti-social behaviour in town and city centres.

Question C2: Do you think the criminal justice system should do anything differently when dealing with drug-misusing offenders?

C2.1 Drug and alcohol use is extremely common among offenders and access to evidence-based drug and alcohol treatment is a cost-effective way of cutting crime. While there is some excellent work going on in many prisons, the criminal justice system can do more to rehabilitate offenders with drug and alcohol problems.

Investment in drug treatment in prisons needs to be maintained and built upon. The Integrated Drug Treatment System has been a positive step, but there remains a shortage of appropriate drug treatment in prisons. There is a particularly acute shortage of provision for prisoners with alcohol dependency, with only two prisons in England and Wales providing intensive accredited alcohol treatment programmes. We would also highlight the importance of interventions for young offenders (including in the secure estate), where patterns of substance misuse will often take a different form to adult offenders, with a strong link between drug and alcohol problems and mental health issues.

The impact of short sentences

C2.2 There has been recent criticism of what is perceived as an over-reliance on the prescription of so-called substitute drugs (particularly methadone) in the prison system. DrugScope shares the concerns about ‘parking’ people on methadone with inadequate support for recovery and reintegration, but stresses that methadone is recommended by the National Institute for Clinical Excellence as a treatment for opiate dependency, and that there is a substantial evidence-base that it delivers benefits to individuals, families and communities. Concerns about methadone prescribing are underlined, for example, when there is poor care planning and a lack of access to other forms of treatment intervention and support, including psycho-social interventions. There are particular issues for prisoners. Firstly, many prisoners are serving sentences that are too short to enable them to participate in structured drug treatment programmes, a problem which is exacerbated where they are moved from prison to prison. Second, imprisonment compounds problems associated with drug dependency, such as family and relationship breakdown, homelessness and unemployment.

C2.3 We welcomed the observation by the Secretary of State for Justice in a speech at Kings College on 30 June 2010 that ‘it is virtually impossible to do anything productive with offenders on short sentences. And in the short time they are in prison many end up losing their jobs, their homes and their families’, with a promise to look at this as part of the forthcoming review of sentencing. More non-violent offenders can and should be diverted out of the prison system and engaged with treatment and recovery services through community based sentences. The commitment to explore alternative forms of secure, treatment-based accommodation for offenders with drug or alcohol problems has the potential to provide an effective alternative to prison for offenders not suitable for community sentences (see below).

Women

C2.4 DrugScope has had a particular policy interest in women prisoners, as they have high rates of drug and alcohol misuse, only a small minority are in prison for violent offences, and many are serving sentences for drug and drug-related offences, often committed within the context of a history of abuse and violent and exploitative relationships with men. In 2004, we published the report ‘Using Women’, which was the culmination of a two year project funded by the Esmee Fairbairn Foundation as part of its ‘Rethinking Crime and Punishment’ programme. This anticipated many of the recommendations in Baroness Corston’s ‘Review of Women with Particular Vulnerabilities within the Criminal Justice System’, which were only partially implemented by the previous Government. We urge the Government to look at the approach to women offenders with drug and alcohol problems as a priority.

Dual diagnosis

C2.5 There is also significant scope for improving the effectiveness with which the criminal justice system deals with people with a 'dual diagnosis' of substance misuse and mental health problems.

C2.6 The Prison Reform Trust's Bromley Briefing 2010 states that 75 per cent of all prisoners have a dual diagnosis (i.e., mental health problems combined with alcohol or drug misuse), and yet HM Inspectorate of Prisons (HMIP) found that dual diagnosis services remain patchy. An HMIP Review of The Mental Health of Prisoners (2007) found that only sixty two per cent of respondents to a survey of mental health in-reach team leads said that they had some links with substance misuse teams either in prison or in the community. Eight prisons (11 per cent) claimed they had a dual diagnosis nurse in their team - the overwhelming majority did not. It appears that people with 'dual diagnoses are less likely to be diverted from prison where this might be appropriate, and that the complexity of their needs might prevent them from being diverted to community sentences. Research conducted by Nacro on court diversion schemes (2004) found that only 17 per cent of schemes had a protocol/policy for dual diagnosis and only 3 schemes had a dedicated drug and alcohol worker. A 2004 National Audit Office review of the use of Drug Treatment and Testing Orders (DTTOs) found that many probation areas considered drug misusing offenders with mental health problems to be unsuitable for a DTTO.

C2.7 The Bradley Report (2009) noted that 'at a workshop hosted for the review by the charity DrugScope, stakeholders sent out a clear message that no approach to diverting offenders with mental health problems from prison and/or the criminal justice system would be effective unless it addressed drug and alcohol misuse.' It concluded that 'services are currently organised in such a way as to positively disadvantage those needing access to services for both mental health and substance misuse/alcohol problems'. We urge the Government to recognise this as a priority issue for prisons and criminal justice policy.

Integrated offender management and DIP

C2.8 There is a need to develop better links between prison and community services to facilitate integrated offender management. There is still a shockingly high level of death from overdose among recently released prisoners – this can and should be addressed as a matter of urgency (see E below).

C2.9 Some DrugScope members have questioned the effectiveness of the Drug Interventions Programme or DIP in their localities. We note that Home Office research discussed by the National Audit Office in 'Tackling Problem Drug Use' (2010) found that the overall level of crime committed by people in DIP and on drug treatment fell by 26 per cent. But it also revealed a 'postcode lottery' in DIP provision, with funding in some local partnerships up to seven times higher per drug user than in the least expensive. It also noted there was often a narrow focus on 'treatment', with inadequate engagement with 'recovery' and 'reintegration'. For example, the National Audit Office notes that 'in some local partnerships, the local authority provided no support to drug users to obtain accommodation despite problem drug-using offenders' views that housing was the major problem they faced'. This should be addressed.

Question C3: Do you have a view on what factors the Government should take into consideration when deciding to invoke a temporary ban on a new substance?

- Yes
- No
- Don't know

C3.1 We welcome the government's commitment to seek the advice of independent experts on the Advisory Council for the Misuse of Drugs (ACMD) before imposing a temporary ban. Clearly, the ACMD would not apply the same evidential burden in advising on a temporary ban as on a permanent ban, and would need to consider evidence and potentially provide its advice to Government in a much shorter time frame. It is our understanding that consideration of a temporary ban, and a referral to the ACMD, will occur where the Secretary of State has reasonable grounds to believe that a substance *may* cause harm. This appears to be a sensible approach.

C3.2 The trigger for a referral to the ACMD for consideration of a temporary ban could include, for example, evidence of Accident and Emergency admissions, the issuing of a Department of Health alert or the seizure and testing of a 'new' substance. DrugScope has argued that we need to develop better early warning processes and systems to flag the emergence of new substances and trends in rapidly evolving drug markets. We would note that the introduction of temporary bans on so-called 'legal highs' could make early identification of new drugs more problematic, as it may incentivise more covert approaches to the production and distribution of new synthetic substances to avoid the imposition of a ban.

C3.3 It is important that the ACMD is in a position to consider evidence for a permanent ban (or the removal of the temporary ban) within a reasonable time frame.

C3.4 Although there is a case for the power to introduce a temporary ban, it has been a concern (as evidenced with mephedrone), that there appears to be no effective means of responding to the (open) sale and distribution of so called 'legal highs' other than by a ban under the Misuse of Drugs Act. It is surprising that the simple act of labelling a potentially harmful psychoactive substance as, for example, a 'plant food' or 'bath salts', seems able to stymie regulation, control or enforcement under other legislation, such as the Medicines Act, or relevant provisions relating to trading standards, consumer protection or health and safety. We welcome the fact that Government is looking at this issue.

Question C4: What forms of community based accommodation do you think should be considered to rehabilitate offenders?

C4.1 DrugScope is planning to consult its membership on this issue as part of its work on a third 'Crossroads' report on prisons and criminal justice, and with a view to responding to the Ministry of Justice's forthcoming Green Paper on criminal justice reform.

C4.2 Community based accommodation should enable offenders to maintain positive links with their families and communities and build relationships with local services to

support social integration and recovery in the longer term (for example, a placement at a local college or with a local employer). In some cases, it may be appropriate to offer community based accommodation that can offer offenders a fresh start in a new locality.

C4.3 Community based accommodation will need to offer 'joined up' support to offenders addressing their attitudes and offending behaviour, drug and alcohol use, health and mental health problems, housing, relationships and parenting, education, life skills and employability. It needs to provide specialist support or co-ordinated access to an appropriate range of interventions that are tailored to each individual's needs and circumstances.

C4.4 A useful reference point for considering new forms of accommodation would be Baroness Corston's 'Review of Women with Particular Vulnerabilities within the Criminal Justice System' (The Corston Report, Home Office, 2009). This makes the case for replacing existing women's prisons with 'suitable, geographically dispersed, small, multi-functional custodial centres' better suited to work with women prisoners with multiple problems, including drug and alcohol issues. DrugScope strongly supported Baroness Corston's proposal for local secure units, and was disappointed that it was not implemented by the previous government (our 2004 'Using Women' report reached similar conclusions to the Corston review).

C4.5 DrugScope would welcome the opportunity to explore with Government the potential to incentivise constructive participation of offenders in secure forms of community-based accommodation by offering this as an alternative to imprisonment, or as an option for early release. We would, however, note that there is a risk of offenders being 'up-tariffed' into new forms of treatment-based secure accommodation where they have significant treatment needs, but where their offence is not otherwise sufficiently serious to warrant such a disposal. It will need to be clear the extent to which the treatment need or the gravity of the offence determines the sentence of being placed in treatment-based secure accommodation, and for how long. There is also a risk that committing a criminal offence could be seen by some as the most direct and immediate way of accessing intensive residential treatment. Newly released prisoners could be incentivised to take responsibility for their recovery and comply with rehabilitation plans if this came with safe and secure community-based accommodation of a decent quality, and support to facilitate resettlement and reintegration. Currently, many former prisoners struggle to access housing, employment and other support.

Question C5: Where do you think we most need to target enforcement efforts to reduce the supply of drugs?

C5.1 Drugscope recognises that drug laws and their enforcement can contribute to the containment of illicit drug markets, as is suggested by a comparison with global markets for tobacco and alcohol.

C5.2 Enforcement efforts should target production and supply, particularly where it is for profit and/or is associated with other forms of criminal activity. DrugScope's submission to the Spending Review questioned the necessity and cost effectiveness of dealing with the majority of low level drug offences through the criminal justice system.

C5.3 DrugScope notes the conclusions of the UK Drug Policy Commission's 2009 report 'Refocusing drug-related law enforcement to address harm'. The UKDPC argued that increased enforcement beyond a certain point will not necessarily reduce the availability of drugs because established drug markets are resilient and adaptable. There are opportunities, however, to target enforcement activities in ways that are more effective in reducing drug-related harm. Enforcement should target particularly violent and harmful activity (for example, drug markets involving gangs and gun crime, sexual exploitation or using children as lookouts and couriers) and markets that are most damaging in their impact on communities (for example, open drug markets in residential areas).

C5.4 DrugScope notes the increased role of the internet, social networking sites and other new technologies in the supply and availability of drugs, and the need to respond with appropriate intelligence gathering, policing and enforcement. There is also scope to explore the potential to use these forms of communications and networking to provide new and, for some, more accessible sources of information about drugs and their harms.

Question C6: What else do you think we can do to keep one step ahead of the changing drug markets?

C6.1 There is a need to review monitoring instruments and to introduce an 'early-warning system', to enable policy and practice to respond effectively to changing drug markets and patterns of drug use.

C6.2 DrugScope's 'Young People's Drug and Alcohol Treatment at the Crossroads' report recommended that a national 'radar' service should be established to provide early warning of new drug trends. Studies like the British Crime Survey are retrospective (if only by a period of under one year) and do not identify new or emerging drug use. Academic research can take time to report on patterns of use and trends that are picked up by drug services today, if indeed such work is being funded. This 'radar' service could draw on the day-to-day experience of front-line services, including picking up variations in drug markets in different parts of the country (DrugScope's annual street drug survey provides a model for this), as well as monitoring the internet. It could be linked into, inform and support, the needs assessment work of local commissioners, while helping policy makers, treatment services and mainstream services (such as schools and GPs) to respond more quickly and appropriately.

Question C7: Which partners – in the public, voluntary and community sectors – would you like to see work together to reduce drug-related reoffending in your local area?

C7.1 Drug Action Teams and Crime and Disorder Reduction Partnerships have sought to involve many of the key partners, including local authorities, police, probation, community safety partnerships, health authorities, provider agencies, social services and children and young people's services. However, their effectiveness in engaging all these partners, and involving sufficiently senior representatives from the key agencies, has been questioned. We would like to see more involvement of the community and voluntary sector at a strategic level. It is

important to incentivise the engagement of sufficiently senior representatives from partner agencies who can make decisions and provide leadership in the development of partnership approaches.

C7.2 There are also opportunities through structures like Police Community Forums and Police Authorities to have an impact on local crime and wider forms of prevention. A useful discussion of some of the key issues locally was provided by the London Drug Policy Forum's report 'Making it Local' (<http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/MakingitLocal.pdf>).

C7.3 More emphasis needs to be placed on social (re)integration - particularly housing, training, employment and other kinds of meaningful activity. If ex-offenders have nowhere to live and nothing meaningful to do with their time, this significantly increases the risks of drug-related re-offending. It is therefore important to find innovative and effective ways of involving local employers, training and education providers, housing providers and sporting and leisure facilities. A number of recent initiatives could help to guide this work, including the Local Employment Partnerships, the creation of drug co-ordinators in JobCentres, and the NTA's 'Commissioning for Recovery' guidance. DrugScope would also highlight an innovative project that is being developed by the Royal Society of Arts in East Sussex (Bognor and Crawley): the RSA User Centered Drug Services Project has engaged local service users in mapping out local recovery networks, identifying and engaging the range of local resources and partners with a potential to contribute to recovery.

Young people's services

C7.4 A particular issue raised by DrugScope members is the relationship between specialist treatment and generic children and young people's services. Locally, Drug Action Team (DAT) chairs and Directors of Children's Services are supposed to meet together to agree priorities, ensure an integrated and holistic approach and share responsibility for delivery. Anecdotal evidence suggests that this is working better in some areas than in others and our members report a lack of consistency across the country in commissioning and service structures. They also report 'differences in the use of the Common Assessment Framework and substance misuse screening tools, meaning that commissioning and delivery of services is more innovative and progressive in some areas than others'. There is also a lack of support for and engagement of families in recovery (see Adfam/DrugScope, 2009, Recovery and Drug Dependency – A New Deal for Families).

Question C8: What results should be paid for or funded?

C8.1 DrugScope believes that it is the responsibility of Government to ensure sufficient funding is available to ensure that anyone experiencing a serious drug or alcohol problem has timely access to drug and alcohol treatment services, and that these services operate on the same principles and to the same standards as other NHS treatment, are consistent with NICE guidelines and compliant with the NHS Constitution. There should be a minimum equivalence of provision across the country and between community and prison-based services. The public supports this position. Nine out of ten respondents to a DrugScope/ICM poll (88 per cent) agreed that 'drug treatment should be available to anyone with an addiction to drugs who is

prepared to address it'. There is also robust evidence that this investment delivers results – including significant reductions in crime.

C8.2 In our response to the Spending Review, we welcome the assurances from the Secretary of State for Health that there will be a ring-fence budget for public health in general, but would like to see a specific reassurance that budgets for drug and alcohol treatment will be protected, and a clear recognition of the contribution of drug and alcohol treatment to pursuing the Government's public health, criminal justice and social policy objectives. Our concern is that the removal of ring-fencing at a time when there is significant pressure on public spending could result in disinvestment from drug and alcohol services, with devastating consequences for some of the most vulnerable people in the community, and a negative impact on the whole community, that may not be anticipated (for example, increases in acquisitive crime).

C8.3 DrugScope supports an approach in which services are judged by and rewarded depending on the results that they deliver, so long as the expectations of them are fair and realistic, and the resources available to them are sufficient to enable them to deliver effectively. We discuss the specific proposals to introduce payment by results pilots for drug treatment and as part of the rehabilitation revolution in D9 below.

C8.4 DrugScope would stress the importance of involving service users in negotiating outcomes with services, which helps to build therapeutic relationships. We also endorse the greater emphasis in the NTA's Commissioning for Recovery on 'building links with mutual aid groups into all local systems, ensuring that all individual services have pathways to mutual aid groups'.

Question C9: What measures do you think should be taken to reduce drug supply in prison?

C9.1 DrugScope welcomed the Blakey Report for providing a useful assessment of the issues and challenges and a framework for policy development (David Blakey NOMS 2008, 'Disrupting the supply of illicit drugs into prison').

C9.2 As the Blakey Report recognised tackling demand for drugs will contribute to reducing supply, so it is important to ensure all prisoners have access to good quality treatment services, including the prescription of substitute drugs where this is clinically appropriate.

Question C10 (if applicable): What impact would the measures suggested have on:

- Offenders
- Your local community

See responses to questions C1-C9 above.

Postcards to the Prime Minister:

Enforcement, criminal justice and legal framework

As part of our survey we asked respondents to write a short 'Postcard to the Prime Minister' on the future of drug policy.

'Be brave - think beyond what is expected - not more of the same. Consider regulating the less harmful drugs so that at least people know what they are taking and are not tempted towards "legal highs" - There is no way you can keep up with the legal highs market so regulate some drugs and make them safer.'

'Update the Misuse of Drugs Act and consider the harms of legal drugs (alcohol, tobacco) within this.'

'Prohibition has failed and will continue to do so; it is time for a serious discussion with regards to decriminalisation.'

'Rehabilitation not punishment, substance misusers are human too! If money was invested in rehabilitation, then the criminal justice 'bill' would drop and counteract the money invested into drug and alcohol users'

D. Rebalance treatment to support drug free outcomes

Question D1: Thinking about the current treatment system, what works well and should be retained?

Treatment expansion

D1.1 DrugScope would highlight the successful expansion of the drug treatment system, with over 200,000 adults and around 25,000 under 18s accessing treatment services in 2008-09; average waiting times down to under a week; around 195,000 adults in 'effective treatment' (which recognising the limits of 12 weeks retention as a reliable measure of effectiveness); and nearly 25,000 adults completing drug treatment free of dependency. We also welcome the increased commitment to recovery and treatment outcomes (for example, in the NTA's 'Commissioning for Recovery') and to workforce development (notably, with the emergence of the Substance Misuse Skills Consortium).

Harm reduction

D1.2 DrugScope would also highlight the significant progress that has been made in reducing drug-related harms – for example, through the early introduction of needle exchange provision in the United Kingdom in the 1980s, which helped to avert a feared HIV epidemic. As the UK Harm Reduction Alliance argues in 'Reducing Injecting Related Harm: Consensus Statement on Best Practice', there is a high rate of hepatitis infection among drug users and some evidence that HIV incidence and prevalence is rising. While developing the recovery model for drug treatment, it is critical that we do not lose sight of the vital need for continued investment in and development of 'harm reduction' services, which save lives, improve health and help to protect from chronic and acute ill-health. As the UK Harm Reduction Alliance argues 'in order to reduce transmission of these viruses [i.e. HIV and hepatitis] we must work to increase supply and reduce the sharing of syringes and other items associated with the risk of blood borne virus transmission'. Special needle exchange services should be available in every area to provide oral and written safer injecting information and advice; general health care assessment; access to confidential hepatitis B and C and HIV testing; hepatitis B vaccination; referral to prescribing and other health services including hepatitis C and HIV treatment; and wound care advice and treatment.

D1.3 DrugScope has supported other recent developments in harm reduction. We welcomed the publication of guidance from the National Institute of Clinical Excellence on the benefits of needle and syringe exchange programmes in February 2009. We welcomed the National Treatment Agency's announcement in June 2009 of a pilot scheme for families and carers of opiate users to be trained in drug overdose management and the administration of naxalone, a drug which reverses the effects of a drug overdose.

Drug treatment at the crossroads

D1.4 In 2008, DrugScope held a series of consultation events with members and other stakeholders to discuss the results and prospects for drug treatment at a time when there was media and political criticism of drug services for the comparatively small proportion of people entering treatment who completed it and emerged 'drug free'. This resulted in our 2009 report 'Drug treatment at the crossroads'. There was widespread concern at DrugScope's meetings that public debate tended to

misrepresent the issues and was unhelpfully polarised – particularly where ‘harm reduction’ was contrasted with ‘abstinence based’ services. There was a broad consensus on the importance of recovery and social re-integration and the need for a more joined-up and personalised approach to individual service users. The challenge for services was to deliver the right intervention, to the right person, in the right way and at the right time. Different people would need different kinds of help at different points in their journey towards recovery.

Consensus statement on drug treatment

D1.5 The Drug Sector Partnership – comprising DrugScope, Adfam, eATA and The Alliance – has since produced a consensus statement on drug treatment, which has attracted the support of over 40 organisations providing drug and alcohol treatment and also service user groups. Signatories include the Chief Executives of leading services providers including, for example, Turning Point, Addaction, Blenheim CDP, Phoenix Futures, RAPT, Action on Addiction, Compass UK, Westminster Drug Project, Lifeline, Foundation 66, St Mungos and the Bristol Drug Project.

D1.6 The drug treatment consensus statement explains that its signatories have come together ‘to ensure that public debate about drug treatment recognises the progress that has been made in improving the lives of individuals, families and communities’, and explains that ‘drug treatment services are available to anyone trying to access them within a week on average, and most people coming into treatment are staying long enough to get real benefit from it’. In particular, it welcomes:

- The development of an evidence-based approach to drug treatment;
- The overwhelming evidence that properly funded and evidence-based drug and alcohol treatment is delivering substantial benefits for individuals, families and carers, neighbourhoods, communities and society at large;
- The introduction of harm reduction services in the UK in the 1980s and 1990s, resulting in one of the lowest rates of HIV infection among injecting drug users anywhere in the world;
- The Home Office evidence that acquisitive crimes – such as shoplifting, burglary, vehicle crime and robbery – to which drug-related crime makes a significant contribution, fell by 55 per cent between 1997 and 2007.

D1.7 The consensus statement concludes by calling on policy and decision makers to commit to an evidence-based approach to drug and alcohol policy, which respects the advice of independent experts, such as the Advisory Council on the Misuse of Drugs, and the National Institute of Clinical Excellence.

D1.8 In short, treatment system capacity has significantly improved nationwide. Clinical care is better and efforts being made to better understand treatment outcomes are welcome. DrugScope supports the recent focus on the service user’s ‘journey’ and the need for treatment to be person-centred, positive and directed through a care plan developed and owned with the involvement of service users themselves (and families and carers, as and where appropriate).

Question D2: Thinking about the current treatment system, what is in need of improvement and how might it need to change to promote recovery?

Targets

D2.1 There is concern that national targets (for example, PSA 25 targets) have focussed disproportionately on increasing the numbers of people in treatment and retaining them in services, rather than supporting recovery and social reintegration. There is also a widespread view among many managers and practitioners that delivery of drug treatment has not been helped by what can appear to be excessive 'bureaucracy', with reporting requirements, performance management and the demands of tendering, re-tendering and other funding processes eroding the time available for one-to-work clinical and other work with service users.

Consensus statement

D2.2 The drug sector partnership consensus statement identifies a number of areas in which there is still work to do. While recognising that we are building on solid and substantial achievements, we need to continue to move forward in order to create world class treatment services. In particular:

- We need to develop better links between different health, social care and support services to support recovery, and address multiple needs – addressing issues like experience of childhood abuse and adult trauma, mental health problems, homelessness, worklessness and lack of meaningful activity and family breakdown.
- We need a balanced treatment system that is focussed on recovery, quality of outcomes and re-integration, and not only on the numbers of people coming into treatment.
- Treatment should be personalised, sensitive to ethnicity and diversity, with service users fully involved in decisions about their treatment with their needs driving the care planning process.
- The important role that families and carers can play in supporting treatment and recovery should be acknowledged and supported.
- We need to develop drug treatment services that can work with different forms and patterns of substance misuse, such as stimulant problems and multiple or 'poly' drug use, including alcohol – balancing a focus on heroin and crack cocaine with other forms of substance misuse and related harms.

Drug treatment at the crossroads

D2.3 DrugScope's 2009 'Drug Treatment at the Crossroads' report concluded with a number of recommendations:

- Politicians from all political parties should publicly commit to an evidence-based approach to drug policy;
- The Government should fund, develop and implement a communications strategy to inform the public about the achievements of front-line drug services;
- Drug services must address diversity more effectively;
- Drug treatment should be provided in accordance with the new NHS constitution;
- Service users should be involved in decisions about their treatment;
- There should be further research on alternatives to substitute prescribing;

- There should be further work to reduce drug related deaths;
- All local drug partnerships need to develop effective partnerships with other local agencies;
- There should be a clear recognition of the contribution of families, carers and other support networks to recovery;
- The next round of the Spending Review should introduce treatment outcome targets that include reintegration.

Improving effectiveness and efficiency

D2.4 On 12 July 2010, DrugScope hosted a meeting of Chief Executives and senior managers of drug and alcohol services to consider the challenges and opportunities of the new economic and policy environment for our sector, which was held at Church House, Westminster. This meeting produced a number of recommendations for improving the effectiveness and efficiency of drug and alcohol treatment services:

- All commissioners need to take account of overall cost-benefit – the cheapest options may not deliver “value for money” in the longer term;
- There was support for a review of the costs of commissioning structures and processes (particularly re-tendering);
- It was pointed out that there are significant costs to competing for contracts and accessing finance, particularly given the comparatively short-term nature of much funding;
- There was a view that aspects of current case management systems and approaches are inefficient (deficiencies in information-sharing and communication between services, duplication of work and unnecessary complexity – including multiple assessment);
- The ‘compact’ between the voluntary sector and the Government provides a good framework for strengthening the role of voluntary and community sector organisations, but it is not widely used; and
- Investment in drug treatment will not deliver optimum value unless the appropriate ‘wrap around’ services and support (such as housing and employment) are in place.

D2.5 The Government will be interested to note that while there is very significant concern about future funding and the impact on services and service users, the majority of 231 respondents to our on-line questionnaire believe that it may be possible for drug and alcohol services to ‘improve outcomes with reduced funding’. Two thirds either agreed that this would be possible (34 per cent) or said that it ‘may’ be achievable, compared to one third (31 per cent) who said it would not be. As discussed further below, there are significant concerns about the introduction of funding based on a system of payment by results and the potential impact of more locally based decision making.

D2.6 DrugScope also invited participants in our drug strategy consultation events in London, Birmingham and Newcastle to consider ‘how the government could achieve better outcomes with less spending’. Suggestions from table groups included:

- ‘A more integrated approach to drugs and alcohol’;
- ‘Reducing the costs of tendering and re-tendering’;
- ‘A leaner approach to commissioning and more training for commissioners’;

- ‘Review the operation of the TUPE system’, which it was felt could limit the value of re-tendering and the ability of service providers to improve quality of delivery;
- ‘More effective engagement of the private sector in supporting drug and alcohol treatment – for example, big business could contribute to the “Big Society” by offering work placements leading to employment for recovering drug users, perhaps offering tax incentives’;
- ‘The drug treatment system needs to look outside itself, think creatively about partnership, and encourage other sectors and organisations to tap into their potential to see drug and alcohol issues as part of their remit (and investment in workforce development to enable this to happen) – conversely, drug workers should be encouraged and supported to broaden their remit’;
- ‘Enabling available funds to be more effectively targeted at local priorities and issues’;
- ‘Better integration of different funding streams to avoid duplication and the creation of silos, with integrated outcomes frameworks to support partnership work’ ... ‘move away from traditional treatment models to more holistic recovery models’ ... ‘help for co-ordination and collaborative commissioning’;
- ‘More effective use of mutual aid, peer mentoring, service user networks, volunteers and voluntary and community sector’;

Challenging commissioners

D2.7 In our submission to the Spending Review, DrugScope noted that a key issue for community and voluntary sector and smaller organisations is a lack of avenues to challenge or complain when they feel that commissioners have acted unfairly or unreasonably, not least because this could damage their future prospects of obtaining contracts and securing funding. DrugScope suggested that consideration should be given to some kind of “ombudsman” system (nationally and/or locally). The “ombudsman” would look into issues or complaints about allegedly poor or inconsistent commissioning. These could be referred to the “ombudsman” anonymously and/or with other safeguards to ensure that the complainant was not unfairly disadvantaged in the future.

Harm reduction work

D2.8 Again, while welcoming the focus on developing more recovery orientated drug treatment, DrugScope would emphasise the importance of harm reduction interventions, such as needle exchange, which is also often a first point of contact, providing a gateway into more intensive and structured treatment. A Healthcare Commission/NTA review of harm reduction services in England, published in May 2008, highlighted the need for urgent action to improve these services. It revealed, for example, that nearly a third (32 per cent) of local partnerships did not have a multi-agency plan for reducing drug-related deaths; over a third (37 per cent) of partnerships did not have access to HIV testing and pre- and post- test counselling; and nearly half of service users (48 per cent) did not think that harm reduction services in their area were comprehensive enough.

D2.9 There were also areas in which DrugScope would have welcomed more ambition from the previous Government in developing new programmes that could reduce the most serious harms associated with drug misuse (including death). We supported the work of an Independent Working Group set up by the Joseph

Rowntree Foundation, and chaired by Dame Ruth Runciman, to look at the case for piloting so-called drug consumption rooms. It concluded that DCRs can avert drug related deaths, prevent needle sharing and improve the general health of users; decrease injecting in public places and reduce the number of discarded, used syringes and drug-related litter; did not appear to increase acquisitive crime; and were generally not associated with public order nuisance or other problems. The Independent Working Group called for pilots of DCRs, and we urge the Government to take another look at their analysis and recommendations.

D2.10 We have also supported calls for a review of section 9A of the Misuse of Drugs Act. This limits the 'paraphernalia' that can be distributed by services to drug users to reduce harm. Provision was made in 1986 for needles and syringes to be distributed, but not for other items that are essential to safer drug preparation and use – such as acidifiers, cookers, swabs, filters, water, matches and foils. Paradoxically, services can provide clients with injecting equipment but not with foil that might result in safer and less harmful forms of drug administration (i.e. smoking, not injecting). We also have particular concerns about the high numbers of ex-offenders who overdose following release from prison (often because their tolerance levels have fallen), and would welcome a review of harm reduction as well as other services and support for prisoners.

Is it possible to deliver better outcomes for less money?

Consultation responses

'Integrated teams and joined up services can be more efficient. Existing resources can be used more creatively ... However, you need enough skilled staff to deliver quality services. You need time for assessment and care planning. And residential services are expensive'.

'Funding cuts are real and inevitable – but I don't see how you can do more for less when your biggest cost is staff unless you think staff are overpaid or working below capacity – which isn't my experience'

'User centred approaches will drive efficiencies and greater partnership beyond the usual suspects, make better use of existing community, family and social resources.'

'If other vital services – such as housing, criminal justice, health and social services – all cooperate, they could deliver more effectively with substance misuse services, and be more efficient'.

'The amount of money spent managing people going in and out of prisons on short-term sentences could be drastically cut with appropriate reform'.

'More innovation is required, particularly from statutory services. Services are too bureaucratic, too tied down to process and system, and have occasionally lost sight of the client and providing an individual, person-focused approach.'

'It is very hard to say – for instance, how much less money? Better outcomes are needed but it will depend on how services are responsive to need. Children's services and Every Child Matters is the right direction. Value for money and better

outcomes means increasing skills and ability to work across agendas. In young people's services this could mean drug and alcohol, tobacco and sexual health'.

'All services are being asked to do this, so drug and alcohol services are no different. A lot of the good work done goes unseen and unrecognised, because of the extra work done by colleagues and service users (volunteers). I think added work loads and less resources can only result in a negative outcome'.

'Not in the particular service I work in – though I do believe money is wasted where duplication occurs between services in the drug sector. In the city where I work, there are 14 commissioned services in the treatment system, which includes two prescribing services and numerous third sector services. Duplication of support does occur with often little benefit to the client, and creates communications challenges'

'Reduced management and more direct commissioning could save costs and allow more focus on front line delivery'.

Question D3: Are there situations in which drug and alcohol services might be more usefully brought together or are there situations where it is more useful for them to operate separately?

Alcohol

D3.1 DrugScope asked respondents to our survey 'how significant a problem is alcohol misuse for people using the service(s) you are involved with', with three quarters identifying it as a pervasive issue for them. Nineteen per cent reported that it was the main problem for people using their services and 54 per cent that it was 'usually a contributing problem'. A further 22 per cent said that it was sometimes a problem, and only 2 per cent that it was never a problem.

D3.2 At our consultation events we invited attendees to discuss how the new strategy could deal with the issue of alcohol misuse and harm. There was support for the proposals for changes in pricing and taxation to reduce alcohol consumption, and, specifically, a call for a tougher approach from Government to 'low quality, high alcohol' drinks that appeared to be targeted at the most vulnerable populations and those with existing drink problems. It was suggested that increased taxation on alcoholic drinks could be partly used to fund new investment in alcohol treatment, which would help to send a clear public health message about health risks.

Poly-drug use

D3.3 A recurring theme was the need to focus on the causes and consequences of dependency, rather than separating drugs and alcohol, particularly in the light of growing concerns about 'poly-drug' use. This would require more flexible approaches to commissioning and performance management, and it was felt that a more 'outcome' orientated approach to investment could help to facilitate an integrated approach. It was noted that investment in alcohol treatment had lagged behind spending on services for 'problem drug users'. There was support for extending the Drug Intervention Programme (DIP) to include alcohol, and discussion of the wider potential to incentivise engagement with alcohol services through innovative criminal justice interventions. The development of more generic 'addiction' services could potentially deliver 'economies of scale'.

The significance of alcohol misuse for drug services

Consultation responses

'Social exclusion, deprivation, injustice and inequality are the main contributors to the problems of people using the services I am involved in. The substance misuse is just symptomatic'.

'Many people with drug problems who use alcohol find it difficult to accept that poly-drug use is dangerous and that their use of alcohol often affects their ability to control their drug use'.

'The role of alcohol is often under-reported and not addressed. Alcohol plays a key part in overdose, dependence and substitution in recovery. Many drug workers do not seem to be able to work with alcohol use ... Consideration also needs to be given to combined or stand alone services for alcohol as the need is great and many people will not use drug services. All the needs assessment I have been involved in doing shows that alcohol is a priority need.'

'Alcohol may play a significant part in many drug users lives - as their drug use becomes more controlled, their alcohol use can spiral out of control due to factors such as price, availability and the social acceptance of alcohol as a drug of choice'.

Question D4: Should there be a greater focus on treating people who use substances other than heroin or crack cocaine, such as powder cocaine and so-called legal highs?

- Yes
- No

D4.1 DrugScope has supported the prioritisation of investment in access to treatment for those forms of drug misuse than cause the greatest harm to individuals, families and communities. The drug treatment consensus statement – developed with our colleagues in the Drug Sector Partnership – states that 'we need to develop drug treatment services that can work with different forms and patterns of drug misuse, such as stimulant problems and multiple or polydrug use, including alcohol. Our treatment system needs to balance a focus on heroin and crack cocaine with other forms of substance misuse and harms related, for example, to alcohol, cannabis, ketamine, GBL/GHB and so called legal highs'.

Recent trends and responses

D4.2 In October 2009, the National Treatment Agency reported a significant fall in heroin use among young adults aged 18 to 24 presenting for treatment, and a substantial increase in the numbers seeking help for powder cocaine use. It proclaimed a 'generational shift in patterns of drug dependence in England'. A 2009 report from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) claimed that 'in Europe today, polydrug patterns are the norm, and the

combined use of different substances is responsible for, or complicates, most of the problems we face.'

Powder cocaine

D4.3 In 2010, the NTA issued guidance on psycho-social interventions in drug misuse, which have a particular role in the treatment of stimulant use (including cocaine use). In March 2010, the NTA published a report that found that one in ten drug users entering treatment in England were seeking help for powder cocaine dependency. Within six months of entering treatment, 61 per cent were abstinent from cocaine and a further 11 per cent had substantially reduced their use. Significant progress is being made in tackling other forms of substance misuse.

Young people's services

D4.4 Young people's drug and alcohol treatment services work effectively with under 18s who as a group will very rarely be using heroin or crack cocaine. For 90 per cent of under 18s in treatment the 'primary substance' causing them problems is either alcohol (36 per cent) or cannabis (53 per cent). Often these services are working with substance misuse issues because they contribute to other problems, such as disengagement from education, unemployment and offending. A shift in emphasis to recovery and reintegration in the adult system could be expected to bring some of the problems associated with other patterns of drug and alcohol use into focus.

D4.5 DrugScope's 'Young People's Drug and Alcohol Treatment at the Crossroads' report highlighted the issue of treatment availability for the young adult group, including those who had been in young people's services, which deal with a much wider range of drug problems. We argued that the next Government should develop a national policy framework for young adult services, which could take the form of a Green Paper, covering a range of issues, and with a focus on transitional processes and arrangements. The Transition to Adulthood (T2A) Alliance Manifesto provides a good framework for developing policy in this area (www.t2a.org.uk/publications).

Intermediate treatment

D4.6 It could be argued that we have a good drug treatment system for the most acute forms of dependency and well-developed approaches to public health and prevention, but very little in between. DrugScope has argued that we need to think creatively about the potential scope for new kinds of drug and alcohol service. In our 'Young People's Drug and Alcohol Treatment at the Crossroads' report we made a case for what we described as 'high visibility, low threshold services' to balance the 'low visibility, high threshold' services that currently dominate drug treatment provision. One possibility would be the creation of a new kind of 'high street' drug and alcohol service, which could be located within existing services (for example, well-being and health centres). It would provide information and advice as well as brief interventions.

Survey findings

D4.7 Our member survey asked respondents what drugs or combinations of drugs they believed would present the biggest challenges for their local communities in the future. The most frequently mentioned was alcohol (27 per cent of respondents), followed by heroin/opiates (17 per cent) with cocaine (12 per cent) and crack (9 per

cent) also figuring prominently. Legal highs were mentioned by 11 per cent, cannabis and skunk by 11 per cent and benzodiazepines by 5 per cent.

Question D5: Should treating addiction to legal substances, such as prescribing and over-the-counter medicines, be a higher priority?

- Yes
- No
- Don't know

D5.1 DrugScope provides secretariat support to the All-Party Parliamentary Drug Misuse Group and facilitated its inquiry into prescription and over-the-counter medicines in the 2007-08 parliamentary session.

D5.2 DrugScope endorses the recommendations of the All-Party Group. In particular, it concluded that 'the DH should require Primary Care Trusts to provide appropriate treatment for those addicted to these drugs' (noting that it 'would be inappropriate to refer patients for treatment to Drug and Alcohol Action Teams'); and that 'PCTs should ensure that pathways for treatment of patients presenting with a dependency should be as flexible as possible and accessible' (including facilitating self-referral). Any changes to commissioning structures (for example, from PCT to GP-commissioning) should ensure that there is clear responsibility for funding and providing appropriate treatment interventions for this population. The All-Party Group also highlighted the value of local and on-line support groups, and the need for these to be appropriately funded.

Question D6: What role should the public health service have in preventing people using drugs in the first place and how can this link in to other preventative work?

D6.1 DrugScope would support the Public Health Service having a preventative, health promotion role with respect to drug and alcohol use. This should be informed by evidence of what works. There is potential to better integrate messages about the harms of drug misuse into wider public health messages.

Question D7: We want to ensure that we continue to build the skills of the drug treatment and rehabilitation sector to ensure that they are able to meet the needs of those seeking treatment, what more can we do to support this?

D7.1 DrugScope is a partner, with the University of Glasgow, for STRADA (Scottish Training on Drugs and Alcohol). STRADA is a national training organisation for Scotland funded by the Scottish Government. We also played an important role in the development of DANOS competencies for managers and for service monitoring and reporting responsibilities. We currently run courses for people taking on their first line management roles through the London Drug and Alcohol Network, and provide other training on a consultancy basis. DrugScope is a member of the Substance Misuse Skills Consortium, which was set up with the initial support of the National Treatment Agency.

D7.2 There is concern that the substantial expansion of the treatment workforce has not been matched by a sufficient commitment by government or the NTA to encouraging and supporting training and professional development. With reductions

in funding, investment in training, practice skills and development is less not more likely. Improving access to and the quality of treatment services has a direct link to the competence, confidence and effectiveness of the workforce (in specialist and generic settings). The focus on service user reintegration, recovery and a greater integration of service delivery will require more multi-disciplinary training and development, with a workforce capable of working across a range of activities and relating to each other with confidence and in collaboration. As has been mentioned, the STRADA project in Scotland provides an effective model for delivering high quality training to meet the demands of national and local policy initiatives.

D7.3 DrugScope has consistently expressed concern about the lack of a workforce development strategy in the previous drug strategy. The treatment workforce has rapidly expanded since 1998, and it is increasingly being challenged to provide a greater range of interventions, requiring an extended skills base. These include the skills to deliver psycho-social interventions, work effectively with people with multiple needs, and develop more recovery-orientated services, including building more effective partnerships with other local agencies. Skills development is also critical for managers and commissioners. We also have concerns about what appears to be a lack of sufficient attention to substance misuse issues in training and development in other sectors (for example, social work).

D7.4 DrugScope believes that the Substance Misuse Skills Consortium has the potential to make a significant contribution to this workforce development agenda, but it can only have a real impact if it has sufficient resources to support its work. Although we acknowledge the difficulties in finding resources at a time of spending cuts, there is a case for Government to support a national training and workforce development resource.

D7.5 With the new emphasis on recovery and re-integration, the Government could consider a workforce development initiative that works across a range of different sectors (including drugs and alcohol, mental health, criminal justice, housing and training and employment) to develop the attitudes, cultures and skills required to work effectively and in a holistic way to deliver on the new recovery agenda. This could also contribute to building relationships between services locally, while delivering economies of scale where elements of training are being replicated across different sectors.

D7.6 Workforce development is not simply about training, but also about ensuring that people working in drug and alcohol treatment have a rewarding career, opportunities for development and good terms and conditions. The potential for developing career pathways across sectors (which share common approaches to recovery and reintegration) should be explored.

Question D8: Treatment is only one aspect contributing to abstinence and recovery. What actions can be taken to better link treatment services in to wider support such as housing, employment and supporting offenders?

A more holistic approach to treatment?

Consultation responses

'I currently work closely with a children's home – all are using drugs to some degree and the home is struggling to cope. All these young people have social workers. Yet I have never received a phone call or referral from any of the social workers in this area. I have contacted them on many occasions, but they never call back'.

'If an individual is to be successful in their treatment journey it is imperative that they have adequate and appropriate pathway support. Individuals need ETE, housing, healthcare, family support services, benefit and debt advice. You can't tackle someone's addiction without taking all of these things into account. Why has it taken so long for these important linkages to be made ... There is currently a lack of opportunities for people in drug and alcohol services to gain meaningful employment, appropriate supported housing and so on. There are not enough ETE placements for this group. All these aspects of the issue need to be addressed if we are to deliver the outcomes'.

'Commitment to partnership working is strong but workforce issues have not been addressed across specialist and universal services' ... 'training is not necessarily taken up – e.g. by GPs and some other health staff – and there is a lack of commitment in primary care in particular.'

'Drug abuse is a contributing factor in relation to domestic violence and this needs to be recognised and cross-referenced to the violence against women and girls strategy'.

Survey responses

D8.1 Respondents to DrugScope's survey were asked to identify what they perceived to be the principal barriers to social (re)integration of people with drug problems. The three most frequently identified barriers, were also those identified as the most significant:

1. A lack of available opportunities – for example, employment or training options for people recovering from substance misuse problems;
2. Targets and funding that do not incentivise "holistic" work;
3. Lack of commitment to joined up work amongst staff in other sectors and/or services.

Workforce development

D8.2 Investment in workforce development and training for frontline drug and alcohol treatment staff to support their clients to access housing, education, training and employment (ETE), health, mental health, domestic violence and offender support is essential. Support workers should not only be aware of the services available, but also how those services work, relevant policy and legislation and their client's rights in order to be able to advocate on their behalf. Each client should have a lead worker

who has effective information sharing mechanisms with partner agencies. All too often, service users are made to repeat their personal histories to each support agency they come in contact with, and can also receive conflicting advice on their situation. Where appropriate, specialisms can be developed within treatment services; for example, some services have specialist employment support, resettlement or dual diagnosis workers.

D8.3 Homelessness/housing, ETE, health, mental health, domestic violence and offender services, need to have a better understanding of substance misuse issues and services. LDAN/DrugScope's London Council's funded homelessness project runs a training forum for frontline homelessness and substance misuse workers. At the first forum we held in October 2009, approximately a third of the attendees from homelessness services felt that they did not have a good awareness of the drug or alcohol services available to their clients. The forum has allowed cross-sector knowledge sharing and partnership development.²⁰ Similarly our London Council's funded domestic violence project and Trust for London funded employment project run cross-sector training events.²¹ More second tier work like this is needed nationally, including in areas such as criminal justice and mental health.

Multiple needs

D8.4 Individuals with multiple needs can fall down the gaps between support services because they don't meet the right thresholds and are continually being referred on, particularly between substance misuse, homelessness, criminal justice and mental health services. DrugScope is part of the MEAM Coalition with Homeless Link, Clinks and Mind looking at solutions to this issue.²²

Recovery and reintegration – barriers and approaches

D8.5 At our drug strategy consultation events we asked participants to identify barriers to 'recovery' and 'reintegration' and to provide some suggestions of how these could be tackled. The barriers identified included:

- 'There is a lack of clarity in what is meant by recovery, different individuals, sectors and services understand it differently';
- 'Recovery is a very individualised process, and different people need to take different routes, services are not always flexible enough to accommodate this';
- 'Recovery is a long-process for many people with drug and alcohol problems, relapse is not unusual, and we need to support people over the longer term';
- 'Stigmatisation of people and families affected by drug and alcohol problems stands in the way of reintegration and social inclusion';
- 'Commissioning systems and skills have not always been supportive of holistic approaches (the NTA's 'Commissioning for Recovery' may help to address this)';
- 'Availability of jobs, especially for people with offending histories or drug-related health problems' and 'wider issues such as the availability of appropriate housing and adequacy of housing benefit';

²⁰ <http://www.ldan.org.uk/cms/view/homelessness.asp>

²¹ <http://www.ldan.org.uk/cms/view/employment.asp> and

<http://www.ldan.org.uk/cms/view/domesticviolence.asp>

²² <http://www.meam.org.uk/>

- 'Where will the shift to the language of recovery leave young people's services – it doesn't really apply to young people in the same way';
- 'Where there are waiting lists for services – whether that is drugs and alcohol, mental health, housing or whatever – people may not have an opportunity to engage when they are most motivated'.

D8.6 Proposals for tackling some of these barriers included:

- 'More user-centred services making use of recovery mapping';
- 'More work to challenge stigma and negative images, and to raise awareness of some of the problems that lead people into addiction';
- 'Contingency management approaches that recognise and reward progress towards recovery';
- 'A longer-term and more joined up approach to commissioning services across the recovery spectrum';
- 'Aftercare needs to be established as a priority within local authorities';
- 'Developing mutual aid and peer support networks, resources and recovery capital';
- 'Really embedding recovery in communities, but that means the community will need to understand its role and be motivated and supported to get involved';
- 'For young people, we should continue to build on things like Every Child Matters, Common Assessment Framework (CAF) and Team around the Child (TAC);
- 'A shift in the focus of treatment, so it looks at the whole family where appropriate and not only the substance misuser';
- 'If there is a move away from over-use of substitute drugs it will be important to give appropriate support and training to the work force – for example, on psycho-social interventions'.

Question D9: How do you believe that commissioners should be held to account for ensuring that outcomes of community-based treatments, for the promotion of reintegration and recovery, as well as reduced health harms, are delivered?

D9.1 DrugScope would like to comment specifically on the potential impact of the 'localism' agenda and the development of payment by results for the funding, commissioning and purchase of drug and alcohol services. These developments are of wide interest to our membership.

Localism – challenges and opportunities

D9.2 At our consultation events we asked participants to discuss the possible impact of devolving responsibility from national to local government (localism). Comments included:

- 'It is hard to comment until the vision for localism has been spelt out and we are clearer about how it will translate into commissioning structures and funding streams';
- 'Developing the skills and knowledge of local decision-makers will be important';

- ‘Local media and local personalities will have a big impact on local decisions about spending, for better or worse’;
- ‘The potential for postcode lotteries is a concern – in particular, different areas may strike a different balance between criminal justice and public health concerns’;
- ‘Less popular services like drugs and alcohol could be cut – sensitive, difficult and controversial issues most need a lead from central Government’;
- ‘It will be important to have some way of holding local authorities to account for how they are meeting the needs of the most vulnerable’;
- ‘Too much localism could lose out on economies of scale, where provision is more effective at regional or national level’;
- ‘Will people with drug and alcohol problems be a priority with less money to spend locally – we are worried about disinvestment’;
- ‘There is already a problem of local authorities and London boroughs displacing ‘difficult’ clients to bordering areas, this should be considered in developing localism’;
- ‘The worry is that localism will mean “problem” clients are displaced from one borough or locality to another. On the other hand, it could result in people being “shackled” to a particular borough and its services and unable to move – which could be a particular problem for prison leavers and people leaving treatment’.

D9.3 In our submission to the Spending Review, DrugScope suggested that where a local authority or partnership is proposing to refocus, significantly reduce or withdraw funding there is a requirement for the relevant local decision-making agency to carry out a “community impact assessment”, with a focus on the impact on the third sector and particularly the most vulnerable and socially excluded individuals and communities.

D9.4 We asked respondents to our survey what they thought the impact of “localism” was likely to be on drug and alcohol services in their area. The positive news is that over half of them agreed that it would result in a greater responsiveness to local need (53.5 per cent). In addition, there was a clear understanding that localism would push drug and alcohol services to do more to promote their role in communities – with 84 per cent saying they would have to do more to promote themselves actively at local level. Of more concern, over half (54 per cent) anticipated that this would result in disinvestment in their area (38 per cent said they ‘didn’t know’, and only 8 per cent said this would not happen). Seventy one per cent felt that the consequence of ‘localism’ would be greater variation in the availability of drug and alcohol services from area to area and a worrying 82 per cent thought it would result in more variation in quality.

Payment by results – challenges and opportunities

D9.5 While we recognise the advantages of an outcome focussed approach, our membership have concerns about the potential design and impact of a system of ‘payment by results’. First, small voluntary and community organisations could be disadvantaged if they are expected to absorb the initial costs of providing services and only receive payment on achieving the agreed outcomes (which in the case of reducing offending – for example - would need to be measured over a protracted

time period). Second, we need to be realistic about the nature of recovery (for example, that it will often include periods of relapse and disengagement). Third, it will be necessary to take account of the impact of a range of factors outside of the control of treatment services on outcomes (for example, the availability of accommodation or employment locally). Fourth, some outcomes for drug treatment services are realised over long time periods (for example, reduction in blood borne viruses or liver disease or supporting service users into mainstream employment). Finally, there is a concern that if ambitious 'results' are specified (for example, entry into paid employment or abstinence from all drugs) this could disincentivise work with those service users with more serious and entrenched problems – including those with multiple needs. DrugScope members would welcome an opportunity to work with Government to consider these issues and contribute to the development of an effective results-driven approach to investment.

D9.6 DrugScope asked respondents to our survey whether they believed that a payment by results system would result in better services and improved outcomes for service users. Our results suggest that further work will be needed from Government to make the case to people involved in drug and alcohol services – only 1 in 5 respondents said that payment by results would improve outcomes - 6 per cent 'strongly agreed' and 15 per cent 'agreed' that it would. A further 8 per cent 'neither agreed nor disagreed' that payment by results would improve services. By contrast, 27 per cent 'disagreed' with this proposition, and 28 per cent 'strongly disagreed'.

D9.7 We also asked respondents to our survey for their views on what the most appropriate outcomes would be for a fair and effective 'payment by results' system, identifying their top three outcomes, and placing them in order of priority. The most frequently identified outcomes in the top three were:

1. Improved health and mental health outcomes;
2. Service users placed in paid employment or employment related activity;
3. Drugs being used and administered in less harmful ways.

The outcomes that were most often identified as first preferences were:

1. Improved health and mental health outcomes;
2. Drugs being used and administered in less harmful ways;
3. Abstinence from all drugs except prescribed substitutes.

A minority of respondents (27 of 168 for this question) identified 'abstinence from all drugs *including* prescribed substitutes' as one of their three preferred outcomes for a payment by results approach. However, the majority (70 per cent) of these 27 respondents identified it as their *first* priority among the three outcomes that each identified. So, while this was a minority position among respondents to our survey, it was a strongly held view within that minority.

D9.8 DrugScope also discussed payment by results with delegates at our consultation events in London, Birmingham and Newcastle. Their comments included the following:

- "It's good to get services to focus on the outcomes for service users and a good opportunity for a range of services to prove what they can deliver";

- “What happens with those with the most entrenched needs, won’t services ‘cherry pick’ the service users they think are most likely to achieve the result?”;
- “Will small, local services be able to engage in this approach if they do not have the resources to defer payment until the result is achieved – they might not want to take a loan” – ‘How do small – and often very effective – organisations compete in a payment by results environment – so you are accommodating the Big Society’;
- “What will happen with people with complex needs – for example, enduring mental health problems – especially where exiting treatment may not be realistic’;
- “What do we do if the wraparound services and resources are not there – for example, if someone relapses because there is no housing or employment available or no services to support people to move into accommodation or work?”;
- “How well it works will all depend on whether the outcomes specified balance ambition and realism”;
- “What will be the role of service users in setting their goals and outcomes – so we work to build relationships and motivate them to move towards the results that they want?”;
- “It could support joint working but it could be a barrier too – it will need to be clear who ‘owns’ the outcome and how the rewards are shared out where a range of interventions contribute to the outcome”;
- “How do Tier 2 services – like needle exchange – fit into the payment by results model? Will they be pushed to the margins?”.

Payment by Results Consultation responses

‘How do we capture meaningful changes in people’s lives that don’t fall into the identified “results”?’

‘Outcomes will need to be realistic and to incorporate more complex cases – for example, if a “working woman” reduces her street work from seven days a week to two days, then that has a massive positive impact for her and for society.’

‘We want to provide a needs led service, but sometimes we feel backed into a corner because we are told that if we don’t hit targets there will be a financial penalty, so we end up doing assessments to get the numbers for the sake of it.’

‘If I manage an organisation and I know I will get paid by results, then I will risk assess my clients and select the ones that are most likely to succeed’.

‘I don’t see how small community based services will find the initial outlay to fund the service – it could also lead to ‘cherry picking’, with services focusing on clients they think are most likely to achieve the results quickly.’

Postcards to the Prime Minister:

Rebalancing treatment to support drug free outcome

As part of our survey we asked respondents to write a short 'Postcard to the Prime Minister' on the future of drug policy.

'Maintain funding for evidenced based AND innovative treatment interventions. Don't get tied up in the philosophies of harm reduction and/or recovery and/or abstinence. Look at what works as evidenced by those with nothing to gain from investment in different treatment methodologies.'

'Please consider carefully what a successful outcome is. We can meet many targets without achieving "abstinence" as considerable progress can be made in other areas. Give funding for aftercare. It can be supportive to a large extent of "recovery models" and does not need to be costly – volunteers need training and need support.'

'Drug treatment works but it needs to be measured in broad outcomes such as protected children, increased employment, education and training, improved health outcomes that will break the ongoing cycle of deprivation.'

'Drugs and alcohol treatment is complex. There is a need to recognise that lapse / relapse is part of the process. Its often when most is learnt by the service user and some recovery capital is gained. Smoking cessation models include lapse / relapse and drug and alcohol treatment needs this included too.'

'Harm reduction approaches to treatment save hundreds of lives each year. The treatment system needs to target recovery, but please don't throw the benefits of harm reduction (including substitute prescribing) out with the bath water!'

E. Support recovery to break cycle of drug addiction

Question E1: What interventions can be provided to better support the recovery and reintegration of drug and alcohol dependent offenders returning to communities from prison?

Drug-related deaths

E1.1 There is rightly concern about the unacceptably high rates of drug-related death following release from prison, and, more generally about the numbers of released prisoners who drift back into drug misuse after making significant progress in tackling their drug problems while in prison. Significant progress has been made in improving treatment in prisons – for example, through CARATs services and the Integrated Drug Treatment System – but more needs to be done. We need to develop more effective harm prevention work in all prisons to prepare offenders for release, which is realistic about the potential for relapse and the risk of overdose (and other harms).

Women prisoners

E1.2 DrugScope's 'Using Women' project talked to women who had stopped using drugs in prison – including many who leave determined to quit – but often return to drugs on release because all they believed was waiting for them beyond the prison gate was homelessness and joblessness. One woman we spoke to explained: 'I always had good intentions in jail and thought when I get out this time it will be different, but getting out of jail with nowhere to go you end up back in some doss house and back in the same old position. It's horrible coming out of jail and knowing what you're going back to'. Another explained 'If you don't have any support when you go to prison, you've got nothing; you go in alone and you come out alone'.

Building on effective work

E1.3 The Government can help to address this by supporting and building on a number of projects that have been developed by DrugScope members working in the voluntary and community sector, including the St Giles Trusts 'Through the Gates' scheme in London and Addaction's prisoner resettlement programme in Manchester. Evaluation of these projects suggest they are extremely effective and deliver good value for money. We are encouraged by investment in the first Social Impact Bond scheme, which was launched in Peterborough in September. This brings Government, social investors and social service providers together in an innovative way to reduce the re-offending rates of short sentence male prisoners leaving Peterborough Prison. Social sector organisations, including the St Giles Trust, will provide intensive resettlement support. If this achieves a reduction in re-offending by 7.5 per cent or more, social investors will receive a return on their investment. This could provide a new model for resettlement.

E1.4 One concern is that the Peterborough pilot assumes that significant numbers of men will continue be sent to prison to serve short sentences. It is necessary to get upstream of this problem and to divert more non-violent offenders away from prison and onto appropriate community sentences, which challenge them to confront drug and alcohol problems. DrugScope is a member of the Criminal Justice Alliance and contributed to its 'Areas for Action' report, which stated that 'short prison sentences for drug users ... make structured drug treatment programmes difficult ... while at the

same time short sentences tend to exacerbate many of the problems linked to drug and alcohol dependency, such as mental health issues and homelessness’.

Accessing social capital

E1.5 The recovery and re-integration of ex-prisoners with a history of drug and alcohol problems also depends on their access to other services and forms of social capital. Around 70 per cent of prisoners report having no employment, education or training in place at the time of their release, while around a third have no accommodation and many more only have access to temporary housing. The discharge grant is limited and many people leaving prisons are unable to access money, open bank accounts or get home insurance. There can be delays in accessing GPs and other support services.

E1.6 DrugScope still hears reports of prisoners being released on a Friday afternoon or evening who are unable to access key community services until the following week. This leaves them without basic support at a critical time, and is something that should be resolvable by Government.

Question E2: What interventions could be provided to address any issues commonly facing people dependent on drugs and alcohol in relation to housing?

Housing

Consultation responses

‘The ring-fence coming off Supporting People has meant that any progress we were making in securing supported accommodation for those who needed it to facilitate their reintegration and recovery has disappeared. Accommodation problems are the single greatest factor impacting negatively upon recovery locally.’

‘Housing is the biggest issue. Local Authority’s should have a statutory duty to provide acceptable housing for those in treatment – i.e. allocation of a fixed number of flats’.

‘To deliver re-integration ... the jobs and houses need to be there. The loss of Supporting People will have a real impact on this priority’.

‘When service users leave one part of recovery – say time-limited supported housing, they are often left to their own devices and placed in residual sink estates where the cycle starts all over again’.

‘Housing is one of the most significant factors – both temporary and long-term. Until there is enough social housing our clients will always be discriminated against. How can anyone who is sleeping on the streets or ‘sofa-surfing’ address substance misuse? The people who give them the most support are often fellow addicts’.

E2.1 There are well established links between drug and alcohol use and housing problems and homelessness. Substance misuse can be a contributing factor to losing accommodation, and conversely, the stress and adverse conditions associated with insecure housing or rough sleeping can lead people to develop a

substance misuse problem. Forty per cent of drug users state that a lack of stable housing is the main barrier to them achieving their treatment goals.²³

LDAN/DrugScope is working with Shelter and Homeless Link to support frontline organisations that provide services to homeless people. Funded by London Councils, LDAN's role is to support frontline homelessness organisations to work effectively with clients who have substance misuse problems.

Homeless hostels

E2.2 Practitioners at our peer support forum have suggested that homeless hostels are often not the right environment for people to try and recover from addiction. Support staff in hostels do not always feel equipped to support clients to prepare for detox or rehab. Clients can be in an environment where others are still using drugs or alcohol. A need for more 'middle ground motivational services for people between use and detox' was identified, as well as more 'dry hostels or housing' whilst accessing treatment (if not residential). Following detox or rehab, often people have no choice but to return to a hostel where the environment can lead to relapse.

Floating support

E2.3 People completing treatment should have access to housing outside of their local authority area if they wish to move away from previous associates.²⁴ 'Solutions' is an example of an innovative supported housing project in Nottinghamshire that provides self-contained flats to homeless people who have completed treatment or are stable on a methadone script, and allows people to move out of their home area if they need to.²⁵

A joined up approach

E2.4 Other suggestions from our forums include:

- improve communication between homelessness services, drug treatment and housing providers (and mental health and offender services, where involved) – for example, by cross-agency training;
- improve training on substance misuse and multiple needs for local authority housing options staff and housing providers, particularly to address stigma and prejudice;
- develop appropriate housing and treatment provision for poorly served groups, particularly Eastern Europeans or failed asylum seekers with no recourse to public funds, women other than those fleeing violence, older homeless people, and single people with 'low level' substance misuse problems who cannot meet the threshold for specialist housing but are also not accepted by mainstream housing.

Question E3: How might drug, alcohol and mental health services be more effective in working together to meet the needs of drug and alcohol dependent service users with mental health conditions?

E3.1 The issue of 'dual diagnosis' has been an important theme for DrugScope's recent policy work. There have been a wealth of policy and guidance documents that

²³ Stephenson M (2005) National Aftercare Survey - Year 3, Addaction, London

²⁴ We published an in-depth article on this issue in Druglink, see:

<http://www.ldan.org.uk/documents/esther2.pdf>

²⁵ An article on this project from Druglink: <http://www.ldan.org.uk/documents/esther.pdf>

have examined the evidence and developed models for effective joint working. These have included: the Department of Health's 'Dual Diagnosis Good Practice guidance' (2002); the Welsh Assembly's 'Service Framework to Meet the Needs of People with Co-occurring Substance Misuse and Mental Health Problems' (2007); the Scottish Assembly's 'Delivering for Mental Health, Mental Health and Substance Misuse, Consultation Draft' (2007) and the Department of Health's 'Guide for the Management of Dual Diagnosis in Prisons' (2009). We refer the Government to these documents.

E3.2 The challenge is not to provide models for effective joint working, but to motivate engagement with this work across the country. In 2008 the Care Services Improvement Partnership (CSIP) produced a 'Themed Review' on dual diagnosis that assessed progress since the publication of the Department of Health's 'Dual Diagnosis Good Practice Guidance' in 2002. Nearly all Local Implementation Teams (LITs) said that they had a local definition of dual diagnosis, with 80 per cent saying that this definition was in operation. But 4 out of ten LITs still did not have a dual diagnosis strategy agreed with local stakeholders, and less than two thirds were able to report that a local needs assessment had been done. Despite the emphasis on training in the 2002 Guidance, fewer than half of LITs had made an assessment of training needs. A wide variation in competencies in both assertive outreach teams and acute inpatient wards was also reported. Generally, the CSIP review revealed a 'postcode lottery' in dual diagnosis services – for example, 83 per cent of LITs in the East Midlands reported that an assessment of training needs had been made compared to only 14 per cent in the South West.

E3.3 The focus of dual diagnosis policy has been on service users with more severe mental health problems. DrugScope has worked to raise awareness of the relationships between substance misuse and common mental health problems, such as anxiety and depression. In particular, we have sought to build stronger links between substance misuse services and the Improving Access to Psychological Therapies (IAPT) programme, both nationally and locally. This is an area of work that needs more attention.

E3.4 In 2002, the COSMIC research project concluded that 67.6 per cent of drug service users and 80.6 per cent of alcohol service users had depression and/or anxiety disorder. It concluded that substance misuse services should work more collaboratively with local psychotherapy services and GPs to improve management of co-morbid patients who do not meet the criteria for access to community mental health services (i.e. those with anxiety and depression in particular). The CSIP 'Themed Review' report on dual diagnosis (2008) noted that the majority of Local Implementation Teams (LITs) had adopted definitions of 'dual diagnosis' that focus on people with severe mental health problems and substance misuse, and stressed that 'the needs of those with less severe mental illness also need to be considered'. More attention needs to be given to this issue – for example, in further developing psychological therapy services for people with mild to moderate mental health problems.

Question E4: Do appropriate opportunities exist for the acquisition of skills and training for this group?

E4.1 LDAN/ DrugScope has been funded by the Trust for London to identify and collate good practice, and to start building an evidence base, on what works in employment support for people with drug and alcohol problems, to disseminate this information to the drug sector and to influence policy and strategy in this area. A pan-London Employment Expert Group advises on this project, made up from key service providers, service user representatives, JobCentre Plus, NTA, London Drug Policy Forum and the UKDPC among others.

E4.2 Skills and training opportunities exist both within treatment services and through partnership with external agencies such as colleges. This provision is patchy across the country however, and more investment is needed to support drug sector providers to provide training, and to help establish partnerships and fund access to courses.

E4.3. Drug treatment providers are well placed in particular to provide life skills and employment preparation support from the start of treatment, rather than as part of aftercare.²⁶ Formal training courses are often limited to skills such as construction and gardening, which do not always match the ambitions of service users. Some projects provide support to start a social enterprise²⁷, and a few are aimed more at young people such as DJ skills and film making which incorporate literacy and numeracy skills. The latter are good for engaging people but need to ensure those involved have realistic expectations. Training and apprenticeships to become a drug worker are an important part of the provision available, and add value to treatment services as former service users can have invaluable personal experience that can help to motivate clients.²⁸

E4.4 Other concerns in relation to training and skills include the lack of apprenticeship schemes for older age groups and the need for courses to be flexible on start dates, so as to be available at the point when someone is feeling motivated.

Question E5: Should we be making more of the potential to use the benefit system to offer claimants a choice between:

- a. **Some form of financial benefit sanction, if they do not take action to address their drug or alcohol dependency; or**
- b. **Additional support to take such steps, by tailoring the requirements placed upon them as a condition of benefit receipt to assist their recovery (for example temporarily removing the need to seek employment whilst undergoing treatment).**

E5.1 DrugScope worked with its membership to influence the previous Government's welfare reform agenda – for example, holding a joint consultation event with the Department of Work and Pensions to discuss the proposals in the Green Paper 'No-one Written Off' and providing both written and oral evidence to the House of Common's scrutiny committee that examined the Welfare Reform Bill. This reflected

²⁶ An example of a project that provides a peer led life skills training course is SUNDIAL, run by Blenheim CDP http://www.blenheimcdp.org.uk/pages/education_training_employment.html

²⁷ For example The Small Business Consultancy <http://www.thsmallbusinessconsultancy.co.uk/>

²⁸ An example is The Apprentice Programme run by Foundation 66: <http://www.foundation66.org.uk/pages/traindevelop.html>

the high level of interest from our members and other stakeholders. We were pleased that the Welfare Reform Act 2009 stepped back from earlier proposals that would have required benefit claimants to participate in treatment or face benefit sanctions, but concerns remained, particularly regarding the unprecedented powers for JobCentre Plus to investigate claimants suspected by Jobcentre advisors of having drug and alcohol problems.

E5.2 DrugScope has strongly supported the greater policy focus on social inclusion for people with drug problems. Access to education, training and employment is critical for social (re)integration. We know that people with a history of drug and alcohol problems can find it extremely difficult to get work. The Drug Treatment Outcomes Research Study (DTORS) has estimated that 80 per cent of problem drug users are unemployed. This is particularly concerning as we know that participation in training, work and other meaningful activity will also tend to improve treatment outcomes, prevent relapse and sustain recovery.

E5.3 DrugScope believes the welfare system has a critical role to play in recovery. We have been supportive of the Progress2Work programme, which was introduced in 2001 to help problem drug users in the benefit system to access training, education and employment, as well as providing help with issues like housing and debt (although we have expressed concerns at the lack of evaluation, which were subsequently echoed in the National Audit Offices report 'Tackling Problem Drug Use' (2010)). We also strongly supported the aim of integrating drug treatment and employment support with the creation of drug co-ordinators in JobCentre Plus in 2009.

E5.4 DrugScope has argued that a benefit regime for problem drug users will only work if it recognises and responds to the realities that:

- Many drug users will find it difficult to disclose that they have drug problems, and will need reassurance and support to talk about them;
- Multiple need is common among people with serious drug problems (for example, many problem drug users have physical and mental health problems, are homeless or in insecure housing and have criminal records);
- Problem drug users often face other significant barriers to employment (including skills deficits and negative employer attitudes);
- For many problem drug users entry into mainstream employment may be an appropriate long-term aspiration, but not a realistic short-term goal. It is important that other meaningful activity (including access to volunteering) is available for this group.

Our concern is that the application of the 'responsibilities' agenda to people with a history of serious drug problems underestimated the formidable barriers that can deter them from accessing education and employment, and the long-term processes of change which motivate people to engage with drug treatment services and move on with their lives.

E5.5 As we argued in our response to the Social Security Advisory Committee consultation on 'The Social Security (Claimants Dependent on Drugs)(Pilot Scheme) Regulations 2010', we believe that 'coercive measures directed against extremely

marginalised and stigmatised people risk reinforcing negative attitudes to them, entrenching their disengagement from statutory services and mainstream society, causing hardship and damaging communities, if they resort to other, illegal, sources of income. We believe an appropriate 'sanction' for problem drug users in the welfare system who do not engage with treatment – if there is to be one - is that they are not able to access the benefits of a 'treatment allowance' and the personalised support provided through a 'voluntary rehabilitation plan'. We would urge the Government to give careful consideration to the SSAC report, which was submitted to the Secretary of State for Work and Pensions on 19 May and provides a detailed, independent analysis of the arguments on the use of benefit sanctions for this group. DrugScope endorses the SSAC analysis.

Welfare Reform

Consultation response

'As a recovering chaotic drug user, I can honestly say that the penalty of removing benefits would not have been scary to me, as I didn't rely on benefits when I was using drugs. It won't be chaotic drug users who are affected by any benefit sanctions, but those who are doing better, and trying not to commit crime – as well as the families of drug users who rely on that income to meet their basic needs'.

Question E6: What if anything could Jobcentre Plus do differently in engaging with this client group to better support recovery?

E6.1 As part of our employment project, we held an event on Welfare Reform, which included a session facilitated by London JobCentre Plus drug coordinators. A key message was that JobCentre staff need more training on drug and alcohol issues so they can feel more confident working with this client group. Mutual cross-sector training between JobCentres and treatment providers would be beneficial. Providers suggested that there was variation between local authority areas in the contact they had with their drug coordinator, but relations were particularly positive where the coordinator had visited services and service user groups. Providers welcomed this outreach role, and benefits advice being provided outside of the JobCentre building. Additional support highlighted were links to employers for their clients, and information and help to establish clear referral routes to employment services.

Question E7: In your experience what interventions are most effective in helping this group find employment?

Finding employment

Consultation responses

'A criminal record for drugs is for life and will almost always deter employers. A change in the Rehabilitation of Offenders Act would help former drug users with "drug only" convictions to move into employment'.

'We need business to contribute resources – such as work placements, training schemes, employment and investment to local service users leaving treatment'.

'It is becoming increasingly difficult to support clients into education, training and employment, when those opportunities are becoming more limited for everyone in this region.'

'In my view, there is frequently work that needs to be done on self esteem, confidence and so on, before an individual is able to make effective use of opportunities such as training. Lack of understanding and prejudice compound these issues'.

E7.1 We have identified many training and employment support programmes that are working well and finding employment for high numbers of clients.²⁹ Individuals need a personalised programme dependent on their support needs and their ambitions. The UKDPC report describes an “employment continuum” looking at the range of support into employment. It starts with addressing health problems, working on motivation, stabilising a person’s drug use, ensuring that they are in appropriate accommodation, developing soft skills often through volunteering, formal training/skills development, help with budgeting, work trials and ending with on-going in work support. A University of Loughborough³⁰ review identified indicators of good practice in employment support:

- Programmes should work closely with local referral services;
- Services should be customised to meet individual users’ needs through one-to-one support and the flexible provision of a diverse range of support services;
- Support should continue after obtaining employment.

E7.2 The review suggests that programmes should start by looking at rebuilding confidence and motivation, developing soft skills to help prepare for employment, training in job search skills and then introducing clients to employers. The setting of realistic goals, development of trust between clients and support workers and effective communication between treatment services and employment support workers are essential in any intervention.

E7.3 The Individual Placement Support (IPS) Model used in the mental health field has a particularly strong evidence base, and has started to be implemented in the drug sector.³¹ Research studies into IPS have shown that this approach achieves a greater success in placing participants into competitive employment than the more traditional “train and place” approach. The key principles of IPS are:

- It aims to get people into competitive employment
- Open to all those who want a job
- Tries to find jobs consistent with people’s preferences
- Job search is rapid
- Employment specialists in clinical teams
- Time-unlimited individualised support for both employer and employee
- Welfare benefits counselling included.

Question E8: What particular barriers do this group face when working or looking for employment, and what could be done to address these?

²⁹ Some examples of practice can be found on our employment webpage:

<http://www.ldan.org.uk/cms/view/employment.asp>

³⁰ Centre for Research in Social Policy, Loughborough University (2004) “Drug and Alcohol Use as Barriers to Employment: A Review of the Literature” Sutton, L. Cebulla, A. Heaver, C. Smith, N. Loughborough

³¹ Central and North West London NHS Foundation Trust have implemented this model for both mental health and substance misuse clients: <http://www.cnwl.nhs.uk/index.html>

E8.1 A number of barriers have been identified. Service users are often worried that the stress of work could lead them into a relapse situation. As such, respondents may see voluntary work, often with drug treatment services, as an initial move to paid employment. Many see their lack of training or education as a key barrier (see question E4 above). Poor self-confidence, sometimes due to an underlying mental health issue, can be a barrier. DrugScope has worked with IAPT services to improve access to people with drug or alcohol problems and have helped establish a 'pilot' in Southwark. Physical health problems are a common theme, especially amongst those with Hepatitis C, and employers need to be flexible around treatment requirements.

E8.2 The UKDPC report noted that two thirds of employers stated that they would not employ a former heroin or crack cocaine user, even if they were otherwise suitable for the job. The UKDPC report on stigmatisation³² found that methadone treatment has been widely stigmatised and those on substitution medication may hide their status for fear of being rejected for work, fired or because they are fearful of their status becoming widely known by colleagues. Gaps in work history due to drug use or treatment are difficult to account for when filling in application forms or compiling a CV.

E8.3 We support the UK Drug Policy Commission's recommendation that the Rehabilitation of Offenders Act should be reformed. In the USA the Americans with Disabilities Act (1990) prohibits discrimination against persons with substance use disorders in the workplace. People in drug and alcohol treatment or with a history of substance misuse problems should be afforded some form of protection under the Equalities Act or the Disabilities Discrimination Act, providing a foundation for addressing wider issues of stigma and barriers to re-integration. Employers need to be supported to increase their understanding of substance misuse issues, to develop relevant HR policies and provide sufficient support, including flexibility for taking time off for treatment sessions or picking up substitute prescriptions.

Question E9: Based on your experience, how effective are whole family interventions as a way of tackling the harms of substance misuse?

E9.1 DrugScope conducted a seminar with Adfam to explore the positive role families can play in supporting recovery from drug dependency. The conclusion was that recovery and family were mutually reinforcing, and that the development and delivery of the 'recovery approach' must place greater focus on the role of families and the positive role they can play, as well as on the support they need in their own right.

E9.2 Whole family interventions can be effective in tackling the harms of substance misuse, if delivered by fully trained professionals, with the appropriate family and at the right time. However, these interventions cannot be effective without the appropriate support, training and considerations of risk. These types of interventions can be particularly helpful when they are delivered by a third party agency. It can provide a more neutral therapeutic approach, and it can also take the pressure off

³² UK Drug Policy Commission (2010) "Sinning and Sinned Against: The Stigmatisation of Problem Drug Users" London: UKDPC.

adult and children's services, which may not have the time or training to deliver these types of interventions.

E9.3 A family intervention worker at our Newcastle consultation event explained that 'a coordination of services, both adult and children, with their families being very much part of the plan and actions, gives everyone ownership and responsibilities. A very effective tool for families is family group conferencing. A co-ordinated meeting from an outside professional, where the family choose the agenda, make a plan and agree on the terms and outcomes. It also gives the user ownership of their addiction. This has a very high success rate with its families because once again it gives the families the power. Being able to offer a family this can be a huge step in the right direction.'

E9.4 There are clear links between domestic violence and substance misuse. Almost two thirds of women involved with domestic violence agencies with substance misuse problems reported that they began their problematic use following their experience of domestic violence. Findings from a review of the British Crime Surveys revealed that 44% of domestic violence offenders were under the influence of alcohol and 12% affected by drugs when they committed acts of violence. This is significant, although it is important not to assume a straightforward link of causation and to recognise that both issues are complex and will need separate interventions. A whole family intervention will not be effective at tackling harms if within that family there is domestic violence and abuse, and in fact this sort of intervention is likely to put family members at an increased risk. At DrugScope's consultation events, members raised domestic violence and drug and alcohol use as an issue that occurred regularly within services, and needed further attention and exploration.

Question E10: Is enough done to harness the recovery capital of families, partners and friends of people addicted to drugs or alcohol?

E10.1 Families play a critical role in supporting family members with drug problems, with benefits not only for the individual concerned, but for their communities and society as a whole, for example, providing emotional support, housing, access to leisure and other meaningful activity and initiating and supporting engagement with formal treatment services. In terms of recovery, families often pay for residential treatment when the funds are not available, and they are often the people that provide the most support during the pivotal phases of reintegration once someone has left treatment. The reparation of family networks is often a key goal of someone's long term recovery, and the success of this process is often the foundation of sustaining recovery. When the recovery capital of family, partners and friends is being harnessed by a member misusing substances, it is often not visible until the point where those providing it are no longer able to continue to do so, often due to reaching 'crisis point'. Family, friends and partners are often isolated, stigmatised and under intense emotional strain. Therefore, it is vital that these support networks are recognised and supported in their own right, including if they feel they need to withdraw their support for a loved one.

- Families effectively subsidise treatment provision and money for the NHS and social care sector, so we welcomed the cost-benefit analysis undertaken by the UK Drug Policy Commission, and would like to see this work developed

- There is still much we don't know about the family's role in supporting recovery, so there should be a full inquiry into their experiences and the services available to support them.

E10.2 In DrugScope's consultation with its membership, the need for state support for family support groups was a strong theme, in addition to the need for these groups to be properly consulted on drug strategy.

Families and carers

Consultation responses

'Family and carers are an essential part of drug treatment and have a right to access their own services.'

'Family support groups across the country are often small unconstituted groups (i.e. they can't apply for charitable funding as they aren't registered charities). Many of them need help to become constituted and registered. The Big Society wants to encourage these groups - and so do we! But, the state could play a role to enable these groups for a time limited period to help them build their confidence and skills to become self-sustaining.'

'Families are often the only people who stick around to support their loved ones who are using drugs. Many find the support they need from speaking to others in similar circumstances. Please ensure that these small groups can still access the vital capacity building support that they need.'

'Fund work with families as they have a major impact on getting people into harm reduction or total abstinence and research shows that those who have family involvement have increased success in remaining drug/alcohol free.'

E10.3 Key workers in drug and alcohol treatment could do more work with the individual misusing substances to explore their family relationships, whether in order to harness these support networks or to reflect on the impact of an unhealthy dependence on their family members. Where appropriate, the beneficial role of the family should be explicitly recognised in care planning.

Question E11: Do drug and alcohol services adequately take into account the needs of those clients who have children?

E11.1 The NTA's Guidance on development of local protocols between drug and alcohol treatment services and local safeguarding and family services, recognises that, if a drug or alcohol user is a parent, the outcome of their treatment is likely to be affected (positively or negatively) by the demands being placed on them in caring for their children. Adult drug services on the whole remain unfriendly to families. They are often located in environments inappropriate for children, have little if anything in way of crèche facilities, and are often open at hours which restrict access for parents caring full time for their children unless they are able to find alternative daytime childcare. Of those parents with serious substance misuse problems, only 37 per cent of fathers and 64 per cent of mothers were still living with their children.

Although many men are the sole carers for children, the majority are women. A reason women are underrepresented in drugs treatment is because some services do not take the needs of parents sufficiently into account. There has been a considerable reduction in the residential services that are available which provide beds and services for mothers with their children. These services can provide an opportunity for women to access intensive recovery focused treatment for their substance misuse, without causing emotional distress by separating mother and children. Many women understandably refuse to enter residential treatment if they have to leave their children, often with the only option of foster care available.

E11.2 DrugScope recommendations include:

- Treatment providers must demonstrate how they can/ have adapted their services so they can be more easily accessed by adults with children
- Treatment providers need to be supported to make necessary changes to their accessibility
- Changes that can be made include: appointments that take into account school and nursery opening hours, flexibility during school holidays, partnership working with children and family services.

Question E12: What problems do agencies working with drug or alcohol dependent parents face in trying to protect their children from harm, and what might be done to address any such issues?

E12.1 There are a variety of problems that agencies face. One of the main issues is a lack of clarity around policy and procedures when there is a child protection/safeguarding issue.

E12.2 There is a clear understanding in drug and alcohol services of the responsibility to protect the children of service users and if a child is at risk of the need to inform social services. However, there are differences between, and within, treatment providers about how, when, what and who by appropriate child risk assessments are undertaken. In some drug treatment agencies, it is felt that if an adult is misusing substances and consequently seeking professional support then any dependent children are at sufficient risk to make an automatic referral to social services, other providers take each assessment of risk on a case by case basis.

E12.3 In children social services teams there can be a lack of understanding about how drug treatment services work, and inconsistent advice to them about the appropriate next steps. In cases where there is already social services involvement with the child of an adult drug user the experience of partnership working is mixed. In the best cases, services are in contact with each other from the offset, retain regular contact and provide each other with updates as and when needed, leading to a collaborative and transparent approach, with the child's needs at the forefront. However, there can be tension between drug and alcohol treatment and social services, which can lead to poor communication and decisions and actions taken by both parties in isolation from each other that are not in the best interest of the child.

E12.4 In DrugScope's consultation events there were concerns expressed by our members about the appropriateness and suitability of the Department of Work and Pension's as the lead department in the context of recovery for children and families

within the drug strategy. The need for children and families to be a priority issue was consistently highlighted, as was the importance of co-ordinated and cross-department working.

E12.5 DrugScope recommendations include:

- A requirement that social workers have drug and alcohol training
- Better access to and support for training for drug and alcohol workers on child protection and safeguarding
- A child protection lead in both senior management and at a project level within drug and alcohol services
- A drug and alcohol lead within children and families social services departments, who is able to be a key contact for drug and alcohol and other services within the local area.

Postcards to the Prime Minister:

Supporting recovery to break cycle of drug addiction

As part of our consultation we asked respondents to write a short 'Postcard to the Prime Minister' on the future of drug policy.

'Recovery is embedded in the whole community so support structures (including training) need to stretch beyond treatment services.'

'There has been a great deal of progress over the past 10 years with some excellent outcomes, build on what has been proven to work. A system based on individual needs and promoting aspiration to succeed.'

'Fund work with families as they have a major impact on getting people into harm reduction or total abstinence and research shows that those who have family involvement have increased success in remaining drug/alcohol free.'

'This is a real opportunity to improve whole life opportunities and options for clients, by looking at recovery and integration into communities. Treatment options need to be person centred with a raft of options to suit the client.'

'Housing is the biggest issue. Local Authorities should have a statutory duty to provide acceptable housing for those in treatment; i.e. allocation of a fixed number of flats etc.'

'Recovery means something different to everyone and services should be flexible enough to offer different interventions dependant upon individual need.'

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