



## **‘Building recovery in communities’ consultation Response from DrugScope**

**May 2011**

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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 and promote recovery
- promotes health, well-being, inclusion and integration
- recognises and protects individual rights
- recognises and respects diversity.

DrugScope is committed to:

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

DrugScope 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 focused; and to engage with policy and decision-makers on behalf of its membership.

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## **Introduction**

DrugScope appreciates the opportunity to contribute to the development of the Building recovery in communities (BRIC) framework. The BRIC consultation document covers a wide range of challenging and complex areas, and DrugScope would welcome future opportunities for discussion of key issues as the BRIC framework develops.

### Related publications

We would also note that a number of recent DrugScope documents cover issues that are relevant to the BRIC framework, specifically:

- Response to the 'Healthy Lives, Healthy People' consultation at <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DrugScopeResponseHealthyLives.pdf>
- Response to the 'Breaking the Cycle' consultation at <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/BREAKING THE CYCLE consultation DrugScope Response.pdf>
- Response to the 2010 Drug Strategy Consultation at <http://www.drugscope.org.uk/ourwork/Policy-and-public-affairs/topics-and-campaigns/key-topics/Drug+strategy+review+-+consultation+2010>
- Response to the 2010 Spending Review Consultation at <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/SpendingReview.pdf>

- The London Drug and Alcohol Network's report 'Pathways to Employment' at <http://www.ldan.org.uk/>
- DrugScope's 'Young People's Drug and Alcohol Treatment at the Crossroads' (2010) and 'Drug treatment at the Crossroads' reports (2009) at <http://www.drugscope.org.uk/ourwork/Policy-and-public-affairs/topics-and-campaigns/key-topics/Crossroads>

### Drug Sector Partnership

We would especially highlight the Drug Sector Partnership's Consensus Statement on drug treatment, including over 30 Chief Executives from the UK's leading drug and alcohol treatment provider agencies. The Drug Sector Partnership has been formed by four national charities – Adfam, DrugScope, eATA and the Alliance – to support community and voluntary sector organisations working in the drug and alcohol sector.

(The Drug Sector Partnership consensus statement is available online at: [www.drugsectorpartnership.org.uk/consensus.html](http://www.drugsectorpartnership.org.uk/consensus.html))

### DrugScope survey and consultation work

DrugScope's response has been informed by an on-line consultation survey specifically targeted at our membership, to which 92 members responded. It has also been shaped by discussions at a number of consultation meetings and events. In particular:

- A meeting of the Treatment Providers Chief Executives' Forum in London on 1 March 2010 which discussed health, welfare, and criminal justice issues (including payment by results). The Chief Executive's Forum is facilitated and chaired by DrugScope and is attended by over 20 Chief Executives of drug and alcohol treatment agencies;
- Consultation events in London (December 2010) and Manchester (February 2011) with DrugScope members and other key stakeholders on the theme of 'Overcoming Barriers to Recovery', which DrugScope hosted on behalf of the Drug Sector Partnership;
- An LDAN/DrugScope BRIC consultation event with service providers in London on 23 March at Skipton House, London, on behalf of the NTA's London Regional Team (see separate BRIC consultation submission on behalf of the NTA/LDAN Service Providers Forum);
- A DrugScope Roundtable Event for a Home Office/Clinks project on monitoring change on 29 March, that discussed the impact of policy and funding changes on drug and alcohol services working with offenders and victims of crime.

Our response has also been informed by the discussions in network meetings facilitated by the London Drug and Alcohol Network (LDAN) for three projects in London on homelessness and domestic violence (funded by London Councils) and pathways to employment (funded by Trust for London). Further information on these projects is on the LDAN website at [www.ldan.org.uk](http://www.ldan.org.uk)

### Making Every Adult Matter

DrugScope has a particular interest in the issues of 'dual diagnosis' and 'multiple needs'. In particular, we have been involved in developing more effective responses to supporting people with complex needs as one of four partners in the Making Every Adult Matter (MEAM) coalition, along with Clinks, Homeless Link and Mind. MEAM is funded by the Calouste Gulbenkian Foundation. It is currently piloting innovative approaches to supporting people with multiple needs in three areas – Cambridgeshire, Derby and Somerset. Further information on the MEAM initiative is on the website at [www.meam.org.uk](http://www.meam.org.uk)

### PRISM

Many of the examples of innovative practice that are included in our response have been taken from DrugScope's PRISM database. PRISM stands for Practice Sharing Model, and enables people to upload details of their projects. Further information and access to PRISM is at <http://www.drugscope.org.uk/prism/prism-home>

## **Overall messages**

DrugScope and LDAN members have been generally supportive of the overarching aims set out in the 2010 drug strategy. They welcome the focus on recovery and social (re)integration and 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 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. The challenge for the BRIC framework is to identify, develop and describe local frameworks that will support the practice that can deliver on this vision.

DrugScope recognises the progress that has been made over the past decade with a major expansion in the availability of drug treatment, reductions in waiting times and the majority of people in treatment remaining engaged for the minimum 12 weeks required for a positive outcome. We need to build on this legacy, with an increased focus on successful completion of treatment and on recovery and social reintegration.

DrugScope would emphasise the need for the BRIC framework to recognise the distinction between those recovery resources that are directly controlled by local commissioners and treatment providers, and resources that may be largely outside their control (for example, the availability of suitable accommodation or training and employment opportunities), and therefore the impact on the ability of services to deliver recovery of spending and policy decisions other than those concerning the allocation of the pooled treatment budget or pooled public health budget (for example, our members report that a reduction in Supporting People funding in some local areas is having a negative impact on their service users).

## **DrugScope response to BRIC consultation questions**

### **Do you think the proposal to replace Models of Care with a new unified document is justified?**

Yes. The further development of a recovery orientated approach involving a closer partnership between treatment and other services (such as housing, ETE, family support and mental health) - and the development of local 'recovery communities' – requires a new framework document. The commitment to bring together adult drug and alcohol misusers within a single recovery framework will be facilitated by a unified document.

### **If so, what are the key issues in bringing together all substance misuse treatment in a single framework?**

Detailed comments on the key issues involved in bringing together drug and alcohol use in a single framework are provided in response to the next question.

Other considerations would include:

- Balancing the development of a national 'blueprint' for recovery-orientated systems with sufficient local flexibility and scope for personalised interventions, which involve service users in identifying their own goals and mapping out individualised pathways to recovery.
- Development of effective strategies to engage new client groups with distinctive profiles and needs (for example, 'invisible drinkers' and people dependent on prescribed and over-the-counter medicines).
- Flexibility to respond to new trends in substance misuse.
- Ensuring that local drug treatment systems continue to provide an appropriate range and quality of services for specific groups – for example, needle exchange services for injecting drug users.
- Balancing the universal requirement to ensure access to evidence-based treatment for people with drug and alcohol problems in accordance with the NHS Constitution, with flexibility to identify and respond to local needs and priorities.
- Achieving accountability for delivering recovery-orientated services without overburdening services with data collection and reporting.
- Incentivisation of the range of stakeholders who will have a role in delivering recovery orientated interventions for people affected by drug and alcohol problems – including housing, employment support, training and education, family support, social services, GPs and mental health.
- Clarity about responsibility and ownership of a framework for recovery orientated services within new local structures and systems (for example, the role of Health and Wellbeing Boards).
- Prioritisation of dual diagnosis (co-morbidity of mental health and substance misuse problems) and multiple need (for example, where

- people with drug and alcohol problems are homeless and/or have mental health problems and/or a history of offending).
- Taking equalities seriously, and ensuring that suitable recovery pathways are available to everyone who experiences a drug or alcohol problem (for example, through gender-specific and culturally-specific services).
  - A clear recognition of the contribution of families, carers and other support networks to recovery.

**What do you see as the advantages and disadvantages of bringing together Models of Care for Adult Drug Misusers (MoCDM) and the elements that focus on treatment of dependence in Models of Care for Alcohol Misusers (MoCAM) into a single recovery-orientated framework?**

*Advantages*

- A single recovery-orientated framework would develop and support the implementation of the commitment in the 2010 Drug Strategy to a more integrated approach to people affected by drug and/or alcohol problems.
- There is a significant overlap between drug and alcohol dependency (for example, a significant proportion of problem drug users will also be misusing alcohol and there are growing concerns about 'poly-drug use', typically involving a combination of alcohol and illegal drugs).
- The wider support needs and the recovery pathways for people with severe and entrenched drug and alcohol problems are broadly similar (for example, homelessness and unemployment).
- There is a high incidence of 'dual diagnosis' (co-morbidity of substance misuse and mental health problems) and multiple needs in both populations. This should be a priority issue for a new unified framework. The BRIC guidance will need to be owned and operationalised by the new public health structures following the abolition of the National Treatment Agency in April 2012, as they will have joint responsibility for alcohol and drug treatment, and will want to develop integrated local frameworks.

*Disadvantages*

- There is a risk of excluding or marginalizing people who are affected by drug or alcohol problems that do not necessarily fit within a 'single recovery-orientated framework' (for example, people who are drinking at harmful or hazardous levels but who may be relatively affluent and socially included).
- There is a risk of unplanned and possibly excessive shifts in the balance of funding of drug and alcohol provision, particularly as drug and alcohol funding is pooled within the new ring fenced public health budget

Responses to DrugScope survey

DrugScope and LDAN members who responded to our online survey identified the following benefits and disadvantages.

### *Advantages*

- 'The majority of drug use is poly-drug use, having separate frameworks perpetuates services being separated';
- 'Destigmatises drug misuse, and suggests that illegal drug use does not equate to highest harm';
- 'Provides a unified approach and opportunities to develop strategies for looking at and meeting the needs of individuals irrespective of the substance(s) they have problems with';
- 'There will be cost benefits in providing a single administrative and strategic framework';
- 'Equity of service provision and pooling of expertise';
- 'Encourages a focus on workforce competencies, client needs and risks rather than particular substances';
- 'Lots of benefits – already happens in the young people's arena and it promotes easy access for service users and less confusion about who/where to refer'.

### *Disadvantages*

- 'From a service user point of view, I have found that alcoholics view themselves differently to drug users and therefore if they are having to walk through the same door they may choose not to enter into treatment';
- 'Potential to deskill the specialist substance misuse workforce (more generalists than specialists), which will be potentially harmful to ensuring those with complex needs around either alcohol or other drugs are met appropriately';
- 'It is simply a proxy for reduced services, diluted skill mixes, revolving doors treatment and disinvestment';
- 'Services will be dominated by more vocal and confident middle class alcohol users and more deprived drug users will miss out';
- 'Not involving other services like the acute hospitals and Accident and Emergency Departments as they play a key role with alcohol problems'.

### **What, if any, are the areas of the framework that may be more difficult to implement in the context of prison-based treatment?**

A prison sentence will often provide the incentive and opportunity for people with long-term drug and alcohol problems to confront dependency issues. The Patel Report on *Reducing drug-related crime and rehabilitating offenders* (2010) noted that funding for prison drug treatment is over 15 times that of 1997, and a record number of prisoners are engaging with treatment. Drug use in prisons – as measured by mandatory drug tests – has decreased by 68 per cent. The introduction of the Integrated Drug Treatment System (IDTS) since 2006 has resulted in improvements in treatment provision in prisons, as well as some improvements in the continuity of care between prisons and the community. DrugScope welcomes the Government's commitment to build on this legacy and to continue to develop effective treatment provision in prisons, as set out in the

Ministry of Justice's 'Breaking the Cycle' Green Paper. We also support the development of a 'one pot, one purpose' approach to commissioning, with the transfer of the Ministry of Justice's budget to the Department of Health.

Specific challenges of implementing a 'recovery framework' in the context of prison-based treatment include:

- The impact of a prison sentence on the service user's ability to access recovery capital, particularly due to the impact of imprisonment on work and training, housing, family relationship and relationships with community services. DrugScope supports the development of more effective diversion services for offenders (as discussed, for example, in the Bradley Report 2010).
- The challenge of developing effective integrated offender management between prison and the community. The Patel Report concluded that 'there is a very clearly articulated need for much greater support and help on release especially with respect to appropriate housing, having enough money, having something meaningful to do and greater integration and co-ordination with community services'. Voluntary and Community Sector organizations have had a lead role in developing effective resettlement projects, including the St Giles Trust's 'Through the Gate' project (which is being developed as part of the Social Impact Bond Pilot at HMP Peterborough) and Addaction's Manchester Resettlement Project.
- The high incidence of 'dual diagnosis' among prisoners. HM Chief Inspector of Prisons concluded (Annual Report 2008-09) that three quarters of prisoners may be experiencing some form of dual diagnosis. The Bradley Report (2010) found that 'services are currently organized in such a way as to positively disadvantage those needing services for both mental health and substance misuse problems'. DrugScope notes that in 2009, the Department of Health and Ministry of Justice published joint guidance on the management of dual diagnosis, and a dual diagnosis training project for criminal justice workers was initiated by the Department of Health, Skills for Health and the Pan-London Lifelong Learning Network. These are welcome initiatives that should be further developed and built on.
- There needs to be greater consistency in the provision of drug treatment in prisons. The Patel Report concluded that 'a multitude of funding streams, commissioning and process targets' had resulted in 'a fragmented system with a "one-size-fits-all" approach with limited choices in the type of treatment and broader social support available'. The UKDPC's 2008 report 'Reducing drug use, reducing reoffending' commented on 'considerable variation in provision between areas' with 'prison drug services frequently fall[ing] short of even minimum standards'. The Patel Report includes practical recommendations for addressing this.
- The development of alcohol services in prisons has not matched the development of drug services. The HM Inspectorate of Prisons report 'Alcohol services in prison: an unmet need' (2010) stated that 19 per cent



of adult prisoners had reported an alcohol problem in surveys conducted by HMIP in 2008-09, reaching 30 per cent in Young Offender Institutes and 29 per cent in Women's Prisons. But many prisons had no alcohol strategy and where strategies were in place they were often felt to be inadequate. HMIP found that 'very few treatment or offending programmes have been developed or accredited specifically for alcohol misusers' and 'none were yet available in any prison inspected'.

DrugScope is aware that some concerns have been expressed about what some have considered an overuse of methadone in the prison service. While we share concerns about 'parking' or 'warehousing' people on methadone, with little aspiration for recovery, and little help to address the causes and contexts of drug problems, we note that methadone and buprenorphine are currently recommended by the National Institute of Clinical Excellence (NICE) for the treatment of opiate dependency. We are therefore opposed to introducing 'strict time limits' for methadone prescribing, whether in prison or the community. Judgments about the appropriate use of medication should be made by trained and experienced clinicians. We do, however, support a shift in the onus of clinical justification to ensure that the suitability and need for substitute drugs is regularly assessed by clinicians, and is not simply the default option.

It is important that a welcome focus on recovery-orientated approaches in prison does not neglect 'harm reduction' interventions. In particular, DrugScope would like to see a high priority placed on reducing the unacceptably high rates of death from overdose among recently released prisoners.

**How do the systems promoting recovery need to reflect specific factors relating to ethnicity, gender, gender reassignment, disability, age, sexual orientation, religion/belief, pregnancy and maternity considerations? What proportionate measures could address those issues?**

These issues were discussed in the UK Drug Policy Commission's report 'Drugs and Diversity: An overview of implications for Policy and Practice'.

### Services

The UKDPC report concluded that the treatment and rehabilitation needs of drug users from diverse groups must be better addressed by public services if they are to achieve recovery from drug problems. Whilst it is not feasible to provide separate services specific to all groups everywhere, mainstream providers will need to be able to have the ability to meet the differing needs of all individuals.

Actions that would facilitate this include:

- Building the capacity and competencies of both existing drug services and generic support services through targeted workforce development initiatives to support flexible service responses to address the drug-related needs of different minority groups;

- Ensuring ‘payment by results’ systems where introduced are configured to generate improved outcomes for minority groups;
- Using local partnership and commissioning processes to ‘engineer’ better collaborative working between mainstream drug service providers and specialist LGBT, ethnic and disability support organisations, mental health and learning disability services and sexual health services;
- Ensure routine impact assessments include outcome data, such as that gathered from the Treatment Outcome Profile system (TOPs), for different minority groups;
- Introducing a national ‘kite-mark’ system for services demonstrating good practice in meeting the needs of different groups could help improve people’s confidence in services and encourage access.

### Communities

The UKDPC report concluded that the risk factors for drug use, the contexts in which use takes place and the consequential harms vary between and within the diverse groups as do the most appropriate means of communicating information. Current drug information, education and prevention programmes do not adequately meet these differing needs.

Actions to harness resources within the communities themselves include:

- Identifying ways of supporting and maintaining cultural resilience against drugs among successive generations in a way that does not stigmatise users and families and hinder help-seeking;
- Fostering supportive peer networks to reinforce positive group identity and cultural norms;
- Developing and evaluating innovative approaches to the use of self-help groups, faith communities and social media networks for delivering new substance use prevention information programmes;
- Developing national and local anti stigma programmes.

([www.ukdpc.org.uk/resources/overview\\_policy\\_briefing.pdf](http://www.ukdpc.org.uk/resources/overview_policy_briefing.pdf))

### Mutual aid and peer support

It is important that local mutual aid and peer support provision is responsive to diversity and equalities issues. We are aware that mutual aid networks have been set up in some areas to reflect specific women’s, BME or LGBT issues. There are also issues about the perceived spiritual elements of some recovery-orientated mutual aid communities, and there is a need to develop local provision for those with different (or no) spiritual and religious beliefs.

### DrugScope survey

Respondents to DrugScope’s survey were asked about equalities and under-represented groups.

Some commented on what was perceived as limited awareness among providers of issues relevant to cultural or religious groups, and said that this 'may impact on the potential to achieve a meaningful therapeutic relationship'.

One respondent observed that 'in smaller towns there are simply not enough people to allow for specific mutual aid groups for different groups, however, in an area such as this I would feel that groups that suffer discrimination (e.g. BME groups) would be vulnerable in general mutual aid groups'.

A number of respondents advocated having specific services to address the differing issues of under-represented groups: 'often the patterns of use and substances used are different; generally recovery support should be built within different community groups'. However, a few respondents did not support separation of services. One stated: 'the main challenge is integration rather than separate provision'. A tier 4 abstinence provider suggested their approach meant they were not challenged by the specific issue of under-represented groups, they 'ensure there are specialist elements in their recovery plan to address any specific areas related to gender or ethnicity'.

Some respondents feared current 'public sector cutbacks and financial restraints will mean that the provision of preventative, recovery orientated services specialising in women or BME communities may be cut or not even created in the first place'. If possible and financially viable, one way to address the issues surrounding under-represented groups would be to 'invest time and support them financially, having staff take the time to make links with them', as well as 'listening to under-represented groups and responding, being innovative and risk taking where possible'.

A commonly identified barrier for women accessing treatment is childcare problems, as well as a fear of social services. This was felt to be compounded by a 'lack of funding to provide services out of hours and childcare facilities' and few services address this issue: 'there is a lack of drug and alcohol services focused to work with families to remove children from either care or the 'at risk' register'.

Some respondents commented that there should be 'women only groups' perhaps to address the issue that one respondent identified: 'some women (but also some men) may have experienced abuse in intimate relationships and may find it difficult to participate in groups involving known individuals or find it hard to mix with people who share characteristics of people they have had difficulties with in the past e.g. are aggressive in tone and behaviour'.

Another respondent suggested that as women are under represented in drugs services, 'their views, experiences and opinions won't be heard in this process as the approach is developed by men for men. It will be hard to find women and gain their views and opinions; ways to do this could be approaching hostels, women's projects, and street outreach'.

A particular issue surrounding the recovery of those from BME groups is attitudes to drugs in particular cultural and religious groups, which may prevent disclosure and make it difficult for people to come forward where they need help. One respondent commented: 'we should not try to enforce the same models as for white adult heroin users, and should recognise these are heterogeneous groups, particularly BME, e.g. differences between BME men and women in some communities'.

### **DrugScope members and stakeholders - Practice examples**

Reaching Out (Manchester). Reaching Out is a project that aims to raise awareness of and treat substance misuse problems in black and minority ethnic communities (BME). The project does not focus on one specific ethnic group but rather uses a community-focused, multi ethnic partnership approach to target seven key groups in the Greater Manchester area: the Chinese, Pakistani, Bangladeshi, African, Caribbean, Somali and Kurdish communities. One of the central concepts of Reaching Out is the recognition that community organisations themselves are often better placed than service providers to gain access to communities, build trust and disseminate information about substance use. ([www.drugscope.org.uk/prism/projects/reaching-out](http://www.drugscope.org.uk/prism/projects/reaching-out))

Newham Community Drug Team BME Engagement Work. The Newham Community Drug Team (NCDT) seeks to support both individuals and family members from culturally diverse groups in the area to engage with drug treatment. By working in a sensitive manner with both clients and drug treatment providers, NCDT staff ensure that cultural barriers to access and sustaining engagement are removed where possible. An example of this would be ensuring that Muslim clients are not asked to attend appointments on Friday or that methadone consumption times are changed during periods of fasting. They also provide easy access to translation services for clients and families and run 9 satellite support services in GPs' surgeries, which provide a more suitable level of discretion and confidentiality for some individuals and cultural groups. Service user groups are held every 6 weeks and 75 per cent of participants are BME and are actively involved in attending events to promote the services at NCDT. ([www.drugscope.org.uk/prism/projects/newham-community-drug-team-bme-engagement-work](http://www.drugscope.org.uk/prism/projects/newham-community-drug-team-bme-engagement-work))

Juice at Greenwich Metro Centre. Juice is a free, confidential alcohol advice and counselling service for young people who identify as lesbian, gay, bisexual, transgender or are questioning their sexual identity and who live in the South East London Area. It offers alcohol-related advice, counselling and one-to-one and group support to 11-21 year olds. ([www.metrocentreonline.org/counselling\\_under25.htm](http://www.metrocentreonline.org/counselling_under25.htm))

## **How do you think these best practice outcomes could be defined and measured?**

DrugScope welcomed the high level outcomes specified in the 2010 Drug Strategy, and our members have supported a greater focus on outcomes in the commissioning and delivery of drug services.

DrugScope has been actively involved in the development of the Drug Recovery Payment by Results pilots, including participating in the Department of Health's expert group. Many of the issues about how the outcomes could be defined and measured have been discussed in detail by the DH Expert Group and sub-groups. We refer the BRIC consultation team to the notes and minutes of these discussions.

DrugScope would add that the Drug Recovery Payment by Results pilots are controversial for some of our members (for example, because of concerns about the risks of creating perverse incentives and the ability of smaller voluntary and community sector organisations to manage the financial risks and uncertainties). There are alternative approaches to incentivising a focus on recovery outcomes (for example, the NTA is currently providing financial incentives for commissioners to increase the numbers of people successfully completing treatment, which does not constitute 'payment by results' as such).

The London Drug and Alcohol Network (LDAN) is currently being funded to develop two programmes in London to improve access to housing and 'pathways to employment' for people affected by drug and alcohol problems, funded by London Councils and Trust for London respectively. LDAN is also funded by London Councils to support services in London to improve the links between drug and alcohol treatment and domestic violence services. We discuss these projects in more detail in response to the specific questions on social reintegration below. However, we would make the following observations on definition and measurement:

- DrugScope strongly supports the inclusion of a housing outcome, as access to suitable accommodation is consistently identified as the cornerstone for recovery by DrugScope members, and there are concerns that recent reforms (for example, to housing benefit) could make it more difficult for clients of drug and alcohol services to secure safe and secure accommodation.
- 'The ability to access and sustain suitable accommodation' will require careful definition and further clarification. For example, having the 'ability' to access housing will make a limited contribution to supporting recovery unless it is actualised. What will constitute 'suitable' accommodation for someone who is seeking to address an entrenched drug or alcohol dependency problem? For example, hostel and other shared accommodation where other tenants may still be using alcohol and/or

- Sustainable employment should include training and education and voluntary work. While employment has a critical role in social (re)integration, it is important to recognise that premature entry into the workplace can have a negative impact on recovery.

Again, DrugScope would emphasise the need for the BRIC framework to recognise the distinction between resources in the direct control of local commissioners and treatment providers, and resources that are largely outside of their control.

**How can services that focus on reducing drug-related deaths and the spread of blood-borne viruses act as a platform for individuals to access structured, recovery-focused treatment?**

Evidence based harm reduction services should be available to all drug users who could benefit from these interventions, including those who may not yet be motivated to participate in structured treatment or recovery orientated services. These services prevent the spread of blood borne viruses, reduce other serious health risks associated with drug dependency and the administration of drugs and save lives. They will often provide a first point of contact with professional drug treatment services (for example, needle exchanges may provide the only contact that injecting drug users have with health and social services).

Harm reduction services such as needle exchange may provide a gateway into more structured treatment and they can and should be integrated into balanced treatment systems and a recovery-orientated framework. Equally, it should be recognised that some users of these services will value their anonymous and more impersonal character, and it is important to engage this group and maintain that engagement.

Needle exchange and other harm reduction services have always had a role in motivating their clients to engage with more structured treatment. For example, the 'Drug misuse and dependency: UK Clinical Guidance on Clinical Management' (2007) suggests that harm reduction services should provide 'brief motivational interventions ... to people with no or limited contact with services'. The 2008 NTA guidelines on 'Good practice in harm reduction' conclude that a key theme to emerge from a national conference on injecting drug use was the need for greater prioritisation in needle exchanges of links with structured drug treatment, with specific proposals including:

- Shared skills and experiences between Tier 2 and Tier 3 services; and
- Delivery of harm reduction through treatment services.

However, discussion of links with structured treatment and recovery have been limited in research and guidance on the role of needle exchange and other harm reduction initiatives. Conversely, documents like the NTA's 'Commissioning for Recovery' (2010) make little reference to these sorts of harm reduction services and their potential role within recovery-orientated systems.

Specific ways in which services that focus on blood borne viruses and reducing drug related deaths can act as a platform for accessing structured, recovery focused treatment would include:

- Providing a first point of contact with health and social services for clients with some of the most serious and entrenched drug and alcohol problems;
- Continuing to provide brief motivational interventions;
- Providing all their clients with information about local services (including structured drug and alcohol treatment, housing, employment, etc) and providing rapid access to more personalised support and guidance on request;
- Co-location of harm reduction services and other forms of drug and alcohol treatment.

#### **DrugScope members and stakeholders – Practice examples**

Harm Reduction Service, 11 St George's Place, Brighton. No 11 is the main gateway service in the city for substance misuse. It provides needle exchange, paraphernalia, condoms and advice and information. Anybody can enter this service and ask for advice and information on any substance issue. 'Abstinence time' is provided on four mornings a week to ensure there are facilities for those who have stopped using and are in need of ongoing support and those who have stopped using and feel they are tempted to use again. Brief interventions are provided for these clients. Friends, families and carers of substance misusers are also encouraged to utilise this service. The Open Access service is also the main point of contact for initial assessment in order for people to enter the treatment system. Medical intervention is provided daily for people to have their drug injuries treated, to access Hepatitis B vaccinations and to receive harm reduction advice.

(<http://cri.org.uk/project/218>)

Harm Reduction, Needle Exchange and Blood Borne Viruses Service, Blackburn with Darwen NHS. The needle exchange element of this service provides injecting drug users with a clean, safe and confidential service where access to information and advice can be sought as well as clean injecting equipment, paraphernalia and disposal units. Basic sexual health information and free condoms are also offered through needle exchange. The blood borne virus element of this service provides a free, confidential and discrete testing facility for blood borne viruses including Hepatitis A, B and C and HIV. It operates an open door policy. ([www.psu.bwdpct.nhs.uk/our-services/sexual-health-and-](http://www.psu.bwdpct.nhs.uk/our-services/sexual-health-and-)

[harm-reduction-services/harm-reduction-needle-exchange-and-blood-borne-virus-service/ \)](http://www.threeboroughs.nhs.uk/index.php?PID=0000000200)

Blood Borne Virus Health Care Team, Three Boroughs Primary Health Care Team. The team is made up of four specialist registered nurses who have various experience and expertise within the fields of substance misuse and blood borne viruses. The team aims to raise the awareness of substance misusers around blood-borne viruses, namely hepatitis and human immunodeficiency virus (HIV), ultimately curbing the incidence of drug related deaths. The service offers on-site testing for blood borne viruses, vaccination against hepatitis A and B, wound care, health assessments and referral to specialist NHS services. The team also provides a peripatetic service, from weekly clinics at statutory and non-statutory drug services. They work across Lambeth and Southwark ([www.threeboroughs.nhs.uk/index.php?PID=0000000200](http://www.threeboroughs.nhs.uk/index.php?PID=0000000200))

### **What are the key things that partnerships and service providers can do to increase the opportunity and access to a range of recovery pathways?**

Drug and alcohol treatment providers need to develop and build upon existing relationships with key services and professionals with a role in supporting recovery and providing recovery capital – including housing providers, ETE services, employers and training/education providers, family support and intervention, social services, children’s services and health and mental health.

This was a key point that emerged at a consultation event with service providers that DrugScope facilitated on behalf of a Clinks project funded by the Home Office on 29 March. It was commented that disinvestment in other local services (for example, housing and domestic violence) would have an impact on the ability of drug and alcohol services to work effectively with clients and deliver recovery and reintegration outcomes. For example, there was a particular concern about Supported People funding and housing benefit changes, with one participant commenting ‘an example is the change of housing benefit rules for claimants up to 35 years of age – it will be more difficult to support recovery if someone is only able to live in a hostel or shared house (possibly where other people are using drugs or alcohol) with no prospect of a transfer to social housing’.

Local partnerships should take advantage of the available opportunities for joint commissioning of recovery services, and pooling of local budgets, building on the learning from the Drug System Change Pilots and Total Places initiative, as this becomes available. The public health reforms will create new opportunities for joint commissioning – for example, with the development of Health and Wellbeing Boards.

Service users have a key role to play in identifying and accessing recovery pathways, and need to be appropriately supported to do so. Clients of services



will not necessarily have the information or confidence to access other local services, so a mapping out of local recovery pathways needs to be a key component in the development of the service user's recovery plan.

DrugScope supported the Royal Society of Arts (RSA) Whole Person Recovery Project, participating in the expert advisory group and helping to facilitate consultations with local stakeholders (including service users) from West Sussex. The 2010 RSA report 'Whole person recovery: A user centred systems approach to problem drug use', provides useful and relevant guidance on what partnerships and service providers can do to increase the opportunity and access to a range of recovery pathways, including:

- acquiring and building recovery capital (developing local recovery capital resources);
- mapping local recovery resources and disseminating information;
- active engagement of service users (providing a 'catalyst for users themselves, and members of their communities, to foster recovery through their collective social effort and innovation')
- identifying and making the most of existing recovery resources (for example, involvement of local 'recovery role models'); and
- providing a wide range of personalised recovery services.

### **What are the key components of recovery planning?**

DrugScope's member survey asked respondents which factors were most essential for the development of effective service user-led recovery planning.

The three most commonly identified factors were:

- 'Access to and involvement of other local services, such as employment, homelessness, domestic violence, mental health and social services' (selected by 33 respondents);
- 'Staff training and workforce development to develop skills and competencies for recovery planning' (selected by 30 respondents);
- 'Availability of local recovery networks and a high level of integration with these networks - e.g. mutual aid and recovery champions (selected by 26 respondents);
- 'Reduce workloads to give case workers more time with each client' (selected by 24 respondents).

A recent discussion of recovery planning proposes five initial steps to an effective recovery plan (Stephen Bamber):

- Recovery plans are 'self directed';
- Recovery planning should be facilitated by the key worker (or recovery coach/mentor), but should be the responsibility of the service user or client;
- Recovery plans should be subject to regular review led by the client;

- Recovery plans should guide the therapeutic journey towards specific (and evolving) outcomes and goals;
- Recovery plans are owned by the service user or client and should accompany them on their journey through and beyond services.

Other considerations identified by DrugScope and LDAN members include:

- The need for an appropriate balance between aspiration and ambition for clients and realism about the often long-term and evolving nature of recovery journeys (for example, service users may need time and space to concentrate on their treatment needs and a premature entry into education or employment could be damaging).
- Assessment of the 'recovery capital' available to the client or service user and the involvement or sign up of other key services in the recovery planning process is critical – for example, housing, education and employment support, health and mental health.

**Do you agree with the proposal to shift care-planning practice towards service user-led recovery planning?**

Recovery is a 'person-centred journey', which places the individual at the centre, with his/her particular needs, resources, aspirations and motivations. A recovery orientated approach therefore requires active, non-tokenistic service user participation. What exactly this requires in practice is less straightforward, and it will be important to provide guidance on good practice in service user led recovery planning.

While DrugScope supports the shift of care planning practice towards service-user led recovery planning, we would make the following points:

- The Government has identified a number of generic recovery goals that will shape the development and performance management of drug and alcohol treatment systems. For example, moving service users into education or paid employment has been identified as a key goal for treatment services in the 2010 Drug Strategy. The Drug Recovery Payment by Results pilots that are due to be launched in October 2011 will introduce a new system of payment to services in eight local areas based on their success in achieving outcomes across four key domains: free of drug(s) of dependence, reduced offending or continued non-offending, employment and improved health and well-being. There will need to be more clarity about how these recovery indicators are to be balanced with service user led recovery planning – for example, will the service user's role have a primary focus on specifying how they will achieve the generic recovery goals (for example, personal routes into education or employment) or will service users have a more active role in selecting those outcomes that are priorities for them?

- Service-user led recovery planning will need to be shaped and informed by
  - the available evidence-bases on what works in securing recovery;
  - a realistic assessment of the recovery resources available in a particular locality at a particular time; and
  - by the clinical and professional judgments of service providers.
- If service users are to lead the recovery planning process they will need to be appropriately supported. For example, in an academic paper discussing the recent development of recovery planning, Thomas Borkman comments that ‘the self-directed recovery plan that clients are expected to develop and follow is formulated within an extensive network of peer “teaching” and support. Mutual peer help ... is manifested both through service staff as senior, more experienced guides and role models, and through resident peers learning recovery together’ (Thomas J Borkman ‘Is recovery planning any different from treatment planning’).
- The development of service user led recovery planning will require a review and possible changes to the role descriptions and competencies of key workers.

### **How can the role of recovery planning be operationalised?**

See response to the previous question.

### **How can systems and services best ensure that recovery planning is sufficiently ambitious and challenging yet does not place the service user at unnecessary risk or set them up to fail?**

See response to the previous questions.

In DrugScope’s on-line BRIC survey, freedom from dependence was identified as the most difficult outcome for problem drug and alcohol users to achieve by more respondents than any other single factor. Research suggests that this is the outcome that is identified as their main goal by many service users accessing treatment. Services should encourage and respond appropriately to these aspirations, but they should also support service users to make informed choices, and they have a responsibility not to set people up to fail or place service users at unnecessary risk. For significant numbers of people entering drug and alcohol services, while a drug or alcohol free outcome will be a realistic longer term objective and an aspiration that should be supported and encouraged, they will first need support to take intermediate steps to this longer term goal over a period of time. They should be actively involved in mapping this journey. It is also important to acknowledge that relapse is common, and to build relapse prevention and re-engagement into the recovery planning process.

## **How do you see the role of mutual aid in an integrated recovery-orientated system?**

DrugScope supports the integration of mutual aid into recovery systems, although we would welcome further research on outcomes and the elements of the most effective mutual aid interventions.

We note that there are a range of approaches to mutual aid and that different programmes will be suitable for different service users. While established mutual aid groups, such as Alcoholics Anonymous and Narcotics Anonymous, can play a key role in recovery for many people, there needs to be further development of alternative approaches to mutual aid (for example, SMART recovery groups). It is important that treatment services develop relationships with local mutual aid organisations and that the potential role of mutual aid is discussed as a key component in service-user led recovery planning. Equally, mutual aid groups should be supported and encouraged to identify and build relationships with other treatment and recovery services.

Fifty seven per cent of respondents to DrugScope's survey said that they had a relationship with local mutual aid groups. However, almost a quarter of respondents (26 per cent) said the services they were involved with did not have a relationship with mutual aid (and 17 per cent did not know).

Most respondents who replied positively reported links with Alcoholics Anonymous or Narcotics Anonymous, and a typical description of the nature of the relationship was 'just providing premises, encouraging people to attend, sometimes more practical support such as administrative support and funding'. A few respondents mentioned SMART Recovery, Intuitive Recovery and Cocaine Anonymous.

Some reported that they had close relationships with mutual aid and even that there was an expectation that clients would attend. For example, one commented: 'the service for which I work has a strong relationship with self-help. All clients coming into our service are informed of the appropriate fellowship and those undertaking our intensive recovery programmes are expected to attend meetings and forge relationships with fellowships in order to sustain recovery capital on exit'. Others said their relationship with mutual aid was more informal – for example, 'very loose, but amiable'. There were some very positive comments on relationships with mutual aid, for example 'very beneficial for clients to see that recovery is a reality' and 'we find these extra tools for recovery extremely beneficial for our service users. Having these meetings happening in the project means that even out of hours support can be offered'.

Some respondents stressed the importance of giving service users choice about involvement with mutual aid groups, and a choice between different mutual aid groups. One commented: 'we host presentations from 'public information'

representatives from three different 12 step fellowships, we also run accredited mentoring programmes non-affiliated with 12 steps, but which have approximately 50 per cent involvement from attendees of abstinence based support groups. We make it clear that our service is about 'inclusion and diversity'. Others stated 'I have seen good and bad practice in this area' and 'we are happy for clients to choose their own routes to recovery rather than push them in any one direction. Not all clients go for a 12 step model, for example'.

Attitudes to 12 step programmes were identified as a barrier to accessing mutual aid by some respondents. For example, one person suggested 'they have a different philosophy to us'. Another remarked 'some staff have prejudice against 12 steps – but this prejudice should be discouraged as it may help clients'.

One respondent commented that a barrier to engagement was that many mutual aid groups will not promote other treatment services. 'Narcotics Anonymous will not promote local drug treatment services in any way', it was stated, 'they will not even have our leaflets available at their meetings'. It was felt that 'the relationship between fellowship and treatment providers is one way'. Concerns were also raised that mutual aid was only available in certain localities: 'mutual aid groups are available, although not in all localities and therefore are not accessible to all'.

#### **DrugScope members and stakeholders – Practice examples**

SMART Recovery. This approach is secular and 'science based', using motivational, behavioural and cognitive methods. It views substance/activity dependence as a dysfunctional habit, while recognising that it is possible that certain people have a predisposition towards addictive behaviour. The purpose is to 'help individuals seeking abstinence from addictive behaviours to gain independence, achieve recovery and lead meaningful and satisfying lives'. (<http://cdn.smartrecovery.org.uk/doc/AC-SMART-Pilot-Evaluation-Summary.pdf>)

#### **How do you see the role of peer support in an integrated recovery-orientated system?**

DrugScope believes that peer support is an essential component in a recovery orientated system. A recurring message from consultations with our members and other key stakeholders is the importance of service users interacting with peers who have achieved key recovery objectives and the inspiration that this provides, as well as the particular authority and 'expertise by experience' of peers who have direct personal experiences of both the challenges and benefits of the recovery process.

Effective peer support is not delivered by a single approach but can take a variety of forms, with different approaches suitable for different service users at particular points in their recovery journeys. The following categorisation is based

on the work of the US based 'Faces and Voices of Recovery' organisation, which has proposed a number of possible roles for peers and peer-support in an integrated recovery orientated system. These can include, for example, one-to-one relationships with peer mentors (who may or may not be based within the drug or alcohol service) and peer led support and service user groups:

1. Peers as 'recovery coaches'. Peer recovery coaches will be trained and supported to provide personal guidance and mentoring support for people seeking or in recovery (which may include medically assisted recovery). This could include role modelling recovery; providing emotional and personal support; contributing to identifying and setting recovery goals for the client (this could include a role within user-led recovery planning); helping the client to develop new and supportive friendship networks and to access services and resources, and advice on general life skills. While the role of a recovery coach should be distinguished from mutual aid work, the coach may link the service user to mutual aid support.
2. Peers as 'resource co-ordinators'. Peers can have a more specific focus on supporting service users to access the concrete resources to support recovery, including housing and employment, but also more 'informal' resources. Peers will often have personal experience of accessing services, and can walk service users through different systems, services and service cultures – such as child protection, criminal justice, mental health, primary care, HIV and dental services. This can include accompanying clients to appointments, and providing some basic advocacy support.
3. Peers as 'co-ordinators of substance-free activities'. Peers can provide and support opportunities for service users, carers and families to access kinship, community, leisure and socialisation activities in substance-free settings.
4. Peers as 'support group facilitators'. Peers may be involved in convening, organising and facilitating recovery support groups, including both general and 'special topic' groups. These need not be based on particular philosophies or assume a single pathway to recovery, and may cover a wide range of issues.
5. Peers as 'workshop facilitators'. Peers may develop and conduct workshops to disseminate information, develop knowledge and build skills to support recovery. Workshops can be single or multiple events and might cover topics such as job readiness skills, re-entry and disclosure issues, nutrition and healthy relationships.

DrugScope's survey asked our members whether the services they were involved in operated a form of peer support for service users. Seventy one per cent said that they did, 21 per cent said 'no', and 9 per cent said that they 'didn't know'.

Respondents highlighted a range of peer-led services they provide including support groups, mentors, outreach, family and friends services, social clubs/evening support and peer drug workers. Some described these services as the “backbone” of their organisation, with some forming partnership relationships (e.g., ‘actively involved in peer support through a partner agency – peers meet new clients, take them to appointments, etc’).

There were a lot of positive comments about the contribution and benefits of peer led services from respondents. For example, ‘having people working in the project as peer mentors is a valuable component of the multi-disciplinary team’ and ‘absolutely invaluable and critical to long-term recovery/abstinence’, adding ‘not utilised enough on site, this could be improved as well as establishing more robust floating support/aftercare, especially following periods in detox’. One respondent suggested that their peer support group offers ‘an independent support service for clients experiencing difficulty with our services and will support or write on behalf of clients and operate essentially along the same lines as a Trade Union might for staff, which has proven highly effective’.

Many comments highlighted the popularity of peer involvement opportunities with service users. For example, one commented ‘peer support in drug projects is a great goal for service users to achieve as they often want to give back’ (although one respondent stated ‘our clients tend not to want it’).

Some concerns were expressed about the potential impact of spending cuts. One commented ‘I can see a danger of peer support being exploited to provide “more for less” services. I think there is a good case for peer support (paid and voluntary) – but not to replace current service provision.’ Another respondent wrote ‘we tried to set up peer support with young people, but hard to keep them engaged when no funding to provide “incentives” such as food and drink’. Young people’s peer support was highlighted as an under-developed area (e.g., ‘there is no current funding for peer led support projects for young people’).

Similar points were made at our consultation event with service providers on policy and funding changes on behalf of Clinks on 29 March. The participants welcomed the appropriate use of volunteers – for example, the greater interest in peer mentoring and mutual aid in drug and alcohol policy and the recognition of the value of volunteering to support the recovery and reintegration of people in drug and alcohol treatment. However, there was concern that at a time when services were experiencing economic pressures there could be an incentive to use volunteers as an alternative to paid staff. It was noted that effective use of volunteers required a proper framework, training and supervision. Using volunteers who were not suitably qualified for their roles was unfair on them and involved risks to the safety of service provision and the service user.

Some respondents believed that the NHS, local government systems and risk aversion was a barrier to setting up peer support groups. Others suggested that

the key barrier was stigma and the negative attitudes of some service managers and workers.

There were a number of comments about the need for peer support workers to access appropriate training – for example, ‘I believe that service users can be very good at supporting their peers as they understand what they are going through. However, it is important to offer some kind of training before service users become peer mentors – as well as supervision to ensure they are able to cope with others’ difficulties without jeopardizing their own treatment’.

There were concerns raised about the difficulties associated with peer support workers disclosing their own treatment history. One respondent wrote ‘It’s helpful to have peer support. However, I have seen many cases where this has been unhelpful as the “worker” spends most of their time talking about their experiences rather than assisting with the particular problems the client has, which could be significantly different’, another commented that ‘it can create barriers for those staff members who don’t have this background being seen as less knowledgeable.’

Quite a few services had ambitions to improve and increase their peer-led services (e.g., ‘service users are at our training events and act as advocates to other clients. We need to get more but we are working on it.’)

### **How can the new framework best support the development of local systems in which mutual aid and peer support are well integrated and valued resources?**

Support for integrating mutual aid and peer support could include:

- Commissioners including requirements to describe the role of peer support and involvement of service user groups as essential/integral components in service tenders;
- Funding of services should recognise and resource the costs associated with the integration of peer support and mutual aid – for example, training and costs associated with meetings;
- The framework could encourage and support local partnerships and relevant agencies to develop and maintain up-to-date information about local peer support, mutual aid and service user groups;
- Services should be encouraged to invite members of NA, AA, Smart Recovery and other mutual aid and peer support groups to give presentations within their services;
- Workforce development for drug and alcohol treatment service providers should ensure that staff have a good awareness of the main forms of peer support and mutual aid, the evidence around their use and effectiveness and local access and availability;
- There should be a requirement to discuss mutual aid and peer support involvement with service users as part of the recovery planning process;



- Mutual aid and peer support groups need to recognise their reciprocal responsibilities to participate as partners in local recovery systems, including developing constructive relationships with treatment services;
- The framework should ensure that mutual aid and peer support is used appropriately and not developed as a less costly alternative to other forms of support at a time of financial restraint (i.e. it should be clear both about what the role of peer support and mutual aid is and is not).

### **How can systems and services best implement the three levels of recovery champions as described in the drug strategy?**

- Strategic recovery champions. A critical question will be how recovery is championed by leaders within the new public health service when it assumes the lead responsibility for drug and alcohol treatment from April 2012. It will be important that the recovery approach and agenda is championed within public health at a sufficiently senior level within decision-making structures. The drug strategy suggests that local Directors of Public Health could act as strategic recovery champions, but it is unclear how this would fit alongside their other responsibilities, and there would be merit in having independent representation for the recovery agenda. One option would be for local public health services to include a 'strategic recovery champion'. Service users and former service users should have effective representation at strategic level – for example, volunteering and/or employed within the public health service, sitting on commissioning boards, and as trustees of services, at local and national level.
- Therapeutic recovery champions. Within therapeutic environments service users in recovery should be utilised as peer supporters, volunteers and/or paid staff. Services should be flexible about engaging and employing service users who self-identify as in medically assisted recovery, as well as those who have achieved abstinence from all drugs, including substitute drugs.
- Community recovery champions. Service user groups are already active in most local areas, and should be supported to work actively in the local community to promote recovery. Many user groups around the country are already engaging the local community. For example, the London Borough of Camden's service user group have produced a video to be distributed to local community services showing those who have used local drug treatment services talking about their recovery. Local partnerships and services have a key role in supporting service user led activity – for example, use of premises, funding and promoting service user involvement within their services.

## What are the key components of a recovery community?

The US recovery specialist William White has identified the characteristics of recovery groups in the United States, which include:

- Independence and self governing structures;
- Recovery communities should provide welcoming environments, with an emphasis on social fellowship and motivational enhancement through mutual support and encouragement;
- Mutual support is provided through the community rather than through a professional or business organisation;
- An absence of hierarchy – the aim is to help each other to address common issues and problems, and there is no rigid dichotomy between providers and users of recovery support;
- Support relationships may be guided by ‘group conscience’ and solidarity rather than professional codes or legal regulations;
- They tend to include practical approaches to ‘guilt’ for past actions related to dependency – such as acts of restitution, restoration and service;
- Approaches are based on ‘pragmatism’ rather than ‘theory’, with a focus on well-tested strategies for daily living, and guidance takes the form of ‘experience-based suggestions’;
- Entry into a recovery community and progress through it is not determined by a diagnosis, medical records, etc.
- There is a strong ‘service ethic’, with members ‘reaching out’ to people who are still suffering from addiction;
- A focus on ensuring support is available during times of heightened vulnerability when professional services may not be available (for example, evenings, nights and weekends); and
- Support is provided on a voluntary and peer basis so it is less contingent on either personal finances or public funding.

[www.williamwhitepapers.com/pr/2009Peer-BasedRecoverySupportServices.pdf](http://www.williamwhitepapers.com/pr/2009Peer-BasedRecoverySupportServices.pdf)

Another article on ‘The Recovery Community Organisation’ which draws upon the experience of the United States identifies the following elements:

- *Recovery Vision:* Recovery Community Organisations (RCOs) have a singular goal: enhancing the quantity and quality of support available to people seeking and experiencing long-term recovery from alcohol and other drug addiction;
- *Authenticity of Voice:* Those involved with RCOs self-identify as persons in long-term recovery, family members, friends and allies of recovery and offer themselves and their personal stories as living proof of the transformative power of recovery.
- *Independence:* RCOs are most credible and effective as stand alone entities. The leading RCOs are open to multiple levels of collaboration with a wide variety of other organisations, but they are not under the control of

other organisations. For example, RCOs may work closely with addiction treatment providers, but will be independent of them.  
(From Phillip A. Valentine, William L. White and Pat Taylor in “The Recovery Community Organization: Toward A Working Definition and Description”

Further information on the strategies of RCO’s can be found in:  
<http://www.williamwhitepapers.com/pr/2007DefiningRecoveryCommunityOrganization.pdf>

White et al have responded to criticism of the recovery movement in the UK at  
<http://www.informaworld.com/smpp/content~content=a929460216>)

Much mutual aid support in the UK already exhibits the key characteristics for recovery communities as identified in the literature from the United States.

We understand that the UK Recovery Federation (UKRF) is approaching service user groups, who may affiliate with UKRF by endorsing ‘recovery principles’ as set out at  
<http://wiredin.org.uk/blogs/entry/7211/uk-recovery-federation-consultation-paper>

Many service user groups will embody recovery principles, as well as functioning as social clubs and providing peer and advocacy support. It could therefore be argued that the UK already has an extensive and diverse network of ‘recovery communities’ in potential, as is indicated by the range of groups listed in the Service User Group directory available at the website of Drink and Drug News at  
<http://view.vcab.com/?vcabid=eehSrapScelagc>

While recognising that recovery communities will have a different culture and approach than other services, DrugScope notes that these community groups work with highly vulnerable people with serious drug, alcohol and related problems. It is therefore important that they operate transparently and are subject to appropriate forms of scrutiny and oversight – for example, to ensure that issues such as confidentiality and the selection, training and support of people providing support and guidance to others is managed appropriately.

### **How can the impact of a recovery community be demonstrated?**

In principle demonstrating the impact of recovery communities requires the same approaches and methodologies as research into other treatment approaches and modalities, and poses similar challenges. In outline it requires:

- identifying the goals or objectives of recovery communities and/or service users involved in recovery communities;
- assessing the number/proportion of service users who achieve and sustain those goals and objectives and over what time periods, taking account of their starting points on entry into the service;

- qualitative research on the experiences and journeys of service users within recovery communities.

The challenges of assessing the impact of recovery communities include isolating their contribution to achieving outcomes in circumstances where service users may be engaged with other forms of treatment and recovery support.

A particular challenge is to develop research and assessment tools that are adapted to the distinctive nature of a recovery community. For example, research methods that require detailed assessment of service user need on entry into a service and use standardised assessment and reporting protocols to track progress may not be compatible with the ethos, culture and approach of recovery communities. Research will need to be designed to take account of these issues, and may have a significant qualitative component.

DrugScope recognises the importance of ‘narrative evidence’ alongside ‘statistical evidence’. The role of narrative is a key theme in the development and literature of service user led recovery movements (for example, in mental health). We would welcome objective analysis and discussion of the strengths and limitations of ‘narrative evidence’, given its evident value for many service users, including in assessment of recovery communities.

### **How can local systems and services better involve families, partners and carers in the treatment and recovery process?**

DrugScope supports and refers the BRIC consultation team to Adfam’s response. DrugScope also refers the consultation team to a briefing produced by Adfam in partnership with DrugScope in 2009 entitled ‘Recovery and drug dependency: A new deal for families’ ([www.adfam.org.uk/docs/recovery\\_dependency.pdf](http://www.adfam.org.uk/docs/recovery_dependency.pdf))

### **What are the key sources of support that families, carers and partners need to enable them to participate in the service user’s treatment and recovery?**

The Adfam 2010 Manifesto states that services should be:

- Ensuring that local strategic plans are developed and implemented in a whole partnership approach, supporting each provider to work effectively with others;
- Raising the awareness of all public service professionals, including GPs, of the impact a patient’s drug and alcohol use has on family members, especially children;
- Ensuring that local partnerships’ structures and procedures make it quick and easy for family members to be signposted or referred to essential support at the right time;
- Implementing a national template enabling all public service professionals to ask the appropriate questions and engage with the *Think Family*

agenda, alongside training packages that challenge the silo approach to service delivery.

Adfam also discuss the need for commissioning to take account of the needs of families:

- Recognising the complex needs of families affected by drugs and alcohol and ensuring that commissioning practices reflect this;
- Delivering local needs assessments that recognise the diverse policy agendas that family support can fulfill;
- Making the commissioning environment accessible to local community-led providers;
- Ensuring that family support is part of a long term commissioning strategy.

([http://www.adfam.org.uk/docs/Adfam\\_manifesto\\_2010.pdf](http://www.adfam.org.uk/docs/Adfam_manifesto_2010.pdf))

The UK Drug Policy Commission's policy briefing 'Supporting the Supporters' (2009) looks at five ways in which families could be supported:

1. The level and quality of direct support to help families in their own right need to be improved.
2. The stigma associated with drug dependency needs to be challenged.
3. The drug treatment system needs to be made more supportive and inclusive for families.
4. Leadership – responsibility for driving forward an agenda to enhance support for families needs to be placed with an identified champion at national and local levels.
5. Information/knowledge development is essential for ensuring the adequacy and appropriateness of service provision – currently even the most basic data are lacking.

### **How can the framework support local areas in strengthening the support that is available for carers, partners and family members?**

By building on and incorporating previous guidance produced by the National Treatment Agency – in particular 'Supporting and Involving Carers: A guide for Commissioners and Providers' (2008), which could be adapted and applied within the public health structures and to a more recovery-orientated framework.

The DrugScope/Adfam report 'Recovery and drug dependency: a new deal for families' (2008) highlighted the importance of making support available to families in their own right that was not necessarily dependent on the individual family member's engagement. In particular, it concluded that 'there is an urgent need to improve support for families that have lost contact with or disengaged from a family member with a drug problem'. A contributor to an expert seminar facilitated by DrugScope/Adfam explained 'the process of recovery requires repairing relationships with the family and in general with others in their lives ...

once the individual has physically recovered from the drug use, their family may still need to recover.'

It was also argued that if local support for families is to be strengthened then the needs of families need to be recognised at the 'grass roots' level and not only by policy and strategic bodies. For example, one seminar participant commented 'we cannot underestimate the importance of key workers developing trust with clients to build upon the family as a resource that can be positively accessed to help achieve and maintain recovery'. Another commented that 'key workers and drug workers look at the individual drug user and not at the system and context in which drug use is taking place' and that 'family involvement needs to be brought in at all stages within an individual's recovery process'.

Another concern was the lack of information and resources available to families – including information on their family members' condition, as well as the more complex medical, social and legal implications of this, such as having drugs in the house. Providing families with resources 'just for them' is a valuable first step. ([www.adfam.org.uk/docs/recovery\\_dependency.pdf](http://www.adfam.org.uk/docs/recovery_dependency.pdf))

### **How can the framework best support systems in developing greater continuity of care between prison and community services?**

DrugScope supports the conclusion of the Patel Report that a cross-governmental strategy is key to developing integrated and 'joined up' approaches for people in prisons, moving between prisons and on release. The report stressed the need to 'increase efficiencies and improve cost effectiveness by ensuring drug treatment and interventions strategy in prisons is not developed in isolation but linked to other relevant initiatives and strategies as they develop'.

In particular, we note the Patel Report's recommendation that complex commissioning systems 'characterised by a multitude of funding streams and process targets' are replaced with 'a streamlined effective and efficient commissioning system. Patel concluded that 'this would mean that local health commissioners, potentially within new consortia of GP practices, and local drug partnerships including local authorities, local Directors of Public Health, prison governors, etc. would share responsibility for commissioning drug treatment both in prisons and on release and would have collective responsibility to ensure effective joint commissioning and to align/pool budgets to obtain best outcomes, efficiencies and value for money'.

The Patel Report: Reducing drug-related crime and rehabilitating offenders (September 2010) at [www.dh.gov.uk/en/Publicationsandstatistics/DH\\_119851](http://www.dh.gov.uk/en/Publicationsandstatistics/DH_119851))

DrugScope welcomed the announcement in the 2010 Drug Strategy that the Department of Health will assume responsibility for all drug treatment in prison and the community' to 'support the Government's ambition for a greater

emphasis on shared outcomes and provide an opportunity to promote the co-commissioning of drug services in England’.

DrugScope welcomed the announcement from the National Treatment Agency in February that in 2011-12 local partnerships would have commissioning responsibility for all prison interventions ‘to make the most of the pooled funding arrangements in order to jointly commission local recovery services’.

From April 2012, the budget for community treatment will be controlled by the public health service, but we understand that funding for prison services will be the responsibility of the new NHS Commissioning Board. DrugScope has asked for further clarification on how the commitment to co-commissioning and a shared outcome framework will be embodied locally following the health and public health reforms. Some concerns have been expressed by DrugScope members that prison drug treatment could potentially be marginalised by local decision-makers following the transfer to public health, unless there are clear and specific duties and responsibilities to invest in prison treatment.

### **Do you consider that moving away from a four-tier model will be beneficial in supporting the development of integrated recovery-orientated systems?**

The highest proportion of respondents (48 per cent) to our online survey suggested that moving away from a four tier model would be beneficial in the development of integrated recovery-orientated systems, compared to 31 per cent who answered ‘don’t know’ and 20.3 per cent who felt that it would not be.

LDAN facilitated a consultation event with senior managers in London on behalf of the NTA on 23 April 2011. A number of relevant points were made at this meeting. It was argued that differentiating between different types and forms of drug services is important, and this is consistent with an integrated approach to treatment provision. These distinctions were felt to be necessary and inevitable in developing a framework for local practice and provision.

One of the risks of mapping the system in terms of ‘tiers’ is that it can encourage a conceptualisation of treatment as comprising discrete and distinct interventions, rather than as an integrated process or journey.

### **How can local systems best work with those in the employment and housing sectors to support successful reintegration into communities?**

Coordination with the employment and housing sectors is essential to support successful reintegration. In the current economic climate this can be challenging, and there is concern about local disinvestment in services to support recovery.

In our online survey, a lack of capacity in other local services (such as housing, mental health, family support and employment services) was the most commonly

identified barrier preventing individuals from successfully completing treatment and achieving recovery. One respondent commented: 'sustained employment and suitable accommodation are challenges in this particular climate, especially when local government pull Supporting People funding and close down hostels'.

Improved coordination with the employment sector is examined under the specific employment questions.

### Housing

Most respondents rated 'housing services' and 'safe, secure and appropriate accommodation', as 'difficult' (35 per cent) or 'very difficult' (35 per cent) to access and 61 per cent believed that these would become 'less accessible' over the next 12 months, compared to 5 per cent who said they would be 'more accessible' and 27 per cent who said they would be 'as accessible'.

One commented that 'in many areas there simply is not any housing available. The ability to find any accommodation is the single most common factor in lapse and relapse'. There was a sense that drug or alcohol workers feel that they may be powerless to address housing issues for their clients. It was commented that 'regardless of the effectiveness of the substance misuse intervention, the housing issue is outside of the control of the substance misuse treatment field, and substance misusers (or those recovering from substance misuse) are often ghettoised.' Another explained that 'it is a lot of work to ask of a drugs worker to support a client with accommodation as well as everything else.'

Suggested solutions included integrating housing support provision more effectively into treatment services: 'regardless of a client's ability to achieve and sustain abstinence and recovery, the shortage of Local Authority housing provision will remain a barrier for service users unless housing need is integrated into treatment provision.' Other suggestions included creating new housing support or link-worker roles within treatment services and increasing cross-agency training. DrugScope's 'Drug Treatment at the Crossroads' (2009) report recommended that 'all local drug partnerships need to develop effective partnerships with other local agencies. These would include JobCentre Plus, housing providers and mental health services ... It may be necessary to create new roles or redesign existing ones to provide a better structure for developing and maintaining relationships between key stakeholders and agencies (an example could be the creation of drug coordinators within JobCentre Plus).'

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

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, with clients placed in environments 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' while in treatment or when leaving treatment.

'Solutions' in Nottinghamshire is a good example of an innovative supported housing project. It 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 this will be beneficial for their recovery. (<http://www.frameworkha.org/pages/solutions.html>).

The LDAN homelessness forum has identified a need to improve training on substance misuse and multiple needs for local authority housing options staff and housing providers, particularly to address stigma and prejudice. In addition, a need to develop appropriate housing and treatment provision for some poorly served groups has been identified, for example:

- more projects for older homeless people (such as the Thames Reach Robertson Project at [www.olderhomelessness.org.uk/?pid=194](http://www.olderhomelessness.org.uk/?pid=194)); and
- more hostels for women who use drugs/alcohol and who are fleeing domestic violence and abuse (such as the Nia project refuge at [www.niaproject.info/housing\\_services/](http://www.niaproject.info/housing_services/))

**In delivering an integrated recovery-orientated system we would expect treatment systems and services to work in a more family-orientated way. How could the framework best support this?**

See comments above. We support the response of Adfam.

#### **DrugScope members and stakeholders – practice examples**

Phoenix Futures Sheffield Family Service. The Sheffield Family Service provides a six month residential rehabilitation programme for single parents, couples and pregnant women who wish to address their substance misuse issues whilst continuing to live with and care for their children. The Sheffield Family Service offers secure and stable living accommodation for up to 28 adults and children, enabling them to rebuild family relationships with the help of a dedicated family key worker. The supportive environment provides the opportunity for parents to successfully tackle their substance misuse and develop their parenting skills. The same service is also available in Brighton.

([www.drugscope.org.uk/prism/projects/phoenix-futures-sheffield-family-service](http://www.drugscope.org.uk/prism/projects/phoenix-futures-sheffield-family-service))

West Sussex 'Families and Friends' Project. This project helps people being affected by a friend or relative's substance misuse. The project provides advice and support through a number of services including drop in and support centres,

a telephone helpline, outreach work, respite care, training and information packs. ([www.drugscope.org.uk/prism/projects/west-sussex-families-and-friends-project](http://www.drugscope.org.uk/prism/projects/west-sussex-families-and-friends-project))

Middlesborough Families First Project. Families First is a family focused crisis intervention service working with families where there are serious child protection concerns directly related to parental substance misuse. The service receives referrals from mainstream children's services teams and aims to keep children with their families where it is safe and possible to do so, help families during times of crisis, and support parents/carers to recognise their drug issues and help them to change. It provides an intensive intervention and support package (for up to 8 weeks) to children and parents/carers, delivering parenting programmes/advice and linking with other local agencies and services. To do this effectively, the team deploys both adult and children's workers flexibly to establish clear goals with the family and address 'whole-family' issues in a structured manner. ([www.drugscope.org.uk/prism/projects/middlesbrough-families-first-project](http://www.drugscope.org.uk/prism/projects/middlesbrough-families-first-project) or [www.middlesbrough.gov.uk/ccm/navigation/health-and-social-care/carers/families-first/](http://www.middlesbrough.gov.uk/ccm/navigation/health-and-social-care/carers/families-first/))

Addaction – Breaking the Cycle. Addaction is working in partnership with the Zurich Community Trust to provide support to parents or carers with drug or alcohol problems. Addaction workers provide an individually designed care package, which takes into account the needs of the whole family. The package includes a wide range of services, such as personal counseling, or help with accessing other services, such as Housing Associations or health clinics. They have sites in Tower Hamlets, Cumbria and Derby, with one team in Tower Hamlets that focuses on Bangladeshi Young Women. ([www.addaction.org.uk/page.asp?section=183&sectionTitle=Breaking+the+Cycle](http://www.addaction.org.uk/page.asp?section=183&sectionTitle=Breaking+the+Cycle))

Newcastle Changing Trax – Crisis Intervention project. The programme works intensively with families in crisis where significant parental substance misuse looks likely to contribute to a child becoming subject to a child protection plan or taken into care. Staff offer intensive support to families over a six to 12 week period and the service aims to create positive change in the families functioning in order to enable children to remain safely at home wherever possible. The programme offers 24/7 support. Changing Trax staff work with the families in their home environment and the wider community. Support is provided through a range of methods (including the use of motivational interviewing techniques and drug and alcohol diaries), all of which are geared towards helping families work step by step towards clear, realistic and personal goals. The project accepts referrals from Children's Social Care in cases where there are substance misuse problems in the family, families are in crisis and there's a real risk of their children being removed from their care or where the child/children involved have a social worker who will continue to have case responsibility throughout the intensive support period. ([www.drugscope.org.uk/prism/projects/newcastle-changing-trax-crisis-intervention-project](http://www.drugscope.org.uk/prism/projects/newcastle-changing-trax-crisis-intervention-project))

Newcastle Strengthening Families Project. This project is based in Newcastle Changing Trax. During the seven week programme parents/carers and children work both separately and together to look at issues such as 'protecting against substance misuse', 'the consequences of drug misuse', 'dealing with stress', 'handling peer pressure' and 'building family communication'. The programme's facilitators come from a multi agency, multidisciplinary background, including workers from the YOTs, Social Care, CAMHS and young people's drug and alcohol services. Support is offered to a range of family members including children, mothers, fathers, grandparents, foster carers, adoptive parents and same sex couples. Any agency in the city, statutory or voluntary, can refer a family to the programme and the project also accepts self-referrals. ([www.drugscope.org.uk/prism/projects/newcastle-strengthening-families-project](http://www.drugscope.org.uk/prism/projects/newcastle-strengthening-families-project))

**What are the main barriers to individuals who are recovering in securing employment (including volunteering) and how could we best overcome them?**

In our online consultation questionnaire, around a third of respondents rated sustained employment as the most challenging recovery resource for drug and alcohol treatment clients to access (it was the second most commonly chosen option after 'freedom from drug and alcohol dependence').

One respondent commented 'I have put sustained employment as the most challenging outcome, because this is certainly influenced by: a) personal history and perception of employers; b) the need to access appropriate and affordable training; and c) lack of jobs in a shrinking job market in an adverse economic climate'. Another felt that with a shortage of employment 'available for the general population', the prospects of finding work were 'even more difficult for the marginalised and unskilled'. Most respondents to the survey rated paid employment as 'very difficult to access', and they expected it to become 'less accessible' over the next twelve months. However, some respondents were more positive about achievability, with one saying that 'I have seen employment achieved regularly, when there is work available'.

Around half of respondents to DrugScope's on-line survey rated 'training and education services' (49 per cent), and 'volunteering opportunities' (52 per cent) as 'reasonable to access', with 10 per cent and 15 per cent respectively rating them as 'easy to access'. By contrast, only 3 per cent said that paid employment was 'reasonable to access', with 25 per cent saying it was 'difficult to access' and 68 per cent that it was 'very difficult to access'. Sixty seven per cent of respondents believed that paid employment would become 'less accessible' over the next 12 months (with 21 per cent saying that volunteering would become less accessible compared to 18 per cent who believed it would be more accessible and 38 per cent expressing concern that education and training would become less accessible, compared to 10 per cent who said it would be more accessible).

The London Drug and Alcohol Network has been funded by Trust for London over four years to improve pathways to employment for people with drug and alcohol problems in London. This includes working to break down barriers such as stigma, and to increase the number of education, training and employment opportunities available to this client group. The project aims to develop an evidence base on what works in employment support for people with drug and alcohol problems and influence policy and strategy in this area.

A report from this project called 'Pathways to Employment in London: A guide for drug and alcohol services' was produced by LDAN in 2010 and can be accessed at: <http://www.drugscope.org.uk/Documents/PDF/Policy/employment-report-revised.pdf>

The LDAN report identifies the following barriers to employment or volunteering:

- Physical health problems - for example, hepatitis C – because treatment can interfere with working hours;
- Poor self confidence sometimes due to an underlying mental health issue;
- Service users can be worried that the stress of work will lead to relapse;
- Stigma and negative attitudes to current and former drug users among employers and other ETE providers;
- Criminal records and anxieties about their disclosure (which can also discourage applications);
- Disclosure of drug and/or alcohol history, including accounting for gaps in work history due to drug use or treatment;
- Lack of education/skills;
- Managing on-going treatment in a work environment (for example, taking time off work for treatment sessions or to pick up substitute prescriptions).

Our experience is that skills and training opportunities exist both within treatment services and through partnership with external agencies such as colleges. However, this provision is patchy across the country, and more investment is needed to support drug sector providers to provide training, and to help establish partnerships and fund access to courses. Drug treatment providers should be supported and encouraged to provide life skills and employment preparation from the start of treatment, rather than as part of aftercare.

At DrugScope consultations some participants have suggested that voluntary work is becoming as difficult to get as paid work. In the current economic climate those in recovery who may not have work skills or high confidence levels are competing with graduates for voluntary positions. At consultations there have also been anecdotal reports that some third sector voluntary placements appear to be for positions that prior to the economic downturn would be paid. As such, there is a risk that those in early recovery may find themselves in inappropriate situations and there is a need for careful governance of the use of volunteers.

DrugScope has been supportive of the development of Progress2Work and welcomed the introduction of drug co-ordinators employed by JobCentre Plus with funding from the Department of Health in 2009. There is concern among DrugScope members and other key stakeholders about the disappearance of drug co-ordinators and that the DWP's Work Programme is developed to work with clients of drug and alcohol treatment providers.

We welcomed the assurance in the 2010 Drug Strategy that 'JobCentre Plus will... continue to work in close partnership with drug and alcohol services at a local level, and will offer face-to-face support, advice and guidance on benefits and employment'. The 2010 'Joint-working protocol between JobCentre Plus and treatment providers', produced in partnership by the National Treatment Agency and JobCentre Plus, is a helpful document in making a reality of this commitment to partnership work. We applauded the commitment in the drug strategy that 'where people are taking steps to address their dependence, they will be supported, and the requirements placed upon them will be appropriate to their personal circumstances and will provide them with the necessary time and space to focus on recovery'. We would welcome further information and clarification on progress on flexible conditionality for this group.

#### **DrugScope members and stakeholders - Practice examples**

Outlook Manchester. Outlook provides opportunities for adults (19+) in Manchester to discover new talents, skills and activities and explore employment and training options. The service is for people who are in drug treatment, on a reduction programme or recently detoxed from drugs and who are ready to make changes. The project offers a range of services along with one-to-one support where service users are encouraged to develop an action plan drawn up with an Outlook caseworker to address their needs and interests. A key part of Outlook's current programme in partnership with Manchester College is the opportunity for service users to study for an NVQ 2 + 3 in Health & Social Care. Service users are given the chance to apply to become a Graduate Member, which entails attending Manchester College one day per week, working towards core competencies with additional literacy and numeracy courses running concurrently for those requiring further support.

([www.drugscope.org.uk/prism/projects/outlook-manchester](http://www.drugscope.org.uk/prism/projects/outlook-manchester))

Stockton Employment Development Project. Stockton Drug Action Team is working closely with Jobcentre Plus to support local service users into training and employment opportunities. As a key part of this work, Stockton DAT has seconded an employment development specialist from Jobcentre Plus who is responsible for devising and implementing an Employment Strategy for service users. In order to maximise the effectiveness of local resources, the Employment Development Manager has brought together treatment providers and training and employment scheme providers to work in partnership. This has seen agencies pool funding and resources for service users in a more effective way. The EDM

has also sought to take a holistic approach, by identifying and addressing the wider needs of substance misuse clients in addition to employment and training. After housing was identified as a major need for service users, the EDM worked with a recognised voluntary sector provider to set up a flexible housing scheme. ([www.drugscope.org.uk/prism/projects/stockton-employment-development-project](http://www.drugscope.org.uk/prism/projects/stockton-employment-development-project))

Education, Training and Employment (Kensington and Chelsea) run by Blenheim CDP. ETE aims to support service users to gain access into education, training and employment opportunities. An expert team assists the clients with objectives such as gaining accredited qualifications, building confidence and self-esteem and developing the necessary skills to return to work. ([www.blenheimcdp.org.uk/pages/education\\_training\\_employment.html](http://www.blenheimcdp.org.uk/pages/education_training_employment.html))

Fresh Start, Red Kite Learning (RKL). The project is delivering work placements, training and employment support to participants with a history of substance misuse. ETE advisors offer support to these clients to help them move forward with their individual career goals. They are eligible if they are over 20, economically inactive, and ready and committed to ETE. It is a three month programme with six months ongoing support and RKL offer travel expenses and limited course funding. They give advice on ETE opportunities, support with additional applications for funding, access to RKL workshops and ongoing support and progress reviews. ([www.rkl.org.uk](http://www.rkl.org.uk))

### **What do you think are the best ways to get local employers to think of individuals in recovery as potential employees?**

The LDAN report on Pathways to Employment (2010) discussed some practice examples of work with local employers (and education and training providers), and these issues are also discussed in the UK Drug Policy Commission's report 'Working towards Recovery', which highlights useful testimony from employers who have had extremely positive experiences of employing problem drug users in recovery. Key points would include:

- Work to develop local partnerships with employers to take on the long-term unemployed, including people with a history of drug and/or alcohol problems, should be build on (for example, Local Employment Partnerships);
- Employers need information, support and training to take on people with a history of drug and/or alcohol problems;

- Effectively promoting the advantages of employing people in recovery from drug problems;
- A clear lead in developing good practice from public sector employers;
- Local employers can be encouraged and supported to take on a role in strategic bodies, service governance and the development of recovery networks (for example, local employer representative bodies could participate in Health and Wellbeing Boards and individual employers could be encouraged to serve as trustees on the boards of local charities);
- Drug and alcohol policy specialists and practitioners can act as advocates for their service users - for example, participating in events and training for HR professionals, both at local and national level;
- Employers should be encouraged to offer service users in recovery opportunities for voluntary placements, work placements and traineeships.

Further discussion is included in the UKDPC 'Working towards Recovery' report at ([www.ukdpc.org.uk/publications](http://www.ukdpc.org.uk/publications))

One respondent to DrugScope's online BRIC survey highlighted the need for more investment in awareness raising work with employers: 'Securing employment means changing the attitudes of employers and the general public - and this will take investment.'

### **How can the framework support improved access to mental health services for individuals with a mental health dual diagnosis?**

DrugScope believes that 'dual diagnosis' should have a higher profile and priority within a new recovery-orientated framework for drug and alcohol services.

DrugScope would suggest that there is no shortage of helpful guidance on improving access to mental health services for individuals with 'dual diagnosis' including:

- Department of Health (2002), 'Dual Diagnosis Good Practice Guidance';
- Turning Point and Rethink (2004), 'Dual diagnosis toolkit – Mental health and substance misuse';
- Welsh Assembly (2007), 'Service framework to meet the needs of people with co-occurring substance misuse and mental health problems';
- Scottish Advisory Committee on Drug Misuse (2008) 'Essential care: A report on the approach required to maximise opportunity for recovery from problem drug use in Scotland'; and
- Department of Health (2009) 'Guide for the Management of Dual Diagnosis in Prisons'.

The issue of dual diagnosis is discussed in detail in other recent policy reports, such as Lord Bradley's report on 'People with mental health problems and learning difficulties in the criminal justice system' (2009).

The challenge is to implement what we already know about effective frameworks to support services for people with dual diagnosis. 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) had a local definition of 'dual diagnosis' with 80 per cent saying that this definition was in operation. But 4 out of 10 LITs 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 completed. Despite the emphasis on training in the 2002 Guidance, fewer than half of LITs had made an assessment of training needs. The CSIP report also revealed wide local variation 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. Most respondents to DrugScope's online BRIC survey rated mental health services as 'difficult to access' for their clients.

Of course, guidance produced over the last decade will need to be revised and reviewed to apply to changing public health, commissioning and service frameworks. For example, it is not clear how 'dual diagnosis' will be managed by the new health and public health and GP Commissioning structures (an issue that DrugScope is discussing with colleagues at the Centre for Mental Health). We also understand that consideration is being given to excluding clients with dual diagnosis from the Drug Recovery Payment by Results pilots, and would welcome further discussion of how this could potentially affect access to services in the pilot areas.

The Making Every Adult Matters (MEAM) project is a coalition of Clinks, DrugScope, Homeless Link and Mind, which was formed to influence policy and services for adults with multiple needs and exclusions, including many who will have a 'dual diagnosis' of substance misuse and mental health problems. It is funded by the Calouste Gulbenkian Foundation. Together the partner charities represent over 1600 frontline organisations working in the criminal justice, drug and alcohol treatment, homelessness and mental health sectors, with a particular focus on voluntary and community sector organisations. The MEAM coalition is currently running three local pilot s that will co-ordinate existing services for people facing multiple needs and exclusions, and seek to improve outcomes and deliver better value for money. The services are based in Cambridgeshire, Somerset (Mendip and Sedgemoor) and Derby. MEAM will be organising a set of regional learning events and a national conference to promote the findings and learning from the pilots. MEAM is also working with Revolving Doors Agency to develop a vision paper for policy on multiple needs and exclusions, which we aim to launch in Autumn 2011. (Further information is available on the MEAM website at [www.meam.org.uk](http://www.meam.org.uk))

The principal focus of dual diagnosis policy has been service users with more severe mental health problems. DrugScope has also been concerned with the



limited provision for common mental health problems – particularly depression and anxiety. We have sought to build stronger links between substance misuse services and the Improving Access to Psychological Therapies (IAPT) programme both nationally and locally – and have been involved in a project working with colleagues at IAPT and the NTA to develop guidelines on working with people with drug and alcohol problems for IAPT and other primary care mental health services. This is an area of work that needs more attention. 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. The CSIP ‘Themed Review’ on dual diagnosis (2008) noted that the majority of LITs had adopted definitions of ‘dual diagnosis’ that focused on severe mental health problems and substance misuse, and stressed that ‘the needs of those with less severe mental illness also need to be considered’.

COSMIC 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). Ten years on from the COSMIC research this remains a key challenge for the development of a comprehensive ‘recovery framework’.

DrugScope’s experience is that clients of drug and alcohol services have been excluded from the IAPT programme in some areas of the country. Some IAPT services have apparently operated a policy of ‘blanket exclusion’ of people in contact with substance misuse services.

#### **DrugScope members and stakeholders - Practice examples**

St Mungo’s Brent Dual Diagnosis Project. The project helps people with a combination of severe and enduring mental health and substance use problems. It takes a holistic approach to helping people by considering their social, physical and psychological needs together and integrating psychotherapists and other professionals into an in-house support team – it is a tailored and personalised service. Clients mainly move into the project on discharge from psychiatric hospitals.

([www.mungos.org/press\\_office/636\\_brent-dual-diagnosis-project-earns-st-mungo-s-an-award-nomination](http://www.mungos.org/press_office/636_brent-dual-diagnosis-project-earns-st-mungo-s-an-award-nomination))

Leeds Dual Diagnosis Project. This project is commissioned by Leeds NHS and managed by St Anne’s Community Services. It aims to improve access to treatment and outcomes for people who experience co-existing drug/alcohol use and mental health disorders. It is a multi-agency network developed to ensure that services that come into contact with this client group are able to assess, engage and to co-ordinate care effectively. The partnership includes professionals from a range of mental health and drug & alcohol services with a shared vision of collaborative and integrated treatment.

(<http://dual-diagnosis.org.uk/>)

Walsingham House – St James Priory Project, Bristol. The Dual Diagnosis Service Model is comprised of a three Stage treatment pathway within the established twelve week abstinence drug/alcohol treatment programme. Stage 1 is for stabilisation of the mental disorder during first period of abstinence. Stage 2 is for review of disorder and confirmation or reframing of known diagnosis and treatment. Stage 3 is for continued review and throughcare planning to maintain stability. The severity of the illness is not an issue for Walsingham House but the cognitive ability to participate in a therapeutic treatment programme is essential. ([www.stjamesprioryproject.org.uk/13.html](http://www.stjamesprioryproject.org.uk/13.html))

Bridge Dual Diagnosis Project, Bradford. The service aims to ensure that the service user's needs and problems are accurately assessed and met to enable appropriate treatment. The provision of the correct care, planned and co-ordinated treatment by a specialist nurse, and methods such as motivational interviewing and cognitive therapy are part of the dual diagnosis service. Additionally, a monthly clinic is held at Bridge by a consultant psychiatrist and home visits can be made where necessary. ([www.bridge-bradford.org.uk/help-and-services/dual-diagnosis/](http://www.bridge-bradford.org.uk/help-and-services/dual-diagnosis/))

### **What can be done to ensure that services and staff are confident and competent to safeguard children and promote improved parenting capacity?**

The key things that can be done to ensure services and staff are competent to deal with safeguarding issues and promote parenting have been identified and discussed in previous policy and guidance documents, including:

- The Advisory Council on the Misuse of Drugs (ACMD) report 'Hidden harm – responding to the needs of problem drug users' (Home Office, 2003); and
- 'Joint Guidance on development of local protocols between drug and alcohol treatment and local safeguarding and family services' (DCSF, Department of Health and National Treatment Agency, 2009).

While progress has been made, the challenge is to ensure that good practice is effectively and consistently implemented across the country. DrugScope and LDAN members report that practice is inconsistent.

Relevant recommendations from Hidden Harm include:

- All drug treatment agencies to record an agreed minimum consistent set of data about the children of clients presenting to them;
- Services should ask about and record the number, age and whereabouts of all their clients' children in a consistent manner;
- Child protection issues and policies should be a key element in workforce development;

- Safeguarding should be an essential component of area strategies for reducing drug-related harm through effective, integrated, multi-agency service provision.

The 2009 Joint Guidance states that:

- There should be a single point of contact for child protection and safeguarding within each local treatment service;
- Treatment commissioning should be consistent with 'Think Families'; and
- Clients entering services should be routinely questioned to establish if they have children, and case loads should be audited.

There is also an opportunity to build on successful programmes like 'Think Family' and the piloting of the Family Drug and Alcohol Court (FDAC) in the London Boroughs of Camden, Islington and Westminster.

DrugScope would note that more work needs to be done to address the child protection issues for drug and alcohol services. We are aware of concerns that the Hidden Harm recommendations have not been fully or consistently implemented (which has, for example, been an issue highlighted by DrugScope's colleagues working in Scotland's STRADA programme).

For example, the research paper 'Is the harm still hidden?' (2007) by Saffron Homayoun and colleagues concluded that 'one of the major problems identified in the initial Hidden Harm survey and report was the marked inconsistency in the provision of services for drug-using parents and their children across the UK. The evidence ... would suggest that this situation has not changed, in that provision was variable in the services participating in this survey and not particularly related to the number of clients with children or the number of children involved. There was also little indication that the monitoring of services had improved'. It also noted that the 'overall rate of reported specialist provision actually dropped between the 2002 and the 2006 surveys'. ('Is the harm still hidden?' is on-line at <http://lx.iriss.org.uk/sites/default/files/resources/Is%20the%20harm%20still%20hidden.pdf>)

Following consultation with DrugScope members our response to the 2010 Drug Strategy consultation reported concerns:

- about a lack of any requirement for training for social workers on drug and alcohol issues;
- about the future of the 'Think Families' programme;
- that too many adult drug services were 'unfriendly to families' (for example, treatment services are often located in environments that are unfriendly to children, there is inadequate provision for creche facilities and they often open at hours that restrict access for parents with child care responsibilities);
- the under-representation of women in drug services, which was felt to be partly a consequence of child care responsibilities;

- a lack of residential services providing support for women with children, which it was felt had the potential to provide intensive recovery-focused treatment in an environment that was supportive of good parenting and child welfare.

Specific recommendations emerging from consultation with DrugScope members included:

- Treatment providers should demonstrate how they could or have adapted services to improve accessibility for adults with children;
- Treatment providers should be supported to make necessary changes to improve the accessibility of services;
- The changes that can be made to improve accessibility include appointments that take into account school and nursery opening hours, flexibility during school holidays and partnership working with children and family services;
- 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 at both senior managers and project level within drug and alcohol services;
- A drug and alcohol lead in 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.

**How do we account for things like the safeguarding of children and vulnerable adults in a recovery model?**

See responses to the previous question.

We note that the US recovery expert William White and colleagues have discussed parenting and recovery in ‘Parenting in the Context of Addiction Recovery: Critical Research Questions’ (<http://www.williamwhitepapers.com/pr/2011%20Parenting%20in%20the%20Context%20of%20Addiction%20Recovery.pdf>)

It will be important to have systems and protocols for safeguarding within the new public health structures that will assume responsibility for drug and alcohol treatment from April 2012. It is unclear how safeguarding and parenting issues are addressed in the outcomes for the Drug Recovery Payment by Results Pilots.

**How can the framework support the development of systems and services that are integrated, identify and respond to the impact of parents behaviour on the child?**

See responses to the previous questions.

## **How can the new framework support systems in developing a competent and inspirational recovery orientated workforce?**

DrugScope is a partner, with the University of Glasgow in STRADA (Scottish Training on Drugs and Alcohol), which is a national training organisation for Scotland funded by the Scottish Government. STRADA has been closely involved in developing and delivering training and support to develop a recovery-orientated workforce in Scotland, and would welcome opportunities to share this learning with colleagues in England. STRADA provides an effective model for delivering high quality training to meet the demands of national policy initiatives ([www.projectstrada.org](http://www.projectstrada.org)).

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 LDAN, and provide other training on a consultancy basis.

DrugScope is a member of the Substance Misuse Skills Consortium, which is developing a sector-led consensus to improve the substance misuse treatment workforce in England, including developing a national skills framework and an online skills hub – our Chief Executive, Martin Barnes, sits on the Consortium's Executive Committee ([www.skillsconsortium.org.uk](http://www.skillsconsortium.org.uk)).

The new framework should give a higher profile to workforce development as a priority in developing recovery-orientated treatment. DrugScope consistently expressed concern about the lack of a workforce development strategy in previous drug strategies. The treatment workforce has rapidly expanded since 1998, and it is increasingly being asked to provide a greater range of interventions, requiring an extended skills base.

We have concerns about what appears to be a lack of sufficient attention to substance misuse issues in training and workforce development in other sectors (for example, social work).

DrugScope welcomed the discussion of workforce development in the 2010 Drug Strategy, with the Government committing to 'work with the National Skills Consortium to develop a skills framework which supports the recovery agenda', and to work with providers and professional bodies across drug and alcohol treatment, mental health, employment, criminal justice, housing and family services.

DrugScope members have expressed concerns about the impact of local disinvestment on staff morale, the attractiveness of work in the drug and alcohol sector compared with other health and social care careers and short-term and insecure contracts within the sector. The framework should make clear that workforce development is not simply about training, but also about ensuring that

people working in drug and alcohol treatment have rewarding careers, opportunities for development and good terms and conditions. (In our response to the 2010 Drug Strategy consultation we suggested that the potential for developing qualification and career pathways across sectors – which share common approaches to recovery and reintegration – should be explored.)

The framework should provide guidance on where responsibility for investing in and supporting training and other workforce development will rest locally. DrugScope believes that the Substance Misuse Skills Consortium has the potential to provide leadership on workforce development, but it can only make a real impact if it has sufficient resources to support its work. Local services must be encouraged and incentivised to invest in training and other development opportunities for their staff at a time when many services will be experiencing increased financial pressures.

Workforce development emerged as a key issue at a consultation event with service providers in London that DrugScope/LDAN hosted for the NTA London Regional Team on 23 April. It was argued by participants that development of recovery-orientated approaches was as much about culture as systemic change, and that workforce development should therefore be one of the main priorities going forward. DrugScope members have stressed that delivering recovery for their service users will require culture change in other sectors and professions, if people who have been affected by drug and alcohol problems are to be empowered to access the support they need. Staff morale was identified as an issue, with some providers reporting that local disinvestment was resulting in redundancies, short-term contracts, higher levels of job insecurity and increased use of volunteers in drug and alcohol services. The workforce development issues for other sectors and professionals were also highlighted. For example, it was commented that the majority of GPs have only limited understanding of drug and alcohol treatment, what treatment systems are like and the particular role of non-statutory services.

### **Which areas of competence do you think will need the most development?**

Key areas of competence for workforce development could include:

- Key skills include the skills to deliver psycho-social interventions, work effectively with people with multiple needs and work with partners to develop recovery-orientated approaches in local communities;
- Skills for partnership work and effective co-operation and communication with other sectors and services (professional cultures, priorities for other services, negotiation skills, etc);
- Training and support to enable drug and alcohol services to work with a broader range of substance misuse problems, and to identify and respond to emerging trends and adapting drug markets;
- Information and awareness to ensure that drug and alcohol treatment workers are aware of recovery resources available to their clients locally -

- Information and awareness on mutual aid approaches, peer mentoring, service user involvement, recovery communities and recovery champions;
- Information and training on equalities and diversity issues;
- Information and training on how new systems and structures work and their practical implications for planning and delivery of front line services (e.g., the public health reforms);
- Competence for recruiting and managing volunteers, including appropriate and inappropriate use of volunteers;
- Training and support resources for volunteers;
- Workforce development for peer mentors and 'recovery champions';
- The Framework should consider the potential for developing recovery-focused workforce development initiatives that work across the 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 recovery agenda;
- The framework should include clear guidance on the competencies that other work forces will require in order to support recovery from drug and alcohol problems effectively.

At the consultation seminar hosted by DrugScope on behalf of Clinks on 29 March, service providers emphasised the issue of maintaining staff morale during a period of significant change. Senior managers said they were looking at workforce development issues and asking 'what do you require in terms of the values, competencies, resources, etc to deliver recovery orientated services?' At the same time, this was felt to be a period of uncertainty and anxiety for staff, who may be faced with redundancy or concerned about their jobs. Organisations talked about the various approaches they were taking to human resource management and staff welfare, including individual support for staff, regional forums, promotion of well-being and staff surveys.

**How can the new framework best support a personalised patient placement model that includes scope to enable individuals to draw upon and develop their strengths and capabilities and address their needs?**

Personalised patient placement depends on:

- Putting service users at the heart of treatment and recovery planning;
- Individualised approaches to assessment; and
- The availability of an appropriate range of services in which to place patients.

These issues are addressed in response to earlier questions, particularly the discussion of service-user led recovery planning. Drugscope welcomes

increased emphasis on strengths and capabilities, as well as need, in treatment and recovery planning.

### **How can we improve people's capacity to choose between residential and community based options?**

Service users should be provided with accessible, objective information about available treatment options, which should be discussed as part of the recovery planning process. Service users should be provided with information about the particular treatment regimes that are provided by different residential and community services (for example, whether 12 steps based or CBT orientated). We note that the NTA in the Eastern Region has produced a framework for preparing service users who are entering residential rehabilitation ([www.nta.nhs.uk/em-t4-workshop.aspx](http://www.nta.nhs.uk/em-t4-workshop.aspx))

The capacity to choose between services will obviously be constrained by the availability of services, and their suitability for a particular service user given the nature and severity of his or her substance misuse problem. There is some evidence, for example, that people with more severe drug and/or alcohol problems are more likely to derive additional benefit from residential rehabilitation ([http://findings.org.uk/docs/nug\\_8\\_9.pdf](http://findings.org.uk/docs/nug_8_9.pdf))

One issue is how treatment options are weighted and assessed where there are significant differences in costs. There may be approaches that could potentially be adapted to help to ensure that service users take account of comparative costs in making their own decisions about treatment – for example, personal budgets.

### **How can the framework ensure that systems deliver a range of effective psychosocial interventions, delivered as the mainstay of treatment and enmeshed with prescribing interventions as appropriate?**

The changing profile of the adult treatment population is necessarily placing a greater emphasis on psycho-social interventions, as will the commitment to address a wider range of drug and alcohol problems in the Drug Strategy 2010. Substitute prescribing is recommended by NICE for opiate users, but as the 'Drug Misuse and Dependency – UK Guidelines of Clinical Management' (2007) stated, 'psychosocial interventions are the mainstay of treatment for the misuse of cocaine and other stimulants, and for cannabis and hallucinogens', as well as treatment of alcohol dependency.

The framework document has the opportunity to highlight and build upon recent initiatives to develop psycho-social interventions. DrugScope notes, in particular, the development of the International Treatment Effectiveness Project (ITEP) and the Birmingham Treatment Effectiveness Initiative (BTEI). ITEP has the potential to become a standard tool in recovery planning, as it can help clients to discuss,



visualise and to map out pathways to recovery. The development of psychosocial interventions is also supported by the NTA's 2010 report 'Psychosocial interventions for drug misuse – a framework and toolkit for implementing NICE-recommended treatment interventions'.

DrugScope believes that clients with co-morbidity of substance misuse and mental health should be a priority for the new framework. Psycho-social interventions will have a particular relevance for this population. It would be helpful if the framework could provide clear guidance on appropriate routes for accessing psycho-therapeutic and psycho-social support for clients with a 'dual diagnosis' (for example, under what circumstances should people in treatment for substance misuse be referred to IAPT and other primary mental health care services). Psycho-social approaches will be employed in other services with a role in treatment and recovery, including homelessness and criminal justice services. There is likely to be some potential for 'joining up' this provision, which could be explored in the framework (for example, looking at opportunities for joint workforce development).

As discussed earlier, the framework will need to address the workforce development challenges of ensuring there is a skilled and competent workforce to deliver the full range of effective psycho-social interventions.

**How can the framework best support local areas in implementing single points of assessment and referral, and avoid repeated assessment?**

DrugScope refers the BRIC consultation team to on-going discussions on the development and design of Local Area Single Assessment and Referral Services (LASARS) as part of the design process for Drug Recovery Payment by Results pilots. However, we would also note that the development of these independent LASAR services is linked to the payment by results approach, and that there are alternative ways of implementing single points of assessment and referral and avoiding multiple assessment – to take one example, the NTA and JobCentre Plus have developed a protocol to improve their collaboration to support service users on their recovery journey, including use of shared assessment tools.

**What do you consider to be the key difficulties and opportunities in implementing a recovery-orientated framework in a prison setting?**

See our response to the earlier question about treatment in prison.

**How can recovery services for drug and alcohol dependence be developed within prisons, building on the recent improvements in prison drug treatment?**

See our response to the earlier question about treatment in prison.

## **DrugScope members and stakeholders - Practice examples**

Rehabilitation of Addicted Prisoners Trust (RAPt) 12 Step treatment programmes. RAPt's 12-step, abstinence based programme which spans 20 weeks was designed as an alternative to four week, low-intensity programmes offered in Britain's prisons. Participants receive concentrated treatment supported by peers and counsellors. They are helped to come to terms with their lack of control of their substance use, to explore the effect that their using has had on them and those around them, and to learn skills that they will need if they are to avoid a return to using. They are given experience of living a drug free life as part of a supportive community, observing high standards of behaviour. ([www.rapt.org.uk/page.asp?section=85&sectionTitle=12+Step+Programme](http://www.rapt.org.uk/page.asp?section=85&sectionTitle=12+Step+Programme))

RAPt's Alcohol Programme at HMP Bullingdon. The Alcohol Dependency Treatment Programme (ADTP) is a six-week intensive programme. Several elements are present every week and provide continuity throughout treatment. These include a weekly speaker meeting with a volunteer speaker from Alcoholics Anonymous (AA), ongoing attendance at a minimum of two AA meetings per week (outside of treatment time), fortnightly one-to-one sessions and the completion of daily significant events sheets. Discussion groups based on reading recovery stories of prisoners in recovery are held every Friday afternoon. From week two onwards, two one-hour group therapy sessions are held per week. ([www.rapt.org.uk/page.asp?section=117&sectionTitle=Alcohol+programme+at+HMP+Bullingdon](http://www.rapt.org.uk/page.asp?section=117&sectionTitle=Alcohol+programme+at+HMP+Bullingdon))

Phoenix Futures - CBT programmes for prisoners

Prisoners Addressing Substance Related Offending (PASRO) - A 20 session programme delivered over a four to five week period (delivered at HMP Highpoint and HMP Ranby)

Short Duration Programme (SDP) - 20 x 2.5 hour morning sessions over four weeks for prisoners who are on remand or with less than six months left to serve of their sentence, who have a history of substance dependence (delivered at HMP Nottingham, HMP Holme House and HMP Styal).

Alcohol Intervention Service (AIS) - This is a flexible service run specifically for people in custody who have experienced alcohol-related problems. It has been developed and designed by Phoenix Futures to address the gap in alcohol treatment provision for offenders (a pilot service is being delivered in HMP Blundeston, HMP Brixton, HMP Foston Hall, YOI/RC Glen Parva, HMP Hollesley Bay, HMP Holloway, HMP Lincoln, HMP North Sea Camp, HMP Nottingham, HMP Onley, HMP Pentonville, HMP Ranby, HMP Sudbury and HMP Wandsworth).

Alcohol Related Violence Programme (ARV) – this programme is delivered at HMP Acklington and HMP Highpoint.

Steps to Recovery (STAR) – this programme is delivered in HMP Stocken. ([www.phoenix-futures.org.uk/103](http://www.phoenix-futures.org.uk/103))

**How can we ensure that substitute prescribing is recovery-focused, and provided as part of a wider package of care that assists the service user in achieving recovery outcomes (for example, recovery orientated methadone maintenance or medically assisted recovery)?**

In our online survey, DrugScope asked ‘in your view is the use of substitute prescribing for the treatment of opiate dependency consistent with the development of a recovery-orientated approach to drug treatment?’. Seventy three per cent of respondents said that substitute prescribing was consistent with a recovery orientated approach.

We asked respondents to tell us whether they believed specific factors could contribute to improved integration of substitute prescribing and recovery-focused treatment:

- 97 per cent of respondents ‘agreed’ or ‘strongly agreed’ that ‘a requirement to integrate substitute prescribing into a recovery-focused care plan’ could improve integration;
- 83 per cent of respondents ‘agreed’ or ‘strongly agreed’ that ‘co-location of methadone treatment clinics with (or close to) other forms of treatment provision’ would be a good way forward;
- 80 per cent ‘agreed’ or ‘strongly agreed’ that there should be a ‘mandatory requirement to have case review meetings with key partnership agencies’ and ‘a greater onus on clinicians to justify continued prescribing at treatment review’;
- 61 per cent ‘agreed’ or ‘strongly agreed’ that we should ‘increase the number of reviews between worker and client’;
- 64 per cent ‘agreed’ or ‘strongly agreed’ that ‘a more positive attitude towards long-term substitute prescribing and its place in recovery-focussed treatment’ was needed;
- The option of ‘introduction of time limits on substitute prescribing’ was the most divisive option, while 18 per cent of respondents ‘strongly agreed’ that time limits would be beneficial, 22 per cent ‘strongly disagreed’;
- There was also disagreement on the proposal to change the name of substitute prescribing to ‘medically assisted recovery’, with respondents who expressed a view almost equally divided – a comparatively large proportion of respondents (18 per cent) said they ‘didn’t know’, perhaps indicating an unfamiliarity with this term.

A report on ‘recovery-oriented methadone maintenance’ from the United States by William White and colleagues concludes that there is a need to:

- ensure broad representation of people in medication-assisted recovery and professional representation from medication-assisted treatment providers within policy advisory groups and technical work groups;
- create an organisational structure to lead a campaign to define and promote medication assisted recovery initiation and recovery maintenance

(sobriety, global health, and citizenship) as a morally honorable pathway of long-term recovery;

- encourage the inclusion of people in medication-assisted recovery in existing recovery support fellowships and develop/support recovery fellowships specifically for people in medication-assisted recovery; and
- encourage the development of venues through which people in recovery (particularly current or former medically-assisted recovery patients) can perform acts of service to those seeking recovery, as well as broader acts of community service.

(White W and Mojer Torres L at [www.ireta.org/resources/romm-exsum.pdf](http://www.ireta.org/resources/romm-exsum.pdf))

Other proposals from the available US literature include:

- Changing public and professional views on methadone maintenance treatment from a practice that may be perceived to simply ‘substitute one drug/addiction for another’ to a scientifically validated medical practice capable of saving and transforming lives, providing a basis for recovery, and enhancing the quality of community life.
- Change the view of methadone maintenance within the heroin using community from that of a passive process of ‘giving up’ to an assertive lifestyle of active recovery.
- Put a face and voice on medication-assisted recovery by conveying the stories of individuals and families in long-term addiction recovery and explaining the role substitute treatment programs are playing in enhancing the health and safety of particular neighborhoods.
- Portray the contributions of people in medication-assisted recovery to their communities through their family support, educational, occupational, and community service activities.
- Encourage participation of medically assisted recovery providers in local community activities to improve the public image of the methadone clinic/patient.

Walter Ginter, who has been involved in the Faces and Voices of Recovery initiative in the United States, argues that ‘maintained recovery’ is an option, but that the systems and structures of treatment make the development of recovery communities difficult to achieve in maintenance clinics and that the culture has not encouraged the development of peer support networks. He argues that there needs to be networks of peers for whom medically assisted recovery has worked who can express this to clients as an option: ‘one has to see successful people to advance in recovery. If you don’t give the patients the opportunity to see that at the program, they’re not going to get it anywhere else. It’s the only place where methadone patients can see other methadone patients.’

(White W (2009), ‘Advocacy for medication-assisted recovery: An interview with Walter Ginter’ at [www.williamwhitepapers.com/pr/2009%20Walter%20Ginter.pdf](http://www.williamwhitepapers.com/pr/2009%20Walter%20Ginter.pdf))

## **DrugScope members and stakeholders – Practice examples**

Beresford Project, Greenwich Council. The Beresford Project supports and advises adult drug and alcohol users who want to be substance-free. They provide: one-to-one counseling, community detoxification, home detoxification from alcohol, well-user clinic (Hepatitis B vaccination, dressings, health advice), HIV and Hepatitis B and C testing, safer sex advice and free condoms, needle exchange and substitute prescribing.  
([www.greenwich.gov.uk/Greenwich/HealthSocialCare/HealthMatters/DrugsAlcohol/DrugsMisuseSupportServices/BeresfordProject.htm](http://www.greenwich.gov.uk/Greenwich/HealthSocialCare/HealthMatters/DrugsAlcohol/DrugsMisuseSupportServices/BeresfordProject.htm))

Southwark REACH Structured Day Programme, CRI & Southwark DAAT. The programme has a clinical service which provides comprehensive healthcare assessments, substitute prescribing, detox assessment and referrals and a blood borne virus service. The 12-16 week intensive programme provides CBT based group work, counseling, life skills, alternative therapies, healthy lifestyle advice, a stimulant specific group, motivational interviewing and access to an on-site BBV nurse. ([www.cri.org.uk/project/141](http://www.cri.org.uk/project/141))

### **How can the framework best support local areas in optimising the number of people who move through the system and successfully complete treatment?**

The development of an effective framework for recovery-orientated services as discussed in response to other questions will contribute to optimising numbers of people successfully completing treatment.

DrugScope would emphasise that lapse and relapse are a recognised part of the longer-term 'cycles of change' for many people with serious drug and alcohol problems, and that it is therefore important to balance ambition and aspiration for recovery with evidence-based assumptions and practices.

We would also note that the ability of drug and alcohol treatment services to increase the numbers of people who move through the system and successfully complete treatment will depend on the availability of recovery resources and effective cooperation with partners in other sectors. For example, someone's ability to engage with and complete treatment may depend on access to safe and secure accommodation.

### **What do you think are the key factors that prevent individuals successfully completing treatment?**

DrugScope's online survey asked respondents for their views on the main barriers that have prevented individuals from successfully completing treatment, and to rank them in order of importance.

Overall, the factors that were most commonly selected were:

- 'A lack of 'recovery capital' to enable service users to (re)integrate into society, for example, access to housing or training and employment opportunities' (selected by 33 respondents);
- 'A lack of capacity in other local services, such as housing, mental health, family support and employment services' (selected by 32 respondents);
- 'A lack of ambition and aspiration for service users and/or among staff' (selected by 23 respondents);
- 'Significant numbers of service users need to remain in services over the long term and many are not ready to complete and exit treatment' (selected by 21 respondents).

The three most popular 'first choice' options were:

- 'A lack of capacity in other local services, such as housing, mental health, family support and employment services' (selected as the highest priority by 13 respondents);
- 'An excessive focus in services on harm reduction, including substitute prescribing' (selected as the highest priority by 10 respondents);
- 'Significant numbers of service users need to remain in services over the long term and many are not ready to complete and exit treatment' (selected as the highest priority by 10 respondents).

### **How can the framework best support local areas to overcome these?**

Approaches that can be taken to supporting local areas to overcome these factors have been identified and discussion in response to other questions in this consultation.

### **What are the key interventions and support that people need to assist them in sustaining long-term recovery following the successful completion of treatment?**

Interventions and support for long-term recovery are discussed in detail in a number of recent publications including DrugScope's 2009 report 'Drug Treatment at the Crossroads' and the RSA's 2010 report 'Whole person recovery: A user centred systems approach to problem drug use', they include:

- structured and personalised aftercare support;
- access to safe and suitable housing;
- support with other key recovery goals, including education, training, employment and other forms of meaningful activity;
- positive relationships and active support networks, including as appropriate family relationships and involvement in peer support networks; and
- rapid access to treatment in cases of relapse.

**What are the key points that need to be incorporated into the framework to support partnerships in continuing to develop a balanced treatment system i.e. placing a greater emphasis on moving people through the system and into sustained recovery while maintaining the improvements that have been achieved in terms of waiting times, access and retention?**

DrugScope supports the development of recovery-orientated approaches, with greater local flexibility and a central role for service users in recovery planning. Equally, we recognise the strides forward that have been made over the past decade in increasing access to drug treatment and reducing waiting times.

The framework should include a detailed description of the duties to provide evidence-based treatments and services for people affected by drug and alcohol problems in all local areas.

We welcomed the statement in the White Paper ‘Healthy Lives, Healthy People’ that the NHS Constitution will continue to apply to the whole health service, whether the NHS or Public Health England. It is our assumption that this means that Directors of Public Health will be required to comply with the NHS Constitution in all local authority areas, which will help to ensure access to and provision of drug and alcohol services is consistently meeting an acceptable minimum standard. If the NHS Constitution applies to local public health structures, then patients (including drug and alcohol service users) will have a right, for example, to expect Directors of Public Health to assess ‘the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary’, to keep waiting times down and to provide access to drugs and other treatments recommended by the National Institute of Clinical Excellence.

The NHS Constitution also includes pledges to provide all health service staff (including, by implication, staff in drug and alcohol services) ‘with clear roles and responsibilities’ and ‘personal development, access to appropriate training for jobs and line management support to succeed’.

It would be helpful if the framework document set out the responsibilities of Directors of Public Health – and other local decision-making bodies, such as Health and Wellbeing Boards and GPs – under the NHS Constitution. It should also include a clear statement that the development of a recovery-orientated system should not detract from the fact that drug and alcohol treatment is a core health service, and must be delivered on the same basis and to the same standards as other health care provision in the UK.

**What are the key gaps in the recovery evidence base and how do you think they could best be filled?**

The National Audit Office (NAO) report 'Tackling problem drug use' (2010) concluded that there was a strong evidence base for the cost effectiveness of drug treatment, but highlighted gaps in the research evidence on some of the key components of recovery:

- There was no UK research on effective approaches helping drug users into housing. The NAO recommended that the Department of Communities and Local Government commissioned independent research 'to establish which measures provide best value for money in accommodating problem drug users, while protecting local communities'.
- It also concluded that there was limited evidence on what is effective in moving drug users off benefits and into work. It concluded that 'the Department for Work and Pensions should review progress2work, to identify how to improve value from expenditure on this programme, and to determine those aspects which have been successful. It should also use this knowledge to ensure the new programme to help problem drug users into work is evidence based, and can demonstrate value for money'.

The evidence-base on mutual aid, peer support, recovery champions and recovery communities is still developing, and there is a need to design approaches to researching the impact of these interventions that are sensitive to their distinctive cultures and values (see responses to earlier questions).

### **What are the main challenges for the field in moving to treat a wider range of substance abuse problems?**

The main challenges will include:

- The financial pressures on the treatment system;
- Developing a treatment service that has appropriate access points and treatment pathways for a broader and more diverse client group;
- Developing new approaches to engage effectively with different client groups (for example, 'invisible drinkers' or people dependent on prescribed and over-the-counter medicines);
- Adapting to more flexible and rapidly evolving drug markets;
- Developing the skills base of the workforce and providing information (for example, information on the risks and interventions for new substances).

#### **DrugScope members and stakeholders – Practice examples**

South London and Maudsley NHS GBL/GHB Clinic. This clinic was the UK's first emergency clinic dedicated to treating GBL/GHB addiction. It was set up to address the lack of available treatment options for the small but steady and growing demand from those suffering addiction and related issues. It provides dedicated in-patient and outpatient treatment and pioneering aftercare support for clients, appreciating that 'detox is just a part of the process,' and that clients need ongoing monitoring over weeks for insomnia, anxiety and high risk of



relapse. Since opening the clinic, 90 per cent of patients have been successfully rehabilitated. ([www.slam.nhs.uk/news/latest-news/uk's-first-gbl-clinic.aspx](http://www.slam.nhs.uk/news/latest-news/uk's-first-gbl-clinic.aspx))

**What are the key challenges in developing and implementing a single framework that deals with drug and alcohol dependence together?**

See response to the earlier question on integration of frameworks for drug and alcohol dependence.

**How can these challenges best be overcome?**

See response to the earlier question on integration of frameworks for drug and alcohol dependence.

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