STATE OF THE SECTOR

2013

DrugScope

Recovery Partnership

By DrugScope on behalf of the Recovery Partnership
State of the Sector 2013
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Foreword

It can sometimes be difficult to identify the start of a period of even great change at the point where that change starts, and particularly so when directly involved in it. Looking back from 2013, milestones for the drug and alcohol treatment sector can be clearly identified, some of which were less visible seen in close.

The most troubling and significant developments of the 1980s were the increase in the availability of cheap heroin, and the impact of blood-borne viruses, particularly HIV. Whilst the impact on individuals, families and communities was terrible, it had a transformational effect on a sector that had, until then, been under-resourced and largely peripheral. Whilst it marked a step change in the professionalisation and effectiveness of drug services in particular, the message was largely concerned with the reduction of harm and risk, and above all with fear.

During the 1990s, there developed a much greater focus on investment in drug treatment and a relationship between opiate and crack use and crime. This link became stronger following the election of the Labour government in 1997. There was new investment to support partnership working between the by now maturing treatment sector and the criminal justice system. In a sense, this could be argued to have changed the nature of the relationship between the treatment sector and some of its clients – those who had entered via the criminal justice route – and the emphasis was shifting to not only be about harm minimisation, but also about stabilising, reducing and ultimately stopping drug use. The message however was still predominantly about fear – in this case the fear of crime, rather than the fear of illness and disease.

The Labour government’s last drug strategy in 2008 saw a greater focus on treatment as a means to support re-integration with a recognition of the need to support people to access training, employment, housing and other services and support. The coalition government’s 2010 Drug Strategy arguably continued this shift to a more positive and explicit narrative – that of recovery, and particularly, recovery supported by a whole-systems approach and by ‘recovery capital’ – or to put it more simply, jobs, homes, friends and relationships. Whilst a positive message about recovery is new and welcome, it poses new questions, including whether all clients can positively engage with services in the light of new expectations.

However, the impact and sustainability of a new and more positive message will become clearer with time. What will probably become apparent sooner is the impact of structural reform to the commissioning and funding arrangements that have been in place in recent years. The transfer of responsibility for commissioning community services to local authority Directors of Public Health, with strategies developed by Health and Wellbeing Boards, marks a significant change, as does the new role of Police and Crime Commissioners in reducing crime and improving community safety.

These changes present opportunities for more flexible and integrated services that better meet local need, but we need to be realistic. Local authority and police budgets are under significant pressure and are likely to remain so for some time to come, and all non-mandatory services (including drug and alcohol treatment) are potentially at risk from disinvestment.

Taking a snapshot of the residential and community treatment sectors at the point immediately before the full effects of these changes have worked through the system has been a useful exercise. The findings are interesting in themselves, but don’t suggest that a ‘big bang’ has taken place, although the proportion of services indicating that they have been through or are expecting to go through recommissioning is significant.

To really gauge the scale of the impact of these changes and others, the Recovery Partnership intends to carry out a further piece of research in 2014. This will hopefully allow us to better understand the trajectory and pace of change, and we also plan to carry out different research with other sectors not specifically targeted in the State of the Sector 2013, including treatment services in prisons and with an additional focus on commissioning arrangements. The level of engagement in this current survey has been very encouraging, although the more services that take part in future research, the more accurate a picture we will have of the sector.

We hope you will find this report interesting and informative.

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

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Key findings and recommendations

• 35% of respondents reported decreased funding, compared to 20% reporting an increase. Around a third to a quarter of services reporting increased or decreased funding had experienced this change as a result of gaining or losing services through retendering and recommissioning. This is not evidence of widespread disinvestment, but key stakeholders including Public Health England should remain alert to this risk.

• Almost half of participating services reported a decrease in front line staff and six out of ten reported an increase in the use of volunteers. Increased opportunities for volunteering, including as a means to support volunteers closer to paid work is a positive, but the sector must retain the expertise and professionalism it has worked hard to acquire.

• Engagement with two crucial new structures – Health and Wellbeing Boards and Police and Crime Commissioners is mixed. Where it is happening, it appears to be meaningful and constructive, but it is patchy. Nationally, under half of the respondents to the online questionnaire indicated any kind of engagement with their Police and Crime Commissioner, whilst slightly more reported engagement with their local Health and Wellbeing Board.

• If the responses to the survey are representative, a particular effort may be needed in London to improve links between the Mayor’s Office for Policing and Crime, London Boroughs and drug and alcohol services.

• There are encouraging signs that Police and Crime Commissioners appreciate the role their position can potentially play in partnership with public health and the advantages of joint commissioning. However, it appears that this interest has not yet been universally reciprocated by Health and Wellbeing Boards. It seems likely that there will be mutual advantage to working closely.

• There is limited confidence in the way and extent to which drugs and alcohol are included in Joint Strategic Needs Assessments, and less still about their inclusion in Police and Crime Plans. Overall awareness of the latter is particularly low.

• In addition to questions about the extent of inclusion of drugs and alcohol, there are some concerns that Joint Strategic Needs Assessments tend to focus on population-level harms rather than services for relatively small but entrenched groups. There are parallel concerns that Police and Crime Plans are more concerned with the night-time economy and antisocial behaviour.

• While many respondents indicated that they were forming new partnerships within and beyond the sector, longstanding areas of concern continue to be problematic, particularly:
  - housing and housing support,
  - support for clients with complex needs or multiple exclusions
  - employment and employment support

• Many respondents and interviewees acknowledged the need for more partnerships, more holistic services and the use of the ‘whole system’ approach advocated in the 2010 Drug Strategy. In the form of localism and mechanisms such as Community Budgets, there is some scope to achieve this ambition, but balancing reduced budgets and competing needs will ask much of local leaders, commissioners and services.

• The positive message of recovery and reintegration has been warmly welcomed by the majority of respondents. However, services, commissioners and policy makers may need to give consideration to how services are designed and commissioned, and the sorts of messages that are delivered when it is difficult to envisage all clients being able to immediately join in the ‘recovery agenda’
• The findings of the survey broadly reflect official statistics that indicate that crack and heroin use is at the lowest point since the current monitoring system was introduced and falling. However, a majority of respondents were concerned by other developments, including novel psychoactive substances and problem alcohol use. Designing and commissioning of transition-age services may be an important step to addressing these emerging themes.

• The negative impact of recommissioning and retendering was raised by many participants and all interviewees. Above all, the disruption caused, cost associated with and potential impact on staff morale were seen as harming services, with little evidence that frequent recommissioning serves any positive purpose where services are performing well.
Introduction

About DrugScope and the Recovery Partnership

DrugScope is the national membership organisation for the drug and alcohol treatment sector and is the UK’s leading independent centre of expertise on drugs and drug use. DrugScope has around 450 members, primarily voluntary sector organisations involved in providing treatment for drug and alcohol use, young people’s services, drug education, and working in partnership with related sectors including the criminal justice system, mental health and homelessness.

The Recovery Partnership is comprised of the Substance Misuse Skills Consortium, the Recovery Group UK and DrugScope. It provides a collective voice for the substance misuse treatment sector and a channel for communication to Government on the achievement of the ambitions in the Drug Strategy. The Partnership works to support the sector and others in improving treatment outcomes and supporting sustained recovery.

The 2010 Drug Strategy

The Coalition Government’s 2010 Drug Strategy Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life articulates a vision for a drug and alcohol treatment sector that has recovery at its centre. It states that ‘recovery is an individual, person-centred journey’ and recognises the role for ‘medically-assisted recovery’, while placing a greater emphasis on ‘getting off drugs and alcohol for good’.

The Strategy introduced the concept of ‘recovery capital’ into public policy discourse. Described as ‘the resources necessary to start, and sustain recovery from drug and alcohol dependence’, these are:

- Social capital: the support derived from and obligations arising from relationships.
- Physical capital: money, and a safe place to live.
- Human capital: skills, mental and physical health and a job.
- Cultural capital: beliefs and values held by the individual.

To meet the aspirations of this whole person approach, the Strategy identifies a need for a ‘whole systems’ approach, where recovery is supported by the involvement of ‘education, training, employment, housing, family support services, wider health services and, where relevant, prison, probation and youth justice services’. The strategy also stresses the importance of services being outcome-focussed and undertakes to trial payment by results (PbR) approaches that might support this.

The Strategy identifies other factors of importance to sustained recovery: an inspirational workforce and the role of peer support and mutual aid, as well as responding to emerging trends such as novel psychoactive substances (sometimes referred to as ‘legal highs’).

Crucially, the Strategy commits to aligning the drug and alcohol treatment sector with the broader principles of localism, with a vision for ‘a system that is locally led and locally owned’. The Strategy further indicates that this includes services that are aligned, locally commissioned and locally led, that are competitively tendered and rewarded, and that are transparent about performance.

Localism comes to drug and alcohol treatment

Public service delivery in England (and to varying degrees elsewhere in the UK) has been through a period of considerable change that predates the formation of the Coalition Government. New forms of accountability alongside greater autonomy for local authorities were already, to a degree, in train and localism could be seen as a continuation of that direction of travel. Significant changes connected to the principles of localism occurred in April 2013, two of which are of particular relevance to the drug and alcohol treatment sector – reforms to public health and to the police.

The changes that we considered when designing the research can broadly be categorised as arising from:

1. Changes to the commissioning of community drug and alcohol services due to public health reforms. As part of the overhaul of health services that took place this year, drug and alcohol services are now largely commissioned by local authorities through Directors of Public Health and shaped by priorities established by new Health and Wellbeing Boards (HWBs). Within the 2013-2015 Public Health Allocations, there is no clear ring-fence or other meaningful protection for drug and alcohol services, although it appears likely that a Health Premium may be introduced that will in part relate to drug treatment. For more information, see Appendix A, p. 106.

2. The introduction of elected Police and Crime Commissioners (PCCs) in place of police authorities. Each PCC is charged with producing a Police and Crime Plan, which should include strategies around drug and alcohol use and related crime. This could include supporting Drug Intervention Programme (DIP)-type interventions, community services or, in some cases, residential services. However, again there is no ring-fence or other meaningful protection for drug and alcohol funding, and PCCs will have the freedom, from April 2014 onwards, to focus their spending where they see fit. For more information, please see Appendix B, p.108.

3. The abolition of the National Treatment Agency (NTA). Most of its functions have been transferred to a new body, Public Health England (PHE), but the precise role that PHE will play in the sector and the relationships it will have with public health commissioners (and with commissioning) in local authorities is not yet entirely clear. PHE’s Chief Executive, Duncan Selbie, has made drugs recovery one of his five priorities and has asked for regular progress reports on progress measured against the Public Health Outcomes Framework metric.

4. The external environment. More than ever, the provision of high quality and effective services relies on partnership and cooperation, for example between treatment providers and providers of accommodation, social care, employment support and mental health services. Many of those services too are in the process of change and adaptation, as are local authorities themselves. The impact of welfare reform, access to accommodation and to the job market may also have a bearing on the ability of the treatment sector to support its clients towards independence.

The need for State of the Sector

With public service reform near the top of the incoming government’s agenda in 2010, taking steps to better understand the cumulative impact of changes has rarely been more important. Homeless Link, an organisation with an analogous role to DrugScope in the homelessness sector as well as a partner in the Making Every Adult Matter (MEAM) Coalition\(^4\) has, since 2008, conducted regular Surveys of Needs and Provision, or SNAP\(^5\). The reports stemming from the SNAP research have helped Homeless Link to understand their membership and their sector well, and allowed changes and trends to be identified early. SNAP is widely regarded by the homelessness sector, by policy makers and the media as an authoritative source of information.

The changes outlined above effectively replace the primary mechanisms by which services have been commissioned and funded for over a decade and are central to the information the Recovery Partnership was keen to discover. There is also a broad sweep of other reforms that either have affected the sector and its clients or are likely to do so in future. These include (but are not limited to) welfare reform, NHS and social care reform, Transforming Rehabilitation\(^6\), the Work Programme, the introduction of Payment by Results (PbR) both in the 8 pilot schemes\(^7\) and elsewhere and broader pressure on local authority funding which might have implications both directly (for example access to funding for residential treatment) and more indirectly (for example through changes to homelessness and tenancy sustainment provision). It has not been possible to ask detailed questions about all of these factors, although we have tried to capture as broad a picture as practicable.

As PHE (and before that, the NTA) already captures comprehensive detail about treatment and treatment outcomes via the National Drug Treatment Monitoring System\(^8\), the State of the Sector research focussed primarily on non-treatment rehabilitative activities, although as services increasingly deliver integrated support, respondents have made frequent references to their ability to provide treatment as a core activity.

Previous work by the former UK Drug Policy Commission, particularly their 2012 report *Charting New Waters*\(^9\), indicated a number of areas where pressure was anticipated, and others where there may be opportunities for more positive changes. From this and from the work of DrugScope and the Recovery Partnership more generally, it was felt that there was a clear need to learn more about:

- Changes to the caseloads supported by services.
- Engagement with new commissioning and funding arrangements for core activities and also in partnership with the criminal justice system.
- The scale and impact of retendering or recommissioning.
- The nature, scale and impact of any funding changes.
- Changes to staffing and the roles of volunteers and recovery champions, including issues of staff morale.
- Partnership working across key activities such as employment and the Troubled Families agenda.
- The services provided by the sector, and any patterns of changes in provision.
- Access to or provision of particular services including family support, housing and resettlement, advice and guidance, education, training and employment (ETE), physical health services and mental health services.

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\(^5\) [http://homeless.org.uk/snap#!lpWb3ft0bM](http://homeless.org.uk/snap#!lpWb3ft0bM) accessed December 2013


\(^8\) [https://www.ndtms.net/default.aspx](https://www.ndtms.net/default.aspx) accessed December 2013

• External changes including the local environment and welfare reform.

This research has primarily focussed on two elements of the drug and / or alcohol treatment system: residential and community. Further work is planned that will look in detail at other parts of the sector and system, including peer-support / mutual aid, and drug treatment in prisons.

Methodology

The outputs of a number of activities have been incorporated into this report. Specifically, these are:

• An online survey promoted to DrugScope’s membership and by other partners in the Recovery Partnership.

• Interviews with the chief executives of three treatment providers: Addaction, Blenheim CDP and Phoenix Futures.

• Interviews with a number of services in priority areas identified by desktop analysis of Public Health Allocation per capita spend.

• Four ‘Building Recovery in Communities’ events organised by DrugScope on behalf of the Recovery Partnership in each of the four PHE regions.

• Requests made to every Police and Crime Commissioner in England and Wales to enquire about the current funding arrangements and future commissioning intentions to support partnership working between the criminal justice system and the drug and alcohol treatment sector.

Included in this report:

• 167 agencies participated in the online questionnaire. 103 described themselves as responding on behalf of community services, 25 on behalf of residential services, and 18 on behalf of services that include both residential and community provision. Not every participant elected to answer every question, with the majority of questions eliciting between 80 and 145 responses. This is, of necessity, a sample of convenience, and whilst we believe the results are likely to be broadly representative, it must be noted by way of context that around 100 residential and 1200 community services in England report to the National Drug Treatment Monitoring System (NDTMS), and that consequently findings should be approached with a degree of caution. There is, however, coherence between the responses received through the different strands of this research – the survey, the interviews with services and chief executives and through the regional summits.

• The survey data has been analysed both by PHE region and by service type. However, in this report, the data is generally presented at the top level, other than where there is significant variance in the responses, or else there is an over-riding reason to present the findings by type of service or by PHE region. All respondents and interview participants were offered ‘tiered’ confidentiality – anonymous, by local authority or by PHE region. In this report, no geographical data beyond PHE region is provided and, where necessary, responses have been cleansed of information that might identify participants.

• Respondents were offered the opportunity to add comments in addition to answering multiple choice questions. This resulted in around 2,000 comments, of which a representative sample is included in each section. These are in boxes headed ‘Respondents’ views’.

• All three chief executives interviewed have given consent to be identified. Their comments are included in boxes headed ‘Chief executives’ comments’.
• The services that participated in short telephone interviews generally did so on condition of anonymity. Where consent has been given to identify a service by PHE region or by local authority, this has been done. Comments from these interviews are included in the main ‘Respondents’ views’ comment boxes, and identified as interview responses.

• The four Recovery Partnership regional events attracted nearly 200 participants, mostly representatives of service providers or commissioners. Particular themes have been identified from table discussions and are included under the heading ‘The view from the summit’.

• The responses to the requests for information under the Freedom of Information Act have been summarised in this report and are available in full, organised by police force area at the following location: http://www.drugscope.org.uk/POLICY+TOPICS/StateoftheSector2013

• Generally, numbers used to label charts indicate the number of responses to questions. For reasons of clarity, percentages have been used to illustrate a small number of charts – where this is the case, it is indicated by the use of the percentage sign (%).
funding

commissioners tendering

EXPECTATIONS treatment pending problems/anti

dependence disruptive Emotional equivalent psychoactive

support community alcohol attending size

recognition over borough Difficulties increasing

onward risks charities Attendance externally Ongoing

Desire cohorts costs capacity training nothing impending

boroughs crack non impacting care timely always risk

integrated Decreases potential effected

stiffing NTA tenders

users Burn

taking

dealing IV delivery next until

don'ts

load

cover away interest

change overload position loose

intervention offer DRR old

steering moved political social

receive turn

years partnership pressure

engaging County/City Clinical

inflexible champion demands

Ineffective opportunities

because

about rehab/detox

Time-consuming Welfare

management Continuity offenders

Relationships

Social/Isolation

staff

Rehabilitation complexity

communications

strategies

volunteers
Part 1 – about participants in the online survey: location, service type, sector and staff.

167 services participated in the survey, with the majority providing a response to most questions. Respondents were asked to confirm their location by local authority and by PHE region, with the regional breakdown being:

![Map of England showing the number of respondents by region.](image)

167 respondents to online questionnaire in England

North - 36
Midlands & East - 29
South - 42
London - 44

We also asked services to identify themselves by type of service (e.g. community, residential or both) and to state which sector (e.g. voluntary, private, NHS etc.) best described their status.
There are around 100 residential services in England, and around 1200 community services, collectively providing treatment and support to around 200,000 people per year, or 135,000 on a typical day.

All NHS and voluntary sector or social enterprise (VCSE) providers who responded offered community services and/or residential treatment, whilst respondents who identified themselves as being private sector providers were either offered residential or residential and community services, with no private sector respondents identifying themselves as community services only.
Where respondents added information to identify themselves by sector when they had answered ‘other’, they were predominantly partnerships, split broadly equally between partnerships between the NHS and local authorities, the NHS and VCSE services and local authorities and VCSE services.

Several respondents indicated that they also hosted a number of volunteers, student placements and recovery champions (see page 52 for more on recovery champions and use of volunteers).
Part 2 – caseloads of participating services

- Median capacity of residential services = 22 spaces (n=18)
- Median caseload of community services = 240 people (n=84)

Change in caseload over last 12 months

Reasons for changes in numbers accessing services

n=117

n=96
Where respondents offered explanations for an increase in their caseload, these included structural changes (e.g. taking over an alcohol service or widening entry criteria), entrepreneurial changes (such as marketing services to different groups or rebranding), changes to partnership working (including increased referrals from GPs and social services) or improved referral routes (such as establishing a single point of contact with Work Programme providers and other potential sources of referrals).

**Respondents’ views**

We have rebranded ourselves to include subpopulations of drug users normally not positively included in service provision: LBGT clients, cannabis and club drug clients - so non opiate and crack users.

*Team Manager*

Where numbers had fallen, the explanations offered mirrored the above, to an extent. Structural changes mentioned by respondents included retendering, leading to uncertainty around future capacity. The knock-on effects of this included lower volumes of clients being able to access services and decreased staffing levels meaning that there was reduced capacity to actively seek new clients. One respondent suggested that the reason for an ostensible reduction in numbers was actually simply due to a thorough data cleanse of former clients. Externally driven reductions in client numbers included changes and restructuring in partner organisations who are traditional referral partners, including from the homelessness sector and local authorities.

Some responses indicate a potential tension between the recovery agenda and PbR models, for example on retaining people in treatment:

**Respondents’ views**

I believe it is because it is harder to retain people in treatment, or pro-actively bring people into treatment with current staffing levels. Also, now that retention is not a target, we close cases more easily in order to concentrate our resources on those who are recovery ready, rather than those who are difficult to engage.

*Service Manager*

Other respondents hinted at potential obstacles resulting from conflict of commercial interest:

**Respondents’ views**

Decrease in referrals from other agencies (possible conflict of commercial interests because of commissioning arrangements).

*Clinical Nurse Specialist*

Overall the picture from community-based treatment providers is mixed, with several respondents reporting a decrease in their ‘traditional’ client base of users of opiates and crack cocaine, off-set (and often more than off-set) by new drug types and alcohol. Other providers indicated that whilst many categories of substance use are acknowledged to be declining amongst young people, there has not been a corresponding fall in the harm experienced:
Respondents’ views

Fewer young people using substances, but those who do are presenting with more complex issues.

Practice Manager

We’re seeing a lot of prescribed medication now, ketamine and the club drugs. They’re managing to hold a job down, they’ve still got accommodation, but it’s starting to have a big impact and they’re only just holding on to those things. They’re coming to us, but we’re still seen as a heroin and crack service regardless of what we actually do, so it shows they’re desperate for help.

Director, PHE London region (interviewed)

Residential services in particular pointed to local authority funding pressures in conjunction with a preference for shorter programmes as leading to a reduction in referrals, although as with community services, the picture is mixed, with some services reporting an increased take-up of residential places.

Respondents’ views

Decrease in referrals due to a reduction in funding for rehabs

Speciality doctor

This last year has seen an increase in referrals into our residential services from community based services throughout the UK

Service Manager
Part 3 – engagement with Health and Wellbeing Boards

Perhaps surprisingly, of the 89 community-only services that answered this question, only a little more than half had definitely had any kind of engagement with their local HWB, although an additional 12 respondents were unsure. Perhaps given their generally much broader catchment area, it is perhaps less surprising that only 3 out of 15 residential-only services had definitely had any kind of engagement, although taken together with respondents offering both types of service, it does mean that rather fewer than half of all services that responded have had any kind of engagement with their local HWB.

It may be significant that whilst 8 community service respondents indicated that they were members of their HWB, nobody volunteered a comment on their membership. Whilst it is certainly possible that a treatment provider could be co-opted onto their local HWB, at this moment at least it appears a rare occurrence.

Considering the same data by PHE region, there was no significant change between levels of engagement from region to region.

Other forms of engagement mentioned in addition to those offered above include:

Respondents’ views

Presentation about service and question and answer session for councillors, partner agencies and service users.

Team Leader

Attend meetings and sub groups which feed into HWB

Service Manager
Members of our local HWB have been to visit some of the agencies in the city involved in the delivery of drug treatment provision, including the recovery service we oversee and which is led by people in recovery.

*Chief Executive*

I sit on the 'Shadow' Health and Wellbeing Board, which is chaired by a person who sits on the actual Health and Wellbeing Board and feeds back our opinions/ideas.

*Area Manager*

However, a minority of respondents indicated a different experience:

*Respondents’ views*

Did try to, sent an email... tumbleweed....

*Team Manager*

Health and Wellbeing Boards are charged with producing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. These will be crucial documents for the drug and alcohol treatment sectors. We asked respondents about their local JSNA and / or JHWS.

![Inclusion of drugs and alcohol in JSNAs](image)

n=94

An often expressed concern associated with the transfer of the responsibility to commission drug and alcohol services to local authority public health officials has been that public health professionals are accustomed to thinking in terms of population-level harms (of which alcohol may be one) rather than the needs of a relatively small cohort. This is reflected in the comments offered by survey respondents, from the regional summits and from interviews with chief executives and service managers. DrugScope’s own sampling of JSNAs suggests that this concern may have some foundation, although the responses to the survey suggest that if there is a difference between the perception of the ways that drugs and alcohol are included in assessments and strategies, it may be quite marginal.

However, several respondents did express some concern about one or other aspect of imbalance between drugs and alcohol:
Chief executives’ comment

There’s a new debate around how important drugs and alcohol are anyway. Do drugs and alcohol matter in terms of the consequences to the wider population or are other things more important? Certainly, you could say that alcohol is more important in relation to the health of the wider population, but many [JSNAs/JHWSs] hardly mention drugs and some of them only pay a very glancing reference to alcohol.

John Jolly, Chief Executive, Blenheim CDP

Chief executives’ comment

The Public Health Outcomes Framework has 66 indicators, 3 of which relate to drugs and alcohol directly. There will be some secondary impact from our services on the other 63, some more tenuous than others. What that’s asking us to do is think more critically about what we’re delivering and how that impacts the wider community. So we’re investing a lot of time and effort in demonstrating the impact of services locally. Whereas before we could produce a national report, make some really grand statements about the impact we’re having on populations across the country, we’re now honing that down very locally. It asks you to collect different information, asks you to think about yourselves in a different way, it gets you to recognise that you are an important part of public health but in some people’s eyes not as important as other agendas.

The localism issue is tricky. We can’t argue with it on an intellectual basis but it makes the whole decision making process quite politicised. If local commissioners in areas don’t want to fund drug and alcohol services they don’t have to.

Karen Biggs, Chief Executive, Phoenix Futures

Respondents’ views

Tokenistic.
Chief Executive

It highlights HIV prevalence, cancer, COPD etc, but mentions drug use, as evident but possibly not a priority. Alcohol use was highlighted more and number of deaths cited.
Team Manager

We work with people from across [region]. We don't feel that LGBT needs are well-represented (if at all) in relation to drug or alcohol needs.
Chief Executive

Both drugs and alcohol are considered to be a concern but are not actually referred to as a priority.
Area Manager

Drugs feature less than I would have expected.
Service Manager

There is still an imbalance between needs regarding alcohol and other drug use, for example gaining BBV and TB screening, supporting stabilisation and reduction, providing holistic wrap around services and opportunities to engage in meaningful use of time and improve wellbeing.
Complex Case Manager
However, several respondents offered more positive comments, and explicitly indicated that the JSNA process may, if not now then in future, offer opportunities to ensure that services better meet local, rather than national, priorities and circumstances:

**Chief executives’ comment**

The positives that come out of it are that we’ve been under a straitjacket in terms of what the system can deliver, so I think there’s a real opportunity for some innovation in the sector. As local authorities start to realise that they have control over what they deliver and can do things differently, so you’ll get much more divergent interventions.

We’re clear that we’re going to do 4 things over the next year, which are:

- Improve the quality of life for people who use our services;
- Campaign on behalf of people to reduce stigma for people using drugs and alcohol;
- We’re going to look at new models for how we deliver and work with people to enable them to actually take that journey and make that change;
- We’re also going to look at funding models and our business models – and how we can bring in the resources to actually achieve these things.

*John Jolly, Chief Executive, Blenheim CDP*

There have been three developments or shifts over the last couple of years. The first is the shift to PHE and localism and the general politicisation of decision making around funding services, which as ever poses opportunities as well as threats. The second is allied to that, but is around the reduction in funding for public services. The third is around the changing needs of our client group.

All three will demand providers to work differently, operate differently, think differently, behave differently. So if our services today are the same as they were three years ago that gives me concerns. If our services are the same as they are now in three years' time we’ll be doing something wrong.

*Karen Biggs, Chief Executive, Phoenix Futures*

**Respondents’ views**

In [unitary authority’s] JSNA 2012, 14 pages are given over to drug misuse and 5 pages to alcohol misuse. There is an acknowledgement that drug treatment has positively affected related crime figures and reporting by the public re drug use and dealing has decreased. There is a clear statement that any reduction to the drug treatment budget would see this trend reversed. There is also an acknowledgement that alcohol service provision needs to increase.

*Chief Executive Officer*

Responses to the online questionnaire suggest a slightly lower level of awareness of the emphasis placed on drugs and alcohol in JSNAs and JHWSs in London compared to the rest of England. As there are no substantive differences between public health structures in London and elsewhere, it is not immediately obvious why this should be the case.
The view from the summit

Discussions held at the four regional summits succeeded in identifying key opportunities to build recovery in the new environment. These included potentially increased scope for ‘intelligent’ procurement and commissioning of partnerships and integrated services leveraging money from non-traditional sources for the sector. Localism was seen as offering the ability to tailor provision more closely to meet local needs, assets and resources, including the flexibility to focus on alcohol and drugs other than opiates and crack cocaine. The need (or ability) to make a case locally was seen as both an opportunity, and a threat. The concern that HWBs are more attuned and pay greater attention to alcohol rather than drugs (and particularly novel psychoactive substances) was expressed by several participants.

The consensus was that the recovery ‘message’ was welcome and positive and many participants discussed ways of supporting clients to build recovery capital; however, some reservations were expressed about the possible implications of division of services into a ‘recovery’ fast stream on the one hand and harm minimisation on the other.

A potential negative aspect of localism was that there may – depending on the role that PHE adopts – be little quality control on innovation and a risk that ideas and proposals without substantial evidential support may surface and be taken seriously. The role of PHE was thought to be particularly important in the context of localism as a result of concerns that good practice in one area may not be identified and replicated. Whilst partnerships were seen as one of the ways to continue to deliver effective services in the face of potential disinvestment, several participants made the observation that they can be messy and complex.

The role of the Equality Act 2010 and the Public Sector Equality Duty was identified by some participants as potentially having a role to play in arguing for the commissioning of services to meet the specific needs of groups with characteristics protected under the Act, although it was acknowledged that this is still an emerging and developing area. The role of HWBs as a new, and potentially, more receptive audience was acknowledged, with this optimism tempered by recognition of the pressure on local authorities and the need for HWBs to meet an increasingly broad range of competing needs.
Part 4 – engagement with Police and Crime Commissioners and the criminal justice system

Survey responses suggest that engagement with PCCs is slightly less common than with Health and Wellbeing Boards. Engagement with the criminal justice sector is strategically important for the sector, in that it forms a pillar of the whole-systems approach required to effect lasting-change. However, currently, it may be of lower priority for services than engagement with the new public health structures which represent, in a sense, the core business of the sector.

Comments from respondents indicate a range of methods of engagement, both formal and informal:

Respondents’ views

The PCC has visited us on 2 occasions and offered to support the work we do with the local commissioners.  
*Acting Manager*

We have met him twice now, and the second time he came to an event we hosted, so quite informally so far.  
*Service Manager*

Sit on Local Police and Crime Board.  
*Drug and Alcohol Service User Involvement Officer*

Comments from other respondents suggest varying degrees of engagement, including Safer Future Communities (SFC) – a voluntary sector partnership led by Clinks and including DrugScope that benefited from Home Office funding until April 2013. Following the expiry of central funding, some SFC partnerships are being funded by PCCs or local authorities, others are unfunded.
It should be noted that formal engagement through Police and Crime Plan consultations is extremely low, at 17% of respondents.

**Respondents’ views**

Have held meeting at our request to discuss broadening the DIP role and have responded to requests to take on additional duties. Four subsequent requests for a further meeting have elicited no response.

*General Manager*

There were mechanisms through Safer Future Communities - not sure now

*Consultant*

Involvement at consultation level to review repeat offenders with dual diagnosis

*Recovery Therapist*

London is unique in that the responsibilities of the Police and Crime Commissioner rest with the Mayor. The executive role is carried out by an appointed Deputy Mayor for Policing and Crime, who heads the Mayor’s Office of Policing and Crime, or MOPAC. The current Police and Crime Plan for London indicates that relatively few services will be centrally procured, with the majority of funding being disbursed to London boroughs.

The structural differences above may be responsible for the noticeably lower indicated level of engagement with MOPAC in London compared to PCCs elsewhere, as may the sheer size of London – with 33 London boroughs and a population of almost 10 million people, the capital is an exceptionally large and complex police force area. Whilst it is possible that by not mentioning MOPAC explicitly the question posed was ambiguous, it also seems plausible that the additional complexity resulting from the unique structure of police and crime commissioning and governance in London may be a barrier to engagement and, ultimately, awareness.
Whilst around half of respondents were able to offer an opinion of their Police and Crime Plan, a little more than a sixth of respondents felt that their plan reflected both the enforcement and anti-social behaviour aspects and also the role that the criminal justice system can have as a route into treatment.

Whilst engagement with MOPAC appears to be somewhat lower than with PCCs elsewhere, levels of awareness of the contents of the respective Police and Crime Plans was not significantly different, although barely over half of respondents were able to express an opinion overall:
Respondents expressed a range of opinions, some more positive than others about the role of the PCC. Some alluded to the arguably unique pressures of a directly elected role:

**Chief executives' comment**

We’ve made strenuous efforts to connect with PCCs, and in the main, they’ve responded positively. Their focus seems mainly to be on the criminal justice perspective rather than health, but some have recognised the public health issue too. We won’t see much change now, but maybe in 12-18 months’ time.

Simon Antrobus, Chief Executive. Addaction

**Respondents’ views**

PCC/Police and Crime Plan not visible.

**Service Manager**

Despite setting out a strong commitment in his manifesto the PCC has not followed this up by action or apparent interest. We still do not know our funding options for next year.

**General Manager**

Our local PCC states that “A priority in my plan is tackling and treating drug and alcohol addiction.” I, personally, am not sure what that means, or how he intends to make that happen!

**Chief Executive Officer**

Too early to tell if they are really committed to drugs and alcohol interventions beyond initiatives that achieve headlines for talking tough etc. No doubt the attitude and approach of PCCs will vary between different areas. However in London we have seen the Mayor’s office have a big influence on the specification of criminal justice based service tenders.

**Chief Executive**

“There is a danger for the sector in framing itself as merely a health issue. The biggest motivator for government to fund us, local or national, is that it makes them feel safer in their beds at night – recovery helps community safety.”

Karen Biggs, Chief Executive, Phoenix Futures

**The view from the summit**

The subject of Police and Crime Commissioners was discussed at all four summits. The consensus at that point was that people were awaiting the first year of fully-autonomous decision making before coming to a verdict. The involvement of a PCC at one of the summits was welcomed and seen as an encouraging sign, but overall, there were concerns that new structures may mean a break in knowledge and a learning curve for the new incumbents.

As with local authority funding, participants were aware that police funding is also under significant pressure, and that from 2014 there is no effective ring-fence for community safety funding.

Agencies were also asked to provide information about existing partnership work with the criminal justice system:
As can be seen, the overall picture is one of business as usual, with some movement both up and down in terms of referrals and support. It may be significant that a higher proportion of residential services than community ones indicated increased referrals from the criminal justice system.

Respondents’ views

People like the crime and disorder partnership had no interest in the health of the user, it was all about crime…. In one area, in one city, there might be issues with needle litter, with visible sex work, and police commissioners want you to focus your efforts in that area on those issues, whereas in another area it might be to do with street drinking, it could be to do with safety of older people. Because of the way in which the police commissioning system, and also local health works, that’s driven from a grassroots level upwards, so it’s about concerns of the local population rather than a top down approach which I think is a big benefit.

Service Manager (interviewed)

More and more forces are investing in custom built custody suites and very often a large central custody suite that replaces a disparate group of geographically spread custody suites. [This] allows the police force to make economies and therefore invest in full time mental health nurses, or a regular visit from a mental health nurse who is on the premises and has more substance misuse support.

Service Manager (interviewed)
Part 5 – Police and Crime Commissioner commissioning and funding intentions

In September 2013, DrugScope submitted requests to every Police and Crime Commissioner under the Freedom of Information Act 2000, with the aim of clarifying the current state of commissioning and partnerships between the criminal justice system and the drug and alcohol treatment sector. The request contained 4 specific questions:

1. For 2013-14 please provide information about how much of your Community Safety Fund has been allocated to services relating to drug and / or alcohol use? This could include (for example) continuing funding for Drug Interventions Programme (DIP) type interventions, investing in other referral routes from the criminal justice sector into drug and / or alcohol treatment, funding diversionary or educational work, or financially supporting community or residential treatment services.

2. Are you able to give any indication of what the allocation is likely to be in 2014-15, and what the decision making process for next year’s funding will be in your police area?

3. Please describe how you engage with Health and Wellbeing Boards within your police area, and what level of involvement you have in Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

4. Please describe whether you currently commission or are considering commissioning within the next 12 months services funded by a payment by results (PbR) mechanism, and if so, what form that mechanism takes.

Police & Crime Commissioner Responses to requests made under the Freedom of Information Act 2000

- We sent FOI requests to all 42 Police & Crime Commissioners (including the Mayor’s Office for Policing and Crime in London), of whom 41 responded. These are summarised below, and are available in full online at: http://www.drugscope.org.uk/POLICY+TOPICS/StateoftheSector2013
- 35 were able to provide detailed information about the services that they commission
- 8 were able to provide an indication of the amount they intend to allocate for 2014-15
- 11 were able to provide an indication of the mechanism by which they will commission and / or allocate funding for 2014-15
- 36 gave an indication of their engagement with HWBs in their police force area, of which:
  - 28 indicated that they were members of or otherwise engaged with all HWBs
  - 7 indicated that they were members of or otherwise engaged with some HWBs
  - 6 indicated that they had experienced some difficulty in engaging with some or all HWBs
  - All 4 PCCs in Wales were engaged with their local Area Planning Boards
- 20 were able to provide an indication of their intentions concerning PbR, of which:
  - 2 said they were actively considering
  - 13 said they were not considering
  - 5 said they were not considering now but might do
## Summarised responses to DrugScope requests made under the Freedom of Information Act 2000

<table>
<thead>
<tr>
<th>Police Area</th>
<th>Q1: How much of your Community Safety Fund has been allocated to drug or alcohol use for 2013-14?</th>
<th>Q2: Give an indication of the likely allocation and decision making process for 2014-15 funding</th>
<th>Q3: How do you engage with Health and Wellbeing Boards (HWBB) in your police area and what levels of involvement do you have in Join Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (HWBS)?</th>
<th>Q4: Please describe whether you currently commission or are considering commissioning within the next 12 months services funded by a Payment by Results (PbR) mechanism, and if so, what form that mechanism takes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avon and Somerset</td>
<td>£1,049,645</td>
<td>Drug and Alcohol Action Teams Test on Arrest Young Persons Substance Misuse Project (Bristol) Substance Misuse Project (South Gloucestershire) Youth Offending Team</td>
<td>Single drug and alcohol arrest referral service being commissioned to commence from 2014/15 at cost of £725,000 - £775,000. Currently consulting on draft commissioning and grants strategy.</td>
<td>Introductory meetings held between PCC and Chairs of Health and Wellbeing Boards. Liaises with health colleagues on drugs and alcohol agenda and other related issues. No direct contribution to JSNA’s but uses them to inform their own needs assessment work.</td>
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<tr>
<td>Location</td>
<td>Funding Details</td>
<td>Status/Details</td>
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<td>Bedfordshire</td>
<td>£786,987 Out of £1m Community Safety Fund</td>
<td>Awaiting Comprehensive Spending Review and currently unable to confirm 2014-15 allocation. Commissioner has met with Directors of Public Health and agreed an action plan with focus on primary healthcare needs of offenders. Currently no plans to use PbR.</td>
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<td>Cambridgeshire</td>
<td>£381,000 Drug Intervention Programmes £321,000 Drug Testing £60,000 Drug Testing</td>
<td>Grant allocation to be confirmed at year end. Allocations will take into account priorities of Police and Crime Plan currently being reviewed with the Constabulary. Has engaged with Health and Wellbeing Board from its embryonic stages. States that it helped shape Health and Wellbeing Strategy but does not give details. PbR commissioning not being planned, but will be evaluating changes to offender management programmes that involve PbR.</td>
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<td>Cleveland</td>
<td></td>
<td>Awaiting response</td>
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<td>Cumbria</td>
<td><strong>£8,955</strong></td>
<td><strong>For alcohol only</strong></td>
<td>2014-15 funding allocation yet to be determined.</td>
<td>Attends meetings of the Health and Wellbeing Board.</td>
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<td><strong>£3000</strong></td>
<td>Alcohol Awareness</td>
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<td><strong>£4080</strong></td>
<td>Tackling Alcohol Related Crime</td>
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<td><strong>£1875</strong></td>
<td>Alcohol Misuse Impact Reduction</td>
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<td>Derbyshire</td>
<td><strong>£430,000</strong></td>
<td><strong>Allocated to city / county council</strong></td>
<td>Allocation yet to be determined, but would as far as possible aim to support current activities. Alcohol is a Police and Crime Plan objective.</td>
<td>Member of both HWBs in area, although activity a little sparse. High level of engagement in annual JSNA including constabulary and probation.</td>
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<td><strong>£326,000</strong></td>
<td>DIP</td>
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<td></td>
<td><strong>£18,095</strong></td>
<td>Derbyshire districts/boroughs</td>
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<td><strong>£86,000</strong></td>
<td>Probation for IOM staff</td>
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<td>Devon and Cornwall</td>
<td><strong>£555,629</strong></td>
<td>Other funding, such as on Community Safety and Youth Offending Service Partnerships, is routed to drug and alcohol services but unable to specify amounts.</td>
<td>Commissioning intentions plan for 2014/15-2016/17 provided but breakdown of spending on drug and alcohol services not given.</td>
<td>Member of Health and Wellbeing Boards. JSNA’s have included data from assessments and strategies underpinning Police and Crime Plan. Seeks to work closely with HWBs on crime and community safety issues.</td>
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<td>Dorset</td>
<td><strong>£243,818</strong></td>
<td><strong>Out of £99,773 Crime and Disorder Funding</strong></td>
<td>Drug Intervention Projects: <strong>£145,318</strong> (* out of full Community Safety Funding allocation of £550,000)</td>
<td>Not represented on either of the two HWBs and no direct involvement in JSNA. Was consulted on HWB strategy for Bournemouth and Poole.</td>
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<td><strong>£145,318</strong></td>
<td>Drug Intervention Programmes</td>
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<td></td>
<td><strong>£98,500</strong></td>
<td>Drug &amp; Alcohol Action Teams</td>
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<tr>
<td>Location</td>
<td>Total Funding</td>
<td>Programmes/Services</td>
<td>Funding Allocation</td>
<td>Engagement with HWBB</td>
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<tr>
<td>Durham</td>
<td>£358,687</td>
<td>Drug Intervention, Positive Futures Partnership, Children &amp; Young People Substance Misuse Service, Drug and Alcohol Action Team</td>
<td>2014-15 funding allocation yet to be determined</td>
<td>Attends meetings of Darlington HWBB. Has made representations regarding County Durham HWB but has not yet been invited to attend</td>
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<tr>
<td>Dyfed Powys</td>
<td>£746,287</td>
<td>Drug Intervention Programmes, Substance Misuse Prevention Services, Youth Offending Prevention Service</td>
<td>2014-15 funding allocations yet to be determined</td>
<td>Unaware of any engagement with HWBB.</td>
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<tr>
<td>Essex</td>
<td>£399,785</td>
<td>Essex DAATs, Essex and Thurrock DIP, Essex New Initiatives Fund, Community Safety Partnership</td>
<td>Too early to say but a reasonable planning assumption is that it will be at a similar level.</td>
<td>PCC sits on the Essex HWB</td>
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<tr>
<td>Gloucestershire</td>
<td>£499,176</td>
<td>Alcohol Arrest Referral Scheme, Drug and Alcohol Referral Scheme</td>
<td>2014-15 spend predicted to be the same as 2013-14.</td>
<td>Attends meetings of HWB.</td>
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<tr>
<td>Area</td>
<td>Total Funding</td>
<td>Funding Breakdown</td>
<td>Actions</td>
<td>Notes</td>
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| Greater Manchester          | £4,116m       | Community Safety budget  
£1,425m             Drug Intervention Programme | Reviewing funding for Drug Intervention Programme (and others) as it relates to historic funding profiles. Drugs & alcohol is one of 5 priority themes in Police & Crime Plan. PCC office has met with all 10 DATs/DAATs in region. | Has attended pan-Greater Manchester HWB, and has asked that all police divisions seek membership of their respective HWBs.  
No current intentions to commission using PbR.                |
| Gwent                      | £913,381      | Drug Intervention Programme  
£907,881 ION Track Detection Device | PCC has set up a Strategic Commissioning Board in partnership with local stakeholders to assess needs and advise on future funding. | Different structures in Wales.  
PbR not used in Wales.                                                  |
| Hampshire and Isle of Wight | £499,573      | Drug Intervention Programmes  
£290,306 Youth Crime and Substance Misuse  
£162,553 Drug Action Team  
£19,125 Alcohol/Substance Abuse Diversionary Activities  
£14,688 Substance Misuse  
£12,901 | 2014-15 funding allocations yet to be determined. | PCC is member of the three HWBs in the county. Aims to work closely with Public Health on substance misuse issues.  
No plans to commission PbR services.                            |
| Hertfordshire              | £387,049      | Drug Intervention Programme  
£233,762 C and YP Substance Misuse  
£79,582 DrugsAction Team  
£48,705 Drugs Worker ‘No More’ Project  
£25,000 | 2014-15 funding allocations yet to be determined. | Not represented on HWB and no direct involvement in JSNAs.  
No direct commissioning of services, but PbR being considered for victim support and transforming rehabilitation. |
<table>
<thead>
<tr>
<th>Humberside</th>
<th>£1,831,689</th>
<th>Community Safety Partnerships £1,011,196</th>
<th>Drug Testing on Arrest £562,023</th>
<th>Youth Crime Prevention and Substance Misuse £285,470</th>
<th>2014-15 funding allocations yet to be determined</th>
<th>Has been consulted on HWB strategies and held meetings with Directors of Public Health. Police and Crime Plan feeds into drugs, alcohol and other public health and social issues.</th>
<th>Does not expect to adopt PbR model.</th>
</tr>
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<tbody>
<tr>
<td>Kent</td>
<td>£553,221</td>
<td>Drug and Alcohol Action Teams £440,034</td>
<td>Young Persons Substance Misuse £113,287</td>
<td>2014-15 funding allocations yet to be determined.</td>
<td>PCC not a formal member of HWBs. State that engagement is undertaken but no details given.</td>
<td>PbR not currently used. Cannot say if it will be used in future.</td>
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<tr>
<td>Lancashire</td>
<td>£90,000</td>
<td>Blackburn with Darwen Drug &amp; Alcohol Action Team £143,000</td>
<td>Blackpool Drug &amp; Alcohol Action Team £364,000</td>
<td>No - not at present</td>
<td>The PCC has been invited to attend all three of the Health &amp; Well Being Boards in the police area. Staff from the OPCC have been involved in some JSNA. The OPPCC had no involvement in setting Joint Health &amp; Wellbeing Strategies at present.</td>
<td>None</td>
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<td>Leicestershire</td>
<td>£548,522</td>
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<td>£803,374</td>
<td>Minimal engagement with HWBs but has requested membership. JSNAs referenced in developing commissioning plans.</td>
<td>No direct commissioning, but contributes to programmes which are partly funded by PbR.</td>
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<tr>
<td>Location</td>
<td>Budget Allocation</td>
<td>Description</td>
<td>Interagency Collaboration</td>
<td>Notes</td>
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<tr>
<td>Lincolnshire</td>
<td>£235,000</td>
<td>Youth crime and substance misuse&lt;br&gt;£50,000 Alcohol Co-ordinator&lt;br&gt;£55,000 DIP Funding</td>
<td>Not possible to say, will be considered as part of budget development and planning process, culminating in proposals being presented to Police and Crime Panel in Feb 2014</td>
<td>The PCC is not a member of the HWB so engagement is undertaken at officer level. PCC is a consultee on JSNAs and Wellbeing Strategies. A PbR mechanism is used in drug treatment services.</td>
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<tr>
<td>London (Metropolitan Police)</td>
<td>£5,047,958</td>
<td>Of London Crime Prevention Fund allocated to initiatives focused on drug or alcohol use</td>
<td>92% has been committed for multiple years. Decisions about future years will be made by London Crime Prevention Fund Advisory Group comprised of senior MOPAC and council officials.</td>
<td>Work with boroughs to support recognition of crime related priorities within the context of health priorities. Engaging with PHE on a pan-London basis looking at co-commissioning opportunities. Also engage with HWBs through London Councils in partnership with NHS England London Region developing a 'Health in the Police and Crime Plan' strategy to be published in 2014. MOPAC does not directly commission drug and/or alcohol services, but funds boroughs, some of which may be on a PbR basis. Commissioning a sobriety 'proof of concept' pilot in May 2014.</td>
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<tr>
<td>Merseyside</td>
<td>£1,122,000</td>
<td>Out of £3,114,000 Community Safety Fund Grant</td>
<td>2014-15 funding allocations yet to be determined</td>
<td>Sits on board but awaiting further details of involvement. Information not provided</td>
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<tr>
<td>Northamptonshire</td>
<td>£568,000</td>
<td>Substance Intervention Programme&lt;br&gt;£575,000 Drug and Alcohol Action Team</td>
<td>2014-15 funding allocations yet to be determined</td>
<td>Commissioner is vice chair of HWB. Has inputted into JSNA and HWB strategy. Information not provided</td>
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<tr>
<td>County</td>
<td>Amount</td>
<td>Description</td>
<td>2014-15 Funding Allocation</td>
<td>Notes</td>
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<tr>
<td>Northumbria</td>
<td>£2,174,000</td>
<td>DIP</td>
<td>Decision making will be following the local strategic assessment and partner consultation.</td>
<td>The PCC is engaged with a wide range of local partners including local health professionals and is keen to engage with local health agencies and strategies as local policies evolve and develop.</td>
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<tr>
<td>North Wales</td>
<td>£1,379,000</td>
<td>Commissioner's Fund made up of previously ring fenced grant funding streams, including the Community Safety Fund, the Drug Intervention Programme (DIP) Fund, the DIP Drug Testing Grant, and the Youth Crime and Substance Misuse Prevention Fund. Detailed breakdown not available.</td>
<td>2014-15 funding allocations yet to be determined</td>
<td>Does not hold this information. Does not commission services funded by PbR</td>
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<tr>
<td>North Yorkshire</td>
<td>£76,421</td>
<td>North Yorkshire Drugs Services Programme. City of York Drugs Services Programme Working with NYP custody staff / visiting custody suites</td>
<td>Community safety will be funded in a different way – instead of issuing grants, providers will bid for projects with community-based outcomes. This is to improve scrutiny &amp; evaluation of outcomes. Community fund allocated 1/4ly, no decision made about future.</td>
<td>PCC has no representation on either York or North York HWB, although North Yorkshire Police are represented on City of York HWB. PCC is working towards being more involved and is in discussions with local authority leads.</td>
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<tr>
<td>Nottinghamshire</td>
<td>£1,219,100</td>
<td>Drug and Alcohol Services Education/Awareness for offenders</td>
<td>2014-15 funding allocations yet to be determined.</td>
<td>Attends HWBs and is consulted on strategies. Does not currently PbR funded services. Currently reviewing commissioning arrangements.</td>
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<tr>
<td>Region</td>
<td>Funding Amounts</td>
<td>Current Funding Status</td>
<td>Future Financial Arrangements</td>
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<tr>
<td>South Wales</td>
<td>£2,483,000</td>
<td>Anticipates reduced funding, but aiming to make efficiencies without affecting frontline services.</td>
<td>Wales does not have HWB. PCC is developing relationships with Area Planning Boards which are responsible for commissioning substance misuse services in Wales.</td>
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<tr>
<td>South Yorkshire</td>
<td>£2,189,892 £1,203,576 £586,316</td>
<td>2014-15 funding allocations yet to be determined.</td>
<td>Has attended HWB but not on regular basis due to other commitments.</td>
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<tr>
<td>Staffordshire</td>
<td>£428,706</td>
<td>£528,706 Indicative as funding plans currently being developed with partners.</td>
<td>Subgroups on drugs and alcohol work streams that feed into the HWB’s.</td>
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<td></td>
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<td></td>
<td>Does not currently use PbR. May be considered in the future but unlikely to be in the next financial year.</td>
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No PbR services in place but open to consideration.
<table>
<thead>
<tr>
<th>Suffolk</th>
<th>£269,237</th>
<th>out of £675,000 set aside for Crime and Disorder Reductions</th>
<th>2014-15 funding allocations yet to be determined.</th>
<th>Commissioner is member of the HWB.</th>
<th>States that all 2013/14 grants were scrutinised by Accountability and Performance Panel but did clarify whether or not Pbr funding used. Will use same internal process to monitor outcomes for future grants.</th>
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<tbody>
<tr>
<td></td>
<td>£146,730</td>
<td>Drug Intervention Programme</td>
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<tr>
<td></td>
<td>£47,507</td>
<td>Drug and Alcohol Action Team</td>
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<td></td>
<td>£45,000</td>
<td>Young Persons Substance Project</td>
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<td></td>
<td>£25,000</td>
<td>Drug Testing on Arrest</td>
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<td></td>
<td>£5,000</td>
<td>Best Bar None Scheme (Additionally, £120,762 was allocated for community safety partnerships, some of which linked to drugs and alcohol, but breakdown not yet available)</td>
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<tr>
<td>Surrey</td>
<td>£117,595</td>
<td>DIP/Drug Testing in Custody Youth Support Service Substance Misuse Team Surrey Drug and Alcohol Care Radio Campaign</td>
<td>2014-15 funding allocations yet to be determined.</td>
<td>Represented on HWBB and meetings held to ensure that JSNA’s and HWB strategies are interlinked in future.</td>
<td>Did not confirm if Pbr is currently being used. 2014/15 commissioning yet to be decided.</td>
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<td></td>
<td>£60,000</td>
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<td></td>
<td>£54,595</td>
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<td></td>
<td>£3,000</td>
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<tr>
<td>Sussex</td>
<td>£537,948</td>
<td></td>
<td>2014-15 funding allocations yet to be determined.</td>
<td>Commissioner has sought membership of all three HWBs. Has observer status with speaking rights on East Sussex HWB but has not been invited to join West Sussex. Brighton and Hove HWB is still being set up.</td>
<td>Does not currently invest in Pbr funded services. If current funding continues, does not intend to use Pbr.</td>
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<tr>
<td></td>
<td>£312,948</td>
<td>Drug Intervention Programmes Young People’s Treatment (via Youth Offending Team) Operation Reduction (drug related offending)</td>
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<td></td>
<td>£95,000</td>
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<td></td>
<td>£126,000</td>
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<tr>
<td>Region</td>
<td>Amount</td>
<td>Description</td>
<td>Funding Allocation</td>
<td>Notes</td>
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<tr>
<td>Thames Valley</td>
<td>£1,734,000</td>
<td>Out of £3,505,000 for community safety initiatives</td>
<td>2014-15 funding allocations yet to be determined.</td>
<td>PCC has written to all nine HWB’s to set up engagement process, but states that response to date has been very poor. Has not been consulted on JSNAs and HWB strategies. Did not confirm if PbR currently being used, but does not intend to use in the immediate future.</td>
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<tr>
<td></td>
<td>£1,119,000</td>
<td>Drug Intervention Programmes</td>
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<tr>
<td></td>
<td>£615,000</td>
<td>Drug Testing in Custody</td>
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<td>£1,771,000 was allocated to community safety partnerships, youth offending teams and other projects, but cannot state how much of this spent on drug and alcohol issues</td>
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<tr>
<td>Warwickshire</td>
<td>£221,411</td>
<td>Drug Implementation Plan</td>
<td>2014-15 funding allocations yet to be determined.</td>
<td>Represented on HWBs and is aware of JSNAs but did not give any further details. Did not confirm if PbR currently being used, but does not intend to commission such services in the near future.</td>
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<td></td>
<td>£125,000</td>
<td>Drug and Alcohol Action Team</td>
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<td></td>
<td>£63,411</td>
<td>Youth Justice Service</td>
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<td></td>
<td>£33,000</td>
<td>Substance Misuse Interventions</td>
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<tr>
<td>West Mercia</td>
<td>£338,460</td>
<td>Drug Intervention Programmes</td>
<td>2014-15 funding allocations yet to be determined.</td>
<td>Attends HWB meetings and works directly with substance misuse commissioners to meet joint objectives. Has set up a steering group of public health commissioners and criminal justice leads. Expects active involvement in JSNA process in future. Does not currently commission services funded by PbR</td>
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<td></td>
<td>£205,360</td>
<td>Substance Misuse Workers (YOS)</td>
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<td></td>
<td>£109,100</td>
<td>Alcohol Harm Reduction</td>
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<td></td>
<td>£15,000</td>
<td>Youth Project</td>
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<td></td>
<td>£4,000</td>
<td>Aftercare Team</td>
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<tr>
<td>Region</td>
<td>Details not available until end of financial year.</td>
<td>2014-15 funding allocations yet to be determined.</td>
<td>Currently has a seat on six of the seven HWBs and will join the other board next year. Police and Crime Plan intersects with many areas of health agenda and collective approach taken at local level through Community Safety Partnership.</td>
<td>Does not currently commission services funded by PbR and does not intend to do so in the next 12 months.</td>
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<td>West Midlands</td>
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<tr>
<td>West Yorkshire</td>
<td>£3,876,688</td>
<td>2014-15 funding allocations yet to be determined.</td>
<td>States that PCC committed to working with HWBs but no details given.</td>
<td>Did not clarify if PbR is currently being used or will be used in future. Is committed to “commissioning against outcome based specifications”.</td>
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<tr>
<td></td>
<td>£1,899,768</td>
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<td>£1,376,417</td>
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<td></td>
<td>£600,503</td>
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<tr>
<td>Wiltshire and Swindon</td>
<td>£174,992</td>
<td>2014-15 funding allocations yet to be determined.</td>
<td>Member of HWBs and regularly attends meetings. Police and Crime Plan takes into account JSNA’s. Joint HWB strategies approved by boards on which PCC sits.</td>
<td>No plans to implement PbR mechanism.</td>
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Part 6 – the impact of retendering and recommissioning

The impact of tendering, and particularly frequent retendering, has been a significant concern for many in the drug and alcohol treatment sector for some time. A number of issues have been raised, including the cost of commissioning to providers and commissioners, the harm done to continuity of care and staff morale in frequent recommissioning, and the experience and expertise of commissioners. Other concerns have reflected the particular issues of TUPE, including when taking on services previously in the public sector, and the overall financial environment, where local authority budgets have been under pressure and are likely to remain so for the foreseeable future leading to concerns that cost is being prioritised over quality.

We were keen to learn more about the impact of recommissioning on services – the financial impact of the process is substantial and a concern to many in the sector. It seemed likely that the quality of services could, in fact, be undermined rather than improved by frequent retendering.

![Services retendered, recommissioned or renegotiated in the last 12 months](image)

n=90

Whilst the fact that over half of participating services had been through a retendering or recommissioning process in the previous 12 months is quite striking, seen in conjunction with the subsequent question relating to potential future commissioning arrangements, it may be that the majority of services who answered these two questions will go through at least one procurement process in 24 months, although that would of course depend on the proportion who answered ‘yes’ to both questions.
n=89

The chief executives interviewed provided some perspective on the process, and particularly on staff morale:

**Chief executives’ comment**

We’re not short of opportunities, but we need to be mindful of what’s being commissioned. There’s a requirement to test the market, but there can also be a huge waste of money on recommissioning high performing services.

We haven’t seen a dramatic change in the quality of commissioning, but it’s become hugely competitive and we’re increasingly seeing contracts bundled into larger financial packages, which raises questions for smaller organisations.

*Simon Antrobus, Chief Executive, Addaction*

Money should fundamentally go on serving people, but as a result of continual processes of recommissioning, the reality is I have to spend the organisation’s money winning the right to do that.

A lot of organisations will miss out because they can’t meet the demands of that commissioning framework, and also there are barriers to entry which prevent them entering even. We’re a reasonable sized organisation but sometimes people want a higher turnover than even we have before we’re even allowed to compete, so you then have to go into partnerships with other organisations. And partnerships, they can be good, they can be bad or they can be marriages of convenience.

*John Jolly, Chief Executive, Blenheim CDP*

There was some divergence of opinion around the impact of uncertainty around employment and employer on staff morale, with one stating that whilst morale wasn’t a problem as such, it wasn’t hard to imagine that motivation could suffer and that it would be foolish to ignore the risk.
Where there was absolute unanimity was around the impact on staff, on services and consequently on clients of constant tendering. All three chief executives observed that they had staff who had joined them after transfer under the Transfer of Undertakings (Protection of Employment) process, sometimes three or more times, and who had therefore never actively chosen to work for them.

Moreover, all three made a direct connection with the quality of service provided, and suggested that whilst morale can be maintained or improved through communication and management support, tendering cycles of (say) three years can mean that a service might only have a year or so of stability between the process of preparing for tender and (potentially) transfer of service.

Respondents’ views

Most commissioners didn’t have the experience of tendering on the scale that they were tendering to be able to do it really well, and commissioning was anything but world class. After the changes in public health commissioning they seem an awful lot more transparent, that the definition of services to be commissioned seems to be a lot better.

*Service Manager (interviewed)*

In terms of cost and quality, commissioners a lot of the time talk about quality, but what they’re really interested in is money. It’s all about getting more for less, but sometimes you can’t do that.

*Director, PHE London region (interviewed)*

My service is made up of several components some of which have already lost funding, some will lose it and some remain unsure. In the wider organisation we have negotiated many of the contracts to avoid retendering. This makes it harder to find resources for niche developments, and sometimes business and financial drivers take over from the public service, care and diversity ethos.

*Complex Needs Manager*

The question of how resource-intensive (or expensive) a round of procurement turns out to be depends on such a broad range of variables (e.g. the size of the contract, the number of participants, matters specific to the process and a range of variables on the commissioning side) that it would not have been practicable to try to estimate this through the process of this survey. Informed estimates of the cost of retendering put the total financial cost to all participants in the range of £150,000 to £300,000 per tender. With around 150 local authorities commissioning drug and / or alcohol services, many through more than one contract, the potential financial implications of this are clear\(^\text{11}\)

Instead, we asked respondents to describe their own experience of the process both in terms of the burden it had placed on their service, and the end result of the process: whilst there is little doubt that retendering is often unwelcome in the immediate term, we were keen to learn if respondents believe that procurement can play a role in improving services.

The view from the summit

There was a consensus that the resource impact and uncertainty of recommissioning and retendering is substantial and unwelcome, including not just cost but also potential unintended consequences such as reluctance to collaborate and cooperate or share good practice that may, in effect, be a competitive advantage.

However, some participants suggested that the sector could manage these challenges more effectively by strengthening its approach to workforce development and to transfers of staff during the transfer between services and providers.

\(^\text{11}\) Figures provided by Kevin Molloy, independent consultant
As articulated in survey responses and chief executive interviews, there was some concern about the experience and expertise of commissioners, and the extent of good practice and evidence base for commissioning, and the difficulty for the sector and its service users to hold poor commissioning bodies to account.

A participant in one summit made a straightforward statement: if a service is performing well and there is no evidence that recommissioning would improve it, the benefits of continuity, maintained morale and non-diversion of provider resources into competition should be compelling.

The comments from services and chief executives, in conjunction with the existence of new structures to support the design and commissioning of broader services, suggest there may be real opportunities to better meet local need. Respondents generally found the argument for longer contracts, providing more stable services delivered by motivated and confident staff, compelling.
Part 7 – funding – changes and impact

Respondents were asked about any changes to their funding compared to the previous financial year, 2012-13.

![Funding changes compared to 2012-13](image)

n=96

There was little to distinguish residential and community services in response to this question, although funding for services was marginally more likely to have remained the same and slightly more likely to have increased, compared to community services.

Many comments volunteered by respondents appear to confirm the relationship between recommissioning and retendering and reductions to funding.

**Respondents’ views**

Not yet, we took a hit two years ago and lost half our staff. So far we seem to be safe with what we have.
*Team Manager*

Unsure, as staff are not replaced when vacant.
*Locum psychiatrist*

Jobs on hold, review of all services, constantly feeling under threat.
*Team Leader Substance Misuse*
Funding moved to local council - actual reduction of 15%

Team Leader

Contract will go out to be recommissioned later this year. We have some small pots from other funding applications and other small pots due to end this year. It is a very uncertain times and very hard to plan.

Operations Manager, PHE South region

We won the tender but the new targets means the cost of reaching them has slashed our unit cost by 40 percent.

Director

Whilst the majority of comments offered were negative, the answer most frequently provided was that of ‘no change’, and that whilst 34 services had lost funding (for any reason), 19 had gained funding. Some comments from respondents shed light on the issue:

Respondents’ views

We went through a long period of generous funding for drug and alcohol services, and they were funded of course because of crime and the fear of crime, and because of blood borne viruses. Then we had a recession and the comprehensive spending review, and funding started to contract. A lot of people were made redundant. Services were cut back. Some of the commissioning focused for a long while on cost rather than quality, and not just quality but the diversity of services that were provided. But I feel that trend is being reversed now. We have the recovery agenda and commissioners are focusing a lot more on the recovery and the health outcomes, long term outcomes of service users rather than on cost. So for example, it's becoming more common to see a tender document that has much less of a weighting on price and much more on service delivery which is a big step forward.

Service Manager (interviewed)

Partnerships with other agencies are being progressed, joint bids have gone in. Interestingly our local authority then complains it cuts down their choice of providers. Damned if you do, damned if you don’t.

Operations Director, PHE South region

In the previous round of cuts and re-commissioning, we lost about 25% of the team and then rebuilt services using mixed funding (grants, donor, surplus from other projects etc.) but now further changes in national and regional structure have resulted in some gains and some losses. Overall there is a short term increase, but some of that will be lost if we cannot find alternatives to fund services that are headed for decommissioning especially in mental health advocacy

Complex Needs Manager, PHE London region

We managed to obtain funding for a Hidden Harm post.

Service Manager

Two years funding for a part time counsellor from Lloyds TSB

Business Manager, PHE London region

Additional fundraising activities - no change in core funds

Business Manager, PHE London region

Whilst it is useful to have a sense of the scale of funding changes and the proportion of services experiencing a change in either direction, this on its own only tells part of the story.
For the four items listed in this chart, community services were more likely to report an increased caseload than residential services, and residential services were slightly more likely than community services to report improved core services. It is notable that the only net improvement in services was in the availability of family support.
For the four items listed in this chart, there was no significant difference between residential and community services. It is striking that whilst elsewhere respondents make repeated references to the gaps in provision for clients with complex or multiple need, a substantial number of services report restrictions in supporting clients with higher or complex needs.

Respondents offered a number of comments:

**Respondents’ views**

We’ve had to be a lot more flexible as funded and private clients are looking for shorter durations. This has implications for a rolling programme; imagine you ran a university degree for a year, and then had to start running a similar but more intense syllabus for three months or six, it’d cause chaos. It’s a lot more stressful on counselling and support staff, but that’s what the market wants.

*Director (interviewed)*

Referring into local services has become more difficult, with providers not accepting referrals for some issues.

*Senior Substance Misuse Worker, PHE Midlands & East of England Region*

Dual diagnosis increasing and instead of specialist services picking these patients up they are being kept in community services that are not meeting client need.

*Team Leader Substance Misuse*

A reduction in funding has led to smarter ways of working and a large increase in clients being assessed and in treatment.

*Team Leader, PHE London region*

Due to cuts and therefore having less staff we have now had to operate a waiting list for alcohol clients wishing to access treatment. This has limited the number of clients we can work with.

*Service Co-ordinator*

The threshold problem has become worse. Clients with multiple conditions have struggled even with support to get basic physical and mental health needs met by statutory services throwing a greater burden on generic staff and therefore more demand on our specialists who are funded by a patchwork of non-integrated funding sources.

*Complex Needs Manager, PHE London region*

We have tried to minimise the impact on service delivery by protecting front line staff and making savings across other functions, such as management and drug testing, supervised consumption and clustering of appointments in rural areas.

*General Manager*

We were also keen to learn more about the sources of funding accessed by the sector. Perhaps unsurprisingly, the majority of respondents identified Drug Action Teams or Drug and Alcohol Action Teams (DATs / DAATs) or local authority public health funding as their main source, with around 70% of services identifying it as their main source of funding. The chart below excludes this form of funding for reasons of legibility:
Funding sources accessed were broadly similar between community and residential services, although as might be expected, more residential than community services indicated social services funding as their main source.

Turning to changes in funding, it is striking that more agencies reported reductions than gains across every single category available, with the exception of fundraising:
Chief executives’ comment

The voluntary sector has always been really good at being able to deliver things in a very cost-efficient way. We’re very good at delivering and developing innovative models that don’t cost that much, that have a significant impact. We need to go back to those roots and think much more like that. To continue to challenge ourselves about our price and our cost and identify different ways of generating income. And again, that’s not a bad thing. It’s the responsibility of all of us to do that, so whilst it might feel a pain it’s a good challenge for us and helps us to think more creatively.

Karen Biggs, Chief Executive, Phoenix Futures

The view from the summit

Unsurprisingly, the issue of funding was raised by many participants at all four summits. Whilst there was a sense of realism about the scale of the challenges facing all organisations delivering services commissioned or purchased by local authorities, some particular concerns were identified.

These included increased reliance on volunteers, risks to professionalism and expertise (for example through reduced budgets for staff training and development), risks that caseloads may become overwhelming, and also that a tendency to rely on more diverse funding streams may actually make services more vulnerable to relatively small changes.
Many respondents indicated that they had taken measures to defend front-line positions, although almost half of the services who answered this question indicated that they had in fact lost frontline staff. Whilst fewer respondents explicitly stated that they had made similar efforts to protect back-office or administrative positions, respondents here and elsewhere indicated that administrative roles had become more prominent due to increases in the volume and variety of monitoring required by commissioners. Overall, more services had lost staff than gained, although it is not possible to extrapolate from this to numbers or to any sense of a net loss or gain across the workforce.

Of particular note, the increase in the use of volunteers is striking, with 44 out of 69 services reporting an increase, compared to only six reporting a decrease. Volunteers clearly come without the expense of paid members of staff and volunteering is often used as part of treatment providers education, training and employment (ETE) strategy as a bridge to paid work, but there are clear implications. In terms of volunteer induction, management, supervision and development, and after many years of increasingly professionalised services, care will need to be taken that that progress is protected.

**The view from the summit**

Several participants in the regional summits observed that whilst accommodating volunteers brought many benefits for the host organisation and, very often, for the volunteer, there are substantial implications in terms of workforce expertise, support and supervision and safeguarding, and that the sector will need to work to maintain its professionalism. A theme that emerged from one summit was that the volunteers may end up being exploited by organisations that become over-reliant on them, and that a degree of realism and reflectiveness would be needed to avoid this.
Whilst the largest single group of respondents indicated that there had been no change in training, workforce development and support, the outlook is mixed, with more services indicating a negative rather than a positive change. A larger proportion of residential services indicated that there had been no change (50% compared to 32%), but in that sector too the services indicating a negative change outnumber those reporting an improvement. Comments offered by respondents provide perspective.

Respondents’ views

No outside training that has a cost
Team Leader Substance Misuse

Investing in this has helped staff to be able to use volunteers and peer supporters more efficiently, use their own time more effectively and generally feel valued by us investing in their development
General Manager

[County] Youth Offending Service is constantly striving to improve staff education and training is high on the agenda
YOS Worker

Many staff working in the drug and alcohol treatment sector have personal experience of substance use and using services. In addition to often making for effective and empathetic staff, this means of recruitment can help to reinforce and promote recovery, as employment is one of the key components of recovery capital. Recruiting individuals with histories of substance use is also a clear show of faith that in the medium to long term may bring a strategic benefit in changing employer attitudes more generally. We were keen to discover the extent to which organisations recruit people with personal experience, and the means by which they do so – for instance, whether or not recruitment of former service users is via a formal programme.
Respondents provided considerable detail about their recruitment mechanisms and strategies, which can be broadly categorised as:

1. Peer led organisations that only recruit people with personal experience.
2. Organisations that provide a formal programme as a pathway into employment in the sector.
3. Organisations that actively encourage applications from people with personal experience.
4. Organisations that whilst not taking positive steps, are receptive of the idea.

A small minority of services indicated that service user recruitment would be impracticable for them due to the particular nature of their provision.
Respondents’ views

Abstinent service users are supported to become volunteers and this can lead to paid work.

Team Manager

We have a trainee programme, apprenticeship delivered in partnership with [local FE college], but will also directly and actively recruit former service users.

Area Director

We have an apprenticeship programme to bring service users through initially as volunteers, and then into the paid workforce.

Hub Leader

We actively recruit people who are capable of doing the work regardless of their status.

Business Development Manager, PHE North region

Not specifically but we are well known for being positive about such recruitment

General Manager

Some candidates are simply ex-service users although I do discuss with service users the potential of obtaining employment in drug treatment in the future and how they can develop educationally and by involving themselves in voluntary work in order to achieve this.

Team Leader

If a former client shows interest we will interview and train in the usual manner after a 'clean period' of two years.

Manager

Volunteers have traditionally been a feature of the voluntary, community and social enterprise (VCSE) landscape. More recently within the treatment provision sector, peer support and in particular an increased emphasis on recovery champions have played significant roles within services. Whilst the roles that recovery champions may undertake are diverse, a common theme is generally that a core part of their position is to motivate and inspire others, and serve as role models to those at a different point in their treatment journey. Many of these positions are unpaid – as with volunteering, the quid pro quo can include reinforced self-esteem, structure and routine, social engagement and experience that can be used to support entry or re-entry into the job market.
Respondents to the online questionnaire volunteered helpful and in some cases quite detailed information about the role of recovery champions in their services:

**Respondents’ views**

We started with two who started up the SMART Recovery Groups etc. But I would now say we need to look to our peer mentors as well and to remodel our recovery champions to possibly lead more on what recovery can look like - presenting stories of recovery, linking in with community agencies which can support recovery etc.

*Team Manager*

Recovery champions’ roles are to facilitate groups with staff, facilitate mutual aid groups, take referrals, inductions.

*Service Manager*

To communicate internally and externally that recovery is possible. To develop social activities and build community assets.

*CEO, PHE North region*

Varying numbers at any one time offering mentoring and support. We are in the process of really improving our meaningful service user involvement programme and about to embark on training that the recovery champions can then cascade down to others.

*Residential Services Recovery Manager*

Five - two staff members, three ex-service-users. [Local authority] has a recovery champions’ forum and our staff and service-users attend this, helping to design/plan/deliver recovery activities. Plus this team and our wider staff/volunteer team deliver recovery stalls, a greeters scheme welcoming new clients to our service, the service-user forum and consultation exercises.

*Innovation and Development Manager*

All our graduates of our residential program have maintained abstinence for a minimum of six months post-completion. They provide current residents with mentoring and moral support and escort residents to appointments, mutual aid meetings etc. They are provided with training and eventually will be supported into employment in the field if that is their goal.

*Service Manager, PHE South region*

We run a peer mentoring project which offers an accredited induction programme, and placements within partner agencies within the city wide drug treatment and recovery system. Our peer mentors are seen as positive role models for others coming through the system. We run four inductions a year with around seven or eight mentors on each induction - at any one time there are between 15 and 20 mentors active across the city. Our Recovery Space is led by people in recovery from drug/alcohol addiction and/or mental ill health - with a membership of 150+. Around two dozen of the members take active roles in running the Space and in promoting visible recovery across the city. Our service is also involved in supporting a pilot project delivering peer-led commissioning in partnership with the City Council. A panel of people in recovery have received accredited training in grant-giving, and have been allocated £10,000 to distribute to user led projects across the city which come up with ideas to promote visible recovery.

*Chief Executive Officer, PHE North region*
Part 9 – services provided, support needs and gaps

Having looked in some detail at the participating services, we were keen to learn about the services on offer, how the services meet local need, and the gaps respondents identified in local provision.

The level of responses from both sectors was broadly similar, with many services indicating that whilst they may not have specialist, specific provision for all the groups identified, they would endeavour to work with them either singly, or in partnership with a specialist organisation. It should be noted, however, that this implies that a “yes” response does not necessarily indicate that a specialist service, intervention or training to support delivery of this is provided. Individual services also volunteered the following information:

Respondents’ views

We also have services for those in active recovery. We will work with anyone who wants to access a recovery service, we utilise local interpreting services and also link with specialist services to ensure supported attendance with case managers and for clinical appointments.

Contract Manager

Users of benzodiazepines prescribed and unprescribed. Some categories above welcome but not a specific service for these groups.

Service Manager
As we are positioned at the recovery end of the treatment system, we are set up to work with anyone recovering from addiction who is able to engage effectively with our more structured interventions as long as they are 18+ and have a local postcode.

*Chief Executive Officer, PHE North region*

We asked services to provide information about the support needs their clients most frequently present with – assuming that support to address substance use, misuse or dependency is a given.

![Client support needs chart](chart)

Reflected elsewhere in this report, housing need was the most common response, both in terms of the highest number of 'most frequently seen' responses, and also in absolute terms. In general terms, responses from the residential and community sectors were little different, with the exception of child safeguarding, which was ranked substantially higher for community services.

We also asked respondents to provide information about local gaps in provision – regardless of whether or not they were the agency best placed to fill the gaps. As this was free text, the responses have been coded and categorised. Whilst this introduces an element of subjectivity, it should be noted that two gaps, housing/ housing support and support for clients with complex needs, were most frequently mentioned by some margin. Whilst respondents were asked to identify a single gap, several offered more than one; where this is the case, they have been included.
Three factors stood out for the frequency with which they were mentioned. In order, these were:

1. Lack of access to housing, whether as move-on from temporary, insecure or low-quality general needs accommodation, or access to specialist accommodation for people with particular needs. This included access to supported housing, housing for those continuing to use drugs and / or alcohol, or conversely, ‘dry’ or drug-free accommodation for those pursuing abstinence.

2. Partnership working to meet the needs of the most complex clients and those with long-term support needs. This was generally expressed as a need for improved working between mental health and substance use services, but also as a need for closer cooperation between treatment providers and others, including references to the fragmented nature of local provision for substance use itself. Local difficulties in making links between drug/alcohol treatment and social care were mentioned by several respondents.

3. Education, training and employment (ETE) was mentioned by a number of respondents, who indicated support for the idea that employment can positively reinforce treatment and recovery and serve as a route out of poverty and into stability. However, all who mentioned ETE pointed to a lack of local, specialist provision. Taken in conjunction with responses to other parts of the survey and from other work undertaken by DrugScope, this raises questions of how well mainstream DWP-delivered or commissioned services are able to work with treatment providers and to provide specialist services.

Given that there is widespread evidence of partnership working (although very little of contractual or funded relationships) elsewhere in this report, it is perhaps surprising that ETE is highlighted as a significant gap. There are a number of potential explanations for this. For instance, whilst employment support in the broadest sense is certainly widely available, specialist provision is rather less so. An alternative explanation might be that the
most keenly felt gap is not in fact employment support, but employment opportunities. As articulated in responses elsewhere in this report, services acknowledge the important role employment can play, whilst the evidence suggests that people with histories of substance use are disadvantaged in the job market and frequently struggle to find and keep paid employment.

With regard to particular gaps, many respondents provided helpful and informative comments – a small number of these are quoted below to illustrate some of the key themes:

**Respondents’ views**

There is a desperate need for clean supported accommodation / dry houses in [County], to assist people in staying clean post-treatment. There are currently 3 projects that are commissioned to provide clean, supported accommodation, but only one of these actually operates and enforces a strict drug and alcohol free policy.

*Service Manager, PHE South region*

Mental Health support for dual-diagnosis clients. There is a serious lack of support with on-going management of mental health issues.

*Chief Executive*

There is a need for more service and resources for people unable to stop drinking or drug use. Often individuals in these situations find themselves placed in the wrong setting without appropriate support. As a result, they end up being evicted back on the streets.

*Team Manager*
Services for women in prostitution-, there is very little tailored support offering services at the times most useful to this client group. We are trying to embed ETE sooner in recovery to support clients with this aspect of their recovery and transition from services, but this is still early days. More joined up support for clients with mental health issues; it’s very difficult working with mental health teams at the moment. The cuts in mental health service provision seem to have had the consequence of pushing more of our clients out of services. Mental health workers seem to be harder to reach and engage with around joint work.

Team Manager

Whole support for recovery. Community recovery networks are very small in our area.

Recovery Team Leader

The connections between substance misuse services and other council based and mental health services - links with the Community Mental Health Team and secondary care mental health are a particular problem in the area.

Director of Development

A ‘zero tolerance’ service which is equipped to deal with service users exhibiting challenging behaviour. The level of challenging behaviour exhibited by current service users is contributing to staff burnout, especially given lower staffing levels, and when this leads to long term sickness amongst staff, then it becomes a downward spiral. We are having to ban service users. In the past 18 months; we have banned nine, and three of these have received custodial sentences as a result of their behaviour towards frontline staff. I have concerns for the needs of complex service users, the health of staff, and the future of services if this issue is not addressed.

Hub Leader

Lack of expertise in regard to sexual behaviours associated with some minority groups (e.g. men who have sex with men) and ignorance of drug use context, ignorance of mephedrone and methamphetamine injecting trends

Trainer

Transitional services for the 16-24 range. The young people’s service only caters up to the age of 18, so there is attrition in the numbers of young people in adult services.

Service Manager, PHE Midlands / East region

Specialist elders service provision. Outreach (we have outreach workers but only three for the whole borough which makes effectively working with street drinkers very difficult)

Innovation and Development Manager

There appears to be reluctance to resource staffed needle and syringe programmes adequately. Also many customers we speak to feel excluded from the 'recovery' focused service provision.

Drug & Alcohol Training Manager

Housing and benefits support and for vulnerable people with high and complex needs who are not easy to work with

Recovery Worker

Finding suitable accommodation is an on-going issue for many of our clients. Timely access to counselling/talking therapies can also be problematic. One of the main problems though, I believe, is raising awareness of the help that is on offer for people struggling with addiction to all substances through more mainstream marketing. Drug treatment still feels too hidden and inaccessible to the majority of the population. This becomes most apparent when talking to parents and families who have really struggled to try to find help, either for themselves, or for a loved one.

Chief Executive Officer, PHE North region
Sustainable housing. I see ridiculous levels of financial abuse of tax payers by slum landlords offering substandard accommodation that in no way supports a recovery model to vulnerable adults. I also see problems in accessing timely support for clients presenting in crisis particularly in alcohol treatment when presenting at A&E or to GPs. There continues to be a massive discrimination against Dual Diagnosis clients who continue to be treated without empathy and an eagerness to refuse appropriate treatment in non-specialist services based on substance use being a treatment exclusion criteria.  
*Drama therapist*

Effective solutions for housing [are needed] whereby in every area there is ready access to reasonable standard accommodation. This is a prerequisite for any progress to be made with individual recovery.  
*Chief Executive*

*The view from the summit*

Many participants raised gaps in provision that broadly reflect the subjects raised above, although a significant number of discussions took place about transitional services and commissioning for up to 25 year olds, rather than the traditional adult / young people / children split.
Part 10 – access to specialist services

Having considered support needs, services provided and gaps in local provision, the following section looks in more detail at the availability of a limited number of key specialist services.

Peculiarly, while responses elsewhere in the survey indicate that there had been a net improvement in the availability of family support services (see p.37), responses here were equal between improved and worsened access to services. This may be as a result of some respondents choosing to answer some questions and not others, and it is worth considering that of all the types of specialist provision looked at in greater detail, family support is the only one where there is not a clear majority of services reporting reduced availability.

Respondents’ views

Done both through in-house (Couples/Family therapy) working in conjunction with Social Services and Children and Family Courts. For legal services - out-sourced.

Manager

We offer 1-2-1 support for family, carers and can also link in with other services in the borough.

Team Manager

We provide individual counselling, couples counselling for parents of addicts, group therapy, evening support, weekend workshops, social activities. Education, counselling and support for young carers/children affected by parental/guardian addiction - work in schools, counselling for students to help them re-engage in their education.

Team Manager, PHE London region

We support our clients and their families; we seem to be carrying a lot more risk as social service seem to constantly raise the access criteria.

Operations Manager, PHE South region
Our staff are encouraged to involve family members as much as possible - this works most successfully in our access to rehab service, as family members tend to be more involved with someone's plans to go away from the city for several months. We work closely with our local Carers organisation, and are also currently exploring ideas to develop a peer mentor model, like our existing model, but for parents and carers.

Chief Executive Officer, PHE North region

![Access to housing & resettlement chart]

n=86

Responses to several parts of the questionnaire indicated that housing, resettlement and housing support were often areas of concern:

Respondents' views

We work very, very closely in partnership with housing providers and I think that’s remained consistent over quite a long period of time, regardless of outside influence. So that’s government funding, or local authority funding changes, the service providers adapt to enable them to continue to provide supporting accommodation.

Service Manager (interviewed)

We never fail to house someone, but we have to rely on our relationship with private landlords. It's only working because we've a network of very forward thinking landlords, a couple of wealthy individuals who happen to be in recovery themselves and understand what we're trying to do. We're really lucky.

There's also been an over-reliance on so-called dry houses that aren't dry. A lot aren't, or haven't been, managed very well, so what we hoped was a safe haven for a graduate from our programmes has turned out not to be.

Director (interviewed)

There have been more clients who are of no fixed abode (NFA) compared to a year ago, and by that I mean NFA rather than sofa surfing. People are finding it difficult – we've a housing support worker who clients can ask for
advice, but it’s very difficult to access housing. If you’ve not got a bed for the night it’s difficult to stabilise your drug use, and alcohol particularly.

Chief Executive, PHE London region (interviewed)

In house move-on worker but referral options very limited.

Service Manager, PHE South region

Housing is extremely dire.

Team Manager

You can move people into properties available. 32 one bed flats free and 137 people wanting to move due to the bedroom tax [generally referred to officially as ‘the removal of the spare room subsidy’]. How can you tell people they have to pay as their house is too big but not have smaller for them to move on to?

Recovery / Harm Reduction Worker

We have named workers within the local authority housing team, who have some understanding about some of our clients’ issues - e.g. in regard to housing issues for people going away for a stay in a residential rehab/detox.

Chief Executive Officer, PHE North region

The lack of move on opportunities causes bed blocking and reduces commissioners’ quality ratings for service providers (and sometimes imposes financial penalties) even though it is ultimately the borough’s responsibility to provide scope for move on. Lack of local connection blocks applicants’ chances, while being fettered to one borough also prevents wider scope for move on. Schemes that pool individual’s resources and help them to move on together or otherwise coordinate resources are scarce.

Complex Needs Manager, PHE London region

![Access to advice service (e.g. welfare, debt, legal)](image)

n=86
The need for advice around navigating the social security system and debt were mentioned by several respondents as priorities elsewhere. In response to this question, many respondents indicated a formal or informal partnership with their local Citizens' Advice Bureau (CAB) as being a key mechanism for providing this sort of service, whilst others referred to the current demand for CAB services:

**Respondents’ views**

Through key working and partnerships with local Citizens’ Advice Bureau.

*Residential Recovery Services Manager*

We do what we can, Citizen’s Advice Bureaus cannot cope with local need.

*Team Manager*

A service user led advocacy service only a few hundreds of yards away provides this advice. Sending service users there for benefits advice is a good way of linking them with a service that also provides a lot of recovery focused activity.

*Hub Leader*

Citizen’s Advice Bureau locally overwhelmed. We have run sessions for staff on benefit changes but are by no means expert. Provision is very poor.

*Consultant psychiatrist*

Citizens’ Advice Bureau and debt advisors attend our services to provide advice and support to clients

*Service Co-ordinator/Manager*

Access to benefits and legal advice is mainly provided by in house staff. Referral to other agencies is to specialist solicitors pro bono or for clients with access to mental health funding stream regarding sectioned clients, and to pro bono housing advice. All have come under considerable pressure and housing legal advice is now very difficult to obtain free which has caused some very harsh decisions to go unchallenged. Attempts to advocate are hampered by pressure of numbers and housing departments that are inadequate to serve the people who most need them. Some of these are better at obstructing applicants than serving them.

*Complex Needs Manager, PHE London region*

Our staff have basic information in-house, but know where to signpost people to, and can either accompany clients themselves or ask a peer mentor to do so.

*Chief Executive Officer, PHE North region*
The vital role that employment can play in supporting recovery was often referred to by respondents, as were the difficulties clients face in the job market. Respondents offered a range of opinions and information about services they provide or can otherwise access:

**Chief executives’ comment**

We think ETE is one of the biggest things you can do to make a difference for people on the ground. So we have pilots, we have pathfinder projects in certain areas which are centres of excellence for us. How do we roll that out across all our services?

*John Jolly, Chief Executive, Blenheim CDP*

**Respondents’ views**

We provide in house education services as well as linking with local colleges.

*Residential Recovery Services Manager*

We deliver Level 2 qualifications in house, we also have tutors in to deliver basic numeracy, literacy and IT. We also take service users to local colleges and the local voluntary service centre. One of the qualifications we deliver ourselves in employability.

*Service Manager, PHE Midlands and East of England region*

Work Programme provides support, but find the demands of our service users a challenge.

*Area Manager*

We have a full time ETE worker. All clients have ETE assessments and as part of their recovery journey will be referred to the ETE worker.

*Area Manager, PHE London region*
We are accredited to deliver Open College Network units. We offer accredited courses as part of our structured day programme, in our peer mentoring induction programme, and as a core element of the timetable at our Recovery Space. We are a learning organisation which promotes learning and education to all those we work with. We link with local external providers to enable progression for people who want to go on to further study. Our peer-mentoring project offers people a taste of going back to work and many continue volunteering with the agency they did their placement with and some go on to gain employment.

*Chief Executive Officer, PHE North region*

We have a dedicated ETE Team that deliver training to service users and volunteers (coming through our Volunteer Programme) They are also linked in with other ETE providers, Job Centre Plus and the Work Programme as well as a myriad of small voluntary sector organisations that deal with helping people to become work ready or provide employment.

*Area Manager, PHE London region*

We have in house training provided to all clients from the local college providing foundation qualifications. We also have links with various external employment services including Job Centre Plus.

*Chief Executive Officer*

We run an apprentice training programme as well as client involvement services that engage and train clients as volunteers, including a peer advice service which provides telephone and face to face peer support. We also provide about 78 courses in four broad streams of health and wellbeing, personal development, creativity and self expression.

*Complex Needs Manager, PHE London region*

**The view from the summit**

Welfare reform and an increased focus on employment and employability were seen as an opportunity to deliver new services to those able to benefit, whilst acknowledging that ultimately, ‘mainstream’, paid employment is unlikely to be an option for all clients. Employment was also seen as a crucial part of the recovery agenda and recovery capital, although it was commented that traditional ‘silo-based’ working will need to be genuinely addressed to make the most of this.

Respondents at every summit indicated the greater role that social enterprises could have in supporting people into employment and building recovery capital, although there was realism concerning the financial risks associated with starting any enterprise, social or otherwise. The beneficial aspects of intermediate labour markets were also highlighted by some participants.
A large number of respondents offer physical health services delivered by their own staff, a smaller number by staff from other agencies but on-site, whilst many others refer to external agencies. As might be expected, there was a particular emphasis on blood-borne viruses (BBV) and general health screening. Comments offered included:

**Respondents’ views**

We provide detoxification services in house. We encourage residents to address physical health needs (including dental) whilst residing here and facilitate support and transport to appointments. Through partnerships we provide BBV screening and vaccinations.

*Service Manager, PHE South region*

All health service needs are referred to the local/individual service user’s General Practitioner to make referral to other medical professionals. Staff support service users to administer medication and monitor their general wellbeing. Staff arrange with GP for medicine reviews and assessments.

*Service Manager, PHE London region*

Joint contract with NHS - consultants and general nurses on site.

*Service Manager, PHE South region*

Blood-borne virus testing and hepatitis vaccinations. Body mass index and healthy eating advice.

*Hub Leader*

We provide healthy living information to our clients informally, and also in some of the more structured groups we offer, including, for example, a weekly walking group. On an individual basis, staff will refer to external agencies for specific physical health issues relating to their clients.

*Chief Executive Officer, PHE North region*
Nutrition guidance; physical activity etc. as part of structured programmes (shortly to be decommissioned).

Chief Executive Officer

We provide health coordination, end of life care coordination and are soon introducing an intermediate health support service. A recent hospital discharge report identified systematic shortcomings that resulted in our being commissioned to provide health coordination for complex needs clients (a win that balances some other areas where my service is under threat).

Complex Needs Manager, PHE London region

![Access to mental health services](image)

n=88

Mental health, dual diagnosis and complex needs were identified by many respondents as key areas of interest and as a significant gap in local provision. In that context, it is striking that 20 services reported decreased availability, the steepest decline of all the specialist areas looked at in detail; this question elicited a large number of comments:
Respondents’ views

This is an age old problem; you can’t really access mental health services if you have an alcohol dependency or a drug dependency and it’s difficult to access appropriate drug and alcohol services, especially statutory services, if you have on-going mental health problems. It’s an age old, catch-22 situation, and that does have an impact on housing as well. People have complex needs and aren’t able to access the right support.

Service Manager (interviewed)

Our local crisis team are great, but access isn’t great unless there’s a crisis. In terms of working alongside the other areas of mental health locally we have no access and a very poor relationship and it’s not for want of trying. But there’s a problem of over-burdening of particular services.

Director (interviewed)

The problem is reduced funding – mental health services are gatekeeping a lot more assiduously now. If they sense a client has any substance misuse history, they have to be seen by us now. We’re also noticing a lot of clients who are really quite unwell but don’t have a care co-ordinator, a couple of years ago they would have done.

Director, PHE London region (interviewed)

Improving Access to Psychological Therapies (IAPT) and primary mental health are available locally, although substance misuse services are not allowed to refer into either service.

Senior Substance Misuse Worker, PHE Midlands and East of England Region

We recruited a Community Psychiatric Nurse last year in order to be able to better manage and support the service users we have. There has been a vast increase in referrals in the last few years with complex mental health needs.

Residential Recovery Services Manager

We are able to cater for stable dual diagnosis clients, but as we are carrying out detox mental health can significantly improve or decline in the process. If mental health declines we have significant difficulty referring to mental health services and community complex needs services have been cut in [County] in the past 12 months.

Service Manager, PHE South region

Generally the supply doesn't meet the demand, staff can offer low intensity Cognitive Behavioural Therapy (CBT), but most clients require more. Services such as Dialectical Behavioural Therapy (DBT) for clients with issues such as personality disorders have vanished.

Team Manager

One dual diagnosis nurse post across the whole borough.

Director of Development and Marketing

There are local mental health services that we refer to, which are often inaccessible to our clients; however we do work closely with our Dual Diagnosis Team who take a lot of referrals (though are restricted due to capacity issues).

Area Manager, PHE London region

Many of our clients have mental health issues. It is depressing how many have no service, how difficult it is to get a service and how drug and alcohol use are given as the reason they cannot access treatment - very little support that recognises that drug or alcohol may be the result of mental illness/pain.

Operations Manager, PHE South region

Our staff work with many people, some of whom have a dual diagnosis and some of whom do not. The fact that some people do not have a diagnosis does not mean that they do not have a mental health issue, however. We continue to struggle to get proper support for some of our clients. We offer one-to-one support to all our clients.
People experiencing mental health issues are treated according to their individual need, be that through talking therapies or relaxation techniques such as auricular acupuncture, or through partnership working with Community Mental Health Teams, crisis teams or acute in-patient units. I attend our local Dual Diagnosis Working Group and am currently trying to gather case studies from clients who have experienced both drug treatment and mental health services in an attempt to get the voices of service users heard.

Chief Executive Officer, PHE North region

Some staff are trained to Postgraduate Certificate level in Cognitive Behavioural Therapy (CBT) so work with common mental health disorders. Those with severe and enduring illness we provide a dual diagnosis worker. Integrated working is poor however.

Team Leader

We can provide in house mental health services to a point, however serious mental health issues we don’t treat. The line being the safety of the client and other service users. We have facilities locally we can refer to for support.

Chief Executive Officer

They go for an appointment with the mental health team and are told to get off drugs and they’ll be fine. This is the majority of the time and is generally wrong.

Recovery / Harm Reduction Worker
Part 11 – the impact of welfare reform

The impact of welfare reform has been a contentious subject for many in the sector, as indicated by some of the responses above. Welfare reform as a whole is complex, and beyond the scope of this survey to explore in depth. The questions asked focussed on some of the main and most visible aspects of reform, meaning that several important reforms (e.g. localising of Council Tax Support and the Discretionary Social Fund) have been omitted. Whilst we did not ask respondents to speculate how well their clients would cope with the transition to direct, single monthly payments under Universal Credit, several added comments which shed some light on the hopes and fears surrounding this particular and potentially significant issue.

n=99

The majority of respondents indicated that the impact of the four reforms covered in the survey question was negative or strongly negative. However, comments offered indicated that while the overall impact was indeed regarded as negative, there was often a nuanced understanding of the situation. Overall, community services were rather more negative about welfare reform than residential services. One residential service highlighted the tension between offering a therapeutic service and being required to collect payments – while this is not directly related to welfare reform, it does highlight a potentially difficult balance that is common to other related sectors, such as supported housing:
Respondents’ views

It’s had a massive impact on our client group. Incapacity Benefit to ESA has been really difficult. We give out food vouchers to people all the time, and [London borough] foodbank is really overstretched, because I’m sure it’s not just me doing it. Our clients struggle to jump through all the hoops – you only have to do one thing or do not do one thing and they cut them off. You can’t get them reinstated for weeks. And Universal Credit, where large sums will be paid monthly – what do they think will happen with our clients? I can imagine them coming and they’ve spent all the money they should have spent on rent on getting wasted. It’s difficult, because they’ve probably had no experience of money management.

Director, PHE London region (interviewed)

We have to 'collect' the client contribution which each authority assesses as part of their total cost of care. It wastes time and effort on the part of the staff to chivvy the clients to pay; the responsibility should be held by the referral agency or payments should be made to the unit to direct. Causes conflict of interest between the therapy and finances.

Manager

On admission, many residents have already built up a significant amount of debt - this has been exacerbated by the housing benefit changes, with residents now also falling behind in their rent prior to admission.

Service manager, PHE South region

Service users are presenting in distress due to changes in benefit system, usually with no money or food due to cancelled benefits and not understanding the changes.

Service manager, PHE South region

All clients have been negatively affected by a reduction or stopping of benefits, new claims, appeals, housing benefit changes and being deemed fit to work while still engaged in recovery treatment.

Team manager

My personal opinion is that some of the changes, although some of our clients may disagree, are having a positive effect in the sense that they (and to some degree, our staff) are having to rethink their attitude to benefits and personal responsibilities. However, there are problems with, for example, clients who want to go on to study away from home for several months and are not able to do so as their housing benefit will be stopped. Our pilot has enabled a more joined up approach and work with Jobcentre Plus advisors has led to a better understanding of the fact that – for example - just because someone has come off their script does not mean they are now ready for work. We have developed a better understanding among JCP advisors, though only on a very small scale, that doing courses or volunteering is part of an individual’s preparation for work, and should be supported by JCP alongside the input of the treatment/recovery provider.

Chief executive officer, PHE North region

We have participated with other groups in presenting case studies to Government about the negative impact. I know of people who have been repeatedly cut off from benefits in the middle of serious physical and mental health problems and treatments, whose cases have gone to court or tribunal repeatedly, and repeated judgements in court say that they should not have been cut off. Serious rent arrears among clients have grown by about 25% in the last year or so due to benefits not being paid.

Complex case manager, PHE London region
The view from the summit

Some participants felt that welfare reform and the emphasis on employment as a component of recovery capital was welcome. However, consensus was that the overall impact of welfare reform was negative, would potentially harm people’s prospects of recovery and place new burdens on services that are already under pressure in other areas.

In terms of negative effects, family breakdown, debt, increased offending, worse physical and mental health and suicide were identified as risks, along with generally higher use of services. One summit made the request that the message that the Recovery Partnership takes to decision makers should include the call to ‘stop targeting the vulnerable’.
Part 12 – partnership working - employment support and troubled families

Throughout this report, the importance accorded to education, training and employment support and the role that employment can play in recovery is evident. There is also the clear sense that services try, as far as practicable, to work with their clients in a holistic way, including family support. This section looks at engagement with Jobcentre Plus and key aspects of contracted out provision – the Work Programme, Work Choice and the Troubled Families agenda, supported by programmes funded by the Department for Work and Pensions and the Department for Communities and Local Government.

Co-location, where Jobcentre Plus (JCP) staff work out of treatment providers’ premises, or vice versa, is seen as an important means of delivering joined-up and coordinate treatment and employment support. It can also be an effective way of attracting new referrals and reaching new customer cohorts. However, relatively few services who responded to this question indicated that they do co-locate, there are encouraging signs of partnership and cooperation in terms of referrals. Perhaps unsurprisingly, referrals between JCP and residential treatment are rarer than between JCP and community services: just under half of residential services stated that they didn’t work with JCP, compared to under a fifth of community services.

More surprisingly, no respondents indicated that they were involved in any funded partnerships with JCP, such as partnership working supported by the JCP Flexible Support Fund. Awareness of this funding (and other partnership opportunities) may not be high compared to initiatives such as the Work Programme, but the funding available is not inconsiderable and is believed to be in the region of £150m per year. Several organisations in related sectors such as homelessness and rough sleeping have benefited from this funding; there may be fewer comparable partnerships in the drug and alcohol treatment sector.

Comments about working with JCP include:
**Respondents’ views**

Through the TPR 1 and 2 forms [i.e. through established, national referral protocols] and also through the recovery integration worker and development of links with Job Centre Plus.

*Contract Manager*

Joint working for the day programme (referrals in) and satellite service at Jobcentre Plus.

*Manager*

We support and deliver training to staff and offer some training for customers accessing work support programmes.

*Drug and Alcohol Training and Education Manager*

At last contact they were not aware of any joint working protocols

*Team Manager*

We favour link style and keyworker services that support clients to engage with Jobcentre Plus and liaise wherever necessary to ensure that the client gains the necessary support.

*Complex Needs Manager, PHE London region*

In some locations this works reasonably well, in others it doesn’t.

*Chief Executive*
The drug and alcohol treatment sector is comparatively well represented on Work Programme supply chains, with at least one service or agency being listed as a specialist subcontractor in each Work Programme Contract Package Area. However, these 30 or so contracts are held by a relatively small number of agencies. On that basis, it is unsurprising that the number of respondents who indicated that they were Work Programme providers or supply chain members is low, although overall engagement appears to be somewhat lower than between the sector and JCP. Comments offered include:

**Respondents’ views**

We should, we’re the single point of contact (SPOC) for the Work Programme providers, but never hear from them, despite sending a worker to their offices to support referrals to treatment. Work Programme staff have also received training around substance misuse.... tumbleweed again.
*Team Manager*

We have specialist education, employment and training workers who work closely with Work Programme providers and employment services generally.
*Service Director, PHE Midlands and East of England region*

We are currently working with the Work Programme providers and Jobcentre Plus on the Recovery Works pilot - this has only recently begun and is very much led by the Work Programme providers. In [city] we are also piloting a small scale project which aims to improve joint working but referrals come from our aftercare team rather than from the Work Programme.
*CEO, PHE North region*

We did a lot of work to join supply chains but [have received] no referrals.
*Chief Executive*
Engagement with Work Choice, the specialist programme for people with disabilities, is lower again. This may reflect the somewhat lower size and profile of this initiative, although unlike partnerships with Jobcentre Plus and the Work Programme, marginally more residential services than community services are engaged. However, the only service that identified itself as a supply chain member or subcontractor was a community service.

Given that a significant number of clients with histories of drug and alcohol use will have conditions that will make them eligible for Work Choice, it is perhaps surprising that there appears to be lower awareness of and engagement with this labour market intervention.

Relatively few comments were offered:

**Respondents’ views**

Who are they?

Service Manager, PHE London region

We have participated with various main contractor bids but the main contractors have often reaped rewards for our work with excluded groups while raking in the money for generic services that are very poor and unsuccessful. We probably achieve more employment, education and health gains as a percentage for our socially excluded stigmatised client group than they do for the generic rest of population.

Complex Needs Manager, PHE London region

We support and deliver training to Work Choice staff and offer some training for customers accessing work support programmes.

Drug and Alcohol Training and Education Manager

![Troubled Families partnerships](image)

n=99
Respondents reported a relatively high level of engagement with the Troubled Families agenda. In this area of work, the proportion of community services engaged was considerably higher than that of residential services, with around 60% of community services being involved in some way, compared to around 20% of residential services. Comments offered illustrate some methods of engagement:

**Respondents’ views**

Referrals and appropriate information sharing

*Director of Development and Marketing*

We support and deliver training to staff and offer some education sessions for customers accessing these programmes.

*Drug and Alcohol Training Manager*

As a provider of drug treatment services we are linked in to our local Troubled Families team - we receive information, updates and opportunities to meet with link workers.

*Chief Executive Officer, PHE North region*

We are aware we have families who we support here, but the Troubled Families agenda has been kept in house at the local authority and they have not shared any information. We have raised the issue with them.

*Operations Manager, PHE South region*
Part 13 – the external environment

One of the accusations levelled at public and voluntary sector service delivery is that it frequently operates in silos. However, from the responses to the online questionnaire and comments made by participants in the regional summits, there is a clear sense that this sector works effectively in partnership with others, and is alive to the opportunities as well as threats posed by localism. Positive outcomes from the shift to localism include those offered by innovations such as Community Budgets and City Deals, and the potential for local authorities to commission broad, wrap-around services that are focused on need, rather than diagnosis, narrow characteristics or specific risk factor.

However, this interconnectedness means that the sector may also be subject to changes elsewhere – whether on the demand side (e.g. changes associated with new types of drugs) or the supply side (e.g. where partner organisations in related sectors such as mental health or homelessness may be under pressure).

The responses above appear to confirm official statistics indicating that while opiate and crack use is continuing to fall, problematic alcohol use continues to be notable and (in particular) the use of new psychoactive substances is increasing.
Across these additional four areas of need, the perception of respondents was that there had generally been an increase, particularly with regard to rough sleeping, street drinking and antisocial behaviour. Increases in rough sleeping in particular have been reflected in recent official statistical releases.

Comments offered included:

**Respondents’ views**

Fewer numbers using, but those who are using substances are more entrenched and complex.  
*Practice Manager, PHE South region*

Psychoactive drugs more an issue amongst under 18’s but some evidence a growing issue amongst those aged over 18.  
*Service Director, PHE Midlands and East of England region*

There are more clients accessing treatment who are using mephedrone or legal highs.  
*Service Co-ordinator / Manager*

Child sexual exploitation is increasingly coming to our attention  
*Operations Manager, PHE South region*

Undocumented homeless with no local connection, and increased alcohol problems  
*Complex Needs Manager, PHE London region*
n=84

Respondents provided information about potential changes (positive or negative) that are either already in hand or anticipated in related sectors. This included:

**Respondents’ views**

Young people’s services are being re-tendered.  
*Area Director*

Changes in homelessness services (No Second Night Out).  
*Service Manager, PHE South region*

Funding for a homeless outreach worker has been withdrawn.  
*Service Manager, PHE South region*

Massive cuts across the council likely to impact on children’s and young people's services  
*Practice Manager, PHE South region*

Reduction in domestic violence / women’s refuge provision  
*Service Manager, PHE South region*

Many spending changes will directly or indirectly impact on our service users. One area will be the closure/withdrawal of some day centres, particularly for people with mental health issues - I do think there feels like a squeeze on mental health services - from crisis interventions to day care provision. That will impact on many of our more vulnerable clients.  
*Chief Executive Officer, PHE North region*

Funding for our young people’s services has reduced by 70%.  
*Area Manager, PHE London region*
Part 14 – priorities for services

Having earlier considered gaps in local provision, the following chart summarises the responses when people were asked to identify using free text the top three issues affecting their own services. Responses have been coded to 23 categories, and are unweighted.

**Chief executives’ comments**

If you look at the policy framework, there’s an emphasis on recovery not on treatment, there’s an emphasis on holistic interventions and wraparound services, which is not bad, but the reality is the money is gone and there’s a focus on DIY treatments, looking after yourself. That again is not a bad thing, nothing’s wrong with any of that, except it’s in the context of cuts to the services so the message is you’re better off doing it for yourself, take responsibility for yourself. Fine, but the services that were there to support you are going.

Karen Biggs, Chief Executive, Phoenix Futures
Additional issues raised were:

7 respondents: referral routes; housing / housing support
6 respondents: referrals (residential services); young people
5 respondents: engaging with the recovery agenda
4 respondents: structural reform including Public Health England; access to residential services
3 respondents: offending, availability of alcohol treatment, administrative burdens
2 respondents: outreach, organisational problems, service user involvement
1 respondent: Clinical Commissioning Groups, client debt

With the option of offering three priorities, there was inevitably a large number of responses, including:

**Respondents’ views**

Not enough skilled staff
*Senior Manager*

Ineffective partner agencies
*Service Manager, PHE London region*

County/City differences in commissioning
*Clinical Team Leader*

Poor commissioning, with no drug and alcohol experience
*Manager, Drug and Alcohol Service*

Lack of coordination between services e.g. benefits undermine work done in health and social care.
*Complex Needs Manager, PHE London region*

Perpetual re-organisation (internally and externally driven)
*Consultant Clinical Psychologist, PHE London region*

Cut throat competitive atmosphere with other providers
*Service Manager, PHE South region*

Retendering process - whilst we have been successful, this has been stressful and disruptive and continues to be during implementation phase which we are now in.
*Innovation and Development Manager*

Absence of a local strategy which in turn affects how services perform and integrate
*Team Leader*

Unrealistic expectations from commissioners
*Senior manager*

Uncertainty about “power” relationships (Local Authorities/Clinical Commissioning Groups/Health and Well Being Boards).
*Consultant*

De-commissioning of wrap around services.
*Service Manager, PHE North region*
Building relationships to provide wrap around services

*Area Manager*

The number of different tenders we continually have to complete.

*Chief Executive Officer*

Impact of low wages on attracting quality staff

*Service Manager, PHE South region*

Lack of communication between commissioners and us, particularly in regard to the changing nature of drug provision required, and the need for commissioners to be brave.

*Chief Executive Officer, PHE North region*

Service users being threatened with homelessness and having their benefits sanctioned.

*Area Manager, PHE London region*

Poor morale and limited resources

*Contract Manager*

Implementing "recovery" agenda without jettisoning all the good that went before.

*Consultant*
Conclusion

Seen from the vantage point of late 2013, the sector can look back on a decade of progress and success. Drug and alcohol treatment generally is more effective than ever, and crack cocaine and heroin use is at a historic low. The United Kingdom can claim a genuinely world class and arguably world leading system of drug and alcohol treatment.

However, some of the findings of this research will cause concern for anyone with an interest in the sector and with the welfare and wellbeing of its clients. The sector will clearly need some time to navigate the new local structures, and the new commissioners themselves may need time to accustom themselves to their new positions and responsibilities. As further cuts to local government funding are indicated, this is time that the sector may not have. It is reassuring to note that many respondents to the online questionnaire, participants in the summits and interviews and all three chief executives interviewed are giving consideration to how their services or organisations can adapt, and how they can best demonstrate the impact they have locally.

The sector clearly faces both threats and opportunities. Whilst the rationale for allowing local authorities to design and commission services that meet their particular areas needs and priorities is clear, and in Community Budgets there is potentially a new mechanism to support this alongside other flexibilities such as coordinating housing and public health strategies. Coming at a time of intense pressure on local government and police financing, the sector will need to make a local political case for investment, as (in all likelihood) will providers of other non-mandated services. The recently announced evaluation framework for the 2010 Drug Strategy12 may assist services in doing that, although the sector and key stakeholders such as Public Health England will need to be alive to the possibility of disinvestment. With around 150 local design and commissioning decisions to be made, it is likely that problems will be encountered.

Turning to the particular issues raised in this research, the impact of recommissioning and retendering is significant. Concerns have been expressed about the frequency and quality of this process, and there appears to be a lack of confidence that recommissioning necessarily improves services. Conversely, many respondents including all three chief executives spoke persuasively of: the cost to competing organisations and commissioners, the effect on staff morale, and the potential disruption to services. All of these have clear implications for the people who use these vital community services.

Many of the individual aspects of non-treatment rehabilitative activity highlighted as areas of concern or in need of improvement across the various strands of inquiry turn out to be activities directly or at least closely associated with strengthening recovery capital, particularly employment and employment support, housing and support for clients with complex physical and mental health needs.

Whilst it is difficult to maintain much optimism in the face of continuing budgetary pressure, localism and innovations such as Community Budgets / City Deals may offer opportunities to address these factors. None of it will be easy – for example, complex needs and particularly the provision of integrated treatment and support for clients with coexisting mental health needs and substance use issues has been a longstanding area of concern, as indicated in the work of the Making Every Adult Matter (MEAM) coalition, of which DrugScope is a member13.

If there is one key message, it should be that the agencies that took part in this research will be willing partners in innovation – the sector is neither ignorant of nor complacent about the need to engage with commissioners, funders, policymakers and other stakeholders. The chief executives interviewed reflected the broader sector in their comments about needing to re-evaluate their mission, their way of working and their services. Many respondents and interviewees provided examples of new partnerships within and beyond the sector, including with commercial partners. The sector has the ambition and aim to be constructive partners in local dialogue and service provision, and it is vital that local and national policy makers and commissioners concerned with community and residential treatment and criminal justice partnerships reciprocate.

December 2013

13 http://meam.org.uk accessed December 2013
Contact & credits

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The word cloud on the front page was generated from the table notes from the 4 regional summits organised by DrugScope on behalf of the Recovery Partnership.

The word cloud on p.15 was generated from all of the responses to the question asking survey respondents to identify the 3 main challenges facing their own service.
Appendix A – Public health reforms

From April 2013, upper-tier and unitary local authorities have assumed lead responsibility for commissioning drug and alcohol treatment services, alongside improving public health, coordinating local efforts to protect the public’s health and wellbeing, ensuring health services effectively promote population health and for addressing health inequalities.

Health and Wellbeing Boards (HWBs) identify local priorities and set out local strategies through the development of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). The core statutory membership of HWBs is contained within the Health and Social Care Act 2012 and comprises of:

- a local elected representative
- a representative from the local Healthwatch
- a representative from each local clinical commissioning group (CCG)
- the director of adult social services
- the director of children’s social services
- the director of public health
- a representative nominated by the NHS Commissioning Board

This list does not include Police and Crime Commissioners (PCCs), although HWBs are free to add further members who can bring particular skills, perspectives or local insight – this can (and in some places does) include representation from the voluntary sector. Directors of Public Health (DPH) will control the bulk of drug and alcohol funding and will oversee a department or directorate that will be responsible for delivering the priorities set out in the local Health and Wellbeing Strategy.

Clinical Commissioning Groups (CCGs) are statutory members of HWBs. Local authorities and CCGs have an equal and joint duty to prepare JSNAs and JHWSs through the HWB. In addition, there is a requirement for a representative of the NHS Commissioning Board to sit on the HWB when it is developing the JSNA and JHWS. The Department of Health has said that this responsibility may be delegated by the NHS Commissioning Board with the HWB’s agreement – for example, to someone from a CCG. The NHS Commissioning Board will also have responsibility for drug and alcohol services in prisons, which now fall under ‘offender health’.

Also in April 2013, most of the functions of the National Treatment Agency (which had the status of a Special Health Authority) were absorbed into a new executive agency, Public Health England (PHE), which provides the national lead on public health issues. It supports local public health commissioners - for example, through research, monitoring and data collection (including the National Drug Treatment Monitoring System or NDTMS) and the training and development of the public health workforce.

The Public Health Outcomes Framework, published in 2012, provides for a range of indicators against which local public health performance can be measured. Although relatively few indicators relate directly to drugs and / or alcohol, the activities that treatment providers undertake will support the improvement of a larger number. The precise status of the Outcomes Framework and its Indicators is somewhat unclear at the time of writing: it is described in the Department of Health’s Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies as ‘a single portal to a suite of indicators, analyses and evidence to support decision-making’. There is no indication of precisely how the different structures will fit together in the era of localism, nor (for example) what PHE’s role would be in the event of disinvestment or declining performance across any given set of indicators.
The majority of funding previously indicated for drug and alcohol treatment now sits within the broader Public Health Allocations, where it is ring fenced for public health, but not specifically for drug or alcohol treatment.

PHE have indicated that a ‘health premium’ is likely to be introduced, and that if so, it will include additional funding to reward high levels of performance against a small number of Public Health Outcome Indicators, including one directly relating to drug use.

Further reading

For more information about public health reform and how it relates to the drug and alcohol treatment system in particular, please see The Public Health Reforms: What they mean for drug and alcohol services (DrugScope, 2013).14
Appendix B – Police and Crime Commissioners

Following election in November 2012 (everywhere other than London, where the London Mayor is accountable for the PCC function), Police and Crime Commissioners serve for a 4 year period in every police force area in England and Wales. These directly elected Commissioners replace unelected Police Authorities and have the remit:

- To cut crime and deliver effective and efficient policing
- To meet community needs as effectively as possible ‘working in partnership across a range of agencies at local and national level to ensure there is a unified approach to preventing and reducing crime’.

PCCs will be responsible for, amongst other things, making crime and disorder reduction grants to organisations, including but not limited to community safety partnerships. Through their control (from April 2014) of the Community Safety Fund, PCCs will be able to commission services that meet local priorities and support a reduction in crime and improvement in community safety. This could include, for example, continuing to fund approaches similar to that of the Drug Interventions Programme (DIP). The allocation for this formerly held by the Home Office will form a substantial part of the £30m Community Safety Funding allocation for England and Wales.

As with public health, there is no ring-fence or effective protection that means that any of this money will be used to drugs and / or alcohol interventions or partnership approaches. The overall allocation for community safety has been reduced by a significant sum; there are likely to be intense pressures for PCCs to find savings, and from April 2014, money nominally allocated for community safety could, in fact, be used to supplement core police funding.

PCCs will themselves be held to account by Police and Crime Panels, and are required to consult on and produce annual Police and Crime Plans. Whilst PCCs are not statutory members of Health and Wellbeing Boards, there may be benefits from the new public health structures and PCCs acting collaboratively.

Further reading

For more information about the introduction of Police and Crime Commissioners and how the role relates to the drug and alcohol treatment system in particular, please see Police and Crime Commissioners – A briefing for the drug and alcohol sector (DrugScope, 2012)\(^\text{15}\).
