Response to consultation:
Independent review of drugs
Call for evidence, part two

August 2020

Action on Addiction's submission

Action on Addiction welcomes the opportunity to contribute to the call for evidence in respect of the independent review of drugs (part two). Our response is predicated on our research expertise, our longstanding experience of working on the front line, extensive engagement with relevant stakeholders, and knowledge of the relevant UK policy landscape. Our response to the consultation focuses on those areas in which we have direct knowledge and experience, and where we believe we can add most value, namely: prevention and early intervention; families, children and young people; community-led recovery; and participative commissioning.

Should you require any further information or have any questions about any aspect of our submission, please contact Sally Benton, Director of Strategy and Communications at sally.benton@actiononaddiction.org.uk

About Action on Addiction

Action on Addiction is a national charity that exists to help people achieve recovery and live their lives free from addiction. Our team of experts offers life-saving treatment to individuals and support to families affected by addiction. Our ambition is to build and strengthen communities of recovery and provide leadership to others in the addictions field by means of research, innovation and professional education.

We are the only UK addictions charity that works across all the areas of treatment, family support, professional education, research, and advocacy. Our experience on the ground with adults, children and families is informed by evidence of effectiveness. We offer intensive and extensive treatment and support programmes for individuals and families linked to community-led pre and post-treatment interventions. A quantitative analysis[1] shows that for every person we treat, another five people benefit indirectly. Our professional education courses, many of which are accredited by The University of Bath, enable practitioners to apply theoretical learning to practice. Our interface with policy makers and influencers is predicated on our in-depth knowledge and experience of addiction and associated issues. Action on Addiction's special commitment to research, along with our longstanding partnership with the National Addiction Centre at King's College, London, has been a defining feature that has set Action on Addiction apart from other addictions charities and one that has added considerable strength to the charity's reputation.

HRH The Duchess of Cambridge joined Action on Addiction as patron in 2012. Action on Addiction also benefits from the support of a long-established and vibrant donor base, and a fantastic group of supporters and ambassadors who speak from the heart about the work we do.

[1] Quantifying our Reach. Report by Robin Alcott-Wolseley, Action on Addiction (2016)

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Prevention

Question One: Preventing problematic drug use

Professor Harry Sumnall's 2015[2] report to the Home Office on behalf of the Advisory Council on the Misuse of Drugs (ACMD) found:

- There is little clear evidence of 'what works' in drug prevention. However, recent advances in prevention science, based on life-course development research, community epidemiology, and preventive intervention trials, means that high quality evidence is being generated.
- There are a number of promising approaches that are likely to be beneficial if correctly implemented. These approaches include pre-school family programmes; multi-sectoral programmes with multiple components (including the school and community) and some skills-development-based school programmes. However, there are a number of challenges in implementing these well organised programmes in routine practice, with fidelity, and on a large scale. These difficulties are more pronounced as robust national and local prevention systems are not well established.
- Environmental prevention activities such as pricing, taxation and marketing controls have shown evidence for success in reducing use and harms associated with alcohol and tobacco use. Although theory suggests that it may also be effective in responding to illegal drugs, opportunities for delivery of environmental prevention activities are restricted by the illegal nature of drugs.

One of the aims of prevention, mentioned in the government's Drugs Strategy, is reduction in inter-generational transmission – something which has been at the heart of Action on Addiction's work for over a decade. Establishing effectiveness in this area requires long-term prospective study and there is good reason to suppose that programmes such as Action on Addiction's M-PACT (Moving Parents and Children Together) programme which helps families with a substance user to improve the adults' and children's communication, knowledge and self-efficacy, could have a beneficial impact on the next generation's risk for developing drug-related problems. A modified version of the programme, M-PACT Plus, was implemented in schools over an independently evaluated 3-year pilot by the charity Place2Be in partnership with Action on Addiction, funded by Comic Relief and The Royal Foundation. The evaluation both quantitative and qualitative was extremely positive. Outcomes from M-PACT generally over a 12 year period are available and are referred to in our response to Question 10 below.

Young people

Question Four: Increases in drug use amongst children and young people

The increase in the use of some substances, including cocaine and ecstasy, by older adolescents is well documented. This increase coincides with an increase in availability and better access to substances – at a time when availability and access to treatment services is declining. With money and resources being poured into a firefighting approach, and less entrenched behaviours getting left behind by policy and resourcing decisions, professionals, family members and young people

[2] Advisory Council on Drug Misuse. Prevention of drug and alcohol dependence. Briefing by the Recovery Committee, February 2015

are reporting problems associated with early onset addictive behaviour and substance misuse in increasing number.

The situation requires well thought-out policies which encourage young people's participation and engagement in early support and early intervention activities, and which provide access to newly developed specialist interventions for young people and families with multiple and complex problems. There should also be much more focus on involving young people in the development and implementation of policies and interventions that relate to them. These policies should be developed within a context of wider, cross government investment in early years because adolescence involves significant physical and emotional changes which affect behaviour, self-image, social interactions and decision-making and for some young people drug using behaviours fits into a wider picture of addictive behaviour linked to other mental health issues and vulnerabilities. Such policies must facilitate collaboration and partnerships between organisations specialising in different facets of young people's vulnerabilities.

Question Six: Gaps in interventions and services for young people

There are very serious gaps in specialist provision for young people aged under 18 who are dependent on alcohol and other drugs and/or affected by other forms of addiction. Action on Addiction is concerned about these gaps and is developing its own strategy, supported by philanthropists, aimed at filling them. Our strategy is predicated on the realisation that services are desperately needed which are accessible and comply with the established best principles of adolescent treatment and with the (limited) evidence base. Current gaps in provision reflect an absence of policies focused on helping young people affected by addiction (or in the context of this report, those affected by drug use), and a paucity of funding for young people. In addition, there is very little by way of age-targeted recovery support or mutual aid for young people. Centres offering residential treatment for teenagers with substance use, mental health and behavioural problems are available in the United States, and are becoming more available in some European countries, notably the Netherlands. The best of these could provide learning for development in the UK.

Brannigan et al. (2004)[3] in a United States national survey reviewed the key elements of effective adolescent drug treatment, listed below, and found that:

> "most of the 144 highly regarded programs we surveyed are not addressing the key elements of effective adolescent substance abuse treatment. More than 40% of the reviewed programs fulfilled fewer than half of the 45 components that make up the key elements, and only 3% of programs fulfilled four fifths of these components."

A review of best practice by Lichvar et al. (2018)[4] suggest that the quality issues highlighted by Brannighan et al remain common in the United States. These shortcomings in quality are likely to be replicated in the UK. and there is no evidence that programmes currently offered in this country meet these standards.

[3] Brannigan et al., 2004, The Quality of Highly Regarded Adolescent Substance Abuse Treatment Programs - Results of an In-depth National Survey, *Arch. Pediatr. Adolesc. Med. 158:904-909*

[4] Lichvar et al., 2018, Residential treatment of adolescents with substance use disorders: Evidence-based approaches and best practice recommendations. In *Adolescent Substance Abuse* (pp. 191-213). Cham, Springer Verlag.

Any filling of the gaps must, as a minimum, ensure the following elements are included and not rely on the 'highly regarded' status of model programmes:

- **Assessment and treatment matching:** Programmes should conduct comprehensive assessments that cover psychiatric, psychological, and medical problems, learning disabilities, family functioning, and other aspects of the adolescent's life.
- **Comprehensive, integrated treatment approach:** Programme services should address all aspects of an adolescent's life.
- **Family involvement in treatment:** Research shows that involving parents in the adolescent's drug treatment produces better outcomes.
- **Developmentally appropriate programme:** Activities and materials should reflect the developmental differences between adults and adolescents.
- **Engaging and retaining teens in treatment:** Treatment programmes should build a climate of trust between the adolescent and the therapist.
- **Qualified staff:** Staff should be trained in adolescent development, co-occurring mental disorders, substance abuse, and addiction.
- **Gender and cultural competence:** Programmes should address the distinct needs of adolescent boys and girls as well as cultural differences among minorities.
- **Continuing care:** Programmes should include relapse prevention training, aftercare plans, referrals to community resources, and follow-up.
- **Treatment outcomes:** Rigorous evaluation is required to measure success, target resources, and improve treatment services.

Question Eight: Specialist drug and alcohol services and interventions for young people

There needs to be much better engagement by government with third sector organisations which specialise in addressing young people's mental health and addictions issues with a view to changing the treatment and support landscape. Such engagement should also include philanthropists whose focus is on better understanding the problems associated with early onset addictive behaviours.

We would like to see an evidence-based focus on:

- **Children and young people,** so that: problems of addiction are prevented or minimised before it is too late; early support is made available within families, in schools and across communities before substance misuse addiction takes hold; and specialist treatment is made available to children and young people who need it before long-term problems develop.
- **Families,** so that: problems of addiction are safely surfaced and not hidden; clear information, advice and guidance is available; and families and children are protected through proper investment in evidenced-based family-focused interventions, family support programmes, and services for families with multiple and complex needs.
- **Self-help and community-led mutual aid,** so that young people, adults and families can establish long-term, stable, abstinence-based recovery can thrive in communities in recovery (both physical and virtual).
- **Reducing stigma for young people and their parents,** so that barriers to treatment and support overcome. It is vital to engage with young people with lived experience, as well as organisations that represent the needs and fight for the rights of young people, to be involved in the co-creation of young people's treatment strategies, systems and services.

- **'Addiction' as opposed to 'substance misuse',** so that: strategies reach beyond the substance and deal with both the causes and the consequences of the behaviour; policy programmes and professions recognise the overlapping nature of addiction with a plethora of other social, physical, emotional and mental health issues; and we stop the stigma borne out of the perception that addiction is an individual's problem of their own making which can be addressed without the need for intensive and extensive specialist treatment, combined with long-term mutual support.

Treatment and recovery

Question Nine: Barriers to implementing evidence-based drug treatment guidelines and interventions

We have touched on some of these barriers in our answers to questions one to eight (inclusive). Most evidence-based interventions in, for example the NICE guidelines, were specifically designed for randomised control trials (RCTs) in such a way as to make them difficult or impossible to deliver in the real world. There is a marked lack of trained practitioners to deliver RCTs even if it was a good idea to deliver them. Current guidelines don't recommend residential treatment except for people with serious comorbid physical mental and social problems. Such people are often excluded from admission to mainstream residential centres on safety or behavioural grounds. The NICE guideline highlights the need for further research into the comparative efficacy of residential treatments and community-based interventions. Action on Addiction would happily participate in any such study(s).

There is a body of non-experimental research which does strongly suggest benefits for residential treatments, including a 30 month follow-up study of Clouds House, not a peer-reviewed publication but a well-conducted study by a qualified researcher, showing excellent outcomes over a 30 month period. Younger adult drug users did not do so well as primary alcohol users, dropping out at a higher rate, but if they completed Clouds they did pretty well and if they completed the follow-on 'secondary care' (usually residential over several months) they did as well as any group, with over 90% in good outcome (either continuous abstinence or abstinent at follow-up).

The Australian Treatment Outcome Study (ATOS), a landmark longitudinal cohort study examining outcomes from heroin dependence in over 40 research publications over three years (2001-2004)[5] showed that completion of treatment was a strong predictor of successful recovery from heroin dependence, and that continuing regular attendance at mutual aid was important, something that effective residential treatment is known to encourage and make more likely. Pathways taken by the participants in this study have continued to be researched up to the present. The UK NTORS also showed good outcomes for residential treatment. A recent review (De Andrade et al. 2019)[6] concluded:

> "Despite the growing need for effective residential substance use treatment internationally, the field continues to lack consensus-based best practice treatment guidelines. In line with previous reviews, this review on the most recent studies in the field (2013–2018) provides

[5] Teesson, M., et al.. (2017). Trajectories of heroin use: 10–11-year findings from the Australian Treatment Outcome Study. *Addiction*, *112*(6), 1056-1068. Manning, V. et al. (2017). Substance use outcomes following treatment: findings from the Australian Patient Pathways Study. *Australian & New Zealand Journal of Psychiatry*, *51*(2), 177-189.
[6] De Andrade, D. et al. (2019). The effectiveness of residential treatment services for individuals with substance use disorders: A systematic review. *Drug and Alcohol Dependence*, *201*, 227-235.

> moderate quality evidence that residential treatment may be effective in reducing substance use and improving mental health. There is also some evidence that treatment may have a positive effect on social and offending outcomes. However, there remains a compelling need to conduct more research in this field that can address significant methodological flaws (particularly attrition) and test multicomponent service models."

By focusing on individualised, highly specified and manualised interventions to suit the research paradigm, the benefits of a holistic, systemic approach, and the need for extensity (spreading less intensive interventions over a period of time) get omitted from the guidelines, despite there being good evidence for this. A close relationship between treatment interventions and local communities of recovery can potentiate the benefit of both.

There are some independent evaluations of innovative interventions such as Action on Addiction's intensive day programme SHARP (Self Help Addiction Recovery Programme), commissioned in Liverpool and Essex, both subject to evaluation and in the latter case involving careful independent evaluations across a three-year pilot period from 2013-2016. All evaluations, both quantitative and qualitative were extremely positive, with high praise for the programme from clients, family members, agency staff and referring agencies. It was demonstrated that such community based day rehab programmes contributed to the development of the local recovering community, which is a vital resource likely to improve the effectiveness of treatment interventions in a reciprocal manner, providing pre-treatment support, role models, mentors and the opportunity for meaningful activities after treatment.

The summary of the evaluation bulletin by the Essex County Council Organisational Intelligence Unit[7] reads:

> "Through this evaluation of quantitative data, SHARP has been shown to be a programme with high rates of successful completion, good self-reported outcomes and low re-presentation rates."

The re-presentation rates are especially impressive accounting for almost 80% of those referred to SHARP and tracked on the county's case management system no re-presenting to the treatment system over the whole three year period. In addition, we have collected measurements using the Assessment of Recovery Capital instrument (ARC), showing improvements across all domains during the period of the programme (9-11 weeks).

The reasons for the demonstrable effectiveness of SHARP relate to well thought out programme design, faithful delivery of the programme by highly skilled, trained practitioners, attention to detail in respect of clinical supervision, and the intensity and extensity of the programme (which for individuals with entrenched problems is essential). One of the key lessons is that stability of provision (all things being equal, commissioning the best proven providers for an extended period with regular liaison and scrutiny) is also likely to improve effectiveness.

Action on Addiction has been delivering SHARP in Essex and Liverpool for eight and 15 years respectively, which has allowed us to become embedded in the local community, developing

[7] Essex CC Organisational Intelligence (2016). SHARP Community Rehabilitation in Essex, Programme Evaluation, November 2016, Chelmsford, Essex County Council.

strong relationships with other parts of the treatment framework(s) (pre-abstinence services, referring agencies, post-treatment recovery management organisations and peer-led recovery resources). On the basis of these relationships, we have been able to improve and refine client pathways and tweak the programme itself, in consultation with our clients and alumni as well as other providers (examples: the addition of an induction week in Essex, and active liaison with referrers to ensure timely and appropriate referrals, both of which significantly improved engagement and completion rates, as reported by Essex County Council Organisational Intelligence).

Question 10: Implementation of evidence-based guidelines and improved effectiveness of drug treatment and recovery interventions

Importance of community-led recovery

It is vital that the measurement of performance against long-term outcomes is not confined to the measurement of effectiveness of individual and specific interventions. In pursuit of its ambition to level-up communities, government must look beyond individual interventions and also take account of the plethora of community-based supports that are available (or could be made available) to individuals affected by substance misuse and addictions. Whilst many people achieve recovery with professional help, few do so without the added benefits of mutual aid and peer-to-peer support, which appears to be a critical component of recovery. Government should therefore take account of these recovery-focused support mechanisms and their interface with treatment services when describing, designing, and implementing programmes and interventions.

A whole system approach to commissioning, which closes the divide between treatment (both pharmacological and psycho-social) and community responses and resources is one that we strongly prefer over one that is siloed. The current century has seen the growing and continuing emergence of recovery-oriented social spaces, such as cafes and recreational clubs, and lived experience recovery organisations. In addition to their achievements to date, these community-led resources have the potential to play a critical role in ensuring the durability of the effects of treatment and other interventions and making recovery accessible to those who might not need or want treatment. This will not happen unless funding to support such resources is adequately distributed via the commissioning system(s).

Action on Addiction's pioneering recovery social space, The Brink Café in Liverpool, which served a range of roles in this regard, offering employment opportunities to those in recovery, connecting those considering change with those who were already on that journey, allowing people to develop a more adaptive social network and illuminating pathways into counselling and rehab where required, was very highly valued by the local community and by the commissioners.

Importance of addressing health inequalities

It is vital that services address obvious health inequalities. We need to hear a plurality of voices from those with lived experience and respond with a diversity of services and resources that are meaningful and relevant to those who participate in them. We must also insist on practitioners being trained in cultural competence. If programming explicitly attends to these needs retention

and outcomes are improved. In a review by Ashley Marsden and Brady (2002)[8], six components of substance abuse treatment programming for women were examined: child care, prenatal care, women-only programmes, supplemental services and workshops that address women-focused topics, mental health programming, and comprehensive programming. The studies found positive associations between these six components and treatment completion, length of stay, decreased use of substances, reduced mental health symptoms, improved birth outcomes, employment, self-reported health status, and HIV risk reduction. It is doubtful whether these elements are adequately addressed in many British services and steps should be taken to remedy this.

Focus on family

Another area needing much sharper focused support from government is the family. The current NICE guideline does emphasise the importance of family-based interventions and makes some strong statements about the need to see addiction in a family context and to provide interventions to family members in their own right. Since the publication of this guideline a very large body of evidence has become available illuminating the extent of 'hidden harm' to children living with drug using family members. However, despite this evidenced and widely acknowledged need, there is very limited availability of such interventions and, since funding is directed at and for the drug user, it has often been impossible to secure funding for interventions and services for family members. Small third sector organisations have tried to provide services in this area but do not have the resources to train enough practitioners and scale their services.

There are models of good practice and evaluated family-based programmes available, such as M-PACT, that could be scaled with more funding and support. The outcomes from a 12-year evaluation of M-PACT (2019)[9] showed that family members attending M-PACT programmes reported improvements in global family functioning, how family members viewed the severity of the problem, and how they coped with life's challenges. A social return on investment analysis, applied to five M-PACT sites, found that for every £1 spent, M-PACT can save up to £6.53 in the first year after a family has completed the programme.

Question 11: Commissioning and providing drug treatment and recovery services

Action on Addiction has long been arguing that the way in which drug treatment and recovery services, and by extension, services relating to alcohol and other forms of addiction, are funded is out of step with the complex needs of adults, young people, families and communities. Whilst neither drug use, nor the complex array of problems associated with it, exist in isolation, many commissioning models are narrow in their focus:

- Addressing drug use in isolation from other public health and social justice;
- Treating individual adults at the expense of young people, families and communities;
- Emphasising contracted service delivery at the expense of long-term investment in 'community'; and
- Not going far enough to fully involve people and communities.

[8] Ashley, O. S., Marsden, M. E., & Brady, T. M. (2003). Effectiveness of substance abuse treatment programming for women: A review. *The American Journal of Drug and Alcohol Abuse*, *29*(1), 19-53.
[9] Templeton L., 2018, M-PACT (Moving Parents and Children Together) Evaluation 2006-2018, Salisbury, Action on Addiction.

Against this backdrop, we would call for an increase in place-based commissioning models focused on:

1. Redirecting resources so that commissioners achieve carefully defined and often shared outcomes by working with community stakeholders to stop interlocking problems developing;
2. Targeting the most vulnerable people and most disadvantaged families and communities who have multiple and complex needs;
3. Involving the people who are most affected by problems, and have most to gain by improved solutions, and who are best placed to enable us all to properly understand their multiplicity of needs; and
4. Developing sustainable solutions for the benefit of the whole community as opposed to a narrowly defined group of service beneficiaries.

Whilst acceptance of these four principles can often be found in many local area drug strategies, insufficient funds, a system that lacks peripheral vision and reinforces siloed working, and under developed approaches to stakeholder engagement impedes their implementation and effectiveness, and limits the potential to build strong supportive far-reaching communities of recovery.

The problems associated with drugs use and addiction are growing in both volume and complexity. Now is the time to reimagine solutions to hitherto intractable problems. Rethinking commissioning models is essential to drive up real quality and effectiveness. The 'lead provider model' which seeks to strengthen integration and streamline service delivery processes, fails to recognise the fact that complex problems such addiction and substance misuse are often deeply rooted within individuals, and deep rooted within families and communities, and cannot simply be addressed by market-driven solutions. The building block approach which has created a solid platform for UK commissioning over the last two decades has, inadvertently, created walls between small and large providers, reinforced barriers to access, and stifled innovation. Given that drug use affects communities at large, we would advocate commissioning approaches that address problems from the 'outside-in', maximise public engagement and hear from the plurality of voices affected by the issue(s). Such an approach is sometimes mistaken for 'co-production' where commissioners and providers quite rightly work together to make services more effective and achieve better value from contracts.

The approach we favour is a 'participative commissioning' model, which goes much deeper than co-production and:

- seeks to properly understand the multiple, complex and interconnected challenges of drug use by combining research and evidence from evaluations with diverse lived experience and frontline expertise;
- builds a vision by widening involvement and participation beyond the purchasers and providers of services and enables other stakeholders including local authorities and other publicly funded bodies as well as housing associations, philanthropists, businesses and local people to jointly commit to and 'invest' in sustainable community-driven solutions; and
- disseminates lessons learned, promising approaches, and evidence of effectiveness widely so that outcomes can be replicated, and models continuously improved through innovation and shared learning.

There are some examples where the commissioning model has created the space in which long term sustainable solutions are able to thrive. Action on Addiction has played a key role in helping to build strengthen communities of recovery in Liverpool for over 15 years. Our work in Liverpool has, in turn, been made possible by the city council's community-focused commissioning approach, which allows a charity like Action on Addiction to also generate investment and income (in the form of both cash and kind) from other sources – notably from philanthropists as well as businesses – so that we can further develop and promote recovery-focused activities for the long-term benefit of the people of Liverpool. This far-reaching and forward-looking approach could only be possible in a commissioning environment predicated on an integrated vision of complete outreach, treatment and recovery – a system designed to meet the needs of different populations including the very complex and hard to reach.

Securing effective accountability at a national and local level

The issue of accountability, whether at the national or local level, requires careful thought, particularly in view of lessons that may be learnt from the COVID-19 pandemic. In its final report (2012)[10], The UK Drugs Policy Commission (UKDPC), stated:

> "Which policy is best will depend on which users and suppliers we are talking about, on what drugs they are using and supplying, and on other factors relevant to their particular case, as well as the types of harms being caused, both at individual and societal levels. There are unlikely to be any silver bullets."

Recovery is not an easy process. It is a process which often takes a long time and is more of a zigzag than a straight line. Our experience of almost 40 years of front line delivery at Clouds House, one of the country's best known and longest standing rehabs, shows that sustained, stable recovery is a process that involves a journey of discovery about one's identity as a person, improving health and well-being and working on their relationship with themselves, those around them as well as their loved ones. It follows therefore, that effective accountability must look beyond the current horizon, and include key accountabilities around strengthening communities in recovery and building sustainable recovery resources in the neighbourhoods and communities that need them most.

Problem drug use is the result of a wide range of factors that combine to ensure that some of those problems may become entrenched with catastrophic consequences for themselves and those around them. The challenge is to ensure that support, intervention and treatment are accessible at the right time – before it is too late. We know from countless stories told by the people we work with the stigma of drug use and addiction is often as damaging as the drug use itself.

Problem drug use is also a cross cutting issue: it should be of as much interest to the Ministry of Housing, Communities and Local Government as it is for the Home Office or the Ministry of Justice; and as much of interest to the Chief Executive of a Local Council as it is to the Director of Public Health. But it should also be of interest to other key stakeholders in all our communities from educators, to business leaders, to philanthropists, movers and shakers and, of course, to service uses and those with lived experience.

[10] UK Drug Policy Commission. (2012). A fresh approach to drugs. London: UKDPC.

UKDPC advocated a policy approach focused on promoting prosocial behaviours, reducing harm, and eliminating deprivation, disadvantage and inequalities – an approach that is hugely relevant as we emerge from the COVID-19 pandemic. It is crucially important to develop key accountabilities for the health and well-being of children, young people and families in the context of drug related harm and addiction, and develop effective evidence-based policies and resources which dramatically improve the reach, accessibility and effectiveness of support, intervention and treatment. Many of the drug using population, as well as their families, have been severely affected by COVID-19. We know that mental health and addiction problems have worsened during the lockdown. At a time when access to treatment is diminishing, service providers are already facing a surge in demand as the COVID-19 lockdown eases. History tells that as the country's economic conditions decline health inequalities increase. In such circumstances, the individual, familial and social impact of drug misuse will become more pressing. Against this backdrop of concern, we must ensure that space continues to be made and time continues to be given to securing effective accountability for decisions made and outcomes delivered.

In terms of infrastructure development, key areas that need addressing include improved integration of data systems to enhance client engagement, better promotion of referral pathways and strengthened shared care arrangements. Local responsibilities must also be clarified, with wider connectivity into local, micro, community based public health data, and linking interventions specific to local areas and communities. A better understanding of barriers to access (for example for BAME, LGBTQ people etc.) is also required – a one-size-fits-all approach is ineffective.

There is, in turn, a need to ensure significant investment in independent research on what works in different facets of drug policy balanced against analysis of lived experience and input from frontline clinicians and other practitioners. We must avoid the failures of the Payment by Results pilot commenced in 2011. More nuanced evidence needs to be collected over a well-chosen time period and should include lived experience of service users. Outcomes should include qualitative evaluation and measurement of community impact. Commissioners should include clear and relevant outcomes in their contracts and insist on regular reporting and review of performance. Clarity of objectives and outcomes is critically important: identifying overlapping social outcomes and distinguishing between objectives for the benefit of places and the people who inhabit them.

Question 12: Effective ways of commissioning, designing, and providing integrated services

It is crucial to commission a joined up set of services with different pathways for those with the most complex needs, but with those pathways also providing access for less impaired clients, and all connecting to the local recovering community. Using genuine expertise to design and refine the system, both from those with lived experience and those providers with strong local knowledge and a proven track record of high-quality provision. Commissioners must ensure collaborative working between providers and lived experience recovery organisations. As previously outlined, more should also be done to involve other stakeholders, including philanthropists, social investors, and locally based businesses, all of whom might have an interest in investing in the overall health and well-being of the local community.

Question 13: Drug treatment market(s)

The ACMD report (2017)[11] highlighted concerns, not all of which were accepted by government, about a "loss of funding" which "will result in the dismantling of a drug misuse treatment system".

In an accompanying letter to government, the committee warned of:

> "A disproportionate decrease in resources, likely to reduce treatment penetration in and the quality of treatment; the frequent re-procurement of services that is using vital resources; and unnecessary 'churn' and disruption resulting in poorer recovery outcomes…"

Today, three years on from when that letter was written, it seems highly likely that the UK is heading into even more straitened times as a result of COVID-19 and that preserving ever dwindling funding supplies will be extremely challenging. Now, more than ever, it is vital to create a new landscape predicated on better understanding the problems associated with drug misuse, maximising opportunities for engagement and involvement, and maximising lessons learnt.

Question 14: Access to treatment

There are many possible answers to questions relating to access to treatment, many of which are to do with: a) the paucity of treatment options for families, children and young people; and b) barriers for adults who are not able to obtain funding or do not have the means to pay for treatment. Moreover, qualitative research into those who do say they want help tends to show that barriers are to do with shame and stigma – both relating to drug use itself and to drug treatment. There may also be a disconnect between treatment that is available and what is needed, for example: those who primarily wish to manage their drug use with aid of opioid substitution treatment often do not see the need for counselling and will reject it, whereas many others strongly want counselling and psychosocial help but seem to be offered only a prescription or minimal counselling from a key worker who may not have the skills and certainly does not have the time to offer a meaningful and sustained therapeutic relationship. Another reason may be that what is offered is not perceived as congruent with their lived experience.

The above challenges call for:

- Much more availability of treatment and more choice;
- Much more awareness of and better access to services;
- Greater understanding of effectiveness and what works; and
- stronger integration with communities of support and lived experience.

Question 15: Parents and their children

As well as working to support the viability of residential parent and baby units, it is crucial to encourage the development and dissemination of programmes that work with parents and children together in the community. An example with sustained positive evaluation in a number of settings, including prisons, schools and drug treatment services, is Action on Addiction's M-PACT programme (see our answer to question 10). This programme involves families coming together, with facilitated therapeutic and educational activities for the adults, for the children and for all family

[11] ACMD Recovery Committee (2017). Commissioning Impact on Drug Treatment. Advisory Council for the Misuse of Drugs, London, Home Office.

members together. The programme has an excellent track record of delivering statistically significant outcomes on a range of measures and is highly regarded by facilitators and participants in independent quantitative and qualitative research. It has been especially valued for raising trust and transforming family communication with a special emphasis on hearing and honouring the voices of the children.

Question 16: Capacity and competence of the drug treatment and recovery workforce

It is important that government addresses the paucity of professional education across the substance misuse and addictions treatment field. Over the course of the last two decades, the focus has been on 'deprofessionalising' treatment. The continuation of this trend cannot be cost effective long term. We would advocate an urgent review of the professional development needs of the workforce and for much greater investment in professionally managed education and training for those taking up roles in the addiction or substance misuse field as well as those looking for career progression.

There is compelling evidence from the United States that counsellors working in treatment settings lack competence and are failing to deliver coherent interventions (this evidence comes from analysis of hundreds of recordings of 'Treatment as Usual' carried out for a series of very large multi-site studies of treatment interventions in the US). There is no reason to suppose the situation is any better in this country, and we urgently need to increase and widen the level of skill and competence in our workforce. Training and ongoing supervision from competent supervisors are both required, as there is widespread evidence that training alone, especially the brief workshop-based training typically provided, does not change practice in a sustainable way.

Action on Addiction has been delivering a Foundation Degree and BSc (Hons) in partnership with the University of Bath since 2004, which built on previous courses in addictions counselling we have been delivering since 1988. The degree programme has provided over 300 graduates, a large majority of whom are working in the field including in leadership positions but given the skills gaps that exist within and across the field, we recognise that these achievements are merely scratching the surface. Despite this success, we have long felt that specialist training in clinical practice is needed in addition to this entry-level qualification. It is clearly possible to train counsellors to a high level of competence if training and clinical supervision are adequately invested in. The number of recognised professionals who might have this clinical competence, such as clinical psychologists, psychiatrists and other clinicians specialising in addictions, is clearly far too small to have any impact on the need for high quality interventions. The base of a qualified professionally competent workforce needs to be considerably extended.

Question 20: Peer support, mutual aid and recovery communities

There needs to be much wider recognition by policy makers, guideline developers, commissioners and service providers of the range of mutual aid and lived experience recovery organisations. There is a wide range of mutual aid organisations apart from the well-known and widely distributed 12 Step 'Anonymous' fellowships such as AA and NA. Secular mutual aid organisations such as Lifering, SMART Recovery, and Women for Sobriety are well established in the United States and are beginning to take hold in the UK. There is emerging evidence that these groups are as effective as AA/NA in helping people to sustain recovery. There is little knowledge of these

organisations in the UK, and the concept that any group of recovering people can form and develop their own mutual aid society is underdeveloped.

What is needed is a better understanding of the importance and effectiveness of community-led support in strengthening recovery and policies and structures which enable communities of recovery to grow and flourish. Gains could be achieved relatively quickly within a commissioning environment predicated on widening participation (see our responses to questions 11, 12 and 13), and through the further development of far-reaching awareness raising campaigns such as Addiction Awareness Week.

Question 21: Barriers to people achieving and sustaining recovery

Although there are many possible answers to this question, involving many different domains, we wish to highlight the need for continuum of care, which is currently not well developed due to the structure of commissioning and established patterns of practice. All too often, the various components of a treatment system are not properly integrated with one another, and this is particularly apparent from a lived experience perspective. Short term contracting, shrinking budgets and deprofessionalisation have dented workforce confidence. A lack of integration with community-led support structures has also hugely damaged stability. Yet it is well established that many if not most drug using clients and their families need a continuum of care over an extensive period of time, due to the chronic nature of the problem, its propensity to relapse and its connection to a plethora of societal and health issues. Extensity is more important than intensity. Services and lived experience recovery organisations need to communicate and co-operate, to provide services including outreach and case-finding, 'pre-habilitation' (preparing people to change) and involving them in practices, ahead of treatment, which promote change, including treatment entry, as a self-directed choice, making it far more likely that clients will be engaged and retained.

We must take very seriously the change in paradigm announced several years ago by William White, from a 'Pathology and Intervention' paradigm to a 'recovery management' paradigm. We must urgently stop conceptualising services provided after treatment as 'aftercare' as though they were an optional extra. Most sustainable change happens (or fails to happen) after treatment and coherent, supportive interventions are hugely important for social integration, improving health and well-being and enjoying the 'rights and responsibilities of society' as the UKDPC recovery statement has it. Funding needs to be increased and shared out across the continuum of care if real change is to be scaled up.

As we discussed in our response to question nine, there is evidence that intensive and extensive treatment programmes can work, even for people with multiple and entrenched problems. Action on Addiction's community rehabilitation programme in Essex has delivered results such that less than 25 per cent of the people who completed the programme reappeared in the treatment system following treatment. This is remarkable when compared with other community-based service outcomes. Graduates of that programme also experienced significant improvements in physical and psychological well-being and quality of life – a prerequisite of a definition of recovery which seeks to maximise health and well-being and participation in the rights, roles and responsibilities of society.