



## **Review of drugs: Call for evidence**

### **Dame Carol Black Review**

**June 2019**

Collective Voice is the national alliance of drug and alcohol charities.

We believe that anyone in England with a drug or alcohol problem should be able to access effective, evidence-based and person-centred support. We know that treatment and wider support has a transformative power for people with drug or alcohol issues, their families and communities. Drawing on the strengths of our members, we:

1. Tirelessly advocate for the needs of people who use drugs and alcohol by influencing partners in central and local government, the media, and allied organisations.
2. Coordinate and lead campaigns and alliances within our sector and with wider partners.
3. Promote the value brought by the voluntary sector to treatment and wider support.

#### **Are there any types of drug use that you think are not accurately reflected in official data?**

- a) Evidence from the frontline of treatment suggests that levels of use of novel psychoactive substances (NPS), steroids, prescription and over-the-counter drugs and Z-drugs such as zopiclone may not be reflected with the same accuracy as heroin, crack and alcohol.
- b) Given that the links between drug markets and serious violence are being explored as part of this review it is worth noting that no national data is currently captured on this link. Information is not routinely gathered on the status of those in treatment as either perpetrators or victims of violent crime. Many people receiving this kind of support are vulnerable and can be subject to violence and intimidation, including cuckooing, whereby a vulnerable drug user has their home temporarily taken over by a gang in return for a steady supply of drugs. One service user described the experience: "I got stabbed by a dealer and a claw hammer to my head because I didn't want him in my property... you let them in in the first place because they are waving drugs in your face." (Gov.UK, *Increase in crack cocaine use inquiry*, 2019)

#### **What do you think are the main factors which drive people to first take drugs?**

- a) It is crucially important here to differentiate between the factors which drive people to first take drugs and those which make them likely to develop problematic relationships with those

drugs. These are two very different things, and the majority of people who take drugs do not run into serious long-term harm.

- b) People initially take drugs for a number of reasons – curiosity; the pleasure of a previous positive experience; exposure to others’ use and the normalising effects this brings; pressure from peers; escape from the boredoms and traumas of everyday life; an urge to self-medicate for diagnosed or un-diagnosed mental health problems. Some type of drugs are closely tied into specific cultures – khat, for instance, being almost exclusively used by the Somali and Yemeni communities.
- c) People develop problems with drugs for different reasons. It is well noted that problematic substance use develops in close cluster with associated life challenges such as mental ill health, domestic abuse, involvement in the criminal justice system and insecure housing/homelessness (MEAM, *In From the Margins*, 2011). These interrelated issues create a network of negative reinforcement, with lack of progress in each area impeding progress in the other. Problematic drug use, for instance, is correlated with a lack of employment (Drug and Alcohol Findings, Issue 6, 2001). Research with young people has found that one in ten stated a lack of employment drove them to substance use (The Prince’s Trust, YouGov Youth Index, 2009). Between 20% and 37% of people accessing secondary mental health services use substances problematically (Nice, *Severe mental health and substance use problems: dual diagnosis evidence review 2015*). Drugs and alcohol can be used as tools for grooming as part of child sexual exploitation (CSE). Drug use has a close, two-way link with sex work, with dependency both driving the sale of sex in order to obtain money to buy drugs, and drugs being a mechanism for ameliorating the worse effects of trauma and accompanying mental ill health (Harm Reduction International, *When sex work and drug use overlap*, 2013).
- d) All of these experiences correlate with the bedrock issues of poverty and social exclusion (Revolving Doors Agency, *Hand to mouth*, 2009). Failure, therefore, to address these interrelated issues in the round jeopardises significant progress on providing support for drug use. Only action addressing the whole range of person’s life experience and behaviour is likely to produce sustainable change.
- e) There is increasing recognition that the bedrock factor for addiction is trauma (MEAM, *In From the Margins*, 2011). Many people’s experiences of trauma date back to childhood, and there is a strong link between that trauma and addiction issues in adult life (NCBI, *Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population*, 2010). The useful ACE acronym has gained more prominence as a tool for understanding how traumatic events shape the experiences of children and young adults and effects their vulnerability to substance use and related issues in later life.

**How, if at all, do you expect these factors to change over the next five years?**

- a) The factors which lead people to first take drugs seem unlikely to ever disappear from our society given the curious and social nature of human beings.
- b) The factors which drive problematic use, though, are less innate to human existence, and exist within a political and economic framework which stratifies society, binds or breaks communities and shapes the lived experience of its citizens. Therefore any major improvement is contingent

on political and economic changes which reduce poverty and inequality, bring people from the margins of society to the centre and promote an equitable access to the goods of life.

- c) Given the cross cutting nature of this issue, substance use will be impacted upon by related policy agendas. The ongoing reforms around universal credit, for instance, have been found to have negative effects on those struggling with substance use issues (MEAM, *Work and Pensions Committee Universal Credit Update Inquiry Submission*, 2017) and the serious lack of investment and major reforms in the prison and probation systems have been found to have had a major detrimental effect on custody to community treatment transitions for opiate users (Blenheim CDP, *Failure by design and disinvestment*, 2018).

### **How, if at all, do you see drug use changing over the next five years?**

- a) Findings from the recent PHE / Home Office report on crack cocaine pose a possible cause for concern (Gov.UK, *Increase in crack cocaine use inquiry*, 2019). A 19% rise was found in the number of adults starting treatment for crack use from 2015/16 to 2017/18 – a marked increase in a short period of time, especially when set against a background of overall disinvestment in services. PHE data indicates that amongst people who inject drugs, the rates of crack use rose from 39% in 2013 to 53% in 2017 (Gov.UK, *People who inject drugs: HIV and viral hepatitis monitoring*, 2014). Given the serious mental and physical health harms associated with crack use this is an important trend to monitor.
- b) NDTMS data indicates the numbers entering treatment for support around their NPS use has decreased significantly over the past two years (PHE, *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS)*, 2018). This is in line with wider evidence which indicates that the use or, and the harms stemming from, NPS use are concentrated in vulnerable population of prisoners and people experiencing homelessness.
- c) Whilst it's crucial we focus on emergent trends and reducing harms amongst particularly vulnerable populations, it's important to maintain focus on the largest population of people experiencing drug harms – opiate, crack and alcohol users.

### **What are the harms to individuals, families and communities resulting from drug use (including physical, mental, social and economic)?**

- a) Harms arise as both cause and a consequence of drug use. People who use drugs widely report self-medication for diagnosed or undiagnosed mental health problems as a driver of use (PHE, *Better care for people with co-occurring mental health and alcohol/drug use conditions*, 2017). Physical health problems and disability can also be a cause, as can depression and anxiety.
- b) Drug use is distributed evenly across society. However harms are concentrated in areas of poverty and deprivation (Gov.UK, *Alcohol and drug prevention, treatment and recovery: why invest?*, 2018). Drug deaths for example (the ultimate form of harm) have a very high correlation with areas of deprivation in the UK (PHE, *Health matters: preventing drug misuse deaths*, 2017). The largest group of people dying from drug related causes is older single men, many of whom are outside the treatment system (PHE, *Understanding and preventing drug-related deaths: The report of a national expert working group to investigate drug-related*

*deaths in England, 2016*). Collective Voice, in conjunction with the NHS Substance Misuse Provider Alliance, has published a good practice guidance on how services can meet this most serious of challenges (Collective Voice and NHS Substance Misuse Providers Alliance, *Improving Clinical Responses to Drug-related Deaths: A summary of best practice and innovations from drug treatment providers, 2017*).

- c) Drug use causes a number of health harms which vary according to the route of ingestion (with injection being the most harmful) and the overall health of the person. These range from liver damage from undiagnosed hepatitis C to poor vein health in injectors and a wide range of mental health impacts including depression, anxiety and psychosis (Department of Health, *Drug misuse and dependence: UK guidelines on clinical management, 2017*). As the ageing population mentioned above become older and iller they place an increasing burden on the NHS as well as on public health services commissioned by local government.
- d) It is worth noting that alcohol is often used problematically alongside drugs, which can result in additional complexity in treatment need which can present additional challenge at a time when the treatment system is under stress (PHE, *Adult substance misuse treatment statistics, 2018*). Concerns have been raised about the consequences of the increase in co-commissioning of drug and alcohol services which has been largely brought about by funding pressures. Extensive PHE research found 'the context in which treatment is currently commissioned and provided, including financial pressures and service reconfiguration, has affected alcohol treatment numbers more than treatment numbers for other substances.' (PHE, *Inquiry into the fall in numbers of people in alcohol treatment: findings, 2018*). For drug users who also have an alcohol problem (of which there are many) this could present a problem.
- e) There is deep-seated stigma in this country towards drug users. This stigma is characterised by the UK Drug Policy Commission as widespread, cumulative and preventing of help-seeking. In addition to the negative human impact, it is also suggested to impede the implementation of public policy: "The continuing stigmatisation of people with drug dependence will undermine the Government's efforts to help them tackle their condition and enable recovery and reintegration into society" (UKDPC, *Getting serious about stigma: the problem with stigmatising drug users, 2010*).
- f) There are mental, and, to a lesser extent, physical health harms experienced by the families and carers of those with serious drug issues. Research has found that each person who 'misuses substances...will negatively affect at least two close family members to a sufficient extent that they will require primary health care services' (Velleman, R., & Templeton, L., *Family Interventions in Substance Misuse in Working with Substance Misusers, 2002*).
- g) The UK Drug Policy Commission describe how as well as substance users 'the families of users are also stigmatised, being seen as partly responsible for their relative's addiction' (UKDPC, *Sinning and Sinned Against: The Stigmatisation of Problem Drug Users, 2010*). This additional stigma means that family members may be reluctant to access services to support themselves or their loved-one.
- h) Family members report running into serious financial problems on account of their loved one's drugs use – for two reasons. First, some take on drug debts, either because they feel compelled to do so to protect their loved one, or in some cases due to threats against them or

their family. Second, some families fund extensive private rehabilitation which can cost many thousands of pounds.

- i) Families bereaved through drug use face a harrowing and difficult journey through a grief that is often 'disenfranchised' by society – not considered to possess the same legitimacy as a more 'natural' or 'timely' bereavement (BEAD Project, *Personal experiences*, [www.beadproject.org.uk](http://www.beadproject.org.uk)).
- j) Many family members are forced by circumstance to take on a caring role for a loved one which at best is considered ambivalently, and at worst is resented. Parents report taking on major life management type responsibilities for adult children with serious drug problems and diagnosed or undiagnosed mental health conditions who they consider to lack the basic competencies needed to pay the rent and shop for food. (Adfam and AVA, *Between a rock and a hard place*, 2010)
- k) For areas with particularly high levels of drug use – and especially drug related deaths – there can be a real sense of the erosion of civic and social fabric and of a community robbed of its citizens. Communities can also be adversely affected by criminal activity of people struggling with drug problems, with the link between acquisitive crime and heroin and crack use being pronounced (Gov.uk, *Financial cost of Acquisitive Crime caused by Class A Drug users in the UK*, 2013).
- l) Treatment and recovery can deliver a powerful community dividend especially for a community which understands and supports its purpose. Many people who have entered recovery become very highly motivated to help others, becoming recovery champions and peer supporters.

#### **What are the most effective ways to prevent drug use/dependency?**

- a) The development and stewardship of an effective drug treatment system with protected funding is one of the most effective steps possible to prevent drug dependency. We consider the essential ingredients to be:
  - I. Political energy and will across government to work inter-dependently to drive forward the agenda, and to bring wider partners along.
  - II. Supportive, assertive energy and leadership from Public Health England, the Association of Directors of Public Health and the Association of Police and Crime Commissioners to help push the agenda.
  - III. Protected funding for substance use services. Whether in the long term funding and commissioning stays within public health at a local level or within an NHS framework held centrally the most important thing is that at a time of austerity the funding of services for a politically unattractive group of people is ring-fenced and increased – or at least maintained.
  - IV. A well trained and supported workforce which can work adaptively to meet the diverse needs of people with drug problems. There is no single standard 'point of entry' in terms of accreditation or qualification to the drug and alcohol workforce. In times of plenty there are ways to remedy this, with both voluntary sector and NHS providers well able to provide programmes of effective training for staff. The loss of some of this development has unfortunately been another impact of disinvestment.

- V. Effective commissioning partnerships at a local level which bring the NHS, public health, the police and other partners together around a clearly defined and shared agenda. Health and Wellbeing Boards were supposed, partly, to perform this function but have widely been considered to have not delivered on their original promise.
  - VI. A system which adheres to this country's impressive and world leading evidence base. The interventions contained within, and endorsed by, 'Drug misuse and dependence - UK guidelines on clinical management' (known widely as "The Orange Book") along with the wealth of high quality NICE clinical guidance, technological appraisals and quality standards constitute a substantial theoretical toolkit to draw on. As a system we know what works, we just don't have the resource to deliver it.
- b) As well as saving and improving human life, drug treatment provides huge savings to the public purse. The case for investment is well established. According to Public Health England: providing well-funded drug and services is good value for money because it keeps people alive, cuts crime, improves health, and can support individuals and families on the road to recovery (PHE, *Alcohol and drug prevention, treatment and recovery: why invest?* 2018). Drug treatment reflects a return on investment of £4 for every £1 invested, which increases to £21 over 10 years.
  - c) It is necessary to consider effective preventative measures alongside more 'downstream' treatment and support measures when looking at a holistic approach to drug use. Mentor UK suggest a tiered approach of universal and more targeted interventions as the most effective approach to prevention work with young people. As they are dealing with less acute and immediate needs, preventative and early interventions are often the first to suffer from any reduction in funding.
  - d) The NHS Long Term Plan was launched in January and majored on the importance of reducing health inequalities (Gov.UK, *NHS long term plan*, 2019). This emphasis is likely to be mirrored in the Department of Health and Social Care prevention green paper to be published later this year which will set out how the government plans to meet its aims of decreasing health inequalities and adding an extra five healthy years to our life expectancies by 2035 (Gov.UK, *Health secretary launches prevention is better than cure vision*, 2019).
  - e) This emphasis on prevention and health inequalities is to be welcomed given the close alignment of drug problems with the wider 'life chances' issues described above and the 'upstream' public health setting from which services are now commissioned. However the potential for local government to deliver an effective public health response to the needs of its population has been severely impeded by the substantial year-on-year cuts to the public health budget. There has been £700m lost since 2014/15, with per head public health spending decreasing by 1/4 since 2015/16 (Institute for Fiscal Studies and The Health Foundation, *Securing the future: funding health and social care to the 2030s*, 2018). The Health Foundation has estimated that £3.2bn per year is now necessary to reverse the impacts of the cuts to our public health services (The Health Foundation, *Taking Our Health for Granted*, 2018).

## What are the barriers to receiving effective treatment in the UK? How might they be overcome?

### What, if any, are the gaps in drug treatment provision?

- a) Drug and alcohol treatment is rightly one of the pillars around which delivery of the 2017 Drug Strategy is built. We welcome its commitment to 'improving both treatment quality and outcomes for different user groups; ensuring the right interventions are given to people according to their needs; and facilitating the delivery of an enhanced joined-up approach to commissioning and the wide range of services that are essential to supporting every individual to live a life free from drugs' (Gov.UK, *2017 Drug Strategy*, 2017).
- b) However, as noted elsewhere, serious reductions in available funding have made it very difficult for the sector to work with the government to deliver these aims. The reductions in funding to substance use services delivered by local government as part of the public health grant have been extensive. £85 million of public health funding is being lost in 2019/20 alone, with 60% of funding for services from central government being lost in the decade to 2020 (The Local Government Association, *Local services face further £1.3 billion government funding cut in 2019/20*, 2018). From 2014/15 to 2018/19 there has been a 19% decrease in spend on adult drug and alcohol services (The Health Foundation, *Taking Our Health for Granted*, 2018). There is predicted to be a 26% decrease overall from 2014/15 to 2019/2020 (Ibid).
- c) Regular frontline intelligence from our contacts at every level of the system paints a picture of a dedicated workforce struggling with rising caseloads, service managers dealing with often radical service realignment and commissioners juggling reducing budgets. If continued, cuts will continue to negatively impact on marketing and promotion, strip out essential outreach services, drive up thresholds, increase waiting times and cripple innovation. The loss of outreach may be particularly felt with regards to marginalised communities, including BME population, which traditionally have not had high rates of engagement with treatment
- d) A local authority public health commissioner with a responsibility for substance use told us: "There's still lots of dedication and passion in this sector but commissioning services is harder than it's ever been. Annual cuts to public health have meant the budget to fund essential services including treatment is getting smaller and smaller. Central government states that local authorities have to decide how to spend what they've got which is fine, but it does nothing to acknowledge the impact of austerity - which is not a local policy. Good quality services cost money and we're talking about vulnerable people with hard and messy lives at the end of the day. There is nothing left to cut. There is nothing left that can be solved by innovation. Cuts have consequences."
- e) A service manager told us: "These are worrying times. The reduction in funding means people have less frequent meaningful contact with us, which in turn restricts the effective capacity of our psychosocial offer and the possibility of change and improved life chances that goes with it. We've had a 25% reduction in staffing since 2017. Paradoxically, as pressures grows we could find ourselves not just being less effective in supporting those with addiction problems but protecting our own health and wellbeing too. I want my clients to have quality and equitable support across all my regions. I think we need a locally and nationally linked commitment to funding and service delivery to do this."
- f) Systems blockage and fragmentation issues have also had a major effect. Mental ill health in people who use drugs presents a specific and seemingly intractable issue around 'dual diagnosis'

or 'co-occurring mental health and alcohol/drug use'. This has been caused by historically differing cultures in the worlds of substance use and mental health, a lack of training around dealing with this challenging issue, differences in the commissioning and funding of the two systems and disinvestment. This lack of effective pathways is also apparent in a wider frame of multiple needs, with a system that creaks at the inter-sector joints.

- g) A recent report focused on custody to community transitions for those with drug problems found 'confusion and miscommunications caused by frequent realignment of services...occasioned by the need to operate with reduced funding' were behind a lack of join up (Blenheim CDP, *Failure by Design and Disinvestment: the Critical State of Custody-Community Transitions*, 2018). Some areas lack the effective network of wider voluntary sector and health and social care organisations needed to support people with drug or alcohol issues. Instead multiple organisations are funded and commissioned by multiple sources delivering different agendas.
- h) There have been substantial changes to the landscape of commissioning in the past decade, driven, as in the provision of treatment, by austerity and localism. Commissioning workforces in local authority public health teams have been hit by major reductions in funding which has shrunk the workforce and led to specialist substance use commissioners spreading their time and energy across the whole range of public health, and conversely brought those from other areas of public health into substance use. These challenges, brought about by austerity, have happened at the same time as the Health and Social Care act moved the commissioners into the local authority and a public health setting. Although that was some years ago, the effects of these two seismic changes are still being felt in all areas of the sector including commissioning.

#### **Which groups of people are these barriers most likely to affect?**

- a) People with wider sets of multiple and complex needs, particularly those affected by a dual diagnosis. The lack of system join-up is a serious issue, and has been for decades in our sector, and one that is only worsened by reforms which have split commissioning responsibilities and austerity which has reduced resource. In political terms the fact this is a group of citizens which is heavily stigmatised by society means resource allocation is unlikely to be prioritised in times of scarcity.
- b) As noted elsewhere there is a serious issue around the transitions between custodial and community based treatment, with prison treatment being commissioned centrally by NHS England in contrast to community support. Austerity has reduced both effective through-the-gate services and 'in reach' from community providers. This issue is particularly pronounced for the group of people with multiple and complex needs who experience the 'revolving door' of multiple short term prison sentences.
- c) The aforementioned report on crack cocaine suggests that for crack users who do not also use opiates there may be a perception that treatment isn't able to offer them much. 'Treatment workers explained that the absence of substitute treatment (as exists for heroin) was a big disincentive for people to seek help. Crack users often felt that there was no treatment available for them.' (Gov.UK, *Increase in crack cocaine use inquiry*, 2019).



### **What are the most effective ways to tackle the supply of drugs?**

- a) With its proven effectiveness and ability to save money as well as change lives, we believe drug treatment is one of the essential health and social policy tools which should be used to reduce the supply of drugs.
- b) There is a growing interest in liaison and diversionary schemes which keep drug users who come into contact with the police out of the criminal justice system where appropriate. By diverting people into treatment and support these can play a useful role in reducing supply. These should be encouraged as a sensible way to avoid the ‘revolving door’ of low level offending and short-term sentencing, and the disruption to treatment that it brings, and offer an opportunity for engagement and support. NHS England is publically supportive and there are local schemes in Durham, Thames Valley and Bristol which have been driven by partnerships between the police, Police and Crime Commissioners, treatment providers and other local partners (NHS England, *Liaison and diversion*).
- c) As noted elsewhere, effective local joint commissioning structures are essential to knit services and smooth over the joints of complex systems. These partnerships should bring the NHS, public health, the police and others together around a clearly defined and shared agenda of reducing health inequalities for local people with drug problems.

### **Are you aware of any approaches – locally, nationally or from other countries – that are effective in reducing the harms of drug use/supply? If so, please provide details, including any evidence of effectiveness.**

- a) As noted above there is a substantial body of internationally recognised evidence on the effectiveness of this country’s core treatment offer – key-working, psycho-social interventions, OST, mutual aid and peer support, and effective pathways into mental health, criminal justice, domestic abuse and other related areas.
- b) OST (opioid substitute therapy) is a highly effective treatment intervention for people with a dependence on heroin or other opioids. It is the most widely evaluated of all drug misuse interventions and has been proven to decrease heroin use, sharing of needles, the spread of bloodborne viruses, overdose, drug related deaths and increase retention in treatment. OST keeps some of our most vulnerable citizens alive, and gives them a chance to enter meaningful recovery and re-engage with their families and communities. OST is recommended by the National Institute for Health and Care Excellence (NICE), The UK Guidelines on Clinical Management of Drug Misuse and Dependence and by The World Health Organisation.
- c) Needle and syringe programmes reduce the spread of blood borne viruses such as HIV and Hepatitis C infections, saving £10-42,000 per year for each case (PHE, *An evidence review of the outcomes that can be expected of drug misuse treatment in England, 2017*).
- d) The Making Every Adult Matter (MEAM) alliance takes a joined-up approach to the overlapping issues of multiple and complex need in an attempt to prevent people ‘falling through the gaps’ of the system (MEAM, *Working together to tackle multiple disadvantage, 2018*). Local managers work with partners from across the domains of multiple needs to change local systems, improving pathways and outcomes.
- e) The rising rate of drug related deaths, and a sense that ‘things can’t go on like this anymore’ has led some commentators to focus much attention on Drug Consumption Rooms (DCRs) and

Heroin Assisted Treatment (HAT). This is understandable but it is essential that attention isn't diverted from the most pressing issue; the protection of funding to support the delivery of an effective core treatment and support offer. HAT provides a good option for in-treatment populations which aren't responding to OST, but it is expensive. DCRs have the advantage of attracting out of treatment populations but are not a panacea.

- f) Voluntary sector providers have a number of characteristics that make them ideally placed to improve the lives of those with drug problems: they straddle the campaigning/providing boundary and therefore have an ambitious and meaningful commitment to social justice in addition to providing services; they often arise organically from the communities they support, and this affords them credibility and access; they can innovate and take risks; and partnership work is part of the operational DNA, which is essential for an issue as cross-cutting and multi-faceted as drug use. Charities can often access populations of people living on the margins of society that more obvious agents of the state cannot.
- g) In response to the challenges of austerity, and empowered by localism, some commissioners are adopting innovative partnership approaches in this area. Although these are by definition varied a number of themes emerge:
  - I. A focus on a 'whole systems' approach as a way of navigating the complexity of the terrains of local commissioning and provision. This philosophy states that that complexity makes it impossible from the outset to contract into existence the outline of a rigid system with clearly defined and agreed outputs over a number of years. Instead a more flexible, iterative approach is needed based on partnership working, co-production and constant learning.
  - II. A move towards longer contracts to promote a sense of stability. Length varies area by area but there are cases of five + five, eight or even more years being awarded.
  - III. A move towards a more partnership type approach, with the commissioner acting as a critical friend and 'system steward' rather than in the more contractual and transactional manner that has happened in the past (and still happens in many areas).
  - IV. An example from Essex local authority is submitted as part of this evidence. The Essex Recovery Foundation brings together a panel of experts by experience (both those living in recovery and family members) with a small number of external positions and an independent chair to form a charity which has responsibility for commissioning local services. The local authority will devolve its budget to the new body for this purpose.

**What policy changes or improvements do you think would have the biggest impact on reducing the harm from drug use and/or supply?**

- a) The most beneficial policy change would be an increase in funding for drug treatment services as detailed above.
- b) Protection also needs to be afforded to the funding. Currently substance use treatment does not appear on the list of services mandated by law in local authority regulation. Its addition to this list would afford it more protection (especially if the ring-fence is removed from the public health grant as discussed below).
- c) Treatment does however appear as a condition of the public health grant channelled via Public Health England. This affords the funding some protection, however the future maintaining of

the grant is far from certain, with the current proposal to be to remove the ring-fence as part of a localist drive to empower local areas and put responsibility squarely onto the shoulders of local actors. If this were to happen, not only would the public health funding as a whole lose valuable protection, the mandate to spend some part of that grant on treatment would also be lost. We understand that this is a matter under current political discussion and recommend that the ring-fence be kept.

- d) Given the cross-cutting nature of drug use, it's essential that policy development is coordinated with the allied areas and parallel systems which support those with the most damaging drug and alcohol problems. Investment will be wasted if these systems aren't shored up, and the pathways between them reinforced.
- e) There is increasing focus on trauma and ACE-informed and life course approaches to service delivery. These are useful, and support the understanding of substance use a complex, multi-faceted issue. A corresponding shift in focus in both commissioning and policy is apparent, and generally is helpful. Similarly, the increase in understanding about the wider effects of drug use, as detailed above, must be matched by a focus on support for those affected by others' drug use. Each local authority should provide support for family and carers in their own right, regardless of whether their loved ones are engaged in treatment.