Collective Voice

Dame Carol Black Review Part 2

Collective Voice Response

6.8.20

1. Prevention and harm reduction

Our answer to this question should be taken as a response to all questions in the prevention and harm reduction section.

There is a robust body of evidence around many prevention and harm reduction interventions, all of which are essential components of a health treatment and recovery system which supports those at all stages of their drug misuse (*Drug misuse and dependence: UK guidelines on clinical management,* Department of Health 2017). Harm reduction interventions such as needle and syringe provision are an evidence-based way to reduce harm for some of the most vulnerable and can certainly be delivered in harmony with recovery-focussed work as part of a healthy system response.

Opiate Substitute Therapy (OST) is the most vital of these interventions, reducing harm, preventing withdrawal, reducing instances of overdose or offending behaviour, and creating a platform for longer-term recovery. Widespread provision of naloxone across the full range of agencies which come into contact with opiate users is another essential element, ensuring life-saving interventions for potentially fatal overdoses (*Guidance: Widening the availability of naloxone*, Department of Health and Social Care et al 2019).

The experience of Covid-19 has demonstrated that even with significant changes to service delivery, the harm reducing core of 'what works' can be delivered in order to keep people as safe and healthy as possible. Our challenge as a field is to now ensure that the psycho-social support necessary to facilitate life changes occurs.

However, these vital interventions can only be delivered as part of our healthy system. The government can take steps to ensure this comes about through the measures outlined below; full funding for the array of interventions; protection for the funding; an increase in political championing of the issue; and robust central oversight to ensure the needs of local people are addressed.

2. Young people

Our answer to this question should be taken as a response to all questions in the young people section.

While the treatment sector has come under sometimes extreme funding pressure over the last eight years, services for young people have fared particularly poorly. This may be partly due to the nature of substance misuse amongst young people, which rarely occurs in isolation from a broader spectrum of trauma or disadvantage (*Childhood adversity, substance misuse and young people's mental health*, Addaction and Young Minds 2017). The concept of adverse childhood experiences

(ACEs) has gained more prominence as a tool for understanding how traumatic events shape the experiences of children and young adults and affects their vulnerability to substance misuse and related issues in later life.

Substance misuse is less likely to be entrenched than for an older cohort, which may make it harder for young people, and the services supporting them, to identify and recognise the nature of the challenges. An appropriate response, as highlighted in part one of Dame Carol Black's review, therefore requires a broad range of services that can support young people around mental health, abuse and exploitation as well as offer substance misuse specific support. However, these areas of allied support have too faced significant cuts to funding, resulting in a patchwork of availability for young people.

Steps are outlined elsewhere that will help to bring this about - around funding and political leadership – but additionally the Government's central programme of work could take the provision of young people's services as a metric for monitoring the performance of local areas. This will help to ensure that young people across the country are able to access well-funded services specifically designed to address the broad range of issues that many young people are currently facing.

3. Treatment and recovery

9) What are the barriers to implementing evidence-based drug treatment guidelines and interventions? Answers can relate to specific interventions or services, such as in-patient detoxification or residential rehabilitation.

Practitioners in the UK are able to draw on a strong evidence base of drug treatment guidelines and interventions. The UK Guidelines on Clinical Management, known widely as the Orange Book (*Drug misuse and dependence: UK guidelines on clinical management,* Department of Health 2017), is a globally recognised resource covering how clinicians should treat people with drug misuse and drug dependence problems. Together with NICE guidance (*NICE guideline [NG64]: Drug misuse prevention: targeted interventions,* NICE 2017) across the field of treatment and support (prevention and psychosocial interventions as well as OST), this provides a very robust platform to shape and deliver crucial services to some of the UK's most vulnerable citizens.

However, there are significant barriers to uniform implementation of the evidence base. A political drive to localism since 2010 combined with the reduction in funding for substance misuse treatment services, which has seen some parts of the country cut their budgets by 40 per cent over the last seven years, has resulted in high levels of regional variation (*Review of Drugs: Executive Summary, Dame Carol Black 2020*). Drug misuse is still highly stigmatised in society (*Getting Serious about Stigma: the problem with stigmatising drug users*, UKDPC 2010), which means that substance misuse treatment is rarely a political priority for locally elected politicians, resulting in a patchwork of availability and quality for people in need of treatment. As a deputy council leader is quoted as saying in a recent report, '*I've never had a voter come up to me and say we should spend more money on drug treatment services*' (*Road to Recovery: Addiction in our society – the case for reform*, Centre for Social Justice 2019).

£85 million of public health funding was lost in 2019/20 alone, with 60% of funding for services from central government being lost in the decade to 2020 ("*LGA - Local services face further £1.3 billion government funding cut in 2019/20*", WiredGov Newswire 9 Oct 2018). From 2014/15 to 2018/19 there was a 19% decrease in spend on adult drug and alcohol services with a prediction of a 26%

decrease overall from to 2019/2020 (*Taking our health for granted*, The Health Foundation 2018). For local government leaders having to deal with these crippling reductions and required by law to deliver a whole host of services to residents - although not drug and alcohol support - local services have inevitably dropped in priority.

Nevertheless, treatment providers across the country have remained agile in responding to these challenges, continued to deliver services in accordance with the evidence base, and frequently worked with partners to do so. An increase of funds for the field would allow a greater number of people to be supported.

Areas of good practice with thriving local systems do exist of course, but are too often reliant on local champions, with public health commissioners with an expert background in the substance misuse field building effective relationships with providers and supported by committed Directors of Public Health and/or elected members. But too often this does not happen - many public health commissioners, faced with a large portfolio of commissioning responsibilities and sometimes savage cuts to their own staffing and resources, do not have the time or expertise to build sufficient relationships, engage with the full system complexity and navigate the terrains of local politics.

The landscape for in-patient detox and residential rehabilitation is particularly concerning. A range of detox and residential rehabilitation services are provided by both NHS and the voluntary sector to those with the highest needs and are underpinned by a strong evidence base for long term recovery (*Quality standard [QS23]: Quality statement 10: Residential rehabilitative treatmen*t, NICE 2012; *Clinical guideline [CG52]: Drug misuse in over 16s: opioid detoxification*, NICE 2007). These services should be an essential part of any healthy system striving to offer the right evidence-based interventions to clients at exactly the right time in their recovery journey. However, they face profound commissioning problems. The overall reduction in community budgets, including for Tier 4 services, has had a significant impact across the sector. But spot-purchasing type frameworks have left detox and residential rehab especially vulnerable, with the necessary pathways within the complex commercial ecosystem easily disrupted.

One example of this has been provided by Covid-19 – in the early weeks of the pandemic community providers were forced to reduce the amount of detox places they offered. This reduced the amount of people successfully leaving detox – usually one of the main stepping-stones to residential rehabilitation. This then meant that both rehabs and detox units, which were already struggling in an adverse commercial environment, had a reduced supply of clients (and therefore income) during what was already an incredibly challenging time, with the number of residential rehab services falling by a third in the six years to 2019.

Before Covid-19, Phoenix Futures was forced to close Grace House, a specialist rehabilitation unit supporting women with multiple and complex needs which was awarded an Outstanding rating by the Care Quality Commission (*Grace House: Quality Report*, CQC Oct 2019), due to severe local authority rationing of resource leading to a lack of referrals. The charity calculated that by the time Grace House closed it has been subsidised by around £1m of charitable funds.

10) What could the government do to better support the implementation of evidence-based guidelines and improve the effectiveness of drug treatment and recovery interventions to help it realise its ambition to 'level-up' communities?

Drug and alcohol treatment is rightly identified as one of the pillars around which the 2017 Drug Strategy is built. 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' (*2017 Drug Strategy*, HM Government 2017) is welcome.

The Addictions Strategy, to be published in 2021, will be essential in driving the government's treatment and recovery strategy within a wider context of 'levelling-up' communities across the country. It must acknowledge the very close links between substance misuse and poverty, social exclusion, and trauma. People often misuse drugs – including alcohol – in response to these pre-existing factors, to numb, forget, or otherwise cope.

The substance misuse treatment field alone, therefore, cannot alone change the lives of those facing multiple and severe disadvantage. However, when effectively delivered alongside forms of support, from mental health to housing and employment, treatment is proven to improve health and wellbeing, reduce harm, support people into employment, reduce anti-social behaviour, decrease contact with the criminal justice system and reduce pressure on other public services, particularly acute healthcare settings (*Alcohol and drug prevention, treatment and recovery: why invest?*, PHE 2018). Drug and alcohol treatment results in a 44% reduction in the number of individuals re-offending in the two years after starting treatment for dependency, with a 33% decrease in the number of offences committed (*The impact of community-based drug and alcohol treatment on re-offending*, Ministry of Justice and PHE 2017).

Given the breadth of positive outcomes it leads to, treatment clearly delivers across multiple political agendas, from reducing social exclusion to improving health equity, tackling homelessness to creating safer communities and from providing routes into employment to keeping families together. The case for investment is well established. Providing well-funded drug and alcohol 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 (*Alcohol and drug prevention, treatment and recovery: why invest?*, PHE 2018).

The most important steps from government are detailed below in more detail but are chiefly: effective, inter-departmental leadership from the centre to drive forward the agenda, with sufficient structures to guarantee accountability regards implementation of policy; an increase in funding for delivery of evidence based interventions, and total protection for that funding; and support of the workforce through the development of an externally accredited qualification hierarchy.

11) What are the best models for commissioning and providing drug treatment and recovery services?

i. *What are the best ways to secure effective accountability for those services across different organisations at a national and local level?*
ii. *What levers or mechanisms could be introduced to ensure that services are effective and respond to the needs of local populations?*

Substance misuse treatment providers, particularly those in the voluntary sector, manage multi-disciplinary workforces delivering across multiple aspects of human vulnerability, multiple public service siloes and multiple government agendas, from improving health to reducing crime, improving employment outcomes to keeping families together.

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 a 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 deliver a wide range of complex services to address the needs of those experiencing multiple disadvantage, with necessarily robust governance in place to manage the substantial accompanying risk; 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 multifaceted as drug misuse. Charities can often access populations of people living on the margins of society that more obvious agents of the state cannot. By effectively providing a whole system response from assertive outreach to OST, facilitating routes into mutual aid to running residential rehabs, charities are well placed to meet the needs of the whole person and not see treatment through a solely health focused lens.

The challenges brought by the concurrent reduction in substance misuse – and allied - budgets and the move of commissioning responsibilities to local government control are well documented, most notably in the first part of the Black Review. The Public Health Grant ring-fence has afforded some small but welcome protection; however it is not sufficient in the longer term to either deliver the Government's vision of an effective and evidence based treatment and recovery system or contribute meaningfully to the levelling-up agenda.

November 2019 saw the intention to create a new combined addictions strategy covering drugs, alcohol, medicines and gambling — and a new monitoring unit 'at the heart of government' to oversee it. Covid-19 has postponed the publication of the strategy until early 2021 which is understandable. When it is published it will offer a vital opportunity to implement the changes discussed here and elsewhere. The monitoring unit could play a useful role if its lines of operation and policy ownership (if any) are clarified.

Whatever the structure used to bring the change about, it is essential that the issue of addiction and recovery is gripped and driven politically from the centre. We suggest this programme of work should be:

- Housed in the Cabinet Office as the natural home for crossing-cutting policy issues and policy innovation, with strong links to No10
- Truly inter-departmental: able to harness political buy-in across government departments
- Senior in nature, with involvement from appropriate Secretaries of State and senior officials
- Focused on the implementation as well as the formulation of policy
- Able to guarantee accountability on policy implementation via appropriate structures
- Infused with expertise across substance misuse treatment; able to draw in experts from the field to help formulate and implement policy.

It will need clear lines into local areas with enough influence to encourage local areas into action where appropriate, reducing the local variation in support. The most effective way to do this may be though robust monitoring of local outcomes data; use of a framework of national standards; partnership work with the Care Quality Commission; and the development of the qualification hierarchy identified elsewhere.

This increase in oversight from central government to drive up standards will only deliver results for the government if it is accompanied by a serious increase in protected funding.

This increase in oversight from the centre should be balanced by the preservation of some freedoms for local areas, allowing commissioning practice to focus on

- A more tailored approach, informed by place and the needs of local populations. Commissioners should have greater freedom to shape a broader palette of outcomes, for

instance around mental and physical wellbeing, employment, housing, families in addition to successful completions.

- A more collaborative approach, acting as 'stewards of the system' by identifying, nurturing, and linking support services to meet the needs of their populations, particularly with respect to specialist support for specific populations. Peer-led organisations, in particular, often offer useful opportunities to engage with people in need of treatment.
- A more integrated approach. Commissioned services need to be effectively integrated with existing primary care services and the wider network of NHS commissioned services. Our sector also needs to be integrated laterally with services supporting other domains of multiple disadvantage, including mental health services, homelessness services, employment services and services supporting people in contact with the criminal justice system.
- A less market-driven approach. There is some consensus between providers, commissioners and peer led organisations that substance misuse treatment services are hampered by short procurement cycles, creating inevitable disruption to service-users' recovery journeys in the early stage of implementation. The situation has somewhat improved in recent years with procurement cycles lengthening, but there is scope for further rebalancing and the adoption of a culture of learning, where best practice is more readily shared.

The loss of Drug and Alcohol Teams (DATs) as local focal points for strategic collaboration - following the Health and Social Care Act of 2012 - combined with the realities of austerity has worsened system fragmentation. Health and Wellbeing Boards do not offer a comparable function and have not always been effective. This means there is no uniform local structure to provide the necessary accountability by bringing together the relevant agencies concerned with substance misuse treatment. We would therefore welcome a refreshed approach to a local strategy and governance for treatment and recovery. Any structure needs to provide local accountability to the national structure, whilst enabling the positive flexible elements of local commissioning highlighted above and bringing together public health specialists, the police, NHS services and other relevant partners.

12) What are the most effective ways of commissioning, designing, and providing integrated services for people with multiple and complex needs?

Many people who come into drug and alcohol treatment services will be dealing with a number of other issues, most commonly mental health, homelessness, contact with the criminal justice system, poverty and social exclusion (*Alcohol and drug prevention, treatment and recovery: why invest?*, PHE 2018). It is therefore crucial that, for this cohort, local services are effectively joined up and integrated to address the full range of a person's multiple and complex needs. However, silo-ed commissioning structures, time-poor staff working in local authorities and across service delivery, and less resource in the system means that joined-up services are few and far between. Treatment providers employ a multi-skilled workforce that, by necessity, has expertise across many areas of need and regularly links in with other services. But there are still inevitable barriers for people with multiple and complex needs, who are shunted between different systems, through different commissioning frameworks, none of which are able to fully support them. There are particular challenges for those who experience rough sleeping and co-occurring substance misuse and mental health conditions.

Partnership working and innovation are at the heart of the solution to many of these issues, and Covid-19 has shown how effective these partnerships can be. The HDAS model, working in London to

support people in emergency accommodation with substance misuse problems, demonstrates the power of a collective approach with a clear social mission to work with 'hard to reach' populations. The model brought together a London NHS trust with voluntary sector providers to provide a single point of contact and round the clock medical support for the homeless hotels.

The problems across system commissioning and design are often cultural, not technical. Excellent guidance, for instance, exists on supporting people with co-occurring substance misuse and mental health needs from NICE and Public Health England (*NICE guideline [NG58]: Coexisting severe mental illness and substance misuse: community health and social care services*, NICE 2016).

The Making Every Adult Matter (MEAM) coalition (of which Collective Voice is an associate member) has shown what can happen at local levels through the development of coordinated services that directly improve the lives of people facing multiple disadvantage (*Ten years of tackling multiple disadvantage nationwide*, MEAM 2019). A strong ethos of co-production is at the heart of this work, ensuring that the voice of lived experience plays a key role in understanding the problems and establishing a vision for the future.

13) How does the way the drug treatment market, in terms of the tendering of services and contracts, impact on outcomes for people and effective service delivery?

An element of competition in provision brings obvious advantage. Local government commissioners can benefit from a range of organisations putting forward effective and innovative offers in response to the identification of local need. Procurement also provides a very useful tool for any commissioning team which feels that despite their best efforts the local provider is not delivering good enough services for local people.

However, as noted, many within the system, from providers to commissioners to those with lived experience feel the methods for commissioning drug treatment have become too marketised. Many believe that shorter commissioning cycles are not in the best interest of the sometimes vulnerable people the system serves; although they have started to lengthen in recent years. The cyclical nature of commissioning can bring disruption and uncertainty to the system as whole, particularly in the first year of any new contract where a provider needs to bed in to the local area and build partnerships. Treatment providers are too often forced to devote resource to tendering process which could better be used to deliver and improve outcomes for service users.

Ensuring local commissioners have the freedom to exercise judgement over when and how to re-commission services would be a valuable step in addressing this.

16) How could the capacity and competence of the drug treatment and recovery workforce (both providers and commissioners) be improved?

Many of the changes highlighted in this response, namely increased national political leadership, sufficient funding and more effective commissioning and accountability structures, would ultimately improve both the capacity and competence of the treatment and recovery workforce.

The treatment and recovery workforce contains many dedicated and skilled practitioners who combine the ability to forge strong empathic bonds with their with the knowledge of just which evidence-based intervention to draw on at just the right time. The role of lived experience in the workforce is also central, with providers routinely reporting at least one in four of their staff

members being in recovery. This is significant, providing both visible beacons of recovery for service users and valuable routes into employment.

It is also worth noting two positive factors: that treatment providers commit a considerable amount of time and energy to supporting and training their workforce, and that many practitioners do have high levels of qualification (albeit rather varied in nature and level). However, there are two issues where intervention would benefit the system and ultimately the people it supports.

First is the sector's lack of a single point of entry or a qualification for frontline workers. The process of re-commissioning of services and the inevitable extensive transfer of staff under TUPE arrangements brings issues when staff with similar job titles have quite different levels of experience and qualifications. For those wishing to enter the workforce no obvious gateway exists. For provider organisation no standardised set of competencies exists against which to assess and manage staff. And lastly, because no externally recognised qualification exists there is no professional body to support (and hold to account) the workers it certifies.

For all of those reasons, and the desire to see the hard work and skills of the many people currently doing an excellent job appropriately recognised, Collective Voice would support the development of an externally verified qualification. This should begin with the 'drug and alcohol worker' type role but not be limited to it; the scope exists for the development of a wider hierarchy of roles. There have been historic efforts to push forwards this agenda, from Drug and Alcohol National Occupational Standards (DANOS) to the Federation of Drug and Alcohol Professionals (FDAP) and most recently efforts to establish a drug and alcohol apprenticeship. All of these have approaches have had their merits but none has 'cut through' sufficiently. The development of a comprehensive structure of qualifications, then, would mark a major step forward in the development of our workforce – but would require substantial and sustained energy and resource.

Secondly, there is concern about the lack of new addictions psychiatrists entering the field. Addictions psychiatrists have been successfully trained by national voluntary sector providers following innovative local partnerships with overseeing deaneries. But the current commissioning approach brings a level of uncertainty, which has made the establishment of training places difficult. However it is absolutely possible within the constraints of the current system to adapt current ways of working and bring about an increase in training places; effective collaboration between Health Education England, The Addictions Faculty at the Royal College of Psychiatrists, Public Health England and provider organisations will be necessary.

21) What other barriers are there to people achieving and sustaining recovery?

i. How could they be addressed?

A healthy treatment system with locally commissioned services that understand their resident populations and a national framework for accountability would go a long way to delivering on people's desire to achieve and sustain recovery. However, the bedrock issues of poverty, social inequality and trauma are barriers that substance misuse treatment alone will not solve, and the healthy treatment system outlined in this response will only flourish where there is sustained action at local and national levels to address social and economic inequalities.

The challenges of recent months have demonstrated more than ever the vital role that collaboration plays in supporting the most vulnerable, with heroic efforts seen at local government level drawing in voluntary sector partners, NHS providers/trusts and other public services. As ever charities are

well positioned to work on the root causes of addiction given their commitment to social justice and proximity to community.

22) What needs to be done to help those in custody address their drug misuse and continue their recovery?

i. How can we improve the pathways between prison and community-based drug treatment, including 'through the gate' services when people are released?

23) How can treatment work better with the criminal justice system? Including through diversion by police using out of court disposals and community sentence treatment requirements as an alternative to custody?

Services providing treatment and connected areas of care need to be able to build relationships with people before they leave prison, especially through the employment of peers with lived experience, so they can provide the person-centred, strengths-based support that is likely to have lasting impact.

For people in need of treatment for substance misuse, the transition from the prison estate to the community is often one of the most difficult points of their journey, where there is significant risk of relapse or overdose ("*High risk of overdose death following release from prison: variations in mortality during a 15-year observation period*", Anne Bukten et al 2017). It is therefore of critical importance that this transition point is targeted, with Through the Gate services that provide an effective link between prisons, probation and treatment services. This relies on proper early assessment of a prisoner's needs before they are released, and communication of these needs to relevant partners. Services then need to work across their respective silos, particularly with respect to housing and substance misuse treatment, to ensure there is a holistic package of care for people leaving custody to keep them safe, healthy and less likely to reoffend.

The returning of the workstreams currently delivered by Community Rehabilitation Companies (CRCs) to the National Probation Service (NPS) offers an opportunity for better joint commissioning of community and custody services which will enable the above to take place.

With some regional exceptions, diversionary schemes have been hollowed out in recent years by disinvestment and reform. However, there is a welcome 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 publicly 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.

4. Cross-cutting issues

24) What lessons can be learned from the way that drug prevention, treatment and recovery services have responded to coronavirus (COVID-19)?

People who access drug or alcohol treatment are, at the best of times, some of the UK's most vulnerable individuals. But in the current climate of a widespread pandemic their vulnerability is especially heightened, and services that were already struggling to deal with significant

disinvestment over the last six or more years have faced an unprecedented challenge to sustain life-saving treatment and recovery support.

Services were rightfully concerned about the potential effects Covid-19 on the populations they serve. However, some of these worries seem thankfully to not have come to fruition. While the reasons for this are not yet clear, there is little doubt that the rapid changes to treatment services, effected by a highly motivated and compassionate workforce, were a crucial factor in keeping people safe. Major decisions over the remote delivery of key-working and pyscho-social interventions and the relaxation of OST prescribing regimes were forced upon the field. Provider organisations, whether NHS or voluntary sector, are now grappling with the question of how to preserve the positive changes the pandemic has forced upon us, as well as the longer term challenge of service specification and delivery that builds in social distancing and enhanced infection control.

The move to greater use of remote working and virtual contact with service-users bears particular scrutiny. The shift to phone/digital ways of working has meant that many people have continued to receive crucial support from their keyworkers (there's certainly anecdotal evidence of services having greater reach than normal), which is something to be celebrated. Remote support enables people to be supported in the relaxed environment of their own home and avoids the stigma some associated with physically visiting a treatment service.

On the other hand, there are some people in and out of treatment for whom remote support will be inappropriate, insufficient or practically impossible. People affected by multiple need often remain digitally disenfranchised, remote support raises safeguarding issues for some, whilst others simply prefer a face-to-face conversation. Perhaps surprisingly, we have heard that some young people may be less inclined to engage with remote support for substance misuse.

Another important lesson of Covid-19 is the importance of robust community networks and the crucial role that the third sector plays in supporting healthier communities by providing a broad range of services, protecting our society's most vulnerable citizens, and engaging community members in this work. Drug and alcohol services are no exception to this broad characterisation of the VCSE sector, particularly in the context of mutual aid groups and recovery communities that support people on their journey to greater wellbeing.

Our experience of working with charities, NHS providers, commissioners and officials has also shown how important it is to collaborate, not just during a time of emergency but also during 'normal' times. Areas that have responded better to the Covid-19 emergency have often been well equipped to do so because of effective relationships between key partners that understand each other's roles and support each other to use their expertise in the right areas and at the right times.

i. Looking to the future, how do they need to respond to the impact of the pandemic?

The early stages of Covid-19 for the substance misuse treatment sector prompted a refocussing of the field on keeping people safe during the pandemic, while maintaining necessary levels of service provision and managing the risks resulting from changes. Covid-19 created a situation where some procurement cycles were suspended as agencies rallied to support the people at the sharp end of the disruption. As things return to a 'new normal', it remains to be seen how the commissioning landscape may shift to accommodate the significant changes to service delivery and learn from the experiences of treatment providers and their service-users during the pandemic.

Looking ahead, there is little doubt that the successful wider use of remote and digital support tools will be one of the keys to unlocking effective public services and delivering person-centred care in an uncertain future. But this shift must not become a cost-cutting exercise, but should be established as a means of additional support to sit alongside face-to-face key working and delivery of interventions.

The pressures of Covid-19 have led to an array of personal and societal harms caused by social isolation, poor quality housing, unemployment and anxiety. It is essential that our field is ready to meet this wave of pent-up demand for its services likely to occur as the consequences of these harms, which makes the potential reforms and recommendations of the Black Review extremely timely and important. We believe the changes discussed her would leave the treatment field well places to provide life changing support to those of us who developed a problematic relationship with drugs – or alcohol – during the pandemic.

25) How effective are drug treatment and recovery services at meeting the needs of black, Asian and minority ethnic (BAME) communities?

The data covering this topic remains poor. In 2010, the UKDPC published a paper on drugs and diversity, noting that evidence on the topic at that time was limited (*Drugs and Diversity: Ethnic minority groups*, UKDPC 2010). A decade later, information of the prevalence of drug use in BAME communities is still lacking. This is particularly concerning in light of our ever-increasing understanding of the health inequalities faced by BAME people, including around mental health. To fully address the needs of BAME communities a more nuanced discussion and greater granularity of data is needed across different ethnicities and geographies. It is essential to avoid treating people from BAME communities as a homogenous group with a single set of needs.

People from BAME communities are underrepresented in treatment figures; this may reflect a lower level of use of some drugs but is also likely to point to unmet need in some areas. Reasons for this include may include stigma around drug and alcohol use in some communities, and a lack of culturally specific services making treatment look unattractive or ‘not for me’.

Some areas have seen positive steps towards a more culturally tailored local system, for instance the charity Kikit provides support to Birmingham’s BAME populations or the charity the Nilaari Agency delivering psycho-social support to Bristol’s BAME communities on a range of issues including drug and alcohol use. However the years of austerity have taken their toll on the landscape of smaller, community level VCSO organisations which would bring closer ties to BAME communities and greater cultural competence.

The measures outlined above could bring a welcome focus on this area, for instance the metrics and outcomes monitored centrally could include a specific measure around supporting BAME communities and an increase in funding could increase partnership and collaboration.