CollectiveVoice

National Audit Office audit - Reducing the Harm from Illegal Drugs – Call for Evidence

Submission of evidence by Collective Voice.

About Collective Voice

Collective Voice is the charity working to improve the drug and alcohol treatment and recovery system. 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.

The voluntary sector plays a key role in providing this support, comprising almost three-quarters of the total treatment provider workforce[1]. We were created through the collective leadership of treatment and recovery charities to ensure that the knowledge and expertise of this field is able to contribute to the development of policy and practice. Together, our sponsoring organisations[2] support over 200,000 people every year and are part of a wider ecosystem of charities across the country which include local, specialist and lived experience recovery organisations, working alongside statutory partners to support people with drug and alcohol issues.

About this response

This submission is informed by the knowledge and expertise of Collective Voice sponsor organisations and leadership group members, focussing on answering the questions for which we have the most relevant evidence. The Collective Voice treatment and recovery providers leadership group membership is drawn from senior leaders across the Collective Voice sponsor organisations and the wider field. In June 2023 we held a roundtable discussion

[1] NHS Benchmarking Network, 2023, Drug and Alcohol Treatment and Recovery Services National Workforce Census, February 2023
[2] Collective Voice, Our Sponsors

at a meeting of our Leadership Group, between its members and officials from the National Audit Office. The notes from that discussion inform this submission alongside additional information and evidence gathered from our sponsor organisations and ongoing engagement with the field.

For further information regarding this submission, please contact

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From your organisation's perspective, what are the practical challenges in developing an effective response to the harm caused by illegal drugs?

The practical challenges faced by the voluntary sector in responding to the harm caused by illegal drugs are manifold, and can be broadly categorised as *resource*, *system & leadership*, *needs-based,* and *stigma-based* problems.

1. Resource:

i) It is important to recognise the effects of a decade of disinvestment on the ability of treatment and recovery services to provide support to a wide cohort of people experiencing substance misuse. Dame Carol Black's report found services 'on their knees', with a depleted workforce and bereft of inpatient, residential, and some specialist services[3].

ii) Public Health Grant funding to local authorities fell 26% in real terms per person between 2015/16 and 2023/24, or 21% when recent additional, time-limited funding for drug and alcohol treatment is accounted for[4].

iii) This disinvestment, combined with the wider impacts of austerity, has placed significant pressure on treatment services directly, as well as on their ability to operate within in a context of a struggling wider health and social care ecosystem. In recent years, this has been compounded by external economic and public health trends in the form of cost-of-living and COVID-19 crises. However, even prior to COVID-19, local public health services were struggling to keep up with growing demand and health inequalities were widening[5].

iv) As well as undermining people's access to and successful completion of alcohol and drug treatment[6], this disinvestment has created significant structural issues. Many specialist and smaller provider organisations have been 'forced out' of the sector, both by disinvestment and marketisation in treatment service commissioning, damaging the 'eco-system' for treatment and recovery. To address this, there would need to be deliberate action by the government, to review commissioning processes and ensure that smaller and specialist services are not disadvantaged disproportionately in commissioning arrangements.

v) Workforce challenges are significant and recruitment to the sector, especially into frontline roles, is a persistent challenge. Organisations report that staffing levels and training for specialist professions have declined severely, while the sector struggles to compete for recruitment and retention in service delivery roles within a tight health and social care labour market.

System and leadership:

i) Drug policy does not sit under a single government department's remit and instead cuts across a number of key agendas. As a result, there are unresolved questions around what

[3] Department of Health and Social Care, 2021, Review of drugs part two: prevention, treatment, and recovery
[4] The Health Foundation, 2023, Public health grant, What it is and why greater investment is needed
[5] The Health Foundation, 2020, Health Equity in England: The Marmot Review 10 Years On
[6] Drug and Alcohol Review, 2021, Is disinvestment from alcohol and drug treatment services associated with treatment access, completions and related harm? An analysis of English expenditure and outcomes data

drug policy is trying to achieve, and through which lens it is viewed. Policy can oscillate between addressing substance misuse as a chronic health condition or as a law and order issue. This can lead to tensions in the development of joint policy between, and challenges in engaging across, departments.

ii) The fragmentation of the system can result in uncertainty in terms of accountability, and overlapping responsibilities in terms of delivery. The importance of ensuring that effective coordination and accountability exists across government has been strongly suggested as an area of necessary improvement, both by the Black Review and by the King's Fund[7]. There is a need for clear lines of responsibility that ensure both accountability and effective joint working, preventing issues falling between the gaps in departmental silos.

iii) The abolition of the National Treatment Agency for Substance Misuse and the shift towards local authority commissioning has left a vacuum for accountability and co-ordination across areas, and hence variation in local delivery has grown massively.

iv) The creation of the Joint Combatting Drugs Unit to provide oversight at a national level is a welcome step towards addressing this, and it is very significant that six departments have now been brought together under one vehicle. Another significant step is the creation of local Combatting Drugs Partnerships (CDPs), but we remain too early in the implementation of CDPs and the JCDU to conclusively assess the effectiveness of their performance of coordination and accountability duties.

v) Historic disinvestment, insufficient accountability, and changing economic, public health, and substance use trends have thus meant that the impact of the additional focus and funding provided by the government's drug strategy on the rising harms of substance misuse are yet to be seen in many areas. These harms include drug related deaths; associated physical and mental health issues; harm to life, employment, relationships and communities; and intergenerational harms.

Stigma

i) People who use drugs are highly stigmatised in our society, and, at every level, stigma undermines the effective response to harm caused by illegal drugs. At the individual level, stigmatisation prevents people who need support from accessing it, with 'self-stigma' and the attitudes of family, friends, the community, or mainstream health and care staff being a barrier to seeking treatment[8]. At the organisational level, it undermines the ability of services and their staff to provide help and treatment, while organisations have highlighted the impact of stigmatisation on their recruitment efforts. Stigma also affects friends, family members and whole communities, impacting them directly as well as preventing them from supporting the wellbeing of people who use drugs[9].

ii) More widely, we are concerned that governmental policy positions on drug possession should be grounded in the evidence base, acknowledging the role that trauma, intergenerational poverty, and mental and physical ill-health play in substance use and recovery. It is imperative that policy does not reinforce unhelpful stigma towards people

[7] The Kings Fund, 2021, Improving drug treatment services in England: Models for commissioning and accountability

[8] NHS Addiction Providers Alliance, Stigma Kills Campaign Paper

[9] Anti-Stigma Network, Adfam's Story (Anonymous)

who use drugs that can deter them from seeking potentially lifesaving support[10]. For this reason, we are pleased to see a pause in the implementation of the '*swift, certain, tough*' white paper proposals.

Increasing level and complexity of need

i) Organisations report that recent years have seen an increase in the levels, complexity, and urgency of need in the population of people who use drugs, which will take time and planning for services to adapt to effectively. These changing need-patterns have arisen due to external shocks, including the COVID-19 and the cost-of-living crises, along with changing trends in drug use, and as both direct and indirect effects of drugs, criminal justice, and housing policy.

ii) While overall use of drugs 2012-2021 appears broadly stable[11], mortality rates from drug poisoning over the same period are increasing sharply, by a rate of 74% over the same period[12]. This is disproportionately spread across regions, with the sharpest increases apparent in areas of higher regional deprivation.
   a. The increase in drug related deaths has commonly been associated with an ageing cohort of people using opioids[13], but recent research instead points to the contributory role of increasing polydrug use, increasing homelessness and incarceration, changing patterns of socioeconomic deprivation, and austerity and cuts to services[14].
   b. Patterns of drug use have changed over time. Recent years have seen an increase in powder cocaine and ketamine use, while polydrug use has increased and there is a visible rise in the number of drug poisonings in which benzodiazepines, pregabalin, gabapentin or zopiclone are present (with these drugs almost always used alongside other substances)[15].
   c. Both homelessness[16] and incarceration[17] are major risk factors for risk of HIV and hepatitis C virus acquisition, while both, along with low socioeconomic status, directly and indirectly affect the probability of, and risks associated with, drug use[1819].

iii) Organisations also highlight that the acuity of need for people coming into alcohol treatment is 'higher than ever before'. This increasing complexity means that it takes more time to deliver successful clinical, psychosocial, and other treatments.

[10] Collective Voice, 2021, Our response to the "Swift, Certain, Tough" White Paper
[11] Office for National Statistics, 2022, Drug misuse in England and Wales
[12] Office for National Statistics, 2022, Deaths related to drug poisoning in England and Wales
[13] Advisory Council on the Misuse of Drugs, 2019, AMCD Report – Ageing cohort of drug users
[14] Journal of Public Health, 2022, Analysis of the UK Government's 10-Year Drugs Strategy—a resource for practitioners and policymakers
[15] Collective Voice, 2022, Home Affairs Select Committee – Drugs Inquiry
[16] Lancet Public Health, 2022, The contribution of unstable housing to HIV and hepatitis C virus transmission among people who inject drugs globally, regionally, and at country level: a modelling study
[17] Lancet Infectious Diseases, 2018, Incarceration history and risk of HIV and hepatitis C virus acquisition among people who inject drugs: a systematic review and meta-analysis
[18] Royal Society of Public Health, 2016, Taking a New Line on Drugs
[19] AMCD, 2019, Report into homelessness and drug misuse published

iv) Both the cost-of-living and COVID-19 crises exacerbated this increase in level and complexity of need, acting as significant triggers for anxiety, stress, and trauma. The cost-of-living crisis and COVID-19 have contributed to a 47% and 32% increase respectively in the relapse or re-occurrence of addictive behaviour according to polling[20].

To what extent does the government's approach to delivering the From Harm to Hope drugs strategy address the challenges that you face?

The increased focus on tackling the harm caused by illegal drugs contained within *From Harm to Hope* is welcomed by the sector, and there is a sense of optimism and relief across the field brought about as a result of the strategy and funding. However, this is coupled with concern that this focus must be sustained beyond the current three year funding commitment if we are to see real impact.

A number of problems persist regarding what the government must still do in order to address the challenges facing the voluntary sector.

1. Resource

i) Funding uplifts are welcome and essential, and we urge continuation of funding at similar or increased levels, but it should be noted that a system starved of sufficient resource over a sustained period will take time to 'warm up'. Long-term challenges around infrastructure, workforce, and the buoyancy of the treatment and recovery ecosystem are difficult to resolve swiftly.

ii) The increased funding has come in the context of a difficult economic climate and a tight health and social care labour market, the latter producing massive recruitment challenges in key roles such as nursing along with specialist professional roles including psychiatrists, psychologists, and Non-Medical Prescribers.

iii) Considerable effort and activity is being undertaken by OHID regarding the Workforce Transformation Programme. This has the potential to resolve numerous challenges faced by the voluntary sector. However this activity is taking place at pace and can present challenges for the sector's capacity to engage, especially when workstreams are not always clearly sequenced or joined-up.

iv) The current uplift in funding is being administered in a way which is not conducive to long-term planning, investment, and innovation. Charities' capacity to look and plan ahead is undermined by the uncertainty caused by annual funding, while the government has not yet confirmed funding for the final two years of the five-year funding plan outlined by Dame Carol Black[21].

v) Information on the value of annual funding uplifts has not been confirmed and released by government until late-in-the-day, while Supplementary Substance Misuse Treatment and

[20] Taking Action On Addiction, 2022, Detailed findings from YouGov National Poll on Addiction Behaviours in UK's lockdowns – Oct 2022

[21] Collective Voice, 2021, Black Review recommends additional £1.78 billion for treatment and recovery

Recovery Grant (SSTMR) funding takes further delay in reaching provider organisations through local authorities. As of the 1st June 2023, some providers have not yet had sign-off for their year two (2023-24) plans, further hindering their capacities for recruitment, planning and investment.

vi) With uncertainty around the future levels of funding set to be made available, we have heard multiple reports that, during the tendering process, providers are being asked to model for the possibility of significant cuts in future funding for treatment services.

a. In the tendering process, commissioners are asking providers to set out plans for delivery according to different potential funding settlements, including how they would deal with reductions in both OHID funding and local authority Public Health Grants.
b. Questions in tenders pertaining to possible cuts to be made are scored questions, on which a contract can be won or lost, with providers therefore having to decide what part 'has to give' if funding declines.
c. Furthermore, in some cases we have heard reports of an increase in the weighting given to 'price' questions over quality questions, with price now being weighted as high as 60% in some tenders when it has typically been weighted around 20%. An over-focus on price in awarding contracts would by necessity encourage undercutting by providers, and speaks to wider questions around how well an increasingly marketised treatment service environment is built to deliver on outcomes for service users.
d. While not the case for every commissioned service, we are aware that some commissioners are increasing the 'asks' contained in some service specifications. Where the tender value remains the same, a wider specification means that real-terms cuts and redundancies are being prepared for at a time when increased funding should mean the opposite takes place.

vii) Finally, underfunding of the wider health and social care system also presents challenges for the treatment and recovery sector. Providers may be picking up more work due to the increased vulnerabilities of people as a result of pressure on statutory services and waiting lists, while also experiencing difficulties in treating people due to the difficulties of referring to associated systems such as CAMHS, liver units, or GPs.

2. System and leadership

i) We welcome the creation of the Joint Combating Drugs Unit (JCDU), in line with the recommendations of the Black Review for a central fulcrum in a cross-governmental approach. The JCDU have been helpful in coordinating departmental activity, but there remain barriers to overcome as regards the fragmented responsibilities and variated priorities across departments.

ii) Within government, activities remain often 'siloed' within departments; there are insufficient drivers to force joined-up working within government, and the way in which government departments work together doesn't enable responsibility to be discharged well. As an example, responsibility for commissioning treatment services in prisons lies with NHSE but policy decisions impacting the infrastructure and environment in which those services are delivered are the responsibility of Ministry of Justice and HM Prisons and Probation

Service. The different policy drivers within these two departments can present challenges in joint working and engagement.

iii) Organisations have also highlighted concern regarding an absence of rigorous sequencing and activation in the delivery of *From Harm to Hope*, suggesting that the absence of a 'project management approach' has meant that the implementation does not have sufficient specifications of timelines or contingencies. Activity that, within a programmatic approach, would be dealt with in sequence is instead happening concurrently. This level and intensity of activity can be challenging for providers to engage with and risks undermining providers' ability to plan for investment and expansion.

iv) There are concerns regarding whether certain services and interventions, which could play an important role in reducing drug-related deaths and drug-related crime, may have been overlooked in the government's strategic approach and data-gathering. Specifically, safe consumption rooms/overdose prevention centres, heroin-assisted treatment, and drug-testing services have not been included, despite their potential contribution to achieving these outcomes.

3. Stigma

i) The Strategy states that substance misuse should be approached as a chronic health problem and that it will create a system where there is no stigma attached to addiction. However, there are no specific actions to support this ambition and it is regrettable that some aspects of the strategy in fact risk reinforcing stigma.

ii) Language choices and "tough on crime" narratives present throughout much of the Strategy run the risk of countermanding the government's anti-stigma stance. As has been stated elsewhere, *"Elements of the Strategy could be seen as promoting stigma, for example referring to acquisitive crime in terms of '[t]he innocent families whose homes are broken into by addicts seeking to feed their habits'*[22]. Independent anti-stigma campaigns have been launched, such as the Anti-Stigma Network[23], but these have been undertaken independently of government and have not been adopted into national policy and practice.

4. Needs

i) While there is work underway to address some of the complexities outlined above, such as work on the Rough Sleeping Initiative and the Changing Futures programme, these are taking place outside of the Strategy, and the needs of certain cohorts of people who use drugs are not adequately addressed by *From Harm to Hope*.

ii) We support AMCD recommendations around improving approaches to young peoples' drug use or risk of drug use, specifically that the government should improve efforts to understand if young people's needs are being met in services and to monitor prevalence and increase focus on young people who are not in structured treatment[24].

[22] Journal of Public Health, 2022, Analysis of the UK Government's 10-Year Drugs Strategy—a resource for practitioners and policymakers

[23] The Anti-Stigma Network | End Stigma Attached to Drug and Alcohol Use

[24] AMCD, 2022, ACMD Vulnerable Groups- Young People's Drug Use

iii) Likewise, the Strategy shows limited understanding or consideration of the specific treatment and recovery needs of women and people from ethnic minority groups, nor consideration of how their needs may not be met by the current treatment and recovery system. Specialist organisations and services to identify and address these needs do exist within the field but have in many cases been disproportionately affected by historic disinvestment and remain vulnerable, without direction from government or commissioners.

iv) It has been noted that the current treatment system has been built largely around the needs of opioid users. To respond to changing drug use patterns, and to meet the needs of people using other substances, multiple substances, or alcohol only, there ought to be more variated service offers built into the system – which treatment providers will need significant confidence and investment in order to develop.

v) A world-class treatment and recovery system would recognise and meet the varied needs of diverse people it is aiming to support. So doing, it would nurture the entire ecosystem of treatment and recovery services, including not only the 'structured treatment' providers which form the focus of the government's strategy, but also the recovery services, peer-to-peer services and others providing specialist services to specific groups and cohorts.

Have you (and/or the organisations you represent) faced any difficulties in engaging with the government's new approach?

Is there effective engagement with (i) central government; and (ii) local delivery partners?

i) Overall, there has been positive engagement with central government on the strategy's implementation. OHID in particular have been proactive and open in their engagement with the voluntary sector across workstreams, and have held regular forums and attended Collective Voice meetings to engage with the sector. Similarly, there has been positive and proactive engagement by the JCDU.

ii) Other departments with responsibilities that cut across the Drugs Strategy are arguably less proactive in their engagement. The lack of clarity and alignment between departmental priorities and the objectives of the drug strategy – in particular whether substance misuse is viewed as a chronic health condition or a law and order issue –impacts levels of engagement.

iii) Of particular concern was the limited engagement and delayed information sharing by the Treasury around announcements of yearly funding, which, along with local authority sign-off arrangements, can cause difficulty for providers' abilities to plan.

iv) Additionally, smaller service providers reported that their engagement with central government was generally poorer than was reported with larger providers, and that information took time to 'trickle down' to community, specialist, and smaller organisations in the voluntary sector. Collective Voice is committed to continuing to play a role in facilitating the sharing of information across the field but the engagement of, and role played by smaller service providers, has received less focus within the strategy.

v) With regards to local Combatting Drugs Partnerships, we understand that approximately two thirds of treatment providers are represented on their local CDPs. However, there is a great

deal of variation in the quality and regularity of engagement, meaning that engagement with local systems is often poorer or more difficult than engagement with central government officials.

Is the government's new strategy leading to improvements in the response at a local level?

i) It is important to recognise that we remain early in the process of implementation for *From Harm to Hope*, and that improvements will take time to become visible as a result of:
   a. the challenging external and economic environment;
   b. the need for the system to 'warm up' given historical disinvestment;
   c. the challenges relating to sequencing, late funding announcements;
   d. and uncertainty around whether funding will continue.

   It will take time before the system demonstrates quantifiable improvements, and we caution that the metrics to be used, particularly numbers in treatment, may not be immediately responsive to funding and policy changes over a short time period.

ii) There is concern that future releases of grant funding will be dependent on progress against measures of the numbers of people in structured treatment and the numbers of prison leavers engaging with treatment within three weeks of release. These measures, within such a short period of time following extensive disinvestment, will not capture the impact of the current funding and thus should not be used to justify reductions in funding allocations over years to come.

iii) Providers expressed worry over the use of numbers in treatment as the 'key ask' of the strategy, with it taking time to rectify the historical decline in treatment numbers from 2009-2012 peaks[25], and concerns that an overfocus on numbers in treatment may mean an underemphasis on longer-term and holistic aspects of the impact of the Drugs Strategy, along with a neglect of other interventions, in particular Tier 2 services, which include much of the harm reduction activity undertaken by the sector.

iv) Concerns have also been raised regarding a potential conflict between ambitions to a) increase treatment numbers while b) reducing caseloads, particularly in a context of workforce pressures. However, it was also noted that caseloads are coming down, meaning that in some areas there is a difference made to the quality of outcomes in interventions by increasing the amount of time expended per individual in treatment.

v) Regarding local performance in the context of government ambitions for 2% of treatment to be delivered in residential settings, it was also suggested that availability of residential rehabilitation services has steep variation across areas, and that many areas – particularly in the North East – are a long way from reaching this 2% benchmark. This is complexified by a lack of mechanisms through which the government can 'force' action from local authorities when they neglect targeted investment in residential services.

[25] OHID, 2022, Adult substance misuse treatment statistics 2021 to 2022: report [Figure 21]

vi) There is a broader question over the best way to measure impact and the focus on 'process indicators' which often track activity over outcomes themselves. This can lead towards the micromanagement of providers and unintended consequences, for instance increasing the number of people 'through the door', could lead to a focus on less complex cases.

What needs to be done to develop a resilient, long-term response?

i) The foremost recommendation of this submission is that the government work to improve the sustainability of funding for the sector, through:
   a) Working to prevent a 'cliff-edge' in post-2025 funds by ensuring that the next Comprehensive Spending Review maintains levels of funding.
   b) Recognising the need for long-term funding of value appropriate to rectifying historical disinvestment, and an acknowledgement that short-term funding cycles are unhelpful for systematic improvements and investments needed to deliver a world class treatment and recovery system.
   c) Ensuring that information about future funding is communicated openly and promptly with the sector, and addressing delays which prevent funds from reaching providers, so that longer-term improvements to systems and infrastructure can be made with confidence that funding will be in place.
   d) Addressing the commissioning practices which are, in some instances, leading to cuts being made or prepared for in services.
   e) Recognising that the significant system improvements required to deliver on the strategy cannot be done 'in a sprint', and that the 18 months between now and the end of the three-year funding period may not be sufficient time to make a conclusive measurement of the impact of the funding, particularly through the metrics selected.
   f) We reiterate the point that narrow metrics may disregard successful achievements in other drug strategy areas and divert focus from making necessary improvements and investments. Of particular concern is whether the 'numbers in treatment' metric may potentially encourage services to focus on certain activity and targets which are not conducive to improving quality and long-term recovery outcomes. We urge the government to reconsider the role of this metric in determining future funding.

ii) More broadly, it is essential for system resilience that there be an acknowledgement that the sector itself looks greatly different to ten or fifteen years ago, and that a robust system that can meet the needs of a diverse population of drug users will need a restoration of and support for the diverse, small, specialist, and community providers which have struggled to exist in the treatment and support ecosystem in recent years.

iii) It has also been reported by providers, and highlighted in a pre-strategy King's Fund report[26], that there is work to be done to address the ways in which commissioners and commissioning practices may at times undermine ecosystem health.

iv) The sector awaits the implementation of the new Provider Selection Regime, which should address some of the competitiveness driven by current commissioning but we none the less

[26] The King's Fund, 2021, Improving drug treatment services in England, Models for commissioning and accountability

continue to be concerned about an overfocus on price, rather than quality, by funding-limited local authorities which can potentially encourage 'undercutting' behaviours and a race to the bottom.

v) More needs to be done to understand, recognise, and respond to the needs of women and people from ethnic minority groups within the drug and alcohol treatment and recovery system, with limited practical steps having so-far been taken by the government to ensure that different demographic or ethnic groups have their needs met.

vi) Action should be taken to monitor and support the health of the treatment and recovery ecosystem at large. If people are to get the support that best meets their individual needs, it is necessary to maintain a dynamic range of varied services, from structured treatment to peer-led recovery, using specialist knowledge of specific populations and areas.

vii) The Drug Strategy commits to addressing addiction as a chronic health condition, and so better joined up working towards this must be driven across all departments.