Written evidence from Collective Voice

Collective Voice is the national alliance of drug and alcohol treatment charities. Our members are Blenheim, CGL, Changing Lives, Cranston, EDP, Humankind, Phoenix Futures and Turning Point, which together support over 200,000 vulnerable young people and adults per year.

Health and harms

1. What is the extent of health harms resulting from drug use?
   a) Health 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. Physical health problems and disability can also be a cause, as can depression and anxiety.
   b) Drug use is distributed evenly across society. However health harms are concentrated in areas of poverty and deprivation. Drug deaths for example (the ultimate form of health harm) have a very high correlation with areas of materials deprivation in the UK. The largest group of people dying from drug related causes is older single men, many of whom are outside the treatment system.
   c) This concentration in poorer areas is due to the ‘clustering’ nature of drug and alcohol problems, occurring as they do at very high levels alongside mental ill health, a lack of decent housing, domestic abuse and trauma. All of these experiences correlate with poverty and social exclusion. Failure, therefore, to address these interrelated issues in the round jeopardises significant progress on drug and alcohol use. Only action addressing the whole range of an individual’s life experience and behaviour is likely to produce sustainable change.
   d) 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. As the aging 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.
   e) 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, and differences in the commissioning and funding of the two systems.
   f) There are serious second order mental, and to a lesser extent physical, health harms experienced by the families and carers of those with serious drug or alcohol 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’.

g) Many health harms can be – and indeed are – mitigated against by the response of an effective, evidence-based, person-centred treatment and support system working closely with local partners. Collective Voice’s view on what this system should look like is outlined below.

h) 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.

Prevention and early intervention

2. How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use? This includes whether a whole-system approach is taken.

a) The NHS Long Term Plan was launched in January and majored on the importance of reducing health inequalities. This emphasis is likely to be mirrored in the Department of Health and Social Care prevention green paper to be published by June 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.

b) This emphasis on prevention and health inequalities is to be welcomed given the close alignment of drug and alcohol 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. 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.

Treatment and harm reduction

3. How effective and evidence-based is treatment provision? This refers to both healthcare services and wider agencies, and the extent to which joined-up care pathways operate.

a) The degree to which our system is effective and the degree to which it is evidence-based are two very different – although closely related – issues.

b) The available evidence base on treatment in the UK is excellent. Our ‘Orange Book’ Drug Misuse and Dependence: UK Guidelines on Clinical Management bring together a world-class collection of evidence on what really works in treating drug problems. As always, there are areas where it would be beneficial to know more, however this cannot be recommended as a spending priority at a time of limited resources.

c) The issue, therefore, is whether I.) the system is sufficiently resourced to enable the full range of evidence-based interventions to be implemented and II.) if it is, is the workforce sufficiently competent, and is the system’s environment and culture sufficiently conducive, to enable it to happen?
I. 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 2020xv. From 2014/15 to 2018/19 there has been a 19% decrease in spend on adult drug and alcohol servicesxvi. There is predicted to be a 26% decrease overall from 2014/15 to 2019/2020xvii.

II. Systems blockage and fragmentation issues have also had a major effect. Mental health and substance use services have struggled for decades to provide a seamless pathway for those struggling with both issues. A recent report focused on the 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 service join upxviii. 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.

d) The effects of system disinvestment and fragmentation are being felt widely. The Advisory Council of the Misuse of Drugs found that “the quality and effectiveness of drug misuse treatment is being compromised by under-resourcingxix” and “there is an increasing disconnection between drug misuse treatment and other health structures”. The Recovery Partnership’s ‘State of the Sector’ report, which offers a snapshot of a system under significant strain, found that “funding cuts are already affecting the quality of services; we have passed a tipping point”xx. Alcohol Concern’s ‘The Hardest Hit’ reports cuts to local alcohol services ranging from 10% to 58% and cites decreasing workforce morale and loss of essential outreach services as a resultsxxi.

e) There has been an overall shift within healthcare towards person-centred care which provides a range of patient options. People with drug issues should be able to expect to access an adaptive system that responds to their needs and preferences just like any other group of service users. Our worry is that funding pressures and wider system stresses, for the instance the pricing crisis over buprenorphine, are trimming away the wider elements of a healthy system and ultimately reducing patient change. Much needle and syringe exchange provision was historically delivered by specialist projects rooted in their communities; the majority is now provided by mainstream pharmacists which does not suit everyone. Standalone family support organisations (often set up by the mothers of drug users) historically had a strong voice; organisational closures have now made that voice much weaker.

f) Similar funding challenges have affected related health and social care servicesxxii which has meant an overall lack of effective response for vulnerable people, including substance users.

g) It’s important to note that the whole system required to enable people to enter recovery and ultimately lead meaningful lives is much broader than the medical sounding process of ‘treatment’. It requires a wider approach which integrates the clinical part of treatment with the psycho-social, and links service users seamlessly into mutual aid and peer support structures as well as addressing wider needs in partnership with organisations in housing, employment and metal health, and offering support to families and carers affected by the substance use.
h) 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.

4. Is policy sufficiently geared towards treatment? This includes the extent to which health is prioritised, in the context of the Government’s criminal justice-led approach.

a) Drug and alcohol treatment is rightly one of the pillars around which delivery of the 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’. xxiii

b) For the first time this strategy makes it clear that drug dependence is as much a consequence of pre-existing social and economic disadvantage as it is their cause. This is to be welcomed, as long as it is accompanied by parallel efforts to protect the vulnerable from the risks associated with drug misuse by broadening economic and educational opportunity, minimising social exclusion, and continuing with a cross-governmental approach to this complex issue which straddles multiple agendas and departments.

c) However, as noted elsewhere, serious reductions in available funding have made it very difficult for the sector to work with the government to deliver this aim. Regular frontline intelligence from our contacts at every level of the system paint a picture of a dedicated workforce struggling with rising caseloads, service managers dealing with often radical service realignment and commissioners juggling reducing budgets.

d) In terms of political leadership The Home Secretary’s readiness to lead the drug strategy across Whitehall, the recently commenced Drug Review under Dame Carol Black and the appointment of a dedicated National Recovery Champion all augur well for the increase in political priority that will be needed if our historic successes are not to be thrown away. However, the appointment of the Recovery Champion is now over eighteen months late and the Home Secretary’s framing of the Black Review has focused narrowly on the links between drug markets and violence. We believe that Dame Black should focus more broadly on the socio-economic drivers of drug use and allied issues such as mental ill health, offending and homelessness. We are heartened by recent media coverage in which she indicated that this would be the case.

e) Treatment can flourish within a criminal justice policy paradigm. Record levels of funding were pumped into drug treatment when it was overseen by the National Treatment Agency and the link between drug use and crime was strongly asserted. The Home Office has always championed the role and importance of treatment. It would therefore be wrong to assume that only a health focused policy paradigm could deliver an effective treatment system. Hitching drugs to closely to a solely health focused agenda risks losing the political capital brought by Home Office policy ownership and useful partnerships with police and Police and Crime Commissioners that help drive local responses.

f) 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. 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.

g) Treatment is the foundational element on which wider recovery systems flourish. Policy is at its most effective when it locates treatment within a broader context, which brings together clinical and psycho-social services and values partnership working with services in allied areas, and pathways into mutual aid and peer support. 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 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.

h) Drug and alcohol treatment provide huge savings to public services. The case for investment is well established. According to Public Health England: 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 treatment reflects a return on investment of £3 for every £1 invested, which increases to £26 over 10 years. Drug treatment reflects a return on investment of £4 for every £1 invested, which increases to £21 over 10 years.

i) In health terms specialist interventions for young people potentially save £5-£8 for every £1 invested, mainly in health and crime benefits. 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.

j) Treatment also has a key role to play in contributing to the successful delivery of the Modern Crime Prevention Strategy and Serious Crime Strategy which recognises drugs and alcohol as significant drivers of crime. It is also an essential component of the diversion and rehabilitation of offenders and hence to the successful rejuvenation of probation services, Community Rehabilitation Companies and Transforming Rehabilitation.

Best practice

5. What would a high-quality, evidence-based response to drugs look like?

a) The majority of people who use drugs do not run into any substantial health, economic or social challenges directly related to their substance use.

b) The outline of a high-quality, evidence-based response has been traced above. Despite all the challenges around funding we still have a good treatment system in this country with low waiting times that delivers free support to anyone who needs it. In the past our system has been considered world leading – it is within our grasp as a society to return to that state.

c) We consider the essential ingredients to be:
I. Political energy and will across government to drive forward the agenda, and bring wider partners along too.

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.

IV. A well trained and supported workforce which can work adaptively to meet the diverse needs of people with drug and alcohol problems. There is serious issues here – the sector lacks a single standard ‘point of entry’ in terms of accreditation or qualification and there is a quiet crisis over the number of training places for addictions psychiatrists.

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.

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8 Velleman, R., & Templeton, L. (2002) Family Interventions in Substance Misuse in Working with Substance


Accessible at www.longtermplan.nhs.uk/online-version

The government’s plans for the green paper are detailed at www.gov.uk/government/news/health-secretary-launches-prevention-is-better-than-cure-vision


Ibid


Detailed at www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/


Ibid