



**DWP**



**Ministry of  
JUSTICE**



# Putting Full Recovery First



**HM TREASURY**

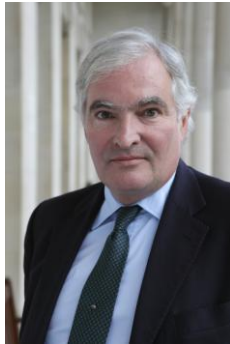


**CabinetOffice**

Department for  
**Education**



## FOREWORD



In December 2010 the Government published its new Drug Strategy, “*Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*”, which set out a fundamentally different approach to tackling drugs and the considerable harms they cause to society.

This document, *Putting Full Recovery First*, outlines the Government’s roadmap for building a new treatment system based on recovery, guided by three overarching principles– wellbeing, citizenship, and freedom from dependence.

To deliver the Government’s ambitions, we have established an Inter Ministerial Group on Drugs that brings together Ministers across Government to drive forward and oversee implementation of the Drug Strategy to enable people to overcome dependence and achieve sustainable recovery.

We do not underestimate the scale of the transformation from a system that has concentrated on engaging and retaining people in treatment to one that is capable of delivering recovery outcomes. To drive this focus, a new recovery orientated body is being established that helps people overcome their dependence for good: Public Health England (PHE).

PHE will carry forward the functions of the National Treatment Agency as the authoritative national voice for public health. From its establishment in April 2013, PHE will provide leadership within a newly integrated recovery sector covering both drug and alcohol dependence working with partners across the public health system and in wider society.

We are also working closely with the recovery sector through the Recovery Partnership, which is comprised of the Substance Misuse Skills Consortium, the Recovery Group UK and DrugScope. The Recovery Partnership not only brings the recovery sector together, it provides the sector with a collective voice and channel for communication directly to the Inter Ministerial Group on the achievement of the ambitions in the drug strategy. Its creation will help to challenge the attitudes and practice of all parties in the treatment system, creating a culture that genuinely embraces change.

Our ultimate goal is to enable individuals to become free from their dependence, to recover fully and live meaningful lives.

A handwritten signature in blue ink, appearing to read "Oliver Henley". The signature is fluid and cursive.

Lord Henley  
Chair of the Inter-Ministerial Group on Drugs

## **Putting Full Recovery First – a new agenda**

### **Dependency: the context for reform**

As part of the coalition government's commitment to ambitious and progressive social reform – which is driven by a commitment to social justice and a belief that everybody deserves a second chance – we are setting a new direction for responding to the danger of drug and alcohol misuse.

Our strategy recognises that drug and alcohol misuse is very rarely an isolated personal problem, its reach is criminal, social and economic; its impact is felt in countless communities across the country. Crucially, we also understand that people often choose such a path in the context of wider social breakdown in their lives, such as chaotic and dysfunctional family relationships, personal debt, criminal behaviour and poor mental health.

Our action on dependence, therefore, is part of our programme to build a social recovery and should be understood alongside: effective early intervention to give every child the best start in life; our work to strengthen families; education reforms to transform poorer schools into gateways of social mobility; radical welfare reform to make work pay and break a debilitating benefits culture; and a robust rehabilitation revolution to confront crime and re-offending.

In view of this our Drug Strategy sets a vision for effective prevention, robust enforcement and a full recovery-oriented treatment system. As well as problem drug users, it covers alcohol, so-called 'legal highs', and over-the-counter and prescription medications. This document, *Putting Full Recovery First*, outlines a roadmap for building a new treatment system based on those commitments. Subject to the passage of the Health and Social Care Bill, the National Treatment Agency will be abolished and functions from that organisation will go to Public Health England which will assume a full recovery leadership role.

### **Towards full recovery: a purposeful policy programme**

Whilst basic improvements have been made to the treatment system in recent years – the most significant of these has included an increase in the number of people entering treatment and reduced harms – there has been too much fatalism and waste. The coalition government has set out its aspiration to challenge the status quo and build a recovery-oriented society. This will bring an urgent end to the current drift of far too many people into indefinite maintenance, which is a replacement of one dependency with another. As a result of the rebalancing reforms we will lead, every effort will be made to confront the root causes of addiction, end chemical dependency and change people's lives.

Building on the Drug Strategy this road map document makes clear political and structural commitments to deliver that reform.

The structural reforms for delivering this are comprehensive and necessary. As *Putting Full Recovery First* says, a new recovery orientated body – Public

Health England will take on the functions of the NTA in line with the Government's focus on recovery. This will provide government with opportunity for clearer leadership and vision-setting within a newly integrated treatment sector, whilst allowing local decision-makers to meet core objectives. As well as creating room for more effective political accountability, this move will also mean that alcohol misuse is finally given the treatment attention its serious impact merits. The Government's forthcoming alcohol strategy will also set out the wide range of action that we are taking to tackle the issue of excessive alcohol consumption

In order to promote full recovery and spread a passionate belief in its power within localities and communities, we will urge local areas to establish Recovery Champions. These Champions will operate at strategic, therapeutic and community levels. They will work to change the treatment culture where it is necessary and demonstrate that hope for full independence from any chemical is real.

Through changes to local commissioning structures we will re-orient local treatment provision towards full recovery by offering people more abstinence-based support and giving them genuine choice about their responsibilities and futures. Where substitute prescribing is used, it will be accompanied by recovery-focused support to maximise a person's chance of freedom from any chemical dependency. People in treatment will be expected to be increasingly engaged in planning for their treatment, with for example individuals plotting a list of objectives and regular actions to take them on their recovery journey.

As with the government's welfare and criminal justice reforms, we are exploring how to incentivise such change further by introducing a carefully designed payment by results (PbR) model for treatment providers. This will shift the focus of providers from process and output to delivering tangible personal and social outcomes, as well as clear value for public money.

A key driver of change is the recently formed Recovery Partnership which is comprised of the Substance Misuse Skills Consortium, the Recovery Group UK and DrugScope. It seeks to be a new collective voice and channel for communication to Government on the achievement of the ambitions in the drug strategy. Its creation is based on a powerful desire to unite the field in achieving a sea change in the treatment system, focusing efforts on creating genuine opportunities for those dependent on drugs and alcohol to recover from dependency and make a positive contribution to society. The scale of the transformation from a system that has concentrated on engaging and retaining people in treatment to one that is capable of delivering recovery outcomes should not be underestimated. Arguably the greatest challenge is addressing the attitudes and practice of all parties in the treatment system and in creating a culture that genuinely embraces change.

The Partnership will independently advise, inform and comment as needed on the implementation of the Drugs Strategy- such as improving commissioning practice, ensuring service user choice, effective local partnership working,

quality standards and best practice framework. The Partnership will work with the new Recovery Committee of the Advisory Council on the Misuse of Drugs to share learning, information and evidence on supporting and driving forward recovery.

### **Full recovery: improved outcomes for everyone**

The reforms contained in the Drug Strategy and this document will shake the maintenance oriented status quo of heroin addiction; they will change lives and transform communities.

The payment by results approach will encourage providers to supply services that achieve a set of defined and measurable outcomes that include being free of their drug of dependence and not involved in crime and in employment.

By achieving full recovery in many more cases than the current norm, we will not only save their lives, reduce drug-related deaths, minimise harm and prevent blood borne viruses, but we will see people living in stable families enjoying the personal freedom the majority of us experience.

As well as these core reforms and others, this document highlights integral criminal justice system change, with particular reference to sentencing and treatment within the prison estate. We want our justice system interventions to confront and change offending behaviour. By improving local approaches to drug misusing offenders, by rolling out diversion and liaison schemes more widely to ensure appropriate offenders are given more opportunities to change, and through continuing to target drug and alcohol treatment within prisons, we will establish full recovery further.

### **Summary of core commitments within *Putting Full Recovery First***

To put full recovery first we will:

- Contextualise treatment reforms within the government's wider social reform agenda;
- Abolish the National Treatment Agency, subject to the passage of the Health and Social Care Bill, and transfer functions to Public Health England;
- Support local areas to re-orient and rebalance local commissioning structures towards full recovery,
- Support local areas to integrate and expand alcohol treatment;
- Inspire and equip the treatment sector to achieve full recovery where possible;
- Develop a PbR model to incentivise outcome-based reform and deliver value for public money;
- Establish recovery champions;
- Build recovery capital in individuals and communities;
- Reform criminal justice system treatment interventions to tackle re-offending and waste.

## **Drug Strategy 2010: *supporting people to live a drug-free life***

The Drug Strategy sets out a fundamentally different approach to tackling drugs use, with commitments to protect our communities more effectively and radical ambitions for recovery-focussed treatment at its heart. The government recognises we must go further than merely reducing the harms caused by drug misuse, and offer every opportunity for people to choose recovery as a way out of dependency.

This new approach is accompanied by an equally radical shift in power both to local areas and people in the system. The Government has set out a distinct national vision and set of expectations for responding to this challenge, but has made it clear that it will be for local areas to design their own tailored responses, by commissioning services which meet the needs of their differing populations and by acting as gateways to full recovery.

In this new landscape, top-down intervention is replaced by direct action and accountability at local level, including through Directors of Public Health, Police and Crime Commissioners, and Health and Well-being Boards. This system will be locally led, competitively tendered, and transparent in its performance.

Recognising that there have been systemic achievements during the past decade in terms of building capacity and broadening access to treatment, the Drug Strategy's goal is to make the same progress in treating those with severe drug and alcohol dependence, and to become more ambitious for all those who want to address their dependency.

We understand that recovery is an individual journey which should encompass a range of changes, including improved wellbeing, increased personal and social responsibility and, of course, freedom from dependence. An individual's recovery capital – or personal capacity – is the best predictor of full recovery. As well as these benefits, successful outcomes should also include the prevention of death and disease, a reduction in crime, suitable employment and accommodation, as well as improved family relationships.

As such, local areas will be expected to commission services that bring improvements to every relevant area of people's lives, including education and employment, housing and family support, and criminal justice. A culture of ambition and belief in recovery will be promoted among the workforce. Mutual aid networks and, crucially, recovery champions will spread the message that the hope of recovery is available and achievable. Furthermore, people on substitute prescribing will also be expected to engage in effective recovery activities to ensure that they move towards full recovery as quickly and as appropriately as they are able to.

For its part the government will explore how to incentivise the system to deliver recovery outcomes through pilot Payment by Results schemes,

including a single assessment and referral mechanism and changes to the allocation of the Pooled Treatment Budget (PTB) while it still remains.

Clearly, recovery is not just about confronting dependence, but also enabling people to reintegrate into their communities. Importantly, therefore, our strategy aims to keep children safe and rebuild families, as well as tackle housing needs and help people find sustained employment and **significantly** reduce their offending.

## **Our strategy for public health in England: *healthy lives, healthy people***

*The Public Health White Paper, Healthy Lives, Healthy People*, sets out plans for a “new era” in public health with a higher priority and dedicated resources. A streamlined national public health service, Public Health England (PHE), will be complemented by a new role for local authorities in improving the health and wellbeing of their population.

There will be ring-fenced public health funding from within the overall budget, separate from the NHS Commissioning Board budget for healthcare. The majority will be spent on local services, either via local authorities through a ring-fenced grant or via the NHS. DH will incentivise action to reduce health inequalities by introducing a new health premium.

Subject to the passage of the Health and Social Care Bill, PHE will be established as an Executive Agency of the Department of Health to ensure rigorous and impartial scientific advice. As well as incorporating critical functions formerly carried out by the NTA, it will be part of a new system to promote public health and will include the health protection and emergency preparedness functions of the Health Protection Agency, elements of public health activity currently held within DH (e.g. smoking and obesity), and responsibilities currently exercised regionally through Public Health Observatories and cancer registries.

As such, PHE will provide information and intelligence functions at a national level. For example, it will publish data on local performance against a core set of outcome indicators.

PHE will also support local substance misuse services by providing evidence of effectiveness, guidance for services, and comparative analyses of performance. The new body will also be subject to the planned reduction of one-third of non-frontline administration costs across the whole system.

Although central government will remain directly accountable for protecting and improving the health of the population, the core principle of the new strategy is that functions should be devolved to the local level wherever possible. This means that local authorities will take on primary responsibility for health improvement. Directors of Public Health, employed by local

authorities but appointed through a joint process with PHE, will be responsible for discharging local authorities' public health functions supported by Health and Wellbeing Boards. These will bring together commissioners of health, social care and public health, with councillors and representatives of patients and the public, via local Healthwatch, to improve services and outcomes and increase local accountability.

Drug misuse and alcohol misuse services, prevention and treatment will all be commissioned via the local authority and funded from the public health budget. We expect that treatment will increasingly be paid for on the basis of results. Associated activity funded by the NHS budget could include brief interventions for drugs, and alcohol health workers in a variety of healthcare settings.

## **Building recovery in communities**

As the Drug Strategy makes clear, the goal of all treatment must now be to enable as many people as possible, to overcome their dependence and achieve full, sustainable recovery. While the treatment system in England has recently improved in terms of reach, efficiency, and drop-out rates, further fundamental work is now required to ensure that recovery outcomes are at the centre of all commissioning decisions and local treatment provision.

The Drug Strategy also seeks to bring together all aspects of substance misuse treatment for the first time. As well as including treatment for dependence of illicit drugs, it covers alcohol, "legal highs", and over-the-counter and prescribed medications. It also seeks to tackle drug treatment in all settings, whether community, in-patient, residential or prison.

Our immediate task, therefore, is to create an integrated and unified system of recovery that helps people to break an addict's dependence for good, increases access to treatment and reduces the harm that addiction causes to our communities.

The existing evidence base underpinning effective treatment interventions for substance misuse is set out in a number of influential publications including NICE guidance<sup>1</sup> and the 2007 UK Clinical Guidelines<sup>2</sup>. This evidence remains the bedrock on which we build the future recovery-focused system.

However, if the system is to be truly recovery-focused, we must challenge and build on the existing evidence base. Learning from experience about what is effective to support people moving through the system, and gathering new evidence about how they sustain recovery and rebuild their lives after leaving treatment, will be essential.

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<sup>1</sup> <http://guidance.nice.org.uk/CG51>

<sup>2</sup> [http://www.nta.nhs.uk/uploads/clinical\\_guidelines\\_2007.pdf](http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf)



Many local partnerships are already reconfiguring their systems to put an emphasis on outcomes, and significant redesign of existing services and service initiatives have been developed locally in response to demand for a new recovery orientation. For example, providers like TTP Recovery Communities<sup>3</sup> and the Park View Project<sup>4</sup> are among early proponents of local recovery-oriented systems in the North West.

Following the Drug Strategy, we consulted on a new national framework for recovery, and we will be responding to that shortly. The outcome of the *Building Recovery in Communities* consultation will supercede *Models of Care for Treatment of Adult Drug Misusers* (originally published in 2002 and updated in 2006). The NTA will write to local areas outlining the response to *Building Recovery in Communities* and the suite of supporting documents to support all those involved in increasing the recovery orientation of local systems. It could also replace the elements that focus on the treatment of dependence in *Models of Care for Alcohol Misusers* (2006).

The response proposes to:

- Widen the scope of local systems to consider dependence on all drugs, including severe alcohol dependence
- Support the development of a range of recovery pathways, particularly evidenced abstinence-based provision
- Ensure local systems and services meet the broader need of users and not just their dependence, by focussing on interventions which build an individual's recovery capital
- Work with users to ensure they take responsibility for their health, their recovery and their future
- Increase the visibility of and belief in full recovery throughout the entire system by an increased focus on abstinence-based treatment, peer support, mutual aid approaches, as well as the identification and utilisation of local recovery champions
- Promote an integrated approach between community-based treatment and a wide range of other mainstream services, including providers of residential rehabilitation and in prisons
- Ensure that people have the necessary support to sustain their recovery after achieving it
- Optimise the number of people moving through the system, successfully completing treatment, and sustaining recovery.

Although the formal consultation period ran until May 4 2011, the Government's new approach is already changing behaviour in the field.

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<sup>3</sup> <http://www.ttprecoverycommunities.co.uk/>

<sup>4</sup> <http://www.parkviewproject.co.uk/>

## **Striking the right balance for people**

The vision of recovery articulated in the Drugs Strategy puts a new hope for individuals and families at the heart of the system. The aim of any such recovery-oriented system should be to enable individuals to become free from their dependency; something we know is the aim of the vast majority of people entering drug treatment.

This means localities will now be encouraged to re-orient local commissioning and delivery systems towards full recovery. Crucially, this means commissioning a range of services – including abstinence-based provision – at the local level - which provide tailored packages of care that give individuals an opportunity to choose and construct their recovery support.

Whilst we recognise that substitute prescribing can play a part in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification, it will not be the final outcome paid for in PBR. There may be people in receipt of such prescriptions who have jobs, positive family lives and are no longer taking illegal drugs or committing crime. But it is important to utilise such interventions as a bridge to full recovery, not as an end in itself or indefinite replacement of one dependency with another.

No longer, therefore, will addicts be “parked” on methadone or similar opiate substitutes without an expectation of their lives changing. We must ensure all those on a substitute prescription engage in recovery-driven support to maximise their chances of being free from any dependency as soon as is practicable and safe.

In view of this shift we are working with an expert group of practitioners to develop new clinical protocols to make the treatment experience more effective, to prevent drift into any unnecessary maintenance programmes, and to focus on overcoming dependence as the desired outcome of all treatment interventions.

These clinical protocols will reflect the optimum balance of medical and psychosocial interventions, and seek to ensure that all individuals receive an integrated treatment offer which provides them with the best support towards recovery. Creating a recovery-oriented treatment system means offering people the right treatment and support at the right time. Such reform, and improvement in people’s lives, will also deliver much better value for taxpayers’ money in the short and longer terms as ultimately payment will be made for full recovery only.

We will also work to develop patient placement criteria, in order to maximise appropriate access to abstinence-focussed pathways, ensure a consistent and transparent approach to the commissioning of community and residential rehabilitation, and achieve a cost-effective balance between different types of treatment. We will ensure that new services and innovative responses are available to address new problems, ensuring that treatments are available for emerging threats such as the misuse of so-called “legal highs”. In addition we

will take steps to improve the “patient experience” in treatment, for example by ensuring a smooth flow between prison and community treatment, and reducing bureaucracy around multiple assessments.

### **Improving Local Practice**

During 2010-11, NTA local teams started working with partnerships to reconfigure local treatment systems to focus on safe and sustainable treatment completions. This built on early progress which doubled the numbers of people leaving treatment having successfully overcome dependency, from over 11,000 in 2005-6 to almost 24,000 in 2009-10. Statistics from the National Drug Treatment Monitoring System (NDTMS) for 2010/11, show that a total of 27,969 individuals “successfully completed” treatment having overcome their dependency in 2010/11. This is an 18% increase compared to 2009/10.

Progress has been particularly strong in London and the South East, where 15% of the entire treatment population are expected to leave treatment having successfully overcome their addiction this year. Progress in the North of England has been slower but is gathering pace. Yorkshire for example has seen a 30% increase in successful completions thus far this year.

However, the best performing areas, such as Kent (where 25% of the treatment population overcome dependency each year) clearly outperform the poorest, like Gloucestershire (with 5%). The lessons learned so far will be shared across the country and between partnerships with the expectation that the number of successful completions in 2011-12 will significantly exceed 30,000.

### **Recovery-Oriented Drug Treatment**

Rightly, the Drug Strategy expresses concern that: ‘for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there. This must change.’ Our core objective, therefore, is to make the system recovery-focussed. We do not want to allow people to drift without effort being made to offer them full recovery at every turn and a chance to change their lives.

As part of this approach an expert group of clinicians and other interested parties, led by Professor John Strang, is developing a clinical consensus to focus practitioners and clients on long term recovery as the desired outcome of treatment, and prevent drift into unplanned long-term maintenance.

They will agree protocols that seek to achieve a fundamental shift in the balance of treatment for opiate dependence, away from long-term maintenance as the default option, and towards achieving full recovery for as many addicts as possible through outcomes based treatment programmes.

We will work throughout 2011-12 to support the work of the group and disseminate its outputs, beginning immediately to challenge and change practice among providers. We will also work with the expert group and

relevant partners to develop appropriate levers and mechanisms to promote the consistent application of the protocols.

We will ensure that open-ended substitute prescribing in the community is only used where absolutely necessary, and only on the basis of a rigorous, multidisciplinary review of a patient's ongoing needs and even so with recovery as the eventual goal.

An interim report *Recovery-orientated Drug Treatment: An Interim Report*<sup>5</sup> has already been published. Its initial findings highlight the need for a renewed emphasis on improving people's recovery and makes some initial recommendations. These include that treatment should incorporate wider social interventions whilst also guarding against incorrect provision or unnecessary drift in to long term maintenance. The full report is due later in the year.

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## **Alcohol**

For too long alcohol has been a neglected and isolated partner in the treatment system. This has been the case despite its reach being broad and its damage extremely serious. Therefore, the Drug Strategy makes clear the government wants to improve services through Public Health England for those with severe alcohol dependence.

Acknowledging that investment in the drug treatment system over the last decade had built capacity and enabled some people to access treatment for a sufficient period of time to bring about substantial health and criminal justice gains, the strategy calls for similar progress in treating those with alcohol dependence, to enable them to overcome their addiction and recover fully.

This will build on the work undertaken by DH at a national and local level over the past three years through the Alcohol Improvement Programme.

The Drug Strategy estimated that about one third of the 1.6 million people with some level of alcohol dependence would face challenges that were similar to those dependent on drugs in needing support to help them recover. The latest figures show that about 110,000 people are receiving treatment for alcohol dependency, and a further 30,000 in drug treatment presented with alcohol as an additional dependence. We know, therefore, that this must be improved upon.

In order to effectively deliver on the required improvements and support the need for local areas to plan and deliver improved treatment for those with

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<sup>5</sup> Recovery-Orientated Drug Treatment: An Interim Report. Professor John Strang, Chair of the Expert Group [www.nta.nhs.uk/news-rod-t-report.aspx](http://www.nta.nhs.uk/news-rod-t-report.aspx)

severe dependency, teams will work with local partnerships to identify their capacity and potential to establish recovery focused alcohol programmes.

## **Maximising recovery capital**

As the Drug Strategy outlines, the greater an individual's recovery capital – the resources they need to seize a second chance – the more likely their full recovery becomes. Therefore, the Inter Ministerial Group on Drugs (IMG) will work with the Department of Health (DH), Home Office (HO), Department of Work and Pensions (DWP), Ministry of Justice (MoJ), Department for Education (DfE), Department for Communities and Local Government (DCLG) and others to support services to work with individuals so they develop and draw on their recovery capital.

This will mean we focus on the development of social capital (such as healthy and stable relationships), material capital (such as finances and accommodation), human capital (mental and physical health, skills, and employment) and cultural capital (values, beliefs, and attitudes).

The Drug Strategy also acknowledged that in the past, positive treatment outcomes have been undermined and eroded by a failure to secure stable accommodation or sustained employment. Pressure on local housing, local priorities for allocation, and in some communities a stigma attached to addiction, have made it difficult to secure the right accommodation for many of those in need. Similarly, drug misusers have been missing from the labour market.

DWP will play its full part in trying to change this to ensure people are given a second chance, but implementing this agenda will also depend on local recovery services being able to adapt to and take advantage of the opportunities presented by the Localism agenda. It is therefore vital that all national and local partners work together to realise the aspiration for full recovery.

### **Treatment Users taking responsibility**

The Building Recovery in Communities (BRiC) consultation document<sup>6</sup> proposes that the new framework promotes a shift in care-planning practice towards people being able to plot and build their own recovery plan. Just as local treatment providers will be encouraged to find their own innovative solutions to delivering a recovery-orientated system, service users will be empowered to take greater responsibility for planning, delivering and sustaining their own full recovery.

An individual recovery plan will provide a tangible list of objectives, actions, and steps that the service user may undertake each day and/or week to accomplish their goal for a particular period. It aims to promote personal responsibility in the task of rebuilding their lives. A recovery plan should also be explicit about the role of others.

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<sup>6</sup> <http://www.nta.nhs.uk/uploads/bricquestionnaire%5B0%5D.pdf>

However, we also need to know more about what drives recovery from an individual's perspective. We will work with the independent service user network *Wired In*<sup>7</sup> to gather data on how and why people have been able to achieve and sustain recovery.

### **Patient Placement Criteria**

We are determined to support local areas to rebalance treatment options for people, improve clinical outcomes and ensure value for public money. In line with the commitment in the Drug Strategy we will develop patient placement criteria to maximise access to abstinence-based treatment and pathways to full recovery.

An expert group is already developing an approach to segmenting the treatment population, according to need and appropriate treatment. The aim is to ensure access to interventions that build the social, material, human and cultural components of recovery capital.

These approaches will help ensure a consistent and transparent approach to the commissioning of community and residential rehabilitation, and achieve a cost-effective balance between different types of treatment.

The ongoing work will seek a consensus about which drug users would benefit most from which recovery-oriented treatment pathways. With a focus on achieving full recovery, this will distinguish between those requiring longer-term treatment and those who could be safely and quickly moved to abstinence, and indicate those who are likely to benefit more from residential treatment.

The criteria will therefore act as a platform on which commissioners can specify systems appropriate to their populations, and front-line staff can support the development of personalised, patient-led plans. We expect this to support local areas in determining a clearer role for abstinence-based residential rehabilitation options.

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<sup>7</sup> [Http://wiredin.org.uk](http://wiredin.org.uk)

## **A locally led system**

As PHE is established, there will be continued focus on supporting local partnerships to commission appropriate services as they too make the transition to the new strategy.

### **Prevalence estimates of opiate and crack cocaine use**

We will publish updated national and local estimates of the number of heroin and crack cocaine users to help support local needs assessment and policy development.

### **Transparency of drug treatment statistics**

In conjunction with relevant stakeholders and the National Drug Evidence Centre (NDEC) at Manchester University, the development of the NDTMS.net website to increase the amount of information that is made available to the public about the profile of drug users in treatment in their local area and also about the quality of the treatment received will continue.

In particular close work will continue with medical epidemiologists at the School of Social Medicine, Bristol University, to develop a methodology that allows local areas to compare themselves to each other, having adjusted for clinical and environmental variations in the makeup and severity of their treated populations.

Similarly work will progress with HO to explore using drug treatment data in local crime mapping, and develop the capacity to compare the English experience of developing a recovery-focused system with the experience from other countries.

### **Spreading Best Practice**

Work with others to ensure local areas are equipped to determine what services are needed to enable people to overcome their drug or alcohol dependency, commission those services, and assess their impact will be pursued.

During 2011-12, the support provided to local areas will be restructured in order to adapt to the changing healthcare environment, recognise the increasing importance of local accountability, and make most efficient and effective use of resources.

As a number of 'early implementer' areas start developing Health & Wellbeing Boards, under the leadership of local Directors of Public Health, a Support Pack to help commissioners and their stakeholders undertake a Joint Strategic Needs Assessment (JSNA) in relation to drugs and alcohol will be developed.

The JSNA Support Pack will include:

- Data on access and the flow of clients into, through and out of treatment

- Tools to review and assess these client patterns to assist in ensuring the best chance of achieving recovery outcomes
- Data and tools to assess value for money and Value Improvement and ensure resources are used to best effect in every area
- Advice on local implementation of these tools, information and data
- Data on the treatment for addiction to prescription-only and over-the-counter medication
- Information on treatment presentation trends for substances not traditionally associated with dependency – for example, so called “legal highs” and “party drugs”

This will then be followed up by a structured process to support local areas to identify how they can transform their local systems to support recovery.

Commissioners will be supported to innovate and develop new provision, in response to our new vision for tackling addiction and the resulting emerging needs. Encouragement and support will be given to commissioners and providers to fulfil their statutory duties in relation to equality, recognising that appropriate responses to the needs of diverse groups in local communities are crucial to delivering positive outcomes for all. In developing the JSNA support pack encouragement will be given to areas to give appropriate consideration to the best commissioning models to meet the needs of all protected groups.

Key to all this will be the identification and transfer of best practice between localities. Local teams will have a unique overview of the treatment and recovery system which enables them to identify best local practice and make it more widely available. This approach has underpinned previous achievements in reducing waiting times and increasing successful treatment completions. We will work to ensure this collaboration plays its part in offering a new hope of freedom from addiction to many more people.

### **Supporting Residential Rehabilitation and Recovery Communities**

Over the past few years a number of different abstinence-based pathways to recovery have been developed which has broadened choice. However, this has not been achieved to adequate levels as there has been reluctance to fund such provision or make appropriate referrals and the mix of provision has been restricted.

The development of patient placement criteria should provide commissioners with a clear cost-effective rationale for making appropriate referrals to residential and recovery community services. This will utilise their significant potential to achieve full recovery much more effectively. In addition, we recognise the need to provide a body of evidence to support the use of residential rehabilitation services by local commissioners which will support the work of the ACMD Recovery Committee and the Recovery Partnership.



## **Where all services are outcome focused**

The Drugs Strategy sets out that the key to successful delivery in a recovery-orientated system is that all services are commissioned with the following best practice outcomes in mind:

- Freedom from any dependence on drugs or alcohol;
- Prevention of drug related deaths and blood borne viruses;
- A reduction in crime and re-offending;
- Sustained employment;
- The ability to access and sustain suitable accommodation;
- Improvement in mental and physical health and wellbeing;
- Improved relationships with family members, partners and friends; and
- The capacity to be an effective and caring parent.

The recently published outcomes framework for public health proposes an evidence-driven framework to measure success in public health at national and local level. As new national outcomes and indicators for drugs and alcohol are developed, we will use the evidence from NDTMS and the Treatment Outcomes Profile (TOP) to establish clearly what services work best to help service users overcome dependency, over what timescale, and how they are provided on a cost-effective basis.

This will be supported by continuing work with others to develop smarter matching of health, employment and criminal justice databases, to ensure that individuals are sustaining their recovery after leaving treatment without relapsing into addiction, unemployment or offending. We are working with others to explore the prospect of extending data-matching across government through the “data warehouse” project, which will also enable us to support the delivery of complex, multiple outcomes such as getting people off drugs, off benefits and into work.

### **Developing metrics to support sustained recovery**

An outcome indicator for the PBR pilots has been consulted on that aims to incentivise commissioners to significantly increase the numbers of individuals leaving treatment free from their drug(s) of dependence. This will be used as part of the Pooled Treatment Budget formula for 2012-13.

## **Investigating trends and a range of possible factors in drug-related deaths**

We will analyse existing data from all sources to better understand the trends in drug-related deaths over the last decade. Alongside this, work will be commissioned to anonymously link mortality data with NDTMS data to investigate deaths that occur while an individual is in treatment or after they have left treatment. This will inform national and local polices to help prevent these deaths occurring.

## **Preventing drug-related deaths and blood-borne viruses**

As the Drug Strategy says, outcomes that are key to successful delivery in a recovery-oriented system include the prevention of drug-related deaths and blood-borne viruses. We will support the activity of local areas by analysing and marshalling the available evidence and producing relevant guidance, and also work with the HPA to coordinate the impact of our combined efforts in this field during the transition into PHE.

In particular we will support local areas in helping those most at risk and targeting their resources on services which the evidence suggests will deliver the most benefit. We will also work to incorporate the outcomes of preventing drug-related deaths and the transmission of blood-borne viruses into the public health agenda and any relevant outcome measures.

All our work on combating blood borne viruses amongst service users will be conducted in line with and assessed against a strategic recovery objective. It is self-evident that the best protection against blood borne viruses is full recovery.

## **Delivered using a ‘whole systems’ approach**

As we have made clear in the Drug Strategy and this paper, full recovery can only be achieved through working with education, training, employment, housing, family support services, wider health services and, where relevant, prison, probation and youth justice services, to rebuild a person’s life. This is a key theme that was explored through the *Building Recovery in Communities* consultation.

Meanwhile we will encourage local areas to jointly commission recovery services so they deliver “end-to-end” support for individuals, and ensure a seamless transition between providers – particularly for those adults moving between the criminal justice system and community services. This will not only ensure that drug treatment services broaden their scope to embrace the government’s new goal of lowering drug use and improving completions free of dependency, but also that those budget holders controlling access to wider recovery services respond to their changed responsibilities and purpose.

This will be challenging at a time when local authority and PCT budgets are under pressure. Local teams will work with local areas to find solutions to funding dilemmas and prevent local disinvestment and/or disengagement from undermining the aspirations of a recovery-driven society.

We will also take a lead in facilitating improved links between community, in-patient and residential treatment and rehabilitation providers, using the model of NTA-hosted Tier 4 events in March 2010 which brought commissioners and residential providers together.

Our aim throughout is to improve the quality of treatment, both psychosocial and medical, by offering more ambitious and individualised interventions. Building on the evidence of what achieves full recovery and what is cost-effective, we will ensure that we utilise treatment that is most aligned to our aims and responsive to the needs of people and communities.

### **Value for Money of structured drug treatment**

Research is being conducted jointly with the Home Office and DH to evaluate the costs and benefits of drug treatment across the four domains of health, crime, safeguarding of children and reintegration.

### **Value Improvement Tool**

In consultation with stakeholders and other government departments, we will develop a tool to help local areas achieve short term and long term value for money. It will include the cost of the different treatment pathways provided and the outcomes achieved for each. This can help determine which interventions are effective and which could be improved.

## **By an inspired, recovery-driven workforce**

In order to see tangible cultural and structural reform in our treatment system, we will work with others to realise the Drug Strategy's ambition of embedding the principles of recovery across all relevant services. In particular we will engage with professional bodies, treatment providers and local commissioners to promote an ambitious culture of life change and a belief in a future free from any dependency for addicts and their families. Where such a belief has taken root in the workforce previously, remarkable change and recovery has been achieved.

We have facilitated the establishment of a national Substance Misuse Skills Consortium to take ownership of a workforce initiative to deliver the recovery agenda. The Consortium now has 140 member organisations, an established executive, and an online 'Skills Hub', an online resource based on a recovery-oriented model of treatment comprised of around 50 specific interventions.

The Consortium plans to achieve a sector-led consensus on how to develop the evidence base that supports the recovery agenda, ensure that qualifications and training meet the needs of services, and add more online resources to the Skills Hub. In line with government aspirations for self-help initiatives, we will work with the Consortium to enable it to become self-financing.

In 2011-12 we will also promote and share best practice on existing interventions which develop individuals' recovery capital. This will include some evidence-based, but currently under-utilised, psychosocial interventions. We will also work with the Recovery Partnership and other relevant partners to develop new resources and improve shared learning about the implementation of interventions. This work will also focus on improving the interface between treatment services and community-based recovery networks.

## **Supported by focussed recovery networks**

The power of full recovery is considerable and its message of hope, contagious. People are far more likely to believe in and pursue recovery in their own lives when they see abstinence work and others like them living free from dependency. As the Drug Strategy makes clear, we will support local areas to develop and promote visible pathways from treatment to recovery so that individuals in treatment, their families and their communities will be able to see firsthand the benefits such change brings.

This kind of transformative change however will not come easily and will require leadership and hard work from all in the sector and Government. Recovery Champions will have a key role to play in Championing this work and the Drug Strategy urges local areas to establish Recovery Champions at three levels, strategic (such as local Directors of Public Health), therapeutic (e.g. among treatment providers) and community (eg mentors for those in treatment who are themselves in recovery).

Central Government though has a further leadership role to play as Ministers across Government will look to champion recovery and its delivery clearing blockages and facilitating innovation and best practice.

Departments will then work together to ensure local areas are encouraged to:

- Create their own strategic recovery champions,
- Support providers of structured treatment to establish therapeutic recovery champions,
- Work with individuals and groups to develop networks of community recovery champions who can model recovery in action.
- Share best practice

They will also help ensure local teams are helped to work with local areas to adopt an "asset-based community development" approach so partnerships can assess the recovery assets of their own communities. This will ensure that access to Narcotics Anonymous and/or Alcoholics Anonymous meetings, SMART recovery techniques, and local recovery networks is taken into account through the JSNA.

## **Protecting children and rebuilding families**

The Drug Strategy estimates that one third of the treatment population has parental responsibility for children. As such, these families require significant and specialist support to help them stabilise, to keep children safe, and to maximise the life chances of those caught up in the chaos which addiction can cause.

Developing new, effective responses for people with parental responsibilities will be crucial to ensure we begin to strengthen these families – especially as strong families act as a protector against a person entering or re-entering the addiction cycle – and protects children from serious harm and damaged futures. No longer is it right or sensible to respond to addiction in isolation from the family unit.

## **To enable reintegration into communities**

As the Drug Strategy makes clear, recovery is not just about tackling the symptoms and causes of dependence, but also about enabling people to successfully reintegrate into their communities and play an integral part within them. This is about ensuring they have somewhere to live, a purpose to their day, and the ability to form stable and positive relationships.

In the past, treatment progress has too often been eroded by the failure to move those in recovery into stable accommodation or employment. The Drug Strategy identifies both sustained employment, and the ability to access suitable accommodation, among the outcomes that are key to the successful delivery of a recovery-oriented system.

People working on the front-line of treatment services, and users and carers themselves, consistently report a lack of access to adequate housing and employment opportunities as the biggest obstacles to individuals realising the potential of full recovery. We will work to end this waste by closely supporting local areas in developing links between treatment and reintegration services including the Work Programme as part of the delivery of a recovery-oriented system.

### **Tackling housing needs**

The Drug Strategy acknowledges the evidence that housing can contribute to improved recovery outcomes. NDTMS shows that in 2010-11, 9% of people presenting to treatment reported being of no fixed abode at the start of treatment and 15% reported having other housing problem. The issue is particularly marked in some parts of the country: in London, for example, 38% of people sleeping rough have a drug support need<sup>8</sup>.

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<sup>8</sup> Street to Home Annual Report 2010-11 using data from the Combined Homelessness and Information Network (CHAIN) on people seen sleeping rough in London <http://www.broadwaylondon.org/CHAIN/Reports.html>

Local authorities work hard with their voluntary sector partners to ensure the needs of vulnerable people are met, including those that are recovering substance misusers. Many local authorities will operate clear pathways for this particular client group, in particular rough sleepers or former rough sleepers. In essence, this would normally mean substance misuse accommodation, followed by rehab and then supported housing through to independent living. DCLG has maintained a £400 million homelessness grant over the next 4 years, enabling local authorities and the VCS to tackle and prevent homelessness effectively.

Central Government will invest £6.5bn for housing related support services for vulnerable people over the spending review period. Local authorities have the flexibility to determine how this unringfenced funding is spent to meet the priorities in their area, and services provide support to a wide range of vulnerable people, including people with drug problems. In 2010-11 local authorities spent £33 million on housing-related support services for people with drug problems funded by Supporting People.

The Department for Communities and Local Government (DCLG) is looking to promote an approach which incentivises local authorities and their partners to secure accommodation and housing outcomes for clients, which could include problematic drug users, without reducing their flexibility to achieve local solutions. They are therefore working with the sector, local authorities and communities to pilot locally developed payment by results (PbR) processes which develop local accountability and transparency for housing-related support services.

In doing so DCLG will support the development of a range of evaluated PbR models that other localities and service providers can learn from and consider whether these might work well for their communities. These models will test payment by results for housing related support services at the local level.

The Localism Act 2011 allows social landlords to issue fixed-term tenancies but, importantly, does not remove their ability to issue 'lifetime' ones. This will enable landlords to better match tenancy lengths to individual circumstances, ensuring that more properties are available for those most in need for as long as they need it. Social landlords will be required to take into account the needs of vulnerable households when deciding on what type and length of tenancy to issue.

In addition DCLG has provided £10m (2010/11 to 2012/13) to Crisis - a national charity for single homeless people, for the 'Crisis Private Rented Sector Development Programme' to fund the voluntary sector to set up private rented sector access schemes for single homeless people. The programme has a clear objective to develop community based voluntary sector services that will help the needs of single people, including priority client groups, such as recovering drug-users, ex-offenders and young people who are threatened with homelessness to access stable accommodation in the private rented sector.

The Ministerial Working Group on Homelessness (MWG) which brings together 8 departments to tackle the complex causes of homelessness such as drug abuse. The Group's first report *Vision to end rough sleeping: No Second Night Out nationwide*, sets out the Government's intention to roll out "No Second Night Out" nationally - the approach being taken by the Mayor of London to quickly identify new rough sleepers.

A second report due for publication in Spring 2012 which will focus on preventing homelessness, tackling the complex underlying causes and delivering integrated services that support an individual's recovery

### **Helping people find sustained employment**

Employment has an integral part to play in underpinning recovery and helping people make a fresh start. Across Great Britain, approximately 320,000 problem drug users and 160,000 dependent alcohol users are estimated to claim the main out of work benefits with their substance misuse creating a major barrier to them finding work.

The Drug Strategy aims to increase the number of drug and alcohol dependent benefit claimants who enter full recovery to find sustained employment.

DWP has developed the Work Programme – the largest and most innovative employment programme the country has ever seen. For the first time, providers will be paid almost wholly based on results. The programme introduces differential pricing – providers will be paid according to the needs of the customers they help. DWP will work closely with drug and alcohol treatment providers to help them link up with their local Work Programme providers and to ensure that recovering addicts are Work Programme ready. This will ensure there is an integrated package of treatment and employment support available in all areas.

DWP has made changes to legislation to allow those with substance dependency to focus on recovery: people in residential treatment are now automatically treated as having limited capability for work for the purposes of Employment and Support Allowance. This legislative change brings residential treatment in line with medical treatment received by hospital in-patients, thus rectifying an unintended anomaly in the legislation.

DWP will go further: they are exploring how the requirements of receiving benefit can be flexed for those in other forms of drug treatment. This "tailored conditionality" will mean claimants can focus on recovery. As claimants move along their recovery journey, their job search requirements can be stepped up so there focus on work is suitable for the stage of recovery they have reached: maximising the chance of recovery, and maximising the chance of employment.

People in recovery can face challenges in securing employment due to their criminal record: the Government is undertaking a full review of sentencing and rehabilitation policies, which includes a review of the Rehabilitation of

Offenders Act, as part of the MoJ Green Paper 'Breaking the Cycle': Effective Punishment, Rehabilitation and Sentencing of Offenders. DWP will work with employers to challenge the stigma recovering addicts can face when trying to find work. They will capture example of best practice and work with employer organisations to delivery guidance on the benefits of employing people in recovery.

## **Making it happen: incentivising success**

As part of its commitment to full recovery for many more addicts, the Drug Strategy sets out government plans to explore how to incentivise people in the system to invest in the treatment which is most likely to deliver.

In conjunction with HO, MoJ and DWP, DH is leading work to explore different models which incentivise local systems to deliver recovery outcomes for individuals and communities. In a number of localities, The Payment by Results (PbR) pilots will identify changes to the current commissioning system by paying providers for tangible outcomes achieved by individuals, not simply for the process which has been the standard approach to date.

Coupled with the development of evidence-based patient placement criteria, this will ensure that investment in drug and alcohol treatment delivers maximum social and economic value. At the same time, we will be working to support non-pilot areas to make the shift towards such outcome-driven work.

### **Payment by Results**

We will manage the programme of PBR pilots set up to incentivise providers to support individuals, including those in contact with the criminal justice system, to recover from their drug and alcohol dependence, resulting in new and clearer outcomes for the individual, their families and communities.

Such a system will finally begin to reward those people and organisations which tackle the root causes of addictions and in doing so, achieve full recovery, transform circumstances and improve life chances.

The pilots will be independently evaluated by the University of Manchester who were awarded a research contract following a rigorous open competitive tendering exercise, advice from an independent expert commissioning panel, and a process of post-tender negotiations with the preferred bidder.



## Rehabilitating offenders

Given the high levels of addiction-related crime and re-offending, it is crucial that we set a new direction for structuring effective and behaviour-changing offender treatment. A rebalanced and purposeful treatment system should still be challenging for offenders, and focussed on reducing drug and alcohol related offending. We will work to achieve this within all criminal justice settings, and to identify the most effective way to establish treatment based approaches that provide appropriate and reliable alternatives to custody for offenders, where appropriate.

### Prison-based treatment

The starting point for reforming offenders is to tackle their drug or alcohol dependency. Prisons will play a greater role in rehabilitating offenders from dependency to recovery. 2010-11 marked a significant year for the delivery of substance misuse services in custodial settings. Revised clinical guidance set clear expectations that ***unless there are clinical reasons to the contrary***<sup>9</sup>, prisoners spending any significant period in custody will be stabilised, safely detoxified and released into the community drug free. The Prison Drug Treatment Strategy Review Group chaired by Professor Lord Patel of Bradford set out a vision for localised, evidence-based prison drug and alcohol treatment, with full recovery at its core.

The Drug Strategy and the MoJ Green Paper “Breaking the Cycle” confirmed that such prison-based treatment, now funded entirely by the DH and made available to local partnerships as part of the “one pot, one purpose” ethos, would be geared towards supporting prisoners to recover from dependency, with an increased emphasis on strengthening the link between custody and the community. This has set a clear agenda for 2011-12.

### Community-based criminal justice interventions

The Drug Strategy confirmed the coalition Government’s commitment to the Drug Interventions Programme (DIP) as the means of ensuring that offenders are offered an effective route to treatment and recovery at every stage of their contact with the criminal justice system.

The piloting and roll-out of wider liaison and diversion schemes by 2014 will present both a challenge and opportunity in terms of extending the range of interventions offered to those in police custody and courts. We are supportive of diversion schemes in custody suites that look at drugs, alcohol, mental health and learning disability with people referred to appropriate specialist support.

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<sup>9</sup> Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive (2007). Drug misuse and dependence: UK guidelines on clinical management 7.3.4.3

Integrated Offender Management (IOM) continues to offer the opportunity to develop multi-level, local partnership-based solutions to identifying, supporting and managing priority offenders, including drug-misusing offenders, with the aim of diverting them away from drug use and crime.

Both the Drug Strategy and the MoJ Green Paper express commitments to build on the use of community sentences to tackle substance misuse by looking at how treatment requirements, as part of community orders, can be used to better motivate and move offenders into treatment. This will also provide sentencers with more effective alternatives to custody, where appropriate. We will work to ensure that offenders are able to access the full range of recovery oriented treatment, including more abstinence-based residential rehabilitation where possible and appropriate.

### **Impact of treatment on re-offending**

An analysis of the conviction rates of offenders before and after commencing structured drug treatment is being conducted. This work is being carried out using data from the HO-commissioned “drugs data warehouse” and uses anonymously matched NDTMS and Police National Computer data. This analysis constitutes the largest study of its kind so far attempted in England and strongly supports previous research in relation to the positive impact of treatment on drug related offending.

## **Intensive support for young people**

Services for young people are different from adult drug treatment, reflecting a unique pattern of need among the under-18 age-group. This reflects the fact that many of the young people who need help have problems with cannabis or alcohol predominantly.

Thankfully dependency on drugs and alcohol in the younger years remains relatively uncommon and most young people who require help for substance misuse will also have behavioural problems associated with truancy, offending and family breakdown.

Although specialist provision for young people already covers both drugs and alcohol, and services have developed significantly in recent years, the evidence base is less developed than that for adults. Yet a cost-benefit analysis of young people’s specialist services, published by DfE in February 2011, found that every £1 spent on services produced benefits worth about £2 over two years and between £5 and £8 over a lifetime.

Accordingly, as the Drug Strategy makes clear, the focus for all activity should be the prevention of escalation of use, including stopping young people from becoming drug or alcohol dependant adults. Drug and alcohol interventions need to respond to the risk in terms of drug use, vulnerability and age.

To support these changes, we will work in partnership with DfE to develop a new service framework that will focus on commissioning, integration with wider children's services, matching interventions with need, and value for money.

Information made available to localities will be improved, including a new risk/harm profile and the development of outcome data. Part of this work will focus on young people with complex needs requiring local multi-agency care.

DH will become responsible for funding for substance misuse services in the young people's secure estate (Young Offenders Institutions, Secure Training Centres and Secure Children's Homes) from 2011-12. We will support localities to exercise this new responsibility to enhance services within the secure estate and ensure continuity of care on resettlement.

We will provide support to localities in delivering these new local authority responsibilities, thereby enabling Directors of Public Health and Directors of Children's Services to fulfil the vision for young people's substance misuse services set out in the Drug Strategy.