

Royal College of Psychiatrists Consultation Response



DATE: 28th Sept 2010

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: 2010 Drug Strategy

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by the Addictions faculty at the College.

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Response to the 2010 Drugs Strategy

A1: Are there other key aspects of reducing drug use that you feel should be addressed?

Yes. The Royal College of Psychiatrists is fully supportive of the ambition to ensure that recovery is put at the centre of attempts to reduce substance misuse. Whilst we recognise that the reduction of crime is one of the legitimate outcomes of treatment, it is not the only one. The policy direction has up until now, been focused on crime reduction. This reduces the ability of the treatment system to concentrate on both individual mental and physical health needs and on public health.

In order to reduce drug misuse, the needs of the whole person need to be recognised. This is particularly important in vulnerable groups such as those with dual substance misuse and mental diagnosis¹ young people, those with significant physical health problems and those with complex social needs such as long term homelessness and unemployment and dependent children.

For many services polysubstance use is the norm rather than the exception. Polydrug users, especially those who abuse drugs and alcohol are particularly vulnerable and there is a need to develop more effective interventions for them allowing them to achieve the best possible outcomes.

The value of reducing harm for those who are using drugs is an important area to be addressed. Significant steps have been made to reduce harm (e.g. needle exchanges, Hepatitis B vaccination programmes). Further work is needed to protect the psychological and physical health of drug users.

¹ Weaver et al (1999) Severe mental illness and substance misuse: BMJ, 318, 137-8

There is increasing evidence supporting the use of brief interventions for patients who harmfully rather than dependently use drugs. Examples include the delivery of brief intervention in Accident and Emergency departments.

Finally, recent NICE guidance has recommended the use of a range of psychological and pharmacological interventions to support newly abstinent patients. Examples include relapse prevention, acamprosate and naltrexone.

A2: Which areas would you like to see prioritised?

- Greater ambition for individual recovery whilst ensuring the crime reduction impact of treatment
- Actions to tackle drugs should be part of building the “big society”.
- A more holistic approach, with drugs issues being assessed and tackled alongside other issues such as alcohol abuse, child protection, mental health, employment and housing.
- Budgets and funding streams simplified and outcome based.

A3: What do you think has worked well in previous approaches to tackling drug misuse?

Over the past 10 years the numbers in treatment have risen substantially. This achievement has meant that there are no (or very short) waiting lists for drug treatment. Prior to this drug users could wait 6 months for treatment and in some areas treatment was not available at all; this delay in treatment increased risks for patients on a range of measures including blood borne infections and crime.

Any changes in the system need to build on and not undermine this achievement. The focus on harm reduction interventions such as needle exchange and methadone prescribing has maintained very low rates of HIV and reducing rates of Hepatitis C in injecting populations. Drug related deaths have reduced. This focus must not be lost.

Services which integrate harm reduction strategies alongside recovery orientated interventions offer the best treatment for patients.

NICE guidelines (CG 51, CG 52, CG 100, TA 114, TA 115, PH 24) and the revision of the clinical guidelines in the substance misuse treatment field (Drug Misuse and Dependence. UK guidelines on clinical management) have provided a clear framework for evidence based treatment.

Services have tended to be delivered by a multidisciplinary team offering a range of medical, nursing and allied health experience. This model has allowed services to manage a range of complex needs so reducing harm and aiding recovery.

Finally the expansion and training of the treatment workforce in the last 10 years means staff now have defined competencies. People with problem substance use can expect better quality treatment from the individuals they see.

A4: What do you think has not worked so well in previous approaches to tackling drug misuse?

Quantity has not always meant quality. The emphasis on getting as many as possible into treatment has been done with insufficient attention to what they get in treatment and makes providing individualised treatment which is more focused towards recovery difficult.

Linked to this is the reduction in the provision of some abstinence focused treatments such as inpatient (medically managed) detoxification and residential rehabilitation.

Interventions which may help service users reintegrate into society have not been emphasised enough resulting in many treatment providers knowing that the service users are “stuck” and cannot move on.

The emphasis on heroin and crack cocaine users means that the needs of users of other drugs (other stimulants, cannabis and over the counter drugs) have been neglected.

The treatment system has become highly complex and difficult for providers and service users to understand. While competition is welcomed as a means of driving up quality, there have been many occasions where the frequent re-tendering of services has been highly disruptive for patients.

Some commissioners have purchased service solely on the basis of cost leading to a ‘negative auction’ in which many services are willing to reduce cost to unsustainable levels in order to win contracts. This process has, in some cases, led to the purchase of services of dangerously poor quality.

There is a perceived lack of accountability of the commissioning process which must be addressed in the current review.

B1: What are the most effective ways of preventing drug or alcohol misuse?

- Attempting to reduce supply or incarcerate those who offend has been shown to be only partially effective. New approaches are needed in addition to old.

- Tackle the link with deprivation (housing, education/schooling, employment, poverty). There is a need to focus on vulnerable populations.
- Improve the information/ knowledge young people have regarding the substances they take. Specific programmes for literacy, poverty reduction, family approaches and early prevention targeted at vulnerable groups have been shown to be helpful.
- Role/support/education of parent/carer- family based interventions.
- Screening (as recommended by NICE).
- Prevention in schools targeting vulnerable groups.
- Reduce harm at earliest opportunity (e.g. prevention of Hepatitis/HIV)

B2: Who (which agencies, organisations and individuals) are best able to prevent drug or alcohol misuse?

- Community organisations
- Parents
- Schools
- Educational welfare trusts
- Local authorities
- Children and adolescent mental health services (CAMHS)
- Substance misuse services- particularly young people services
- Housing
- Criminal justice services (youth offender teams, court diversion schemes)

B3: Which groups (in terms of age, location or vulnerability) should prevention programmes particularly focus on?

- Deprived areas, by Jarman index.
- Vulnerable adolescents (e.g. Families where parents use drugs or alcohol problematically)
- Those with risk factors (e.g. conduct disorder, ADHD)
- Families already highlighted to the various agencies involved.
- Use screening as suggested by NICE
- Problem adolescents arise because they grow up in an environment that fosters them becoming problem adolescents - change the environment to make it easier for them to choose other options.

B4: Which drugs (including alcohol) should prevention programmes focus on?

- All drugs
- Increasingly, polysubstance misuse is the 'norm' across a range of substances. While it makes sense to consider the relative harm caused by different individual substances, we must remain vigilant to emerging trends. The references below can be re-cycled to support this.

Authorities who have demonstrably reviewed and collated available evidence include: -

- a) NHS National Institute for Health and Clinical Excellence

"Interventions to reduce substance misuse among vulnerable young people", March 2007.

- b) EMCDDA (European Monitoring Centre for Drugs and Drug Addiction)

Situation Summary for UK 29 July 2009

Provision of Framework of Prevention Strategies

- c) National Treatment Agency

Guidance on Commissioning Young People's Specialist Substance Misuse Treatment Services 2008

- d) National Institute for Drug Abuse (NIDA)

Preventing Drug Use among Children and Adolescents

A common thread within these documents is the focus on specific sub-groups of vulnerability rather than sub-grouping according to substance.

B5: How can parents best be supported to prevent young people from misusing drugs or alcohol?

Measures that rely mainly on information-passing 'health promotion' techniques are generally found to be ineffective, especially in relation to any appreciable and lasting changes in drug-taking or drinking behaviour.

Targeted, structured programmes involving social institutions, like schools, family, community organisations, which support parents and allow families to play a pivotal part over an extended period of time.

Psychosocial strategies such as the teaching of specific skills for resisting drug influences, increasing assertiveness in social settings if needed, and general coping, problem-solving, decision-making abilities, reducing truancy.

B6: How can communities play a more effective role in preventing drug or alcohol misuse?

- Approaches which aim to reduce the accessibility and availability, and relative affordability of drugs and alcohol.
- This is particularly clear in alcohol use where there is a measurable central relationship between price (per capita), consumption, and harm.
- Young people are a highly price-sensitive. Increasing the real price of alcohol (e.g. by Minimum Unit Pricing) will have a significant direct impact on the drinking of young people.
- There are also practical, common sense approaches of proveable effectiveness such as Age Verification Strategies which, with Test Purchasing, have contributed to reducing alcohol availability to children.
- These lessons from Alcohol studies will apply in many practical ways to "Prevention" in drug misuse, and of course to "Polysubstance misuse".
- Reduced tolerance of drug and alcohol misuse and improved availability of accessible, quality treatment.

B7: Are there any particular examples of prevention activity that you would like to see used more widely?

We know the protective factors for drug abuse (Home Office 2007). We need to pursue the strategy that focuses on introducing, maintaining and optimising these during the early years. Minimum pricing of alcohol could be a valuable intervention to reduce alcohol consumption in the most vulnerable groups.

B8: What barriers are there to improving drug and alcohol prevention?

- A need for a clear conceptual framework.
- Over-emphasis on ineffective interventions such as universal education
- Relatively poor evidence base for the effectiveness of currently funded interventions.
- Lack of resources to develop new, evaluated preventative interventions.

C1: When does drug use become problematic?

Drug use becomes problematic when it marginalizes the individual from the society they live in, either through crime or through a disinvestment in the opportunities society has to offer, be they occupational or family based.

The problems may not be perceived by the user, but his family and immediate relevant others may be experiencing negative consequences of his or her neglect of roles and responsibilities taken on, be they parental or social.

C2: Do you think the criminal justice system should do anything differently when dealing with drug-misusing offenders?

Drug misusers need speedy access to quality treatment. They need a seamless transfer from prison to treatment services with a clear and shared treatment care plan the offender has been involved in.

Methods for matching treatments to offenders must be explored. Abstinence based rehabilitation will be appropriate for some whilst others may need substitute prescribing as a first step to recovery.

Time limited treatment of any form should be avoided. Treatment of substance misuse should be delivered according to need, as in any other health condition, with careful review and consideration of the goals and aspiration of the individual.

Risk increases for an individual in the period immediately following release. Consideration must be given to the best service models to reduce these risks during transfer from prison to the community and drug service.

C3: Do you have a view on what factors the government should take into consideration when deciding to invoke a temporary ban on a new substance?

Yes. The factors the Government could take into consideration when deciding to temporarily ban a new substance are:

- a- A complete review of all available information on this new substance, concentrating especially on modes of use and possible risk of harm
- b- Advice from Specialist bodies, for example the Advisory Council on the Misuse of Drugs, Royal College of Psychiatrists, and the Royal College of General Practitioners.
- c- Experience of users and their families.
- d- In terms of the substance itself, factors which may influence the decision to impose a temporary ban include a lack of information about the substance, potential dangerous combinations of the new substance with other existing substances and risk to the general public.
- e- Consideration should be given to the effect of a ban on the new substance. Care must be taken to ensure that a ban does not inadvertently increase the popularity of the new substance.
- f- Any ban must be supported by clear evidence and not driven by media coverage or public opinion.

C4: What forms of community based accommodation do you think should be considered to rehabilitate drug offenders?

A range of community accommodations must be available including:-

1. Secure/forensic units
2. Staffed rehabilitation units
3. Low intensity/non-staffed units
4. Service for those with specialist needs- dual diagnosis, personality disorders
5. Consideration should be given to accommodation for vulnerable patients who continue to use substances but who need supportive accommodation

It is vital that staff have been properly trained to deliver effective interventions for substance misuse problems (e.g. relapse prevention, motivational interviewing)

C5: Where do you think we most need to target enforcement efforts to reduce the supply of drugs?

We agree that enforcement efforts to reduce the supply of drugs need to continue to have a multi pronged focus starting from production to end distribution.

We also agree that enforcement efforts need to target all points of the drug supply chain. However, the data on what works in terms of enforcement efforts to reduce drug supply on the street in the UK is limited and can be contradictory. This is a similar problem in the USA.

There are also the problems of unintended consequences where an effort to reduce the supply of one drug leads to a surge in popularity of other drugs or dangerous fillers being used.

At a local level, targeting one dealer or one gang over another can lead to a monopoly drug provider.

We do not support the use of criminal justice systems for managing individuals with drug problems. Treatment has been shown to be a better option for both the individual and society.

The internet is increasingly becoming a source of illicit substances and an important area to consider.

Monitoring of prescribing practices by doctors and non-medical prescribers is important. There are well-developed competencies with respect to prescribing practice against which individual prescribers can be assessed.

We believe the Government's focus should continue to be demand reduction along with a strategy to target organised crime to reduce supply.

C6: What else do you think we can do to keep one step ahead of the changing drug markets?

Any policy initiative to keep ahead of the changing drugs market needs three elements

- a) Accurate intelligence: there are already mechanisms to track the development of new illicit drugs, to track novel ways of using existing drugs and new combinations. Examples of these include the Psychonaut project in the UK, which monitors the Internet, and the EMCDDA (European Mentoring Centre for Drugs and Drugs Addiction) at a

European level. What these projects need is a mechanism to feed new developments into the Home Office and funding.

- b) Dissemination of information: There are currently information cascading arrangements that work well, e.g. the National Treatment Agency to Regional offices to local Drug Action Teams and then on to local services. Another network is the SCAN (Specialist Clinical Addiction Network) of Specialists in Addiction Psychiatry.
- c) Action: this can range from information dissemination and harm minimisation advice to treatment options and requests for further information on the ground.

C7: Which partners-in the public, voluntary and community sectors-would you like to see work together to reduce drug related reoffending in your local area?

A range of partners- reduction of drug related offending is clearly the business of the police, prison and National Offender Management Service- their 'core' business.

The treatment sector also has a large part to play, by offering effective evidence based treatment and collaborating with partner agencies.

Key principles are rapid access to evidence based (i.e. based on NICE guidelines and technology appraisals), psychosocial and pharmacological treatment.

In terms of drug related offending, the drugs causing most harm remain opiates and crack cocaine, and therefore prompt access to well delivered opiate maintenance treatment is central in approaches to reduce offending.

Alcohol remains strongly linked with offending behaviour and is increasingly seen in the context of poly-substance misuse. Access to effective evidence based alcohol treatment services remains crucial.

Good quality drug treatment has been shown to reduce drug related crime. The majority of the treatment services for drug dependence are provided by NHS organisations making the NHS locally and nationally a central resource able to collaborate with other organisations to reduce crime.

Treatment centres which offer peer support, mutual aid, and evidence based psychosocial approaches can be very effective in enhancing and sustaining the positive effects of NICE endorsed treatment.

These centres are provided by a range of the charity sector and NHS organisations. They are especially effective when they are part of a well-integrated treatment system with few bureaucratic barriers for patients to negotiate. This can be achieved by close partnership working between the charity and NHS sectors, and also can be delivered effectively within the NHS.

C8: What results should be paid for or funded?

Results which should be paid for include;

- Improvement in physical health (e.g. referral to Hepatology for treatment of Hepatitis C)
- Improvement in psychological health/wellbeing (e.g. Management of mood in those who are depressed, management of psychotic symptoms in those with schizophrenia/drug induced psychosis)
- Reduction in high risk activities (e.g. sharing needles)

- Reduction of illicit drug use
- Reduction of harmful alcohol use
- Prevention (e.g. Hepatitis B vaccination, access/use of needle exchange)
- Reduction in drug related offending
- Reintegration with community (e.g. progress to work/ study)

Crucial service components which should be funded include:

- The provision of rapid access to good quality, effective opiate substitution treatment.
- Availability of services equipped to manage co-morbid mental health and substance misuse problems.
- Services able to deliver evidence based (NICE) treatments for polysubstance misuse including alcohol.
- Services equipped to manage personality disorders.
- Services promoting the health of offenders (e.g. Needle exchange, Hepatitis B vaccination).
- Effective evidence based (NICE) treatment within prisons.
- Pro-active links between prison and community treatment.

- Rehabilitation services based in the community where appropriate.

Issues relating to payment for results:

- Work will need to be undertaken to identify ways in which the population of offenders can be segmented or clustered according to complexity.
- Complexity should include metrics for physical health, mental health (including personality disorder), housing, social functioning and criminal activity
- Clear recovery pathways need to be defined which take account of the variation in complexity and morbidity.
- Recovery does not equate to abstinence and a payment by results system should account for the many patients who recover while remaining on opiate substitution treatment (e.g. return to work, raise families).
- Care needs to be taken to avoid perverse incentives resulting in providers 'cherry picking' less complex populations for financial benefit.
- There must be caution in investing in treatment without proven benefits for patients.

C9: What measures do you think should be taken to reduce drug supply in prison?

There have been a number of recent reports that have looked at this question including;

- Home Office report 39/05 Tackling prison drug markets: an exploratory qualitative study (Clarissa Penfold, Paul J. Turnbull, and Russell Webster)
- Blakey report (2008) Disrupting the supply of illicit drugs into prisons.

The latter outlines the 5 main routes for illicit drugs to enter prisons (visitors, over the wall, post, from reception and remand prisoners and from staff). It suggests 5 ways of disrupting the supply routes.

- The use of good practice (Home Office Good Practice Guide 2003),
- The use of searching including the use of the Body Orifice Scanner System (BOSS) chair for the non-invasive detection of metal and plastic and can be used on inmates, visitors and staff,
- The disruption of mobile phones by both detection (using BOSS chairs, special dogs, routine searches) and by implementing signal disruption mechanisms.
- Better and more effective use of search dogs to detect drugs and phones. They can be utilised at visiting times to

act as a deterrent, and also as part of the patrol of the perimeter fence.

- The use existing regulation so that the CPS is better prepared to prosecute inmates, visitors or others trying to bring drugs in or trying to throw drugs over the boundaries. This also involves the use of intelligence and sharing of information between the community police services and the prison.
- Routine drug testing should be continued with a consideration to the use of tests that have longer window detection periods e.g. urine testing (window of ~ 3 days, depending on the substance) over oral fluid testing (may only detect drug use in < 24 hour period) or even hair strand testing (which can detect use in the past 90 days). The latter has been used in Pennsylvania prisons with apparent success in reducing drug use (Reducing Drug Use in Prisons: Pennsylvania's Approach by Thomas E. Feucht and Andrew Keyser, National Institute of Justice Journal October 1999).

These methods of disruption should be accompanied by the widespread availability of good treatment. Treatment will work better if prisons are drug free, and the need to use in prison is reduced where effective treatment is available.

Treatment options will need to include the full range of evidence based treatments available in the community, namely, substitute prescribing (NICE TA 114), medically assisted detoxification (NICE CG 52); the use of blocking medications such as naltrexone (NICE TA 115), psychosocial interventions

(NICE CG 51) and prison rehabilitation e.g. 12 step programmes or Therapeutic Communities.

Treatment must be delivered within a robust governance framework to ensure national standards.

C10: What impact would the measures suggested have on:

a) Offenders?

Reducing drug availability in prisons should act as a motivator for inmates to take up treatment options in prison, gaining the many benefits that treatment provides.

Good treatment pathways within prison will then help offenders to progress on the road to recovery and the rebuilding of abstinence based lifestyles with less need to reoffend on release.

A proportion of the bullying that occurs in prison has been linked to drug use. However, some of this is around the abuse of prescribed medication. With a reduced availability of illicit drugs in prison, there could be an increase in the exploitation of weaker prisoners to divert prescribed medication into the general prison population.

In the Pennsylvania Approach, reducing drug use in prisons also reduced the incidence of violence both between prisoner on staff (by 57%) and between prisoners (by 70%).

Prison without drugs, may be perceived as a harder option for drug using offenders. Prison then becomes a less attractive option and more of a deterrent both to reoffending, and also to taking up community treatment options as an alternative to a custodial sentence.

There is a chance that greater search and surveillance of visitors could deter prisoners from having visits from friends and family.

These links are of benefit in maintaining mental health, maintaining relationships between family members, particularly for parents, and also for promoting recovery when the offenders are released from custody.

b) Your local community?

Assuming that the measures reduce the re-offending rate by promoting recovery, the impact on the local community will be a positive one.

The benefits, as outlined in Drug Misuse and Dependence: UK outlines in clinical management (Department of Health 2007) should include a reduction in drug-related crime, health related benefits to the individual and as many are public health related e.g. the spread of blood borne viruses, the incidence of MRSA, TB, tetanus etc., there will be further benefits to the community generally.

The *Hidden Harm* report by the Advisory Council on the Misuse of Drugs (ACMD, 2003) outlined the impact of drug use within families that have young children. Reducing drug use will consequently have positive effects on families, carers and communities.

D1: Thinking about the current treatment system, what works well and should be retained?

- Much greater access and accessibility: in terms of waiting lists rapid access to pharmacological management
- Less stigma: the partnerships have worked well with each other with the aim of stabilising and reducing drug use, with less stigma.

- User involvement: with much less judgemental approaches and involvement of the user in their care.
- Access to maintenance therapies which have an evidence base. There is not in general the philosophy of '3 strikes and you are out' but more a philosophy of continued engagement and support to reduce and achieve abstinence.
- Significant increase in quantity – though this had been at the cost of alcohol services and quality.
- Carer involvement
- Awareness of safeguarding, this starting with 'Hidden Harm' and then with policy and implementation of safeguarding policies in drug services.
- Involvement of primary care, with a significant minority who have received training in managing substance misuse.

D2: Thinking about the current treatment system, what is in need of improvement and how might it need to change to promote recovery?

Fragmentation of services: in general there is agreement and usually successful working together, however, threats of decommissioning and re-tendering services increases tension and difficulties between services. Frequent changes of providers are confusing for both clinicians and service users. Fragmented and complex pathways with a variety of providers can make it difficult for both clinicians and service users to navigate their way through the system.

The increase in drug services has been impressive, though there has been much management development which seems to be excessive. This has resulted in inefficient and over complex bureaucracy.

Much of the emphasis has been on opiate users and crack cocaine, with little access to services for those with amphetamine or other stimulant use. Many are simply not accepted even for assessment. Drug services should be available for those with misuse and dependence, this regardless of any specific drug or alcohol. This would also be for those with dependence on prescription drugs.

There needs to be a range of philosophies that encompass the whole journey. The recovery agenda is in focus at the moment, reflecting what psychiatrists have worked towards for some time. Residential rehabilitations can be useful for the patient at some time, however there is little evidence on outcome and they are very expensive.

There is little emphasis, either assessment or management, of those with mental health difficulties. For those with severe and enduring illness, such as schizophrenia, there is easier access to mental health services. However, for those with drug problems, the majority have personality problems or mood disorders and these are not recognised or indeed treated. This lack of treatment is probably related to the relapse of drug use and the inability to reintegrate into society.

Access to housing can be difficult - if this is not available it is likely the person will not continue improvement.

The co-ordination of care between specialist services and primary care needs further development in many parts of the country. Those who have done very well on maintenance, even back to work, but who find it difficult to reduce or stop maintenance should be managed by GPs and not specialist services.

There should be no service called "a prescribing service". Those who run methadone programmes should be able to optimise these programmes for those who are not stable, not simply by altering the prescription. There is a

significant lack of evidence based (NICE) psychosocial services throughout services.

Commissioning is very patchy and often a post code lottery - some excellent, some very disjointed with a lack of clarity between different aspects, e.g. Drug Alcohol Treatment commissioner, Primary Care Treatment commissioner, Drug and Rehabilitation Requirement from probation. The measures are more related to process but much work needs to be done on appropriate outcome measures. The Royal College of Psychiatrists believes we have much to offer in developing outcomes appropriate to a re-balanced treatment service.

There is a need for better network of recovery in local areas, but those who are still on prescriptions should not be banned from attending recovery focused services. The goal for all patients is abstinence as soon as the patient is able. Stability on a prescription is part way towards that goal. Continued support at all levels is required.

Issues of governance: there is significant variability in governance across services. There is a need for all services to have competent staff who hold issues of governance, particularly of clinical work, of great importance. Standards need to be set for adverse incident reporting, investigation of untoward incidents, to pathways of care and safeguarding links for vulnerable adults and children. There is huge variability in the delivery of NICE guidelines.

Some services continue to deliver services with no supporting evidence of benefit (e.g. use of the 'black box' for stimulants including acupuncture, massage etc). While these might be relaxing in some way for patients, in this era of evidence base treatment and value for money, there needs to be scrutiny of what care is commissioned.

D3: Are there situations in which drug and alcohol services might be more usefully brought together or are there situations where it is more useful for them to be operated separately?

We consider that drug and alcohol services should be considered together. This is because of the nature of addiction; many do not have just one addiction, e.g. alcohol and drugs. It seems both inappropriate for the patient and not value for money to have one service to manage alcohol, another to manage drugs; another to do some counseling and another to care coordinate.

However, it is important that the delivery of services have different access points in some situations, but this is for age as well as substance. For example, patients who attend with children, patient with chronic pain disorders leading to dependence.

Psychiatrists in addiction are trained in both alcohol and drug use and are trained to deliver services across a range of substances including prescribed and illicit drugs, legal highs.

All substance misuse services irrespective of type of substance must be able to assess and if necessary refer patients with complex mental health problems that often coexist. Services which include an addiction psychiatrist are best placed to provide ongoing care to patients with coexisting mental health and substance misuse problems. Patients in such services will receive holistic care and not be referred between different services for different aspects of their treatment.

D4: Should there be a greater focus on treating people who use substances other than heroin or crack cocaine, such as powder cocaine and so called legal highs?

The treatment system must be adaptable to meet the needs of drug users. This must include regular reviews of changes in drug using trends.

There is increasing evidence of a shift in drug using trends away from heroin and possible crack cocaine although these drugs continue to cause very significant harm and be strongly linked to crime.

Service providers need to be able to adapt to changing drug patterns without the need to commission new services.

Powder cocaine is widely used but few services cater specifically for this group. The prevalence and harm of the so called legal highs are at this stage difficult to assess. Few services across drug treatment providers are experienced in managing these substances however it would be anticipated that the current evidenced based (NICE) psycho-social treatments (e.g. motivational interviewing, relapse prevention) should be helpful.

Legal highs emphasize the need for constant treatment innovation in the context of research and service evaluation. Services with track records of robust service innovation within the framework of research governance should be supported in this work.

Misuse of prescription and 'over-the-counter' drugs remains under-reported (e.g. Benzodiazepines). Many services do not feel skilled to manage these patients as they have become focused on heroin and crack cocaine. These patients are often highly complex and specialist assessment and treatment is often necessary.

D5: Should treating addiction to legal substances, such as prescribed and over-the-counter medicines be a higher priority?

Yes, current evidence from the UK and abroad suggests an increasing problem with prescribed and over the counter medicines.

The effects of these addictions can be as devastating as addiction to illicit substances. Unfortunately, many patients with addiction to licit substances do not feel that current drug treatments services meet their specific needs.

A higher priority to researching trends and evaluating the most effective treatments and service models is timely.

D6: What role should the Public Health Service have in preventing people using drugs in the first place and how can this link in to other preventative work?

- The Public Health Service should support the prevention work outlined in NICE public health guidance 4 ‘Prevention of substance misuse in vulnerable young people’
- Other preventative interventions such as brief intervention in Accident and Emergency departments, and primary care should be supported.
- The Public Health Service should also strongly advocate for evidence harm reduction interventions including;
 - Testing for blood borne viruses
 - Vaccination for Hepatitis B

- Referral to specialist hepatology and HIV services for medical intervention
- Needle exchange services
- Evidence based opiate substitution
- The Public Health Service should encourage better links between substance misuse services and general medical services to improve access to physical health treatments for drug and alcohol misusing patients.
- The Public Health Service should support mental health in the same way it supports physical health.

D7: We want to ensure that we continue to build the skills of the drug treatment and rehabilitation sector to ensure that they are able to meet the needs of those seeking treatment. What more can we do to support this?

The Royal College of Psychiatrists has developed a competency framework for addiction psychiatry. This is part of an accreditation process to achieve 'specialist in addiction' status.

All addiction psychiatrists undertake peer appraisal of their work on an annual basis. Personal development plans outline the learning needs of the individual within the framework of continued professional development.

Workforce skills development for other groups working in substance misuse should also be based on the competencies required to deliver the interventions supported by the evidence base and guidance (NICE and others).

The ambition is for agreed standards of competency and the quality of treatment to be delivered uniformly across the country.

Drug and National Occupational Standards (DANOS) which were developed as part of NHS Skills for Health programme are an example of quality standards developed within a broader governance framework for all staff working within substance misuse. They outline the basic core competencies.

For more complex interventions, NICE have produced a range of guidelines (CG 51, CG 52, CG 100, TA 114, TA 115) outlining evidence based practice along with implementation strategies.

The UK Departments of Health published the latest edition of Guidelines on Clinical Management (The Orange Book) in 2007. There should be an implementation programme for these guidelines which includes staff skills development.

Commissioners must see clear evidence of training and supervision of staff by an organisation before considering purchasing their services. This will be one element of ensuring that services are delivering interventions of appropriate quality.

The work of the Skills Consortium should be a reference point for benchmarking competencies within the field.

D8: Treatment is only one aspect contributing to abstinence and recovery. What actions can be taken to better link treatment services in to wider support such as housing, employment and supporting offenders?

The challenge of linking treatment and wider support services and the gains which can be achieved through better linkage was identified in the Government's NHS White Paper, *Liberating the NHS*.

This announced the establishment of local Health and Well Being Boards as a statutory function within local authorities. *"These health and wellbeing boards allow local authorities to take a strategic approach and promote integration across health and adult social care, children's services, including safeguarding, and the wider local authority agenda."* Para 4.17 *Liberating the NHS*

We believe this integrated local approach could provide a strategic and governance structure which will enhance joint working between treatment and wider support services at a local level.

We would therefore recommend for Drug Services to be one of the key responsibilities of the Health and Well Being Boards.

D9: How do you believe that commissioners should be held to account for ensuring that outcomes of community-based treatments, for the promotion of reintegration and recovery, as well as reduced health harms, are delivered?

Commissioners should have a range of competencies in the way clinical staff do. Commissioners should be accountable for maintaining and improving their competencies through a process of regular appraisal.

The commissioning process will be defined by agreed outcome measures. Commissioners should develop a dialogue with local providers to define the local needs. Local needs will then need to be integrated with national outcomes.

Clearly identified outcome measures which encompass both reduction of health harms and key stages of recovery will enable commissioners to understand benefits across the treatment system.

The outcome measures could form a basis for payment if appropriate tariffs were developed which accounted for varying complexity.

The research, analysis and evaluation functions of the Public Health Service will develop expertise in this and we welcome the decision to transfer the NTA functions into the Public Health Service.

A strong relationship between the national and local elements of public health will be important and will enhance the work of the Health and Wellbeing boards that should monitor the outcomes of the local treatment systems.

E1: What interventions can be provided to better support the recovery and reintegration of drug and alcohol dependent offenders returning to communities from prisons?

- Improvement in the quality of community and prison based services will benefit offenders.
- In particular, better liaison between community and prison services will allow for better co-ordination of transfer from one service to the other.
- Community services should be funded in a way which allows them to rapidly respond to the individual needs of newly- released offenders.

- Practical issues such as length of discharge prescription, day of release and availability of escort to services must be considered.
- For some offenders the provision of anti-craving medications such as naltrexone or acamprosate is helpful.
- For all drug and alcohol dependent offenders, the provision of evidence based psychosocial interventions (NICE) such as relapse prevention and motivational enhancement, delivered to a high standard, is essential.
- Appropriate housing and social support are crucial elements of recovery and re-integration.

E2: What interventions could be provided to address any issues commonly facing people dependent on drugs or alcohol in relation to housing?

- Current problems include;
 - Most housing on offer not suitable for people dependent on drugs and alcohol
 - Too many hostels have residents actively using
 - Many people with drug and alcohol problem have limited abilities to manage independent housing.

There is a need for structured housing which provides a range of options to cater for the diverse needs of people with drug and alcohol problems.

E3: How might drug, alcohol and mental health services be more effective in working together to meet the needs of drug or alcohol dependent service users with mental health conditions?

Drug and alcohol problems with co-existing mental health conditions (dual diagnosis, co morbidity) are common and the rule in community and clinical drug treatment settings. However, policy on this addresses only those with severe and enduring mental illness –in addition those with depression, personality issues etc who may not be routinely accepted by mental health services need to be considered.

A cross-sectional prevalence survey in four urban UK centres showed that of CMHT patients, 44% reported past-year problem drug use and/or harmful alcohol use. 75% of drug service and 85% of alcohol service patients had had a psychiatric disorder in the past year.

Many services have barriers to avoid treating dual diagnosis patients.

Large proportions of dual diagnosis and co-morbidity patients are not identified by services and receive no specialist intervention (Weaver et al, 2003). Moreover the pattern of this co morbidity varies between co morbid mood, anxiety and personality disorders in patients accessing addiction services, and co morbid alcohol, cannabis and cocaine misuse in patients accessing general psychiatric services.

Co morbidity is associated with increased risk of violence, suicide and worse clinical and social outcomes. The National Confidential Inquiry into Suicide and Homicide has reported substance misuse as a factor in over half of homicides and suicides by people with serious mental illness.

Moreover, this group has high rates of criminality and blood-borne infections, including HIV infection and hepatitis B and C. The severity of this morbidity

also varies between these specialist settings: severe psychiatric disorder is associated with non-dependent use of substances (problematic substance misuse), whereas severe addiction is associated with personality disorder with or without minor psychiatric disorder.

Numerous studies in community and clinical settings have shown the high unmet health and social care needs of people with co morbidity particularly those with serious mental illness and co-existing substance misuse.

The National Service Framework (NSF) for Mental Health (Department of Health, 1999), while emphasising the importance of tackling dual diagnosis, failed to include standards and service models to address the challenges posed by patients with dual diagnosis, including those with severe mental illness. It was in the context of this gap in policy that the Dual Diagnosis Good Practice Guide (2002) was launched.

The NSF also omitted to provide standards and service models for people with substance use disorders, an omission that was addressed by the complementary guidance on models of care launched by the National Treatment Agency for Substance Misuse (2006).

The key message in the Dual Diagnosis Good Practice Guide is that substance misuse is usual, rather than exceptional, among people with severe mental health problems, and that the relationship between the two disorders is complex.

Individuals with dual diagnosis have varied and complex needs and require high-quality, comprehensive and integrated care that should be delivered within the mainstream mental health services. These remain the exception rather than the rule. The complex and fragmented treatment pathways for addiction treatments, means that there is often limited sharing of staffs and expertise.

The Dual Diagnosis Good Practice Guide recognises that mainstreaming will not reduce the role of drug and alcohol services, which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues.

The guide summarises good practice in relation to treatment and sets out a programme for local implementation of the appropriate service model. It is concluded that integrated care by a single team delivers better outcomes than serial care (sequential referrals to different services) or parallel care (more than one service engaging with a patient at the same time). This is what commissioners should ensure is provided.

The guide recommends that more UK-based research is required to establish the evidence base, and that well-organised parallel care can be used as a stepping stone to integrated treatment delivered by existing mental health services following training and support from substance misuse services.

The Dual Diagnosis Good Practice Guide was launched at the same time and place as two other guidelines: Adult Acute Inpatient Care Provision Guidance (2002) and National Minimum Standards for Psychiatric Intensive Care Units and Low Secure Environments (2002). Neither of these other publications emphasises the importance of dual diagnosis. The intensive care guidance specifies substance misuse as an exclusion criterion on two counts, and falls into the trap of emphasising the primacy of one diagnosis over another in the acute situation, potentially perpetuating the passing of complex patients from 'pillar to post' – of the recognised diagnostic uncertainty and tautology. It is simplistic to adopt a dualistic approach to behaviour where the relationship between the two conditions is properly co morbid, with shared aetiological factors.

There is growing evidence for the effectiveness of psychosocial interventions such as motivational interviewing and cognitive-behavioural therapy. However, within addiction and general psychiatric services there are serious implementation barriers related to service organisation, staffing levels, training and – most importantly – the difficulties of engaging people with severe mental illness and co morbid substance misuse in treatment.

Substance misuse service without the input of an addiction psychiatrist, are poorly equipped to manage the challenge of patients with coexisting mental health and substance misuse problems.

The recently introduced draft NICE Guideline for the assessment and treatment of patients with psychosis and coexisting substance misuse (NICE, 2010) has been a major advance: The guidelines provide evidence-based standards for assessment, treatment interventions, service models, integrated care pathways and key priorities for their implementation within primary care and secondary community and inpatient mental health and substance misuse services.

The guideline advocates specific care pathways and made recommendations for the provision of integrated service models for people with psychosis and coexisting substance misuse in the UK.

Moreover it proposed key priorities for research including research evaluating the effectiveness of psychosocial and pharmacological interventions and service models to meet the health and social care needs of this challenging population of people with drug and alcohol misuse and co-existing mental health problems.

E4: Do appropriate opportunities exist for the acquisition of skills and training for this group?

No, not yet. The DANOS (Drugs and Alcohol National Standards) does not fully address this. Many services do not have access to an addiction psychiatrist. GP specialists do not have the mental health training to manage complex co-morbidities.

Despite the strong emphasis laid on the implementation of Dual Diagnosis Good Practice Guide (2002) advocating 'mainstreaming' of provision of integrated mental health and substance misuse interventions within mental health services, there has been limited implementation of this guidance in NHS Mental Health Trusts in the UK.

The NSF- 5 years on showed that only 17% of Local Implementation Teams (LIT) have produced a Dual Diagnosis Strategy.

The recent NICE Guideline for the assessment and treatment of patients with psychosis and coexisting substance misuse highlighted the need to enable the development of appropriate skills and competencies of health and social care workers in specialist mental health and substance misuse services as summarized below.

Skills and competencies for working with people with psychosis and coexisting substance misuse need to be developed through training and supervision to match demand. Suitable frameworks exist for developing skills at core, generalist and specialist levels depending on the type of staff and exposure to individuals with psychosis and coexisting substance misuse (Hughes, 2006). For example, staff working in psychiatric inpatient settings, early intervention for psychosis teams, and assertive outreach teams are likely to have high exposure to dual diagnosis patients.

The recommendations from guidance on building capacity and meeting the training needs of health and social care workers in the NHS and non-statutory substance misuse service providers should be prioritised.

There is a dire need for the development of training packages and the evaluation of their effectiveness and cost-effectiveness in improving health and social care outcomes for this challenging population of people with drug and alcohol misuse and co-existing mental health problems.

E5: Should we be making more of the potential to use the benefit system to offer claimants a choice between?

Any use of the benefits system to penalise people needs to be approached with caution. Reducing benefits in those who do not access addiction services may just increase the disadvantage in an already socially excluded group. In addition levels of crime may increase as people require increased funding to support their drug misuse. Furthermore punitive benefits policies may actually hinder an individual's ability to access employment as they may be unable to afford to dress appropriately or travel to interviews.

The use of the benefits system to impact on substance misuse needs to be integrated combining support with any sanctions; otherwise the most vulnerable would be further excluded.

Research from the United States has indicated that "welfare to work programmes" which emphasise job training and job seeking skills e.g. writing a curriculum vitae, completing employment applications, learning effective networking strategies, and interview skills are effective in improving employment rates particularly in women.

In addition the use of positive reinforcement in the treatment of substance misuse has a good evidence base in contingency management. Financial

rewards for attending drug treatment programmes, drug urine screening negative for illicit drugs and vaccination have proved effective. As a consequence linking treatment with financial reward within the benefit system is more likely to be successful.

Research from the USA has shown that targeted intensive contingency management interventions and training programs have been effective in promoting consistent attendance, high rates of productivity and establishing job skills for employment.

The literature indicates that employment may be an important factor for retaining substance misusing clients in treatment for their drug or alcohol problems.

E6: What if anything could jobcentre plus do differently in engaging with this client group to better support recovery?

JobCentre Plus may produce better outcomes by focusing on people with less complex needs and for the interventions based in addiction services to provide employment services to people with multiple or complex needs.

“Welfare to work” programmes focusing on the practical aspects of gaining employment have a good evidence base and tying these into financial rewards through contingency management. In addition many services offer an outreach model to engage service user’s into drug and alcohol treatment and report this as successful. It is a model that is helpful in engaging this group back into work. The recovery approach can be helpful though the difficulty can occur when the patient’s recovery goals do not necessarily involve work.

Stable and safe housing is vital for people to achieve a level of stability so they can engage with work.

Many drug users are hampered from gaining employment due to criminal justice histories. Employers prepared to take on people with previous convictions are important. This process may need employment support in the initial instance to support both employee and employer.

E7: In your experience, what interventions are most effective in helping this group find employment?

Intensive case management has been shown to be effective in improving employment rates in substance misusing adults.

Assertive Community Treatment (ACT), a multi-component, team-based service model which delivers an integrated package of treatment, rehabilitation, and support to reduce substance misuse and increase employment. This has been shown to reduce substance misuse and increase employment in US trials and is currently being trialled in the UK.

“Welfare to work” programmes focusing on the practical aspects of gaining employment have a good evidence base. One US study demonstrated that targeted vocational services towards substance misusing people on parole increased rates of employment but required coordination of activities with parole officers, vocational programs, substance abuse treatment professionals, and funding systems.

Employment counselling has also been shown to increase rates of employment in people with substance misuse.

E8: What particular barriers do this group face when working or looking for employment and what could be done to address these?

Drug and alcohol dependence is stigmatized by the wider community and in addition some people with substance misuse problems have criminal convictions.

Punitive drug and social policies related to employment, housing, education, welfare, and mental health and substance abuse treatment make it extremely difficult for substance misusing people to gain employment.

Often the only jobs available are short term and poorly paid which do not incentivise a person to stop benefits or reduce their substance misuse
People who are developing substance misuse problems are at risk of losing their, evidence based (NICE) substance misuse treatments is essential to prevent deterioration in physical, psychological and social functioning.

For those in employment, research has shown that workplace mandates can improve performance and outcomes in substance misusing employees.

US studies have demonstrated people who had a workplace mandate were more likely than those who did not to be abstinent at follow-up. It appears that pressure from the workplace is likely to get people to treatment earlier and provides incentives for treatment adherence. This requires supportive employers with an open approach to substance misuse.

Employment advisors to help employers manage more effectively their employees who developing substance misuse problems and support them to take on employees with substance misuse histories could improve employment rates in this group.

Research has shown outpatient opiate substitution programs are effective in increasing ability to work. Employment specialists are increasingly recognised as a core member of substance misuse teams.

Another service model is close partnership working between the substance misuse teams and employment services.

E9: Based on your experience, how effective are whole family interventions as a way of tackling the harms of substance misuse?

The evidence base (see NICE draft guideline Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence) suggests that family interventions are helpful in those with ongoing family networks.

E10: Is enough done to harness the recovery capital of families. Partners and friends of people addicted to drugs and alcohol?

No. There is evidence from NICE (2007) that behavioural couple therapy is effective in improving outcomes. The picture is complex and many substance users have little recovery capital in their families.

Much of the paperwork required to be completed by local Drug Action Teams, takes as the default position the non-engagement of families unless specifically asked for by the patient.

E11: Do drug and alcohol services adequately take into account the needs of those clients who have children?

All statutory services (NHS) have systems in place to ensure joint working with children's services, but these are less well formalised (and frequently variable) within those services delivered by non-stat agencies.

Resource limitations are the main barrier to being able to access childcare or offer groups at times (and in places) that would be helpful for parents (and grandparents) with childcare responsibilities.

Some services have developed 'maternal health' services supporting mothers and their partners through pregnancy and into the first few years of parenthood. Unfortunately, these services are often seen as outside the core commissioning brief and are therefore under-resourced.

E12: What problems do agencies working with drug or alcohol dependent parents face when trying to protect their children from harm and what might be done to address any such issues?

Resource limitations are the main barrier locally to being able to work quickly and effectively with child care agencies.

Joint systems and 'virtual teams' of specialist social workers based within specialist addiction services are two methods which can work effectively.

'Safeguarding' is a major issue addressed by services however closer working with children's services is needed.

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