Quaker Action on Alcohol and Drugs

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RESPONSE TO HOME OFFICE CONSULTATION ON DRUG STRATEGY – OCTOBER 2007

Quaker Action on Alcohol and Drugs (QAAD) is a listed group of the Religious Society of Friends - Quakers. We do not speak on behalf of the Religious Society of Friends as a whole, but the perspectives we express are rooted in our Quaker principles.

QAAD is an independent national charity concerned with legal, illegal, and prescribed drugs and with gambling. Trustees have experience in voluntary and statutory settings that include prevention, treatment, medical interventions and criminal justice. QAAD acts as an information-giving body within the Society of Friends, and gives advice to individuals and significant others with personal concerns about substance misuse. Our comments are informed by all of these perspectives.

Question 1a and b. Are these the right aims for the drug strategy? Which are the most important and why?

We support the aims of the drugs strategy in general terms, and welcome the resources that have been allocated to drug interventions via the criminal justice system. However, we believe that the prime focus of the drugs strategy should be health-driven. This is partly on grounds of principle: the treatment needs of the drug user are vital in their own right, and drug issues are most appropriately located in a public health framework. On a practical level, those who have not committed offences can now have greater difficulties in gaining access to services, even though their treatment needs may be as substantial as those who have. This can be particularly the case for detoxification and higher tier treatment. The focus on criminal justice also influences the disjunction between alcohol and drugs services and under-provision for the former, even though alcohol problems are more widespread.
Our experience is that those lower down the supply chain can be drug users themselves, and the distinction between 'dealer' and 'consumer' may not be a meaningful one in many cases. We note from European evidence that legal interventions and enforcement does not have a linear relationship with drug misuse, and that attitudes to alcohol are more moderate in many parts of Southern Europe. In general terms we believe that enhancing community and individual resilience is likely to afford greater protection from the harms of drugs than seeking to extirpate them by control/enforcement measures.

Question 13. Where is drug treatment succeeding, and where are the gaps?

We welcome the increase in provision that has occurred in recent years. We concur with the general analysis in the consultation document about the areas of gain and deficit. We welcome the extremely useful work of the NTA in promoting evidence-based policy and best practice. However, in our advice work we observe some divergences from their recommendations in some areas of the country and some other, more general gaps in provision.

We have particular concerns about carers/close others, who often feel a responsibility but may not be included in treatment discussions because of confidentiality. The lack of independent support for them in dealing with problems that can extend over years can be isolating and undermine their own health.

We are aware of situations where structured assessment tools have not been used in primary care/drug advisory settings, particularly in relation to higher tier services and detoxification. We are concerned that such practices may mask the extent of unmet need as regards need and waiting times, and on occasion involve a lack of responsivity to service user wishes. Despite NTA initiatives, provision of Tier IV services is still insufficient and local mapping still has a way to go. The greater cost and limited availability of Tier IV services may be influencing the balance between abstinence and maintenance provision in ways that have not been fully tracked.

Access to prescribing services has improved greatly but prompt triage services can sometimes be followed by a much longer wait for a key worker/full assessment and/or prescription.
Quantitative targets have generally resulted in improvements in prescribing services, but there are still gaps in qualitative standards, which impact on the effectiveness of treatment. In some areas the provision of counselling and other support for those on prescriptions is extremely limited. Supervised clinics can deal with client numbers into three figures within half a day, and meaningful contact is almost impossible when there may be only a handful of workers. Particularly in rural situations we have observed cases where those on high levels of methadone are maintained long-term with relatively little review, and offered little opportunity to discuss further options after stabilisation has been achieved. We fully endorse harm reduction/maintenance approaches, but are concerned that lack of counselling/other support can prevent optimisation of their benefits, and may mask the potential for further treatment gains. It is to be hoped that TOP will help address this problem, but routine support services are required as well as regular case review.

Conversely (but not in contradiction) we are also concerned about gaps/unevenness in local practices with regard to prescribing. This can be as a result of the range of substitute drugs available locally, or the character of services provided via GP/other channels. These factors may result in a lack of responsivity to service users, both in terms of the substitute prescription that is offered, or how it is managed. We follow the progress of trials of heroin prescription with interest, particularly in relation to an evaluation of the use of street drugs in addition to different types of prescription. We hope that policy and practice will follow this emerging evidence-base.

We agree that a significant gap occurs in 'wrap-around services' and our experience is that **safe** accommodation is the most critical deficit. This occurs for people at all levels and stages of a substance career, but the need is particularly acute for offenders, for those on prescription, and those who have been in residential treatment (notwithstanding that many treatment centres do an excellent job in providing move-on accommodation and other support services). We are concerned that within the existing housing 'priority' system need far exceeds capacity - and though service users may gain accommodation, it can be unsuited to treatment goals, particularly (but not only) abstinence. While multi-agency partnerships are certainly helpful, they may operate from situations of long-term deficit. Extra resources are needed in such areas.

Deficits in provision for those with dual diagnosis and personality disorders – who often touch health or criminal justice services in a transient way but do not find their needs met - remains a continuing concern. While local responsiveness is vital, people with such needs may not exist in great numbers in some localities, and may best be provided for through national planning. Residential treatment for mothers is another case in point.
Finally, there are large gaps and a huge area of unmet need for those with alcohol problems, at all levels of service provision.

Questions 14 and 16. How can drug treatment be made more cost-effective so that existing resources can go further? What can be done to help local partnerships meet the needs of drug users? How could local accountability and support structures support this?

In some areas additional resources are needed to improve the benefit of existing provision: for example, extra resources are needed for safe housing, if treatment gains from direct drug provision are to be realised.

There are historical deficits in some areas (including in wrap-around services) and there are practical difficulties in providing and comparing services in rural and urban areas across the country. We would like to see more transparency about the allocation of the treatment budget nationally, and a needs-led rather than a historical approach to distribution. This could involve pump-priming or pilot funding to remedy deficits or to innovate.

The proportionate costs of tendering, commissioning, and performance monitoring, and some of their effects could usefully be investigated or modified. A substantial amount of resources and staff time is devoted to these processes, both by purchasers and providers. Small local providers can bear the costs of tendering less readily than larger bodies, and suffer more from the effects of short-term contracts (even those of a minimum of two years, as recommended.) Whilst outcome monitoring is very important, it can involve a considerable administrative burden, particularly if providers are jointly commissioned and have to furnish many different types of detailed returns. Local bodies (both statutory and other agencies) also require, collect and process output and outcome data for local and national purposes. Since there is a large overlap in goals and methods between drug, criminal justice, health, housing and education agendas, and deprivation/exclusion are common factors to all, we believe it would be helpful and cost-effective for rationalisations to be made in terms of process. We further observe that renegotiation of service contracts can be unsettling to users, and cause problems of continuity

(and at least potentially, of effectiveness) in drug provision, in an area where there is considerable evidence that therapist skill and rapport affect outcomes.

We suggest national cross-departmental leadership to assist a greater streamlining of commissioning and other procedures - in order to ensure that these are contiguous as far as possible and involve a greater convergence of output data. We would like to see stronger incentives for longer term commissioning so it becomes the norm. We would like to see the overwhelming balance of resources going directly into treatment services, and for clear information about the balance of resources between infrastructure and direct drug services to be readily available, locally and nationally. Research into the cost-effectiveness of commissioning procedures and practices would be helpful in maximising the effectiveness of resources.

We welcome the initiatives of the NTA in moving beyond general quantitative proxy outcome measures (such as treatment retention). A greater emphasis on, and more innovation in, qualitative approaches (including service user experience) would assist cost-effectiveness. Difficulties of measurability should not deter this endeavour, but rather prompt a broader approach to effectiveness criteria.

Question 15. There are many competing priorities within local areas. How should the provision of drug treatment be prioritised locally?

Resources for drug treatment should continue to be ring-fenced rather than mainstreamed. This is partly necessary because competing with other areas of need would be almost certain to result in a diminution of resources for drugs services within health and social services budgets. It is also our experience that the rationalisation of local PCTs into larger areas in order to save costs can result in a loss of local knowledge in the commissioning process and a more distant evaluation process.

Questions 18 and 26. What can be done to ensure that effective drug treatment is provided both to offenders in prison and the community, ensuring continuity of care between the two? What could be done to provide continuity of care for prisoners with sentences of less than 12 months?

One of the major difficulties – and gaps – is that statutory post-release provision is predicated on length of sentence rather than on the basis of risk or need, even though OaSys and structured drugs assessment tools are available and are likely to have been applied. Criminogenic/drug-related problems can also be compounded by the policies of other departments: for example, offenders with short-term sentences who lose their accommodation may be considered 'intentionally homeless.' Many have chronic drug problems of some severity. Too often they have to report to agencies on the day of release, seeking accommodation that is insufficient and often unconducive to stability. It is scarcely surprising that relapse, with its risk of re-offending and of overdose occurs in these circumstances. While CARATs and other initiatives have improved post-release access to advice and prescription services, gains are undermined by these continuing problems.

We would suggest that risk/needs assessments (both OaSys and drug-specific instruments) be used in a more thorough-going and systematic way. They should both inform service provision and target appropriate levels of intervention at individual offenders with drug problems, including those serving shorter sentences. Development of systems to achieve this could be incorporated within the role of regional offender managers – though in view of movements among the prison population, with many away from their home areas - national co-ordination would also be necessary. Piloting might be the best initial approach.
We would also recommend the development and piloting of post-release 'half-way' houses (which in Canada was the type of provision that led to the development of the LSI-R risk/needs tool). Such provision would enable a smoother and more supportive transition to community reintegration. It should be allocated on the basis of need and responsivity – and indeed, if successful, consideration could be given to it becoming an element of the custodial sentence.

Less movement among the prison population, and more access of short-term prisoners to programmes in custody would also be helpful.

Question 33a/b. Harms caused to young people and families by drugs; do young people's and adults services need to work more effectively together?

The studies of Becker and Roe (2005) as well as Home Office studies (e.g. RDS 47) have moved on understandings about risk and resiliency. Young people in more than one 'at risk' group are particularly vulnerable to progression to Class A drugs, though choices are context- specific. In general terms we would advocate policy and practice initiatives that promote resilience - including broader work such as the Positive Futures programme, which concentrates on responsivity, qualitative factors and local involvement, without being too narrowly or specifically targeted in terms of outcome measures.

Question 31a. Working with governments in drug producing countries.
We believe that in the long term trade justice is the effective way to deal with supply issues, and that efforts should be re-doubled in this area.

Question 39a. Do you think cannabis should be reclassified and if so, why?

We share concerns about the relationship between mental health problems and cannabis use, particularly for vulnerable groups. We are also concerned at early onset and the proportion of young users presenting for treatment for whom cannabis is the principle substance. However, we also note the general evidence that UK consumption has fallen slightly since re-classification and that in a European context legal classification seems somewhat less significant than cultural factors. Messages have been somewhat confusing, but we believe that an evidence-based approach should be taken and that at this stage the matter should be kept under review