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2010 Drugs Strategy Consultation

Revolving Doors Agency response
30 September 2010

About Revolving Doors Agency

Revolving Doors Agency is a charity working across England to change systems and improve services for people with multiple problems, including poor mental health, who are in repeat contact with the criminal justice system. We call them the revolving doors group.

Multiple problems experienced by women and men in the revolving doors group often include drug and/or alcohol misuse, homelessness, learning difficulties, physical health problems, poor relationships with family, poverty and debt. Drug and/or alcohol use are often used as coping mechanisms to deal with current problems or previous trauma, for example from childhood neglect or abuse.

Each problem feeds into and exacerbates the others. However, on their own, each need is usually not severe enough to meet the threshold for statutory services. So while poor mental health is a core or exacerbating factor, this is usually not considered severe enough to warrant care from statutory mental health services.

This all creates a downward spiral that brings people into contact with the criminal justice system. Our police, courts and prisons see people in this group everyday yet they get little or no effective help from mainstream health and other services.

We estimate this population to be approximately 60,000 at any one time, with further people at risk of entering it, or recovering.

Our response

This response to the 2010 Drugs Strategy Consultation Paper combines evidence and insight from our work with partners, our research, and most importantly from members of our service user Forum. The voice of people with experience of multiple problems is drawn from a focus group with Forum members, and a number of other discussions in prisons and community based locations across the country. A full list of consultations is included in Annex A. All quotes are from these discussions unless referenced otherwise.

Key points

- The government should adopt an overall language and approach to substance misuse which challenges stigma, recognises multiple needs and promotes the potential for people to recover.

- While we welcome the cross departmental approach signalled in this consultation, we recommend that lead policy responsibility for reducing substance misuse is moved to the Department of Health. This would signal a shift to a health and wellbeing led approach to the problem.

- Problem drug use rarely occurs without the coexistence of a range of other problems. Revolving Doors therefore welcomes the Government's aim to take a "more holistic approach".

- There should not be an 'either / or' approach to harm reduction or abstinence based treatments. Both have an important part to play in a staged journey with an end goal of abstinence.

- The new strategy should promote the involvement of service users and former service users in the commissioning, design and delivery of services.

- Support for young people making the transition from children's to adult services must be improved.

- Continuity of support between prison and the community must be to be improved.

- Revolving Doors welcomes the Government's proposals for accommodation based community accommodation but urges that they include provision for people with multiple problems.

- Availability of alcohol treatment must be improved. The coexistence of drug and alcohol problems should be recognised and responded to.

SECTION A: VISION FOR THE NEW DRUGS STRATEGY

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

Yes. Revolving Doors believes the following aspects should be addressed alongside the other aims outlined in the document:

Continuity of support between prison and the community: The outlined aims only include a mention of criminal justice in terms of crime reduction. While this is important, it is essential to recognise the negative impact of moving in to and out of prison has on the effectiveness of drug treatment. Far too often positive work done in the prison is undone due to a lack of continuing support on release. See question C2 for full details of how continuity between prison and the community should be improved.

Improved access to alcohol treatment: Nearly five times as many people in England and Wales are dependent on alcohol as are dependant on drugs. However, drug treatment expenditure is over double that of alcohol. While 58% of drug dependants are in treatment, this applies to only 6% of alcohol dependants (Alcohol Concern, 2010, p.8). This is despite the fact that "providing support to dependent drinkers is not only known to reduce dependency but also to reduce health and social care costs as well as crime. In fact for every £1 spent on treating dependent drinkers, £5 is saved on health, welfare and crime." (Alcohol Concern, 2010, p.7)

Levels of alcohol treatment availability remain far too low in prison. *"The lack of an adequate pathway from prison into community treatment is arguably the single biggest gap in local alcohol treatment systems. This needs to be addressed urgently."* (Alcohol Concern, 2010 p.18)

Question 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

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

Tiered System: The current National Treatment Agency (NTA) tiered system ensures that there is a range of provision and a clear pathway through the drug treatment system.

Engagement: Current services are good at engaging with problem drug users (PDUs). The impact of this is that the UK has a relatively low level of HIV infection and other blood borne viruses associated with injecting drug use. We should be clear that these infections can easily spread outside of the PDU population. Hepatitis C Virus infection however is prevalent amongst injecting drug users.

Availability of treatment for opiate use: Drugs services often focus on opiate users. While this has negative consequences for users of other drugs (see A4 below), it means that

those seeking help for heroin misuse can easily access methadone treatment.

Improvements in prison drug treatment: Provision of drug services in prisons has made great progress. The universal delivery of Counselling, Assessment, Referral, Advice and Throughcare (CARATs) and the implementation of Integrated Drug Treatment System (IDTS) are both enormous advances in both reaching hidden users and also delivering an equality of provision between prison and community.

Trials of maintenance based treatments such as Randomised Injectable Opiate Treatment Trial (RIOTT): This approach has worked very well for long-term addicts where nothing has worked before. Almost everyone on the trial has improved immensely. Several have good jobs while others are involved in voluntary work, service user involvement or education. The evaluation of the trial concluded that:
"Treatment with supervised injectable heroin leads to significantly lower use of street heroin than does supervised injectable methadone or optimised oral methadone. UK Government proposals should be rolled out to support the positive response that can be achieved with heroin maintenance treatment for previously unresponsive chronic heroin addicts." (Strang et al 2010)

One member of the trial is employed by Revolving Doors. He provided the following quote:

"Getting onto the RIOTT treatment programme has been exactly what I had been seeking for many years. This approach has totally turned around my previously chaotic life. I have now been working steadily for 4 years in the voluntary sector. It feels absolutely brilliant being a productive member of society once again!"

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

Lack of recognition of multiple needs: Too many drugs services take a narrow approach to tackling drug use. This can be exacerbated by an overemphasis on pharmaceutical approaches, for example prescribing methadone without seeking to address factors contributing to a service user's drug use. Participants at a focus group in Middlesbrough described how drug workers only assess and address drug needs, in particular methadone provision, without taking in to consideration other support needs.

"If you say drugs and then depression, the first thing they deal with is your drugs and that's that. But there's a list of things you need dealt with."

Additionally, whilst access to treatment in prison has improved, the needs of prisoners with multiple needs are still not met.

Focusing on a wider spectrum of need can be particularly important for young people. Research by Nacro (2004) with young people up to age 25 found that those who had developed problematic drug use described an intricate relationship between drug use and family relationships, peer relationships and homelessness, education and criminal behaviour. This work, along with many other sources, recognises the importance of addressing substance use as part of a wider spectrum of need when delivering substance use services to young people.

Dual diagnosis: Drug services often do not respond effectively to people who have mental health problems alongside their drug use. Drug services often refuse to treat people who have mental health problems, saying that mental health needs must be addressed first. Those trying to access mental health services may be

excluded due to their drug use, leaving them without support.

"Drugs services are telling me that I need to sort out my mental health and mental health are saying they can't deal with me 'till I sort out my drugs, so it's a catch 22 situation. . . . I committed crime just to get a community sentence to get help."

Discussions around dual diagnosis often focus solely on secondary mental health services. We are keen to underline that this exclusion also affects those with lower level mental health issues. We heard from people who had been denied access to talking therapies to address previous traumatic experiences despite these experiences being a major contributory factor in their drug or alcohol use.

Case study from HMP Lewes2Brighton project (see project description below)
John is in his 50's, has 56 convictions for 118 offences and has spent a total of 17 years in prison. John is diagnosed as having Obsessive Compulsive Disorder (OCD) and says that he drinks very heavily (up to 50 units per day) to manage the symptoms of his OCD. John's drinking acts as a barrier to accessing mental health support. His support from community mental health services was ceased due to his drinking and he was assessed as unsuitable for Cognitive Behavioural Therapy.

Prioritisation of reduced waiting lists in response to NTA targets resulted in drugs services striving to get as many through the doors as possible (*"The overall purpose of the NTA is to double the number of people in effective, well managed treatment between 1998 and 2008"* NTA 2006, p.3), resulting in many agencies having caseloads that are far too high to allow any effective psycho therapeutic and psycho social interventions (PSI). All the evidence is that pharmacological interventions are more effective when combined with PSI (for example NICE 2007). However, there is research to indicate that this approach has reduced blood borne viruses (BBV) and crime (Home Office 2009). Anecdotal evidence is suggesting an alarmingly high morbidity and mortality amongst users over 50 years old, which challenges the assumed health benefits of maintenance.

Forcing people in to rehabilitation: Mandating people to undertake rehabilitation when they are not ready for or interested in it is a waste of money. Treatment is very expensive, but is likely to fail if the person is not motivated to become free from their drug and/or alcohol misuse.

Overemphasis on opiates: Services often also focus their attention largely on opiate users. This can result it those seeking treatment for problems with crack or powder cocaine or cannabis feeling services are 'not for them' or that they are not taken seriously.

Poor management of transitions: The current system is inadequate in managing transitions from young people's services to adult services, and in responding to the needs of 18-24 year old drug users. Young people are more likely to use a range of substances particularly cannabis and alcohol. While young people's drugs services effectively respond to this pattern, focusing on a range of substances, adult services are in the main targeted at PDUs. Transitions between these two types of services are often poorly supported, and many young people fail to engage with adult services effectively if at all.

Lack of alcohol treatment: Provision of alcohol treatment far outstrips demand and must be improved. See question A1 for details.

Delays: We have heard extensive evidence of lengthy delays in accessing drug and alcohol treatment.

"Drug services should be more open to people 'cos when I went to the drug project with my heroin addiction, it took two

months to assess me and then another two to three months before they decided to give me methadone. It took six months to decide whether I deserved treatment."

"It was January when I was first sentenced to go to the drug and alcohol rehab unit. I was doing my best, I was off alcohol for five months but by the time they got me into rehab, not only had I fallen back on drink but I'd actually lost where I was living and I was back on the streets. They didn't get me in until July."

Patchy provision: Accessible, high quality drug services are by no means universally available. Areas with high concentrations of drug users, such as Brighton, have a range of services that are well established. Other areas have poor provision leaving those seeking help with little opportunity to find it.

Over assessment: Problem drug users are frequently arrested and regularly sentenced to short prison sentences. Each time they come in to contact with the criminal justice system they are assessed and have to 'tell their story'. This may happen several times a month, yet ***information is not shared*** between agencies or retained by institutions undertaking multiple assessments. This can be frustrating for those being assessed, and discourages people from participating fully in assessment.

Former prisoners in our focus group on drugs services in prison described the experience of being passed from agency to agency in the past: ***"one place for mental health, one place for drugs, one place for housing"*** which was particularly difficult for someone who is chaotic. They wanted one person to help them to tackle a range of problems. ***"I can't believe it's taken so long to do something like this."***

Revolving Doors has developed a range of responses which use a lead professional or link worker model to provide this single point of contact. See case studies on Milton Keynes Link Worker Plus and HMP Lewes to Brighton below.

Milton Keynes Link Worker Plus

The Milton Keynes Link Worker Plus project aims to address the needs of socially excluded clients (18 years plus) for whom outcomes are extremely poor and who are not eligible for / fall through the gaps of statutory services. Clients of this service are in crisis due to one or more of the following support needs: mental health issues; accommodation instability; substance misuse; repeat users of crisis services; offending and Anti-Social Behaviour. The service was developed by Revolving Doors and is delivered by P3.

HMP Lewes to Brighton

The HMP Lewes to Brighton project was developed by Revolving Doors and a multi-agency partnership with HMP Lewes and local Brighton agencies and is delivered by Brighton Housing Trust (BHT). The pilot project employs a coordinated lead professional model to improve health and social care outcomes for short-term prisoners with multiple problems leaving HMP Lewes and returning to the City of Brighton and Hove. The Project Coordinator for the Lewes to Brighton project worked with 38 clients in its first year. Clients are generally prolific offenders who have more than one mental health condition and have long histories of drug and/ or alcohol misuse.

SECTION B: PREVENTING DRUG USE: DEPARTMENT FOR EDUCATION LEAD

This part of our response focuses on preventing children and young people from entering in to a spiral of crisis, crime and multiple needs including mental health problems and drug use as adults. We do not focus on the wider issue of drugs education which apply to all children and young people.

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

Identify problematic lives early: All agencies which are in contact with children and young people should be provided with the skills to identify early signs of factors that may lead to drug use as a coping mechanism (such as abuse, domestic violence, family breakdown, poor housing, parental drug or alcohol problems). Robust information sharing protocols should be in place to ensure these early signs are responded to effectively. Professionals working with children and young people should have access to up to date information on agencies that may be able to address issues including access criteria and methods.

Extra support should be offered to children of problematic drug or alcohol users: Children and young people whose parents are problem drug users are more likely to turn to drugs as a way of coping with the trauma of their parent's drug use and associated behaviour. These children and young people should be provided with additional support to address problems as they emerge.

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

Early intervention is everyone's responsibility: Most children and young people come in to contact with a range of public services. Professionals in these services have a shared responsibility to identify problems as they emerge. Sharing information is essential in achieving this, as each service will see only one part of the full picture. This good practice guide sets out some approaches that can help overcome barriers to sharing information in relation to children and substance misuse including advice about protocols between the police and schools: http://www.scotland.gov.uk/Publications/2003/02/16469/18711.

Through working together, indications of potential or emerging problems can be shared, helping to create a fuller picture of a child or young person's needs. This point also applies to adults, notably those in contact with the criminal justice system, or receiving support for drug and/or alcohol issues, mental health, housing or other problems.

Schools have an important role to play: Children and young people experiencing problematic lives often turn to drug use as a coping mechanism. Schools are well placed to spot early signs of these problems developing, and of any emerging drug use. Teachers and other school staff may need support to understand identify and respond to emerging problems.

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

16-24 year olds: Between the ages of 16 and 24, young people make a number of transitions from children's to adult services. Those who are in contact with the criminal justice system, and/or experiencing a number of other difficulties such as family breakdown, mental health problems, or homelessness, are particularly vulnerable of developing drug and/or alcohol problems. This group should be recognised as a distinct group on account of their developmental stage, as well as the social, economic and structural factors that specifically impact on them. Revolving Doors is a member of the Transition to Adulthood alliance (see www.t2a.org.uk for more details) who are contributing to Addaction's response to this consultation.

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

Joint working and information sharing: Children and young people are generally in contact with a wide range of agencies and organisations including schools, GPs, and voluntary organisations. They may also be in contact with social services, the criminal justice system and/or employers. As outlined above in question B2, all these agencies hold a joint responsibility for identifying emerging problems early. Through working together and sharing information emerging problems can be identifies and tackled earlier, reducing the chance of children and young people turning to drug and alcohol use as a coping mechanism.

SECTION C: STRENGTHEN ENFORCEMENT, CRIMINAL JUSTICE AND LEGAL FRAMEWORK – JOINT HOME OFFICE AND MINISTRY OF JUSTICE LEAD

Question C1: When does drug use become problematic?

Problematic drug use is not easy to define. However, one description is when it starts to have an adverse effect on the user's life or that of others.

It is vital to recognise that problematic drug use rarely occurs in isolation. It is frequently concurrent with mental health problems, relationship breakdown, unstable housing or homelessness and/or contact with the criminal justice system.

The point at which drug use becomes problematic is often linked to the point of addiction. Current drug services associate problem drug use with opiates and crack cocaine. This does not recognise the fact that for many people cannabis, powder cocaine and/or prescription drugs (obtained through a prescribing doctor or otherwise) are also 'problem drugs'.

Members of the Revolving Doors service user Forum were also keen to underline the limited access to treatment for crack cocaine addiction due to the lack of a pharmaceutical substitute. Despite this crack can be an extremely destructive drug for the individual user and society more widely. Further work is needed to promote effective interventions for crack users and those using crack together with heroin or other drugs.

The increasing dual use of crack and heroin (known as speedballing) (Newcombe 2007) underlines the importance of this last point and calls in to question the relevance of separate approaches to crack and heroin use.

Question C2: Do you think the Criminal Justice System should do anything differently when dealing with drug-misusing offenders?

Early intervention and diversion: The police are the first point of contact of the criminal justice system. Many people with drug and alcohol problems pass through police custody. *The Bradley Report* (Department of Health 2009) stated that: "In a study of arrestees, an average 69% gave positive urine samples for at least one drug; 36% tested positive for two or more drugs; and 38% tested positive for opiates and/or cocaine" (referenced to Bennett 1998). Many of these people will also have consumed alcohol and/or have mental health problems. However, where arrest referral or diversion schemes operate, they often only focus on one of these areas. Arrest referral schemes should take a holistic approach to supporting arrestees, either working together or delivering joint services. This approach should also apply across all stages of the criminal justice system.

Improved pathways between prison and the community: There is a desperate need to improve support on release from prison. As noted above, much progress has been made in the provision of drugs services in prison, however with lack of support on release, much of this good work is often undone. The following quote illustrates the current lack of planning:

"I think that's the problem; when they give you a release day, but they don't do anything until you've been released. No planning, right. What they do when you're released, as soon as they have signed you out, that's when they send information to your GP for instance, and they post it. So you get released on the Monday, the first thing they tell you is "You must go to your GP within 24 hrs" but when you make your appointment to go and see him he's not got your records."

The following arrangements should be put in place before release to ease reintegration back in to the community, hence reducing the likelihood of re-offending.

- Meet at the gate support with a mentor, volunteer or professional who can support access to support arrangements.
- Registration with a GP prior to release, with immediate access to medication and/or scripts
- Access to benefits. Ideally, benefits should be maintained through a short sentence to ensure retention of accommodation and ease of access to benefits on release
- Immediate access to drug and/or alcohol treatment
- Accommodation, with an option of moving to an area away from drug-using associates. This should be stable accommodation, not just for the first few nights following release. The importance of this element of support is illustrated by the first quote below. The second quote shows the difficulties in accessing accommodation in a different area.

"Basically if you haven't got that … support when you are homeless, you're going to go back to someone, one of your friends who's a drug user. Someone who is on drugs is going to be happy to put you up 'cause you're an extra person to put the graft in to get the drugs in. You're an extra person to feed their habit, two's company both raise together. It's just a vicious circle."

"I've found that … [returning to a different area is] not always an option. [Prisoners] have to return to an address that they're familiar with. So I think the system is set up to say when we release you from prison we're going to send you somewhere clean but that never happens."

- In order to ensure access to these arrangements, prisoners should never be released on a Friday afternoon.

"…there is now a strong call amongst drug users and carers for greater continuity of drug treatment both within and between prisons. And there is a very clearly articulated need for much greater support and help on release especially with respect to appropriate housing, having enough money, having something meaningful to do and greater integration and co-ordination with community services." (Patel, 2010, p.7)

The One Service at HMP Peterbrough and the HMP Lewes2Brighton project (see project description in question A4) are examples of services that focus on improving continuity of support between prison and the community.

Ongoing support after release: Support to prisoners should be 'through the gate' and happen before, during and after release. If support is removed soon after release, relapse in to drug use and crime is more likely. Ongoing (but in many cases tapering off) support will increase the likelihood of remaining drug free and not reoffending.

Those coming off drugs may need particular support around their mental health. At a focus group in Middlesbrough, one service user explained: ***"Cause all your feelings come back and that, and the world's, like, real then…it's hard to deal with…that normality."*** Participants agreed how hard it

was once the support stops: ***"People think you're alright – 'oh, you're doing marvellous' – but that person's got everything to deal with them."*** A common reported experience was coming off drugs and turning to alcohol for support to deal with your emotional issues.

Improved provision of support to short sentenced prisoners: Service users we consulted felt strongly that short sentences do not give enough time to focus on rehabilitation (*"your head's already out the door"*). Focus groups in several prisons raised the issue that although support services such as benefits and housing advice or drug/alcohol courses were available within the prison, short term prisoners are often unable to access them. Prisoners we spoke to put this down to the short length of their sentence (*"you put in an 'app' but by the time you get an appointment you're already out"*). We also repeatedly heard that prison staff simply have too many prisoners to oversee, leaving little flexibility to escort prisoners to appointments.

Better use of treatment requirements at sentencing: There is currently insufficient use of mental health and alcohol treatment requirements. This is likely to be due to sentencers' lack of awareness of or confidence in these interventions.

"An alcoholic woman with no history of drug problems was inappropriately given a Drug Rehabilitation Requirement as opposed to an Alcohol Treatment Requirement. She was sent back to court to have this changed to an Alcohol Treatment Requirement but the judge gave her a short custodial sentence instead."

- Notes from focus group in a female prison

Improved access to alcohol services in prisons and in the community: While access to drug treatment in prison has improved, there remains a poor level of alcohol treatment availability. Recent data from the HMP Lewes2Brighton project (see project description in question A4) showed that 77% of men seen had a history of problematic alcohol use and case notes indicated that this was often a contributing factor in violent offences. Despite this, only 20% had been in contact with alcohol services in the six months prior to their imprisonment. (Accendo for Revolving Doors Agency 2010)

Pathways from prison to community treatment are also in desperate need of improvement.

"The lack of an adequate pathway from prison into community treatment is arguably the single biggest gap in local alcohol treatment systems. This needs to be addressed urgently." (Alcohol Concern, 2010, p.18)

Improved drugs services in prison: Although the provision of drugs services in prison has greatly improved in recent years, there are still improvements to be made.

"Looking back 10 years ago there was very little help available. There is more help now but still not nearly enough"

- Prison questionnaire respondent - Review Group Service User and Carer Consultation - Patel, 2010, p.6

Too often, prisoners are put on higher levels of methadone on entry to prison than they were on in the community.

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

Revolving Doors welcomes the Government's commitment to explore accommodation based alternatives to custody, provided the prevalent coexistence of drug and mental health problems is recognised and addressed. We are keen to

work with the government on what models may be most appropriate to deliver this.

Revolving Doors urges the Government to recognise the success of existing preventative supported accommodation and ensure that developments of community based accommodation do not divert funding away from this provision.

Accommodation for people with multiple problems: The Government has outlined plans for community based accommodation for both offenders with drug problems and those with mental health problems. As outlined above, we urge the Government to consider the concurrence of drug and mental health problems for many offenders. Alongside these two issues are also often a multitude of other problems such as homelessness, relationship problems, poverty, debt, etc. Any community based accommodation needs to be able to address this range of issues if it is to be effective.

When we asked a group of female prisoners what a good community sentence would look like, they said that it would include a number of components: detox, self-help groups, counselling, and the ability to access other agencies.

"My probation officer was talking to me about a more intense DRR [drug rehabilitation requirement]…with self-help, housing, police, DRR appointments…that doesn't sound bad."

The Government must recognise the prevalence of multiple problems and the level of need in the design of new provision and the provision of management support.

Range of provision available: In preparation for this response and other work we have consulted with a range of current and former drug misusing offenders. From each discussion the importance of a range of treatment options has emerged as a key theme. Many people we spoke to told us that it is *"all in your head"* whether you succeed in drug treatment, and that a prerequisite for success is a desire to stop using. Abstinence based treatment was seen as an important part of this range but clients must be 'ready' if the treatment is to be a success. Offering blockers (such as Subutex or Antibuse) was also suggested for people who *"genuinely want to come off it but aren't strong enough to stay off it."*

Clear accommodation based pathways on departure: It is essential that offenders in community based accommodation are supported to access stable accommodation on release. Without this, progress in addressing drug issues and other problems is likely to be lost.

Ongoing support: It is also important that offenders have access to ongoing support after they have been released. The following quote from a female prisoner describes the withdrawal of support and structure once a probation order is completed: ***"I felt lost [when the order was over] – I ended up going into probation once a week off my own back just to see them."***

Gender specific provision: The Corston Report (2007) called for a *"fundamental re-design of women's custody introduced in parallel with other gender specific workable disposals and sanctions"* (p.24). Baroness Corston recommended that community solutions for non-violent women offenders should be the norm and that custodial sentences for women must be reserved for serious and violent offenders who pose a threat to the public. The Government should continue to take heed of this valuable report and learn from the work that has been undertaken since to expand community based provision for women.

Separation of heavier users: The separation of people at different stages in their recovery

journey was a recurring theme in discussions with our service user Forum members.

"Putting people at the beginning of their problem with people who're just at the end of the problem – for a weak minded person, it's an automatic fail."

"Having appointments at the same time for people who are doing well with people who aren't doesn't help … they need to have places for people who are trying or have stopped."

Question 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?

Wide range of local agencies: Drug related offending can most effectively and sustainably be tackled through a whole-person approach, which takes in to account the full range of factors contributing to offending. In order to achieve this, a wide range of local agencies need to work together. This must include both agencies directly related to offending and drug use (criminal justice agencies, community safety partners, drug services) and wider services (housing and homelessness services, mental health). Special attention should be paid to engaging agencies which may seem to more peripheral including GPs, Jobcentre +, A&E, schools, education and training establishments and children's and adolescent mental health services.

Question C8: What results should be paid for or funded?

A range of results which recognise people's journey to recovery: As outlined above, problematic drug use rarely occurs in isolation. Problem drug users are also likely to misuse alcohol, experience mental health problems, be in contact with the criminal justice system and be socially excluded. The combination of these problems can lead to a cycle of chaos and crime. When someone comes in to contact with a support service, often basic needs such as accommodation need to be addressed before they can sustainably tackle their drug use. A range of results should be paid for in order to recognise this staged journey towards recovery; including both treatment and non-treatment outcomes.

Range of treatment outcomes: For some people, an immediate expectation of abstinence is neither realistic nor helpful. Including stability and harm reduction as measures of success is vital to ensure people can start on a journey towards recovery. Once reduced use and greater stability have been achieved, then further goals can be negotiated. However this is not to say that harm reduction is the only outcome that should be measured – a range of outcomes should be measured, including moving on to a substitute reduced use of illegal drugs and substitutes, and abstinence.

Non-treatment outcomes: In his paper *The 10 most important things known about addiction* (2010), D. Sellman underlines the importance of *"the vital ideographic approach of tuning into the uniqueness of each individual and fashioning a plan together, which addresses individual needs. Often practical solutions to social problems are required in the plan including accommodation, legal and vocational problems as well as addressing specific medical, psychiatric and family issues. The more a treatment plan addresses the individualized broad-based needs of a person the more effective it is."* (Sellman, 2010, p.10)

Non treatment outcomes such as stable accommodation, reduced re-offending, and more constructive social networks should be included in paid-for results. There is a challenge here regarding identifying non-subjective

metrics to measure these outcomes that will incentivise and reward providers to support people with their recovery. We are keen to work with Government to explore the development of these.

Risks of performance based contracts:

There is a risk that a move to performance-based contracts will result in providers 'cream skimming'; selecting those most likely to engage, leaving those who are more challenging to work with without support. There is also a risk of 'parking', where more costly-to-help participants receive only minimal services and make little progress in a programme. Carefully choosing intelligent outcomes, for example paying providers by the numbers who remain drug free for 6 months post treatment would encourage commissioners to invest in relapse prevention and start to address this risk. Contracts must be designed to reward and stabilise work with even the most difficult to reach clients, recognising the cost benefits of supporting this group towards greater stability and recovery.

SECTION D: REBALANCE TREATMENT TO SUPPORT DRUG FREE OUTCOMES – DEPARTMENT OF HEALTH LEAD

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

A role for both harm reduction and abstinence based approach: Any drugs treatment system should retain both harm reduction and abstinence based approaches. *The Patel Report* (2010) recently recommended that the Government agree to an updated national framework which *"outlines an appropriate 'menu of services' including medical treatment, psychosocial interventions, harm minimisation and broader social care that promotes resettlement and recovery" (*Patel, 2010, p.15)

Where a person is using drugs very heavily, a harm reduction approach is often the most viable starting point for engagement and treatment. In these cases, reducing drug use is a legitimate aim as a step towards greater stability, and should be recognised as such. Once the level of drug use has been reduced and other issues such as accommodation have been addressed, the aim of treatment may legitimately be changed to full abstinent recovery. Both are valid aims at different points on a journey to recovery.

"We believe that the goal of all treatment is for drug users to achieve abstinence from their drug – or drugs – of dependency. For some this can be achieved immediately, but others will need a period of drug-assisted treatment with prescribed medication first so their overall health can be improved, which will enable them to work, participate in training or support their families. They can then be supported in trying to achieve abstinence." (Patel, 2010, p.10)

"The worst experience was being detoxed without any warning or consultation"

- Service user forum -Review Group Service User and Carer Consultation - Patel, 2010, p.9

Maintenance programmes, especially those that enable problem drug users to be productive members of society, such as the Randomised Injectable Opiate Treatment Trial (RIOTT) (see A3 for more details). These type of programmes should be available as part of a range of treatment options.

Needle exchanges should be retained, as they have been highly successful in getting people into treatment while also reducing the spread of blood borne viruses. Their success can be seen through the rapid decline in used needles visible on the streets.

Family focused approaches: Many drug users, particularly women, have additional issues in their lives relating to their children. Some problem drug users have had children taken in to care, which is an extremely traumatic experience. The emotional impact of this can become a barrier to the process of recovery which is predicated to a significant degree on hope.

When treatment addresses wider aspects of service user's lives it is possible to really get to the root causes and therefore achieve a better chance of abstinence. There are some pilot services of this approach that have had powerful outcomes (e.g. Middlesbrough Families First Service). A more family-centred approach that put protecting children first but which also worked alongside supporting recovery of the parent might be more effective.

Question D2: Thinking about the current treatment system, what is in need of improvement and how might it need to change to promote recovery? (E.g. how commissioners get the most out of community and residential rehab)

Recognition of multiple problems: Problematic drug use rarely occurs in isolation. Users are likely to also misuse alcohol, experience homelessness or unstable housing, and have mental health problems. Women are likely to experience domestic violence and/or be involved in sex work. In order to promote recovery, treatment services need to take a holistic approach in addressing these issues.

Dual diagnosis: The current treatment system has been poor in responding to those with a dual diagnosis See question A4 for more information. This is particularly relevant for people with a personality disorder.

Improved access to alcohol treatment: Despite high prevalence of dependant drinking, there remains a poor level of alcohol treatment availability. See question A4 for more detail.

Access to therapeutic services that do not demand abstinence: Many problematic drug users have experienced trauma in early life (a contributory factor in their adult drug use) and/or experienced trauma as an adult, for example through seeing drug using friends and associates overdose. Women also experience trauma through losing children to care. If these experiences remain unaddressed they can become serious blocking factors in addressing problematic drug use. However, many therapeutic services deny access to people who have ongoing drug or alcohol problems. This self reinforcing pattern leaves the person using drugs or alcohol to block the trauma and recovery is unlikely. As part of the recovery process, therapeutic services should be made available to people who are still using drugs and alcohol.

Continuity between prison and community is in desperate need of improvement. Too often positive steps made in prison drug treatment are lost on release due to a lack of sustained support, as illustrated by the quote below from a female prisoner:

"The last prison I went to, I found out about the meetings and Alcoholics Anonymous, and they do the first five steps of the twelve steps. I wasn't there long enough but I did the first three steps out of five and I really thought I would change when coming out but when I come out I picked up exactly where I left off. I thought "things would be different this time" I'll just have one more go and I was back to square one."

Continuity can be better achieved by arrangements for accommodation, access to drug and alcohol treatment, GP registration, benefits etc. all being made before a prisoner is released. Through the gate support, provided by a mentor, volunteer or professional is a vital part if ensuring access to these arrangements. (See question C2 for more detail).

Focus on younger less entrenched adults: The current treatment system largely focuses on people who are already entrenched drug users. Widening the focus to include those at an earlier stage of drug use has the potential to prevent many people from reaching this point.

Reduce caseloads in order to allow for more structured work with each individual. This may mean a diminished treatment capacity however is likely to yield better results with those worked with more intensively.

Challenge labelling: Work is needed at a strategic level to challenge labelling. For example evidence says problem drug users benefit from psycho social interventions, yet most Improving Access to Psychological

Therapies provision will explicitly or discreetly block access for drug users. This pushes them back into special services. Problem drug users have a right to use mainstream services, the current stigmatisation has driven a growth in the inappropriate use of specialist Tier 3 provision. The NHS should embrace their own good practice guidelines for dual diagnosis.

Access to treatment for couples: Current provision rarely gives couples concurrent access to treatment. This fails to recognise the dynamic between drug misusing couples where one partner's drug use reinforces the other's, and is hence an ineffective use of resources. Holistic recovery should also be addressed as a couple; in addition to drug treatment, support for wider outcomes should also be given jointly.

Personalisation needs to take a higher priority in treatment services than it currently does. We need to value providers' knowledge and expertise in supporting drug users and enable more freedom in service design. To support this more flexibility is needed in local priority setting, however potential risks around this are highlighted below.

Risks of GP led commissioning: We recommend that the Department of Health take steps to ensure that the proposed NHS structures, including GP commissioning, do not reduce the priority afforded to minority issues and potentially unpopular groups including problem drug users.

Question 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?

Arguments for and against joint services: *"Evidence suggests that at least a quarter of problem drug users will also develop alcohol problems"* (Alcohol Concern, 2010, p.14), so there is a clear rationale for the provision of services to address both drugs and alcohol. However, there is also a need for distinct services. Members of Revolving Doors' service user Forum were clear about the need for separate services, for example alcohol users in a drug hostel maybe pressure to use drugs, or move to harder drugs.

Pathways between services: Despite the need for distinct services for different patterns of substance misuse, it is essential that robust pathways exist between all types of services. Many drug users are addicted to both drugs and alcohol or to multiple drugs. Those with mental health problems (a significant proportion of problem drug users) may use alcohol to self medicate their mental health. Alcohol use as a replacement for drugs, during or after detoxification is also a common theme. Professionals in each service should be aware of and have positive relationships with those in other services. There should be reciprocal referral opportunities and strong information sharing mechanisms.

Question 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?

Yes, especially for young people and BME groups, who are more likely to use drugs other than heroin or crack cocaine.

However, evidence from our service user forum has shown that drugs services are not deeming users of crack cocaine sufficiently vulnerable to access treatment.

"Drug services mostly cater for people that are on heroin so if you go there and heroin is not your main drug of choice or you're not

on methadone, there's no possible way for you to get any real treatment . . . My drug . . . is crack and weed . . . I can't get a council flat 'cos I'm not vulnerable enough 'cos I don't take heroin, but I still have an addiction . . . Deal with the addiction.'

See question C1 for more detail.

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

Higher priority for alcohol: Despite the high prevalence of alcohol dependency, spending on treatment remains low. There is an urgent need to improve access to alcohol services. See question A1 for more detail.

More flexible definition of problem drug use: Definitions of problem drug use should be expanded to include cannabis and prescription drugs (whether obtained legally or by other means). These drugs can have damaging effects on people's lives yet people seeking help are often denied access to support. As described above in A4, young people are more likely to use a range of substances especially cannabis, yet services are designed primarily to respond to those fitting in the current opiate/crack cocaine definition of problem drug use.

Question 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?

Building understanding of need for holistic approach: With responsibility for reducing health inequalities, the Public Health Service has a unique overview of the broad social context of drug use. It therefore has an important role to play in highlighting the complex and interrelated range of needs that drug users often experience and the effect these have on their families and communities. The Public Health Service has a key role to play in bringing together a range of partners (criminal justice, health, local authorities, and voluntary organisations) to recognise the need for a holistic approach and take action.

Build evidence on different pathways for different groups: With this overview, the Public Health Service could have a role of observing and collecting evidence on outcomes for drug users at a range of stages in their journey to recovery.

Question 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?

Build drug and alcohol misuse models into all health and social care training give this a higher profile in continuous professional development. All professionals working in provision of public services (and related voluntary and private providers) should be trained in basic awareness of drug and alcohol misuse, be able to carry out a basic, non-specialist, assessment of need in order to be able to understand and signpost. Early intervention should be everyone's responsibility, and there should be 'no wrong door'.

Improved interagency working: Most people with drug and alcohol issues are in contact with a number of services in the same area. Some will be very well known to these services. Professionals should be aware of the work of other agencies in their area, including

their access criteria and processes in order to be able to signpost service users for support in other areas. Information should be shared between agencies.

Greater awareness of alcohol issues for GPs: It is particularly important for GP's to develop a greater cognisance of alcohol issues and be more willing to engage in shared care for both drug and alcohol treatment. Neither is difficult and relatively few cases should be treated in specialist care.

Tackling stigma: Stigma associated with drug use often prevents people from disclosing a drug habit to agencies that may be able to support them. Improved awareness of drug and alcohol issues across the board is an important step towards reducing the stigma faced by problem drug users. A recent report by the Drug Policy Commission found that: *"Problem drug users are a very strongly stigmatised group and this has a profound effect on their lives, including their ability to escape addiction… If recovery really is to be the ambitious 'new' goal of drug treatment, then politicians and policymakers will have to look carefully at the question of stigma and how they and others can shift society towards a more compassionate approach to this deeply stigmatised group."* (Lloyd, 2010, p.11-12)

Question 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?

Importance of strategic buy in: Revolving Doors' has learnt through its service development and delivery that the success of services for people with multiple needs are often to a large degree attributable to local ownership and buy in; in other words, to the 'permission' given by several commissioners and organisations to projects operating according to a more flexible and responsive set of rules. The most successful of our project have had steering groups comprised of leaders from a range of local heath, social care and criminal justice agencies. Strategic buy in enabled partnership groups to be convened and resources to be made available. (Revolving Doors Agency, forthcoming)

Improved information sharing and signposting: Research carried out with young adults as part of our Transition to Adulthood work has shown that practitioners are often not aware of what services are available in a local area, meaning they cannot effectively signpost clients to further support (Revolving Doors Agency, 2010). Improved protocols for sharing information between agencies and improved awareness of service availability are needed to link treatment services with wider support services.

Ongoing support and aftercare should be provided across all support services to underpin change. *"One of the keys to achieving recovery from compulsive behaviour is having the patience to practice new behaviour for a long period of time. Addicted people with temperaments featuring low persistence will benefit from persevering therapists who can join in the process, genuinely valuing small improvements along the way and continuing despite disappointments."* (Sellman, 2010, p.10)

Question 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?

Measurement of a range of results which recognise people's journey to recovery: As outlined in C8, a range of treatment and non-treatment outcomes should be measured when holding commissioners and providers to account. Different measures of success should be applied at different points of the journey to recovery. Revolving Doors is developing a series of possible metrics for these measures and would be keen to work with Government on this area.

Local health and wellbeing boards should have a role in holding commissioners of drug services to account and ensuring joint work with other commissioners to constructed support pathways that promote a staged recovery.

SECTION E: SUPPORT AND RECOVERY TO BREAK CYCLE OF DRUG ADDICTION – DEPARTMENT FOR WORK AND PENSIONS LEAD

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

See question C2 for full response.

To support recovery and reintegration, **ongoing and through the gate support** should be provided. This should include:

- Before release: Ensure support arrangements are in place and will be immediately available following release, crucially accommodation, benefit payments, drug and alcohol treatment (e.g. methadone scripts) and GP registration.
- Continuity of support: Support should not stop at release or even soon after. People who have spent frequent short sentences in prison are likely to need support for months or even years to prevent them falling back in to a cycle of crisis and crime.
- Alcohol pathways between prison and the community.
- Option to return to different area away from drug using friends. (See also E2 for more details.)

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

Higher priority for people who are sofa surfing: Often those who are staying with friends are not prioritised for housing, leaving them little opportunity to move away from this situation. This is particularly damaging as they are often staying with drug using friends.

"Basically if you haven't got that … support when you are homeless, you're going to go back to someone, one of your friends who's a drug user. Someone who is on drugs is going to be happy to put you up 'cus you're and extra person to put the graft in to get the drugs in. You're an extra person to feed their habit, two's company both raise together. It's just a vicious circle."

Flexibility in local connection rules: Moving away from former negative networks of associates is often a key factor in starting a journey to becoming drug free. However, local connection rules mean that for many it is very hard to move away from one's home area.
". . . the only thing I wanted to do was make sure I didn't need to go back to [area residing before prison] and meet up with all the other people that I had got involved with in drugs in the first place, so I wanted to stay completely away from it."

Greater flexibility is needed in housing allocation rules to enable people to be rehoused in a different area. Special arrangements, for example reciprocal protocols, may be needed.

Dual diagnosis: There should be greater provision of services that will accept drug users who have a dual diagnosis of mental health problems. Far too those with a dual diagnosis are excluded from accommodation based services. Remaining homeless they are unlikely

to address their drug use or receive support for their mental health problem.

Question 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?

More and better services for personality disorder: Mental health services often refuse to work with people who have a diagnosis of or display behaviours of having a personality disorder. Drug services may also refuse to work with them due to mental health problems. This leaves them left without support and unlikely to address either drug or mental health issues.

Ongoing support: Often once people have been though a treatment pathway, there are few routes for returning for further support if they become concerned they are about to relapse. If ongoing support is available, people can be supported before they relapse reducing overall burden on treatment services. The following was proposed by one member of our service user Forum.

". . . a rolling system in a service where people come in, the people who are further along in their treatment help them."

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

No. Training is hard to access: In recent discussions with our service user Forum, members expressed frustration in not being able to access basic courses for qualifications such as Food and Hygiene Certificates, meaning they are unable to apply for certain jobs. Those that are able to obtain a place for training often find that they cannot afford to complete it. This lack of training means they are unable to gain experience, a prerequisite for many jobs. This leads people to have no choice but to accept a minimum wage job where they are paid so little they easily get in to debt.

Benefits of service user involvement: All organisations, whether statutory, voluntary or private should involve service users for the benefit of both the service users and the organisation. Revolving Doors and Clinks recently published a guide on service user involvement. Below is an extract:

"*There is widespread recognition and growing evidence that involving offenders, ex-offenders, their families or carers can improve the services they use. Because of their direct experiences of services, service users know better than anyone what works – and what does not. Involving them in your work brings unique insights and taps into a valuable resource. Service user involvement can also have a positive impact on the individuals involved by boosting their confidence and skills. This can lead to other opportunities such as training or employment.*

"For service users, service user involvement:

- *Offers them a voice if they have felt excluded*
- *Makes them feel valued and respected*
- *Gives them ownership of the services provided for them*
- *Enhances their understanding of services and how they work*
- *Improves skills and abilities*
- *Builds confidence*
- *Furthers the goal of recovery through inclusion, developing life skills and enhancing self-esteem*
- *Is a way of bringing people together to achieve mutually desirable outcomes."*

(Clinks and Revolving Doors Agency, 2010, p.14)

The RSA's User Centred Drug Services project is currently exploring how drug users can work with drug services to coproduce provision. For more information, see http://www.thersa.org/projects/user-centred-drug-services.

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

a) some form of financial benefit sanction, if they do not take action to address their drug or alcohol dependency, or b) additional support to take such steps, by tailoring the requirements placed upon them as a condition of benefit receipt to assist their recovery (for example temporarily removing the need to seek employment whilst undergoing treatment).

No. Revolving Doors strongly opposes the linking of benefit sanctions to efforts to assist recovery. Benefits are a building block for stability. They enable access to supported accommodation, where basic needs can be met and clients can access help to address drug/alcohol issues, poor mental health, and a range of other problems. If financial benefit sanctions are applied, this foundation stone is removed, and it is unlikely that clients will retain support. This will push people back in to chaos, crisis and crime.

Question E6: What if anything could Jobcentre Plus do differently in engaging with this client group to better support recovery? (For example, greater use of specialist advisers and outreach, use of different communication channels for benefit advice and administration)

Poor experience at job centre: We have collected significant anecdotal evidence from our forum members relating to negative experiences they have had at Jobcentre Plus and the profound effect this can have in perpetuating the cycle of substance misuse, crisis and crime. These negative experiences include general stigma pertaining to their background, failure to understand their situation, poor communication and not being supported to access further education, voluntary work and to achieve their long-term career goals.

"It's very hard… I tried [to claim benefits], but as soon as you're walking into the Jobcentre – 'cause your homeless…you're in scraggily clothes, you're all rough looking, and straight away you're getting barriers from the security, when you're going to use the phone they're standing over you and things like that – it just makes you feel uneasy going in there anyway. It's not like it's open for everybody."

These unhelpful experiences are often at a time when people are not only going through the complicated process of applying for Jobseeker's Allowance but are likely to be simultaneously trying to deal with mental health difficulties, register with a GP, apply for housing and avoid slipping back into misusing substances and offending.

Our Forum members recommended the following improvements:

More face to face contact: Being able to speak to a person face to face rather than over a telephone or computer was highlighted as a key priority. Telephone calls are often stressful for people with poor communication skills and anxiety. More face to face contact would make it easier to explain one's situation, and to discuss what one needs to do to receive benefits.

Better training for staff: Many felt that better training would help staff to overcome stigma and be more accepting of drug users and people with mental health problems.

Service user involvement: *"You want someone who's been through it and knows about it"* The proposal of working as peer advisors at the Jobcentre was proposed by a number of individuals. This could be a voluntary position, undertaken by a recovering drug user who is further on in their journey to recovery.

Better internal administration: We heard extensive evidence of poor administration leading to delays in benefit payments, especially hard copies of documentation being lost in the internal post between London and Glasgow. Delays in benefit payments can have a profound and damaging effect on recovering drug users, as they may lead to housing problems, stress and anxiety and/or relapse to drug use.

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

A staged approach: People who have developed problematic drug use are likely to be at a considerable distance from the job market. They are likely not to have worked in many years, in fact for many having a job is unimaginable. They are likely to be experiencing other problems often related to problematic drug and alcohol use i.e. homelessness, debt, health problems, stigma, and poor family relationships. These issues need to be addressed before work is imaginable.

For those who are in an emergency situation (sleeping rough, leaving prison) basic needs including accommodation and food must be addressed first. Once these have been met, other needs can start to be addressed, such as reducing drug use, and building a trusting relationship. As these areas are developed, the person may be in a situation to start thinking about what is needed to prepare for work; training, volunteering etc. Only at this stage will it be possible to consider what kind of work is possible. For more entrenched individuals, this process may take years, and there are likely to be relapses along the way. Sustained support is needed during the whole process.

The staged approach that we recommend recognises the need to build self efficacy (a person's belief in their own capability to achieve a goal) among people who are some way from the jobs market. The work of Albert Bandura (1997 etc) suggests that self efficacy is influenced by three factors: mastery experience , modelling (vicarious experience) and affective state (anxiety, depression etc).

Question E8: What particular barriers do this group face when working or looking for employment, and what could be done to address these? (For example, how could employers be encouraged to look beyond stigma to employ recovering addicts)

Variety of obstacles: Research by Bauld et al (2010) found that problem drug users *"face a variety of obstacles with regard to looking for*

employment, of which most are deeply entrenched. These include poor self-confidence and mental health problems, physical health problems, a lack of education, training and skills, ongoing drug use, receiving treatment whilst working and stigmatisation by employers, amongst other barriers." (Bauld et al, 2010, p,5)

Distance from the job market: These combined obstacles place problem drug users at a considerable distance from the job market. In this climate of diminishing resources and increasingly scarce job opportunities, competition for jobs is likely to be higher. It will be harder for everyone to find employment, not least those with drug problems; who are likely to have a criminal record, little or inconsistent work experience, and have may have few qualifications and training.

Criminal record: Many of our Forum members spoke of the challenge posed by having a criminal record in gaining employment. A particular challenge is the time it takes for sentences to become spent. Nacro have recently launched a campaign *Change the Record* which aims to address this issue, helping ex-offenders back to work by tackling discriminatory practice and laws that prevent them finding a job. The campaign focuses on amending the Rehabilitation of Offenders Act 1974. One former prisoner we spoke to had received training from probation about when it was necessary to disclose convictions and how to go about doing so. He found this very helpful, and we recommend that this is made available to more (ex)offenders.

Question E10: Is enough done to harness the recovery capital of families, partners and friends of people addicted to drugs or alcohol?

Research by Revolving Doors Agency (2009) exposed the difficulties experienced by practitioners who are working with adults with multiple needs in regard to family issues. While they were aware of the importance of multi-agency work, integrated work was made difficult by a lack of clarity of their remit in working with the families of their clients and of organisational boundaries to that work. Our report, *Unfamiliar Territory*, sets out a number of recommendations in response to this analysis.

Role for peer to peer support

"People who have done drugs who are clean, let them help us, be our peers. Let them keep us to our journey. If you wait for them [drug workers] to come to you, they won't but an ex-drug user will come to you because they understand."

Question E11: Do drug and alcohol services adequately take into account the needs of those clients who have children? (e.g. are they afforded sufficient priority; is there adequate access to childcare; are the design and opening hours of services appropriate; and could more be done, taking into account child protection issues, to ensure that service users maintain contact with their children whilst engaged in treatment)

It is vital that drugs services recognise that many of their clients have children. We have heard many stories of decisions that have been imposed on clients which have serious consequences for their children. If children are not taken in to consideration, the intergenerational cycle of drug misuse is encouraged.

Many drug users do not tell support services that they have children, for fear of them being

taken in to care. While in some cases this may be the optimum outcome for the child, in many others staying with parent(s) as they are supported to recover may be the most suitable situation. To encourage disclosure about children, drugs services need to build trust and understanding with clients around this issue.

Honest dialogue between key worker and clients about the presence of children in the home has also been hampered by previous targets around getting people in treatment and retaining them there. Agencies have worried that clients will drop out of treatment if they ask questions about children, thus the agency misses targets. The NTA have been slow to make this a priority area (for the same reason). This has encouraged a culture where the needs of children affected by parental substance misuse are not identified and addressed the majority of the time.

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

Revolving Doors' report *Unfamiliar Territory* (2009) found that practitioners working with adults with multiple needs are often confused about the role of children's services and frustrated with thresholds for intervention. There was an apparent lack of knowledge about the range of preventative and early intervention services that exist to work with families. Conversely, many agencies who work with adults with multiple needs have developed a body of expertise in engaging with this group which may be valued by children's and family services. Improving links between adults and children's services can help to improve individual and collective responses to families with complex problems.

As mentioned above, drug users often do not disclose the fact of having children to professionals for fear of losing their children to care. In order to address this, drugs services need to work to build up trust with their clients around this issue, showing that family support is about more than child protection.

Conclusion

Our key message is that the government has an opportunity in its new drug strategy to adopt an overall language and approach to substance misuse which challenges stigma, recognises multiple needs and promotes the potential for people to recover.

We are pleased that the need for a holistic approach is a key principle. We recommend that in further developing the strategy the government makes every effort to involve people with direct experience of substance misuse, including people who are still in the process of recovery and those for whom the current system is not working.

Members of our service user forum, who have helped us prepare this response, would be happy to help with this.

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Appendix A

Sources of service user quotes

- Focus group on 2010 Drugs Strategy Consultation Paper with members of Doors Agency's service user Forum, 9 September 2010
- Focus group with former Drug Intervention Project service users on proposed Revolving doors work in Middlesbrough, Middlesbrough, 22 July 2010
- Focus group with female prisoners on proposed Revolving Doors work with short sentenced prisoners in Yorkshire and Humberside, HMP New Hall, 1 July 2010
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