Dear Mike and David

I am very grateful to the relevant officer, Ben Hughes, who has so speedily provided me with the response below to the questions you raised at cabinet this morning. As indicated by the Leader, I shall be asking that these responses are published alongside the minutes of the cabinet meeting.

With regards,

John

1) **From Councillor Mackrory: How will we create a seamless model, fully involving the voluntary sector?**

The treatment system commissioned in Essex is already a collaboration between NHS (EPUT, Primary and Secondary Care) and voluntary sector providers (Open Road, The Children's Society, Phoenix Futures and The Forward Trust). All of the providers we commission are contractually obliged to work jointly as part of the Essex Drug and Alcohol Partnership. Each partner/provider brings with them their own specific skills and specialisms and the system depends on the whole working effectively together. The operation of the system as well as contractual compliance of individual providers is monitored on a quarterly basis.

2) **From Councillor King: When might we be ready to produce a comprehensive summary of the Black Report and of our response to it?**

I have attached a 6 page summary of the DCB Review report (below) – I (Ben Hughes) was not intending to draft a specific response from ECC as this is primarily a review and report for Government. I am on the Board of the English Substance Use Commissioners Group and we, along with Collective Voice (the national alliance of drug and alcohol treatment charities), ADFAM (the national charity tackling the effects of alcohol, drug use or gambling on family members and friends) and the NHS Addictions Provider Alliance have responded collectively. In addition the Government have published its own response to the review report. It may be of interest to Members to know that I was asked by Dame Carol to join the expert panel supporting the review process and was one of only two commissioners nationally to support the evidence gathering and report creation. I have also been asked to join a small central group led by the newly developing Office for Health Promotion within DHSC to develop the Commissioning Standard referred to in the report recommendations.

Cllr John Spence CBE

Cabinet Member for Health & Adult Social Care

Essex County Council, County Hall, Chelmsford

Independent Review of Drugs: Prevention, Treatment and Recovery

Published 8th July 2021

Conducted by Professor Dame Carol Black

Summary for Essex County Council Members

Introduction and context

This report was the second part of a major independent review by Professor Dame Carol Black into the misuse of illegal drugs in England.

The first part of the review was commissioned by the Home Office and produced the phase one report, which looked at the challenges around drug supply and demand and was published in February 2020.

Dame Carol was then appointed to lead the second part of the review which focused on treatment, recovery and prevention giving consideration to adults and young people. The report's aim is to make sure that vulnerable people with substance misuse problems get the support they need to recover and turn their lives around, in the community and in prison.

The report contains 32 recommendations for change across various government departments and other organisations, to improve the effectiveness of drug prevention and treatment and to help more people recover from dependence

What the review set out to achieve

The review aims to help government reduce demand for illegal drugs. Problem drug users, including an estimated 300,000 opiate and crack users, need high-quality treatment and recovery services, alongside pathways into treatment and away from the criminal justice system. For recreational drug users, we need to find ways to change attitudes and behaviour.

This problem and its solutions span many government departments, local government and other organisations. So, this review makes a large number of recommendations that fall to different players within the system. These should be seen as a package of reforms that are interdependent and mutually reinforcing.

Reform of central government leadership

Tackling the demand for illegal drugs must start with clear central government leadership and oversight. Responsibility for this agenda spans multiple departments. People with drug dependence are a small part of the much wider populations that departments serve, so tend not be prioritised in policy and funding decisions. There is no systematic way for departments to co-ordinate plans so that they cohere when implemented on the ground.

We recommend the formation of a central Drugs Unit, sitting in whatever department or joint arrangement seems appropriate, with clear ministerial sponsorship. This unit should take the lead in setting clear objectives and targets for the rest of government, and translate these into a new National Outcomes Framework, with the sponsoring minister reporting annually to Parliament on progress.

Increased funding for drug treatment and wider recovery support

Local authorities are responsible for drug treatment. Spending on treatment has recently reduced significantly because local government budgets have been squeezed and central government funding and oversight have fallen away.

We have concluded, based on current evidence of prevalence, that an additional £552 million is needed from DHSC by year 5 on top of the baseline annual expenditure of £680million from the public health grant, to provide a full range of high-quality drug treatment and recovery services, as follows:

- year 1: £119 million
- year 2: £231 million
- year 3: £396 million
- year 4: £484 million
- year 5: £552 million

An additional £15 million by year 5 is needed from DWP for employment support, as follows:

- year 1: £6 million
- year 2: £11 million
- year 3: £16.5 million
- year 4: £15.9 million
- year 5: £15.1 million

This would allow for increased capacity for under-served groups, including non-opiate users and young people, and for larger numbers to be diverted away from the criminal justice system. Further work needs to be carried out by MHCLG before the next Spending Review to identify how much additional funding is required to provide housing support to people in treatment who lack adequate housing.

In parallel, we recommend additional investment by NHS England (NHSE) in high quality physical and mental health for this group.

Given fiscal pressures, government may have to take a long-term view and fund this programme over a time frame longer than 5 years. If this is the case, I strongly recommend ensuring the whole package is delivered immediately, with all its components, to those areas in greatest need.

Allocating and protecting funding

Additional investment in treatment and recovery cannot be allowed to disappear to fund other local priorities. We recommend that funding for drug treatment be allocated to local authorities based on a needs assessment and then protected. Where relevant, other government departments should protect funding at local level for their wider recovery services.

Commissioning

Many local authorities do not commission the full range of services required and there are important gaps in provision, such as suitable treatment services for non-opiate users. We recommend that DHSC should develop a national Commissioning Quality Standard, based on clinical guidelines, to help specify the full range of treatment services that should be available in each local area.

This national Commissioning Quality Standard should exist alongside strong local leadership, with local authorities working closely with NHS organisations and wider recovery partners. Joint local plans should be produced across all local organisations involved in treatment and recovery. Commissioners should also work more collaboratively with providers and introduce longer commissioning cycles of at least 5 years, to encourage service stability and improvements to quality. Commissioning arrangements should mirror NHS practice where there is a move away from competition towards collaboration.

Strengthening local authority accountability

With more investment in treatment and recovery, there must be greater accountability for this spend. We recommend that the new Office for Health Promotion use the new National Outcomes Framework and the national Commissioning Quality Standard to hold local authorities and partner agencies to account.

Rebuilding services: workforce

Sufficient capacity and quality in treatment services depend on a suitably trained workforce. However, the drug treatment and recovery workforce has deteriorated significantly in quantity, quality and morale in recent years, with excessive caseloads, decreased training and lack of clinical supervision. DHSC should commission Health Education England (HEE) to devise a workforce strategy for substance misuse treatment and give it sufficient new funding to support the required training. In parallel, DHSC should support structured peer-led recovery networks in every local area, to complement the professional workforce.

Rebuilding services: treatment

Local authorities should commission a full range of evidence-based harm reduction and treatment services to meet the needs of their local population. However, some services have all but disappeared and will not automatically return even with higher funding and better commissioning. High cost but low volume services, such as inpatient detoxification, are too costly for a single local authority to procure and should be covered by a new regional or sub-regional approach to commissioning.

More funding needs to be available to improve capacity and quality of specialist substance misuse services in response to increased drug use among children and young people. The national Commissioning Quality Standard should ensure that these services are linked with other local services for vulnerable young people.

Rebuilding services: recovery support

DHSC and the Office for Health Promotion should support local areas to ensure that thriving communities of recovery are linked to every drug treatment system, working to standards on quality and governance developed by the government's Drug Recovery Champion and the Office for Health Promotion.

Diverting more offenders into treatment and recovery services

Too many people with addictions are cycling in and out of prison, without achieving rehabilitation or recovery. The recent sentencing white paper committed to greater use of police diversions and community sentences with treatment as an alternative to custody. This must now be put into action, alongside extra funding for treatment places to accommodate the extra demand.

In prisons, MoJ should work with DHSC and NHSE to improve the experience of treatment, with prisoners always taken to their treatment appointments. On release from prison, prisoners must have ID and a bank account and the ability to claim benefits on the day of release. Those with drug dependence should be helped to continue with drug treatment in the community as soon as possible.

Employment support

Employment is an essential part of recovery, both for financial stability and to offer something meaningful to do. Intensive, employer-focused employment support inside treatment centres has shown promising results, based on a recent trial of Individual Placement and Support (IPS) in 7 local authorities. The IPS model should be rolled out in treatment settings across the whole of England. DWP should also introduce peer mentors in each Jobcentre Plus to help people with drug dependence to receive more tailored and sympathetic support.

Housing

Drug dependence can be both a cause and consequence of homelessness and rough sleeping. MHCLG has estimated that almost two-thirds of people who sleep rough have a current drug or alcohol problem. PHE's drug treatment data shows that one-fifth of adults starting treatment in 2019 to 2020 reported a housing problem, increasing to one-third of people in treatment for opiates.

MHCLG and DHSC have secured welcome substantial additional funding to improve treatment services for people who sleep rough. We know that housing and housing support have a crucial role to play in the success of drug treatment and that many of those entering treatment report a housing need. MHCLG should work with DHSC to assess the types and levels of housing related needs among people with substance misuse problems.

Mental health

For many people, mental health problems and trauma lie at the heart of their drug and alcohol dependence. However, they are too often excluded from mental health services until they resolve their drug problem and excluded from drug services until their mental health problems have been addressed. DHSC and NHSE should work together to set out a plan to solve this problem.

The workforce in both services should be trained to better respond to co-existing drug and mental health problems. This should be a key component of HEE's competency and training requirements for the workforce.

Physical healthcare

Many drug users have poor overall health. The NHS is poor at engaging with the wider health needs of drug users with medical co-morbidities (for example, hepatitis C, HIV, heart and lung disease), many of whom are ill-equipped to navigate complex pathways, and feel stigmatised. DHSC and NHSE should work together to develop an action plan on improving access to physical healthcare.

Prevention and early intervention

Preventing drug misuse is more cost-effective and socially desirable than dealing with the consequences of misuse. The Smoking, Drinking and Drug Use among Young People in England survey has shown that drug use among children (aged 11 to 15) has increased by over 40% since 2014, reversing a previous long-term downward trend.

The Department for Education (DfE) must ensure that schools seize the major prevention opportunity presented by the statutory guidance for Relationships, Sex and Health Education (RSHE). This guidance came into force in England from September 2020 and sets out requirements in relation to teaching about tobacco, alcohol, prescription drugs and illicit drugs.

It is equally important that children attend school and have rewarding, fulfilling activities available to them outside of school. They also need adequate support services, particularly for mental health. We recommend that the DfE and Department for Digital, Culture, Media and Sport (DCMS) lead investment in age-appropriate evidence-based services and support all young people to build resilience and avoid substance misuse. Local authorities should identify, and provide additional support to, those young people most at risk of being drawn into using illicit substances or involvement in supply.

Research

Research in many areas of addiction is underdeveloped and under-resourced, with the exception of opioid substitution treatment. The research infrastructure in local authorities is far less developed than it is within the NHS, and current service models often do not provide the stability, expertise or right staff mix to undertake high quality research.

We recommend that DHSC and the Department for Business, Energy & Industrial Strategy (BEIS) encourage and facilitate research into what works to combat

substance misuse, across supply, prevention, treatment and recovery. DHSC should promote innovative research on addiction and its implementation in practice by offering incentives or rewards to companies and other organisations for effective developments in this field. For example, pharmaceutical advances.

There is also a lack of evidence on what works to deter people from taking drugs recreationally. The majority of recreational drug users do not see themselves as having a drug problem and it is a difficult population to influence. However, this misuse carries risks and fuels the illicit drug market. We recommend HO invests now in an innovation fund to test out which marketing and behavioural interventions could work in the UK to diminish recreational drug use, building on evidence from abroad.