ACMD

Advisory Council on the Misuse of Drugs

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Dear Minister,

The Advisory Council on the Misuse of Drugs (ACMD) are pleased to contribute to the 2010 drug strategy consultation paper.

The ACMD prepared the response after convening a one-day meeting (8th September 2010).The attached response reflects the collective consideration and views of the ACMD provided at that meeting and by correspondence.

The consultation has several substantial questions that, for a detailed and thoroughly considered response, could have discussions and meetings devoted to themselves. Therefore, bearing in mind the relatively short consultation period the ACMD's response is not a systematic review, but evidence that has been provided at the time.

Yours sincerely,

Professor Les Iversen

The Advisory Council on the Misuse of Drugs

The Advisory Council on the Misuse of Drugs (ACMD) makes recommendations to Government on the control of dangerous or otherwise harmful drugs, including classification and scheduling under the Misuse of Drugs Act 1971 and its Regulations. It considers any substance which is being or appears to be misused and of which is having or appears to be capable of having harmful effects sufficient to cause a social problem.

The ACMD also carries out in-depth inquiries into aspects of drug use that are causing particular concern in the UK, with the aim of producing considered reports that will be helpful to policy makers and practitioners.

2010 Drug Strategy consultation

Overall comments

One of the opportunities afforded by a change in administration is a fresh look at some of the more difficult areas of policy. It might be argued that the previous drug strategy was very much a continuation of the one before that, with relatively minor adjustment of priorities.

The current government is proposing a more radical re-think, which helpfully encourages us all to re-visit assumptions about what the drug strategy is trying to achieve.

The greatest concern of the Advisory Council on the Misuse of Drugs is always to be reflective of how policy changes can be informed by evidence. We hope that the current consultation will dig beneath the strong feelings and rhetoric from the many corners of interest in drugs policy and check new proposals and changes in focus against research evidence where this is available.

We do have some concern that the timescales for this consultation are relatively short. They do of course meet the standard *requirements*, but as this may be the most radical shift in drugs policy for at least a decade, we would encourage the government to allow time for further examination and discussion, if necessary by delaying a final report beyond December.

As a Council, we have had a tight schedule of activity in the last few months and do not, collectively, feel we have been able to put as much time and consideration into the enclosed response as we would have liked. In particular, we have recently begun a 'Treatment Working Group' which will be well placed to comment on these complex issues, but probably not until after Christmas. We welcome your officials to the meetings and will keep the government up to date with developments on the group.

Responses from the Advisory Council on the Misuse of Drugs to questions for consultation

Section A: Vision for the new drug strategy

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

The ACMD believe that the drugs strategy should be based on the understanding that addiction is viewed as a chronic and relapsing brain disorder. This perspective does not preclude the possibility of full recovery for some, but accepts that for many others treatment will, by necessity, be long term; best described as a 'chronic disease management' model.

A2. Which areas would you like to see prioritised?

Regarding the list given, the ACMD would like to see the following areas prioritised:

- Greater ambition for individual recovery whilst ensuring the ongoing availability of substitute medication where this is appropriate. It is vital that the concept of 'appropriateness' is driven by clinical need and a clear understanding of the robustness and limitations of the evidence base.
- A more holistic approach, with drugs issues being addressed and tackled alongside other issues such as alcohol abuse, child protection, mental health, employment and housing.
- Budgets and funding streams simplified and outcome based.
- Maintaining interventions which leverage treatment to reduce crime.

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

The expansion of the treatment sector has been immensely beneficial to the wider society and it was probably appropriate for the previous strategy to focus as it did (in practice) on substitute prescribing services; there is a need for well qualified and experienced addiction psychiatrists. This does not preclude the conclusion that a greater focus on recovery is now important or should have been considered earlier.

The introduction of the Integrated Drug Treatment System within prisons, and handing of treatment services to local providers / commissioners has been a qualified success. To the extent that changes to treatment in prisons are required, we strongly recommend that this builds upon rather than replaces the current governance framework. Making IDTS become more recovery focussed is however a considerable challenge, especially within existing or constricted resources.

Introduction of Non-Medical Prescribers (NMPs) to improve cost-effectiveness and improve access has also been a qualified success, especially in areas where primary and secondary care prescribers are 'less engaged' with drug treatment. It is not entirely clear how best to build upon this, though there would be risks in expanding this purely as a cost saving exercise.

It is vital there is high quality clinical leadership to drive improvement through experience, expertise, training, research and policy development.

Criminal Justice interventions help in reducing crime. However, we need to be careful that the shift in perspective toward abstinence does not have a negative impact on crime by relapsed users. It will be important to balance the need to achieve patient recovery whilst working effectively with prolific offenders in reducing crime linked to drug use.

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

The priorities for treatment were skewed toward getting and keeping injecting opiate users in treatment. There is a strong argument that this did not encourage development of the kind of services needed by stimulant users. A greater emphasis on psycho-social interventions and broader based recovery models *might* be more applicable to most stimulant users than a more medical approach, though more thorough consideration and review of the evidence should be considered before this is pursued. It should be borne in mind that many of the new / novel drugs appearing in the UK, such as mephedrone, are stimulants. It is as yet unclear what level and nature of treatment response would be appropriate.

We agree that Tier 4 / residential services could play a more important role in the treatment system, but would argue that this is a more complex area than it first appears.

To more fully utilise Tier 4 services there is a strong need for better tools to identify which clients would be most likely to benefit. This is particularly important of these services for two reasons a) they are very expensive compared to community interventions and b) the failure of these interventions is dangerous in terms of increased risk of overdose on relapse.

To support this there should be a system that allows practitioners and commissioners to judge the effectiveness of different Tier 4 service providers against realistic outcome measures. This will also help to quickly identify the additional support mechanisms that are required to secure the treatment gains from these interventions. For example, the aftercare models that minimise risk of overdose and are most effective at building recovery capital.

The focus on substitute prescribing, even if desirable as a priority in terms of public health and crime reduction, served to distort planning priorities such that services more focussed on abstinence were often peripheral to the

treatment system. The clearest case is with residential rehabilitation, with the budgets and planning system often outside of the DAT planning structures. This is explained more in a later section. It should also be noted that addiction psychiatrists have not been as engaged as they might have been with the DAT commissioning processes.

Although injecting opiate users were probably the best served group of drugs users by the previous drug strategy, the need to expand treatment capacity rapidly left serious gaps in the quality of services. The most obvious example has been the slow development of robust and meaningful psycho-social interventions alongside substitute prescribing. We would particularly commend the work carried out by the NTA in the last couple of years with the tools brought over from the USA. We do not however believe that the average person on substitute prescribing receives anything approaching the quantity or quality of psychological interventions they require. A priority should be to establish the true picture and a more robust rollout strategy for the most evidence based interventions to support the still needed substitute prescribing services.

Section B: Prevent Drug Use – Department for Education lead

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

The ACMD identified in its report *Pathways to Problems* (2006) that there are many factors which influence whether or not young people will use alcohol and/or other drugs in a hazardous way. The most important of these factors include early life experiences, family relationships and circumstances, and parental attitudes and behaviour.

The ACMD consider that the most effective way of preventing drug or alcohol misuse is to be led by the evidence that good parenting and a stable family life can reduce the risks of hazardous alcohol and drug use by young people.

In support of this, it is important that the government invests heavily in minimising the number of children and young people in relative poverty and also in protecting and supporting the most disadvantaged and vulnerable young people in the UK.

The ACMD have previously recommended to government that there should be a careful reassessment of the role of schools in drug misuse prevention. The emphasis should be on providing all pupils with accurate, credible and consistent information about the hazards of alcohol and other drugs.

However, the ACMD stresses that research has indicated that such programmes have little impact on drug use – the most important determining factor being found to be parenting and stable family life[1].

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

- Services that work to support family cohesion and resilience, such as "strengthening families" approaches, Sure Start and supportive social services interventions.
- Police and criminal justice service through appropriate initiatives.
- Schools, colleges and higher education organisations.
- Other informal settings can provide education and prevention such as, for example: scouts and guides, sports clubs, youth clubs.

Also, see third bullet point to B3 below.

[1] A minority opinion, however, was more supportive of the value of education programmes, and did not support this view.

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

One area that should be given greater focus is inter-generational issues (families with grand-parents, parents and children being affected) regarding crime and drug misusing behaviour. The strategy should link in and consider the harm caused to children of drug misusing parents. This is fully detailed in the ACMD's report – *Hidden Harm* (2003) (pp-89-91).

The four key points in the conclusion of *Hidden Harm* (2003) are highly relevant to this strategy:

- Effective treatment of the parents' drugs problems is one of the most likely ways to enhance their parenting capacity – expanding high quality treatment services across the country should benefit children as well as adults.
- Effective treatment of the parent is not enough: substance misuse services must see the child behind the client and recognise their responsibility for ensuring the child's well-being, in partnership with others. The children must be seen and listened to, their needs assessed and responded to. Substance misuse services must therefore become family-focussed and child friendly.
- Health services, social services, education services and the criminal justice system can all do more to help the children of problematic drug users in ways we [ACMD, in the report *Hidden Harm*, 2003] have outlined. These require a willingness to work together and share information, and better training. Additional or redeployed resources may also be required.
- We [ACMD] have seen there is considerable untapped potential in the non-statutory sector for developing genuinely helpful services. Again additional resources are likely to be needed to enable the few examples we [ACMD] found to develop and multiply.

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

Prevention programmes should focus on those drugs that cause the most harm. On a population level, Alcohol causes more harms overall than illegal drugs and should be the highest priority for prevention work. We would suggest a bold approach that is consistent with World Health Organisation recommendations, even if these are more politically difficult than less effective approaches.

Although public health campaigns are difficult to evaluate and generally do not have a strong evidence base, the Council has been generally impressed by the work of Frank and would recommend it's continuation as a campaign vehicle.

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

- See sections above, describing work to strengthen families and improve parenting. The key to prevention is well functioning families and perhaps a direct focus on drugs is not always the best approach.

- Having a parent with a drug or alcohol problem is the single greatest risk factor for a child to grow up with a problem of their own. A high priority must be given to getting parents with drug problems into treatment services that engage and respond to their treatment needs.

- Evidence based education for the parents through schools, internet and other media sources that supports them in delivering a credible message and allows them to signpost and support children if drug use becomes problematic.

Also see response to B3.

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

- Be supportive and not discriminatory to people who misuse drugs and alcohol – particularly in terms of employment and employability of people with drug misuse history.

- Form effective relationships with the police and drug services so they can work as a partnership in preventing substance misuse.

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

- The strengthening families approach and more focussed work with addicted parents. The evidence base is stronger than 'education' models. Parental drinking is a far greater problem than drug using parents, yet the treatment system is skewed heavily toward drugs. This leaves huge numbers of children vulnerable.

- A credible message approach that uses all the agencies in a coherent drug prevention strategy rather than the ad-hoc arrangement that we currently have.

B8. What barriers are there to improving drug and alcohol prevention.

The present economic climate is likely to be a barrier to developing drug and alcohol prevention strategies. We would particularly note that some of the treatment interventions that most obviously come to mind with a shift toward

abstinence, such as residential rehabilitation, are also by some margin the most expensive. We would recommend careful economic / outcome modelling to understand the medium and long term consequences of decisions of shifting resources from one intervention to another. In schools, Personal Social and Health Education has suffered following it not achieving statutory status.

There is also a lack of good quality evidence as to what works. The ACMD has concerns that properly understanding the effectiveness of drug and alcohol education is hampered by projects such as Blueprint that failed to deliver. There is currently a Europe-wide study looking at drug prevention quality standards which should be considered.

In addition, in some areas, there is a lack of multi-disciplinary working in some areas. A further barrier would be losing focus on educating the professional as budgets are reduced.

Section C: Strengthen enforcement, criminal justice and legal framework – joint Home Office and Ministry of Justice lead

C1. When does drug use become problematic?

Drug use becomes problematic when it impacts on the individual, their family and communities they live in. This impact will be judged by the individual and society as a whole but may include:

- Deterioration in health – both physical and mental;
- Impact on family relationships and children;
- Crime including violence against other people and against the drug user as a result of their drug use;
- Breakdown in social cohesion.

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

The Drugs Intervention Programme (DIP) was successful – the highlighting of drug use by testing in custody suites and then subsequent arrest referral onto treatment has been a success, with evidence of a fall in offending behaviour. The ACMD believe that there could be merit in considering extending drug testing in custody suites as it makes referral to treatment far more likely.

The ACMD believe that there is an opportunity to be more creative in dealing with those who have committed an offence by possession of drugs. For people found to be in possession of drugs (any) for personal use (and involved in no other criminal offences), they should not be processed through the criminal justice system but instead be diverted into drug education/awareness courses (as can happen now with speeding motor car offenders) or possibly other, more creative civil punishments (e.g. loss of driving licence or passport). If, however, there were other trigger offences (e.g. theft, burglary etc) then the usual test and treatment procedures would occur. Such approaches may be more effective in reducing repeat offending and reducing costs to the criminal justice system.

There should be “drugs awareness” courses to which those found in possession can be referred as a diversion – this would be the equivalent of the apparently successful “speed awareness” courses to which drivers can be referred as a diversion. These could also be available to those being conditionally cautioned where there is evidence of drug use.

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

The ACMD are responding separately to the Minister for Crime Prevention on this issue. The ACMD's consideration of the 'trigger point' for a Temporary Banning Power (i.e. factors), as sent to the Minister is:

The ACMD does not believe the point at which consideration is given to invoking a Temporary Banning Power should be too prescriptive. The purpose of the temporary banning power should be the prevention of harms. Therefore, the ACMD considers that the trigger point should be '[on the available evidence] there are *reasonable grounds* for considering that a substance does, or has, the *potential* to cause harm'. As part of the ACMD's initial consideration as to whether a temporary banning power should be invoked it will look to understand the identity of the substance, consider related substances, consider any legitimate uses and gather evidence internationally and locally regarding the substance and its harms (including, for example, A&E admissions, known pharmacology, dependency and social harms etc.). However, it is not possible to detail the 'level' of evidence that would be required, nor what that evidence would be – evidence, and the relative importance of each type of evidence, will depend on the substance being considered.

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

These should suit the needs of the service user - local commissioners should provide a menu of options to service users. It should be noted that the Supporting People program did encourage innovation, particularly as a mechanism to provide housing to service users and ex-offenders whilst encouraging engagement with treatment services.

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

Supply of many drugs to UK markets is from sources outside of this country. There is a requirement for more joined up international action, especially with regard to drug producing countries where more creative solutions are required.

Particular attention should be focussed on internet supply activity.

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

Changing drug trends can be identified at many levels, all of which should be monitored and information gathered so as to be aware of changing drug markets and ultimately, harms to users. Reports may be gathered from the National / European level to local level concerning initially, (among others), seizures, forensics, accident and emergency admissions, internet based

sales, service users etc. Such evidence should be used to inform drugs that are to be considered.

The internet has become a critical vector in the development of drug markets for novel / legal highs. Monitoring sales sites and conducting test purchasing (with forensic examination of the products) provides key information on emerging trends and markets. At present this is an occasional academic activity but there is a strong case for this to be routine.

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?

All agencies that are affected by drug related offending e.g. LA's; drug services; PCTs; Police; Hospitals; probation services, YOTs; T4 service providers; Public Health, and so on. The current Drug (and Alcohol) Action Team model does however provide a good mechanism to draw these partners together. With a modest change of remit it would be advisable to adjust this existing group rather than replace or create a new one.

C8. What results should be paid for or funded?

Payment on results can result in negative un-intended consequences. The ACMD would urge the government to be very cautious in considering this approach.

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

It is apparent that there is currently a failure of the criminal justice system to deal properly with the supply and use of drugs to and within prisons. More needs to be done to tackle the supply of drugs in prisons. It should be noted that prevalence of drug use varies substantially between prisons so there must be an opportunity to learn from and identify best practice.

A comprehensive treatment programme should be available through The Integrated Drug Treatment System

C10. (if applicable):
What impact would the measure suggested have on:
a) offenders
b) your local community?
It meets the needs of both.

Section D: Rebalance treatment to support drug free outcomes – department of health led.

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

See question A3.

There should be recognition of the benefits of expanded access to treatment that has been achieved in recent years. In particular, the availability of substitute prescribing has been a success.

Close links to the criminal justice system should be maintained such as arrest referral and other pathways.

The Integrated Drug Treatment System is imperfect, but is much better than what came before. It should be built upon rather than replaced.

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

The ACMD will, next year, be providing advice to ministers regarding the treatment system. This report will consider those areas where there is good practice and where improvement is necessary.

Create incentives for the drug treatment system to promote opportunities for abstinence within and alongside a sustainable investment in harm reduction.

Improve the overall quality of the services offering substitute prescribing. In particular, establish the correct quality and quantity of psycho-social interventions that should be delivered and ensure that commissioning arrangements provide an incentive to deliver this.

Adopting a Commissioning rather than purchasing model for residential rehabilitation and bringing this activity closer to the DAT planning structures. This should be supported by better outcome and performance monitoring of all T4 services and investment in appropriate aftercare to maintain therapeutic gains.

Early observations of recovery orientated systems are encouraging, although more analysis of what does and doesn't work is required. Linking treatment services with wider support structures (housing, employment etc) is clearly and area that could be improved even within existing resources.

It should be recognised that the evaluation of inpatient treatment and residential rehabilitation is a fundamental requirement.

More attention must be given to the needs of people with multiple needs / dual diagnosis. The fragmenting of the treatment system, with even prescribing

services now often being run by the voluntary sector, risks an even wider disjuncture with mental health services.

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?

Drug and alcohol treatment services should be considered together wherever possible, but there will be some primary alcohol users who feel stigmatised by having to engage with a 'drug and alcohol' service.

In practice, services such as 'Alcohol In Primary Care' / Screening / Brief Interventions strategies are best implemented by alcohol specialists. When clients are referred on to tier three services there is a stronger case to offer integrated services. The difficulty has tended to be that Alcohol problems greatly outnumber drug problems, though the resource allocation within the treatment system is the inverse. This tends to make alcohol treatment the 'poor cousin' whether services are separate or combined.

Even when operating separately, drug services should also be funded to tackle alcohol as the high levels of problem drinking amongst drug users often remains un-treated.

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?

See earlier answer regarding prevention. Service needs should be delivered based on the harms experienced by each individual drug (although a full service for all drugs would be the ideal). This principle is even more important during a period of austerity. It would be difficult to ask for a widening of remit whilst reducing available resources. The ideal answer to this question is different from the pragmatic one.

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

The ACMD consider that there should be access to drug treatment services for people using legal prescribed and over the counter medicine. This has proven problematic due to the way funding currently operates. We support the recommendations of the All Party Parliamentary Group on Drug Misuse in 2007.

The ACMD understand that the Department of Health (DH) is currently finalising an expert review of the literature and prescribing data on the benzodiazepines (National Addiction Centre, King's College London) and is working with the National Treatment Agency to complete an audit of specialist

services that supports medicine addicts to withdraw; including from the use of over-the-counter drugs. This review was announced by Ministers on 16 June 2009 in response to the recommendations of the All-Party Parliamentary Group on Drugs Misuse inquiry into dependence on prescription and over the counter drugs. Upon publication the ACMD would welcome considering the findings.

D6. What role should the public health service have in preventing people using drugs in the first place and how can this link into other preventative work?

The evidence base for the effectiveness of prevention is not strong. Please see the other comments on prevention, particularly around early years and families.

The work carried out by Frank or other public information services needs to be fed 'downwards' through the planning structures to a local level. The evidence to support public education to achieve behaviour change is strongest where there is a multi-factorial approach, with education backed up by enforcement and cultural shifts. The Joseph Rowntree Foundation has commissioned some work reviewing what can be learned from effective programmes of public education / behaviour change.

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?

Much depends on what changes are made to the treatment system within the current climate.

The ACMD has concerns that there is a continuing decline in the training and research in this sector and a de-skilling of individuals. In particular there should be greater training on drugs awareness.

There should be support for training services e.g. RCGP/SMMGP/SCAN. Consideration could be given to link training needs and delivery of training to one of the outcomes for services to meet as part of the new strategy. Training needs to support the changing drug environment (e.g. legal highs).

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?

There should be effective local lead and commissioning groups to ensure all service providers are included in development of local drug strategies. The work done on creating 'Recovery Oriented Integrated Systems' is both

interesting and encouraging, though it is likely that some aspects of this approach work well and some do not. A considered and evidenced approach is needed if such an approach is to be more widely adopted.

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

Clear outcome and quality markers that are evidence based and will improve outcomes for the individual drug user and social functioning in the local area. [It should be noted that outcomes for different groups may differ, for example young people and adults.] This should be linked in with the local treatment plan so there is buy in and an element of agreement to the markers and outcomes that need to be delivered.

Section E: Support recovery to break cycle of drug addiction – Department for Work and Pensions lead.

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

Through assessment framework at the start, during and end of prison sentence.

To better support recovery, good communication with community services at release from prison is required to ensure all relevant information is shared and an appropriate community care plan is in place

Licences should include a condition of attendance at a DRR type programme (including drug testing) rather than the present general one and this provision should be funded by DAATs as a priority given the high rates of relapse.

In addition, there needs to be continued emphasis on reducing the risk of overdose at release as a result of the loss of tolerance to opioids. The Scottish pilot study offering naloxone to released prisoners as a “rescue” medicine for heroin overdose may prove one method of achieving this .

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

Floating support for those released from prison, in transient accommodation or at risk of losing their accommodation.

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?

This is one area that is poorly managed – where a client with dual-diagnosis is passed between services. There needs to be joint working including MDT meetings between the two services and a common policy framework to support service users and practitioners providing support to service users.

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

There are many opportunities for training, however it is whether individual practitioners and agencies engage with them. Joint training and the development of MDT dual diagnosis groups to manage and identify needs of service users and practitioners would be a useful addition.

Some young people who access services have had a poor education or experience in the system. There is a need for very basic education e.g. numeracy and literacy in some cases

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 to 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).

Treatment should not be linked to financial sanctions. In this scenario a few may benefit, however the majority may not as it does not take into account the genesis of the addiction.

Defining drug and alcohol dependency may cause some problems – even though there are clear definitions there may still be differing opinion. Sharing information also presents the ACMD with some concerns.

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

There could be more engagement with local drug services to find solutions to the problems at a local level.

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

Working links and support groups are interventions that are most effective in assisting claimants find employment.

Incentives and support for employers to take on people with substance misuse problems or history

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

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

We have not considered this in detail, but recommend that you seek access to the evidence review being carried out by Richard Vellerman, at Bath University.

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

Not enough is done to harness recovery capital, this is often missed in the current framework.

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

In the experience of members of the ACMD the answer is ‘yes’, especially when safeguarding issues are concerned; staff are well trained and services are aware of the need to take children into account.

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?

The ACMD consider that trust with other agencies and a common understanding of markers and goals for parents who are drug users who have children within the safeguarding process.