

ACMD

Advisory Council on the Misuse of Drugs

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Countering Extremism
Home Office
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06 September 2017

Dear Minister,

RE: Commissioning impact on drug treatment

The Advisory Council on the Misuse of Drugs (ACMD) has taken notice of emerging evidence on reductions in funding and concerns about the impact of trends in commissioning of drug and alcohol treatment services on drug and alcohol service user outcomes. The ACMD's previous advice submitted during the development of the 2017 Drug Strategy expressed these concerns.

A range of evidence was heard by the ACMD Recovery Committee and I am pleased to enclose their report. This report follows on from previous ACMD reports exploring what outcomes could be expected from people recovering from drug and alcohol dependencyⁱ and how opioid substitution therapy could be optimised to maximise recovery outcomes for service users.ⁱⁱ

In brief, the ACMD has concluded that drug and alcohol treatment appears to be facing disproportionate decrease in resources, likely to reduce treatment penetration and the quality of treatment in England.

This situation is compounded by frequent re-procurement of services that is using vital resources, creating unnecessary 'churn' and disruption and resulting in poorer recovery outcomes – at least in the short term.

In this complex and changing context it is difficult to see how the levels of substance misuse (particularly drug treatment) coverage and quality will be maintained without significant effort to protect investment and quality.

The ACMD has welcomed the 2017 Drug Strategy, published in advance of this report. In particular the ACMD welcomes the commitment to have “effectively funded and commissioned services, targeted at helping people fully recover from dependence”. However, the ACMD finds it difficult to see how that aspiration can be delivered and makes the following recommendations:

- National and local government should give serious consideration to how current levels of investment can be protected, including mandating drug and alcohol misuse services within local authority budgets and/or placing the commissioning of drug and alcohol treatment within NHS commissioning structures.
- National government should ensure more transparent and clear financial reporting on local drug misuse treatment services, together with new mechanisms to challenge local disinvestment or falls in treatment penetration.
- National government’s commitment to develop a range of measures which will deliver greater transparency on local performance, outcomes and spend should include a review of key performance indicators for drug misuse treatment, particularly those in the Public Health Outcomes Framework (PHOF), to provide levers to maintain drug treatment penetration and the quality of treatment and achieve reductions in drug-related deaths.
- National bodies should develop clear standards, setting out benchmarks for service costs and staffing to prevent a ‘drive to the bottom’ and potentially under-resourced and ineffective services.
- The Government’s new Drug Strategy Implementation Board should ask PHE and the Care Quality Commission to lead or commission a national review of the drug misuse treatment workforce. This should establish the optimal balance of qualified staff (including nurses, doctors and psychologists) and unqualified staff and volunteers required for effective drug misuse treatment services. This review should also benchmark the situation in England against other comparable EU countries.
- Local and national government should consider strengthening links between local health systems and drug misuse treatment. In particular, drug misuse treatment should be included in clinical commissioning group commissioning and planning initiatives, such as local Sustainability and Transformation Plans (STPs).
- Commissioners should ensure that recommissioning drug misuse treatment services is normally undertaken in cycles of five to ten years, with longer contracts (longer than three years) and careful consideration of the unintended consequences of recommissioning. PHE and the Local

Government Association (LGA) should consider the mechanisms by which they can enable local authorities to avoid re-procurement before contracts end in systems that are meeting quality and performance indicators.

- The Government's new Drug Strategy Implementation Board should address research infrastructure and capacity within the drugs misuse field. Any group set up to work on this should include government departments, research bodies such as the Medical Research Council (MRC) and the National Institute for Health Research (NIHR) and other stakeholders.

Yours sincerely,



Dr Owen Bowden-Jones
(ACMD Chair)



Annette Dale-Perera
(Chair of the Recovery Committee)

CC: Rt Hon. Amber Rudd MP, (Home Secretary)
Rt Hon. Jeremy Hunt MP, (Secretary of State for Health)
Steve Brine MP (Minister for Public Health and Primary Care)

ⁱ Advisory Council on the Misuse of Drugs (ACMD) (2013) What recovery outcomes does the evidence tell us we can expect? London: Home Office

ⁱⁱ Advisory Council on the Misuse of Drugs (ACMD) (2015) How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users? London: Home Office

Commissioning impact on drug treatment

The extent to which commissioning structures, the financial environment and wider changes to health and social welfare impact on drug misuse treatment and recovery

September 2017

EXECUTIVE SUMMARY

Background

This report by the Advisory Council on the Misuse of Drugs (ACMD) looks at the extent to which commissioning structures, contracting arrangements and the financial environment are impacting on drug misuse treatment. The ACMD has been keen to report on this issue due to:

- the significant changes occurring in health, social care and the criminal justice system in England;
- emerging evidence of reductions in funding; and
- concerns about the impact of trends in commissioning on drug misuse (and alcohol) treatment outcomes.

The Recovery Committee of the ACMD co-opted individuals with commissioning expertise and considered evidence from a broad spectrum of sources, including:

- a review of published literature on changes in health, social care and criminal justice commissioning;
- financial data on drug and alcohol misuse treatment;
- surveys of substance misuse providers;
- an online survey of and interviews with substance misuse commissioners;
- two professional membership bodies;
- Public Health England;
- drug and alcohol misuse treatment providers; and
- directors of public health.

Structural changes in commissioning drug treatment

Recently there have been significant changes in the commissioning of health, social care and criminal justice structures in England. Drug misuse treatment oversight and commissioning moved to public health structures in England in 2013. Local commissioning moved into local authorities, overseen by local authority-hosted health and wellbeing boards aimed at bringing together the NHS, public health, adult social care and children's services. National oversight of drug misuse treatment moved from the National Treatment Agency for Substance Misuse (NTA) into Public Health England (PHE).

The ACMD found reports of positive aspects to these changes, such as alignment of drug misuse treatment with other local authority and public health-related issues. However, there also appeared to be negative aspects, including challenges to local authority budgets.

The ACMD heard mixed evidence from surveys and testimonies on whether local strategic commissioning links were functioning well; many substance misuse commissioners and providers pointed to an increasing disconnect with wider health commissioning and provision.

Resources

The ACMD found evidence of reductions in local funding for drug misuse treatment in England (from 2008–09 to 2010–11 by around 12%). However, it was difficult to establish a clear picture on more recent trends due to changes in financial reporting and a lack of comparable published financial data. The ACMD received conflicting evidence on trends since 2013–14 from local authority published financial data and evidence from provider and commissioner surveys and case studies. The

majority of evidence from providers and commissioners described a level of reduction in funding, which was not apparent in published local authority financial returns. Evidence from the King's Fund also reported that cuts in public health services were planned up to 2020–21, particularly for drug misuse (and alcohol) treatment (Buck, 2016). The ACMD noted that NHS leaders had called for adequate investment in drug and alcohol misuse services as being 'vital' to prevent unsustainable demands on scarce NHS resources in the future (Health Select Committee, 2016).

Re-procurement

Re-procurement of contracts for drug treatment services between service providers and local authorities is a frequent occurrence in England. The ACMD heard evidence of positive and negative impacts of re-procurement. Many commissioners and some providers cited positive impacts of re-procurement in relation to positive drug misuse treatment system change and gaining efficiency savings. However, the ACMD also heard evidence that frequent re-procurement led to 'churn in the system' causing instability, disruption of local system performance and negative impacts on treatment outcomes in the short term. From an ACMD survey of commissioners, for the purposes of evidence gathering for this report:

- 71 per cent (20 out of 28 who responded to the question) reported a negative impact in the 3 months prior to the start of a contract;
- 66 per cent reported a negative impact in the 3 months after the start of a contract;
- 62 per cent reported a negative impact up to 6 months after contract start;
- 44 per cent reported a negative impact a year after contract start; and
- 23 per cent were still reporting a negative impact after 2 years.

Re-procurement was reported in this survey to be an expensive process for commissioners and providers. Some commissioners reported having to 'fight' for contract lengths of more than three years; others were frustrated by delays in local decision-making processes, which led to rushed processes and poor transitions.

There was a great deal of synergy between the views of providers and commissioners from surveys and expert witness evidence. In summary, providers generally perceived that:

- reductions in funding were greater than the official figures portrayed;
- frequent re-procurement of services, particularly when systems functioned well, was unnecessary and a major drain on resources, resulting in 'churn in the system' causing disruption and creating 'risky transition points' for service users;
- short contracts (of two years or less) and truncated re-procurement timetables were unhelpful, disruptive and had negative impacts on service users' recovery outcomes;
- workforce management was critical of re-procurement, with some providers suggesting a lack of leadership from commissioners;
- there were serious concerns among commissioners about the balance of clinical and professional expertise, and whether staff and volunteers without professional qualifications or competence were being lost due to financial constraints.

Conclusions and recommendations

The ACMD concludes that there is evidence that there have been reductions in resources for drug misuse treatment services (including young people's substance misuse services). ACMD also considered the Kings Fund report that suggested further reductions are planned to all substance misuse treatment services.

The ACMD is concerned that a system that has been seen nationally and internationally as highly successful is at risk of being undermined. The ACMD is concerned that loss of funding will result in the dismantling of a drug misuse treatment system that has brought huge improvement to the lives of people with drug and alcohol problems.

A loss of funding could lead to decreased treatment penetration and increased levels of blood-borne viruses, drug-related deaths and drug-driven crime in communities. Furthermore, reductions in drug misuse treatment funding are likely to result in reduced capacity and coverage of drug treatment services and/or the quality and effectiveness of drug treatment will be severely compromised if resources are spread too thinly – especially where service users have significant and complex long-term treatment needs. The clinical guidelines on drug misuse and dependence (Department of Health, 2017) include recommendations on clinical practice and competence. The ACMD is concerned that there could be a mismatch between these national guidelines and what underfunded local drug misuse treatment systems are able to deliver.

The effects of reduced resources appear to be compounded by services at risk of disruptive and frequent re-procurement that drains vital resources and creates a 'churn', resulting in poorer service user recovery outcomes, at least in the short term.

Moving drug and alcohol misuse treatment into local authority public health structures appears to have been detrimental to treatment in the context of the financial challenges faced by local authorities. In this complex and changing context it is difficult to see how current levels of drug (and alcohol) misuse treatment coverage and outcomes will be maintained over the next few years without significant extra efforts to protect investment and quality.

The ACMD has reviewed and assessed the report in light of the Government's recently published 2017 Drug Strategy. While the ACMD welcomes the strategy's recognition that "effectively funded and commissioned services, targeted at helping people fully recover from dependence" are crucial, decreasing local budgets and a lack of levers make it difficult to see how this aspiration can be delivered.

Conclusion 1

Despite the continuation of the ring-fenced Public Health Grant to local authorities until April 2019, reductions in local funding are the single biggest threat to drug misuse treatment recovery outcomes being achieved in local areas.

Recommendations

National and local government should give serious consideration to how current levels of investment can be protected, including mandating drug and alcohol misuse services within local authority budgets and/or placing the commissioning of drug and alcohol treatment within NHS commissioning structures.

National government should ensure more transparent and clear financial reporting on local drug misuse treatment services, together with new mechanisms to challenge local disinvestment or falls in treatment penetration.

National government's commitment to develop a range of measures which will deliver greater transparency on local performance, outcomes and spend should include a review of key performance indicators for drug misuse treatment, particularly those in the Public Health Outcomes Framework (PHOF), to provide levers to maintain drug treatment penetration and the quality of treatment and achieve reductions in drug-related deaths.

Conclusion 2

The quality and effectiveness of drug misuse treatment is being compromised by under-resourcing.

Recommendations

National bodies should develop clear standards, setting out benchmarks for service costs and staffing to prevent a 'drive to the bottom' and potentially under-resourced and ineffective services.

The Government's new Drug Strategy Implementation Board should ask PHE and the Care Quality Commission to lead or commission a national review of the drug misuse treatment workforce. This should establish the optimal balance of qualified staff (including nurses, doctors and psychologists) and unqualified staff and volunteers required for effective drug misuse treatment services. This review should also benchmark the situation in England against other comparable EU countries.

Conclusion 3

There is an increasing disconnection between drug misuse treatment and other health structures, resulting in fragmentation of drug treatment pathways (particularly for those with more complex needs).

Recommendation

Local and national government should consider strengthening links between local health systems and drug misuse treatment. In particular, drug misuse treatment should be included in clinical commissioning group commissioning and planning initiatives, such as local Sustainability and Transformation Plans (STPs).

Conclusion 4

Frequent re-procurement of drug misuse treatment is costly, disruptive and mitigates drug treatment recovery outcomes.

Recommendation

Commissioners should ensure that recommissioning drug misuse treatment services is normally undertaken in cycles of five to ten years, with longer contracts (longer than three years) and careful consideration of the unintended consequences of recommissioning. PHE and the Local Government Association (LGA) should consider the mechanisms by which they can enable local authorities to

avoid re-procurement before contracts end in systems that are meeting quality and performance indicators.

Conclusion 5

The ACMD is concerned that the current commissioning practice is having a negative impact on clinical research into drug misuse treatment across NHS and third (voluntary) sector providers. Many treatment providers are third sector and current research structures are not designed to recognise them. System churn due to recommissioning and reduced resources mitigates the stability and infrastructure required for research.

Recommendation

The Government's new Drug Strategy Implementation Board should address research infrastructure and capacity within the drugs misuse field. Any group set up to work on this should include:

- government departments;
- research bodies such as the Medical Research Council (MRC) and the National Institute for Health Research (NIHR); and
- other stakeholders.

CONTENTS

Executive summary	2
1. Introduction	
1.1 Background	9
1.2 Evidence for this report	9
1.3 Quality of evidence for this report	10
2. Shifting public services landscape in UK countries	11
2.1 Significant changes in drug and alcohol misuse treatment structures and processes, including devolution	11
2.2 England	11
2.3 Scotland	12
2.4 Wales	13
2.5 Northern Ireland	14
3. Changes in financial resources for drug misuse treatment in England	16
3.1 Challenges in tracking financial investment in drug and alcohol misuse treatment	16
3.2 Drug misuse treatment in England, 1998–2003	16
3.3 Funding streams, 2003–13	16
3.4 Drug misuse treatment funding allocations, 2004–09	17
3.5 Drug misuse treatment funding, 2008–09 to 2010–11	18
3.6 Funding structures and resources after 2013–14	18
3.7 Conflicting evidence concerning drug misuse treatment resources	19
3.8 Evidence that further reductions in substance misuse resources are imminent	19
3.9 Risks posed by changes to local public health grants	20
3.10 Conclusions	21

4. Commissioners' views	23
4.1 Advisory Council on the Misuse of Drugs online commissioners survey 2015	23
4.2 Advisory Council on the Misuse of Drugs qualitative interviews with commissioners, 2015	26
5. Providers' perspectives on commissioning and procurement	28
5.1 State of the Sector survey, 2014–16	28
5.2 Providers' experience of procurement and contract transfer	29
5.3 Evidence from professional bodies	30
Conclusions and recommendations	33
Appendix A: Membership and Secretariat	36
References	38

1. INTRODUCTION

1.1. Background

In 2015 the Advisory Council on the Misuse of Drugs (ACMD) through its Recovery Committee made a commitment to look at:

“The extent to which commissioning structures, contracting arrangements and the financial environment, impact on recovery outcomes for individuals and communities.”

The ACMD was keen to report on this due to the significant changes occurring in health, social welfare and the criminal justice system in England. There had been reports of both reductions in funding and concerns about the impact of trends in provision and commissioning on drug and alcohol misuse service user outcomes (Recovery Partnership, 2014; Recovery Partnership, 2015; Recovery Partnership, 2016). This report follows on from previous ACMD reports exploring what outcomes could be expected from people recovering from drug and alcohol dependency (ACMD 2013) and how opioid substitution therapy could be optimised to maximise recovery outcomes for service users (ACMD, 2015).

This report distinguishes commissioning from procurement – with procurement being a component part of commissioning. Commissioning is a cyclical process with the following strategic planning steps:

- assessing needs;
- reviewing current services;
- determining priorities;
- designing services;
- engaging the market;
- procuring services;
- tendering and awarding the contract;
- monitoring performance and managing services; and
- evaluating the impact on priorities.

The procurement element of the process is governed by legislation and regulations, including EU regulations.

1.2. Evidence for this report

A range of evidence was collected and heard for this report and discussed by the ACMD Recovery Committee. To assist this process, the Committee co-opted individuals with substance misuse commissioning expertise, including a director of public health and commissioners or local strategic leads for substance misuse. Evidence included the following:

- A desktop review of published literature on:
 - commissioning frameworks and guidelines, and recent changes to health and social care commissioning;
 - payment by results (PbR) pilots;

- financial data on substance misuse treatment and recovery – historic National Treatment Agency for Substance Misuse (NTA) and Audit Commission publications, local authority ‘outturn’ reports’ etc.;
 - joint strategic needs assessments and other local needs assessments; and
 - reports on the impact of changes and austerity on wider social care, housing, criminal justice and healthcare.
- An online survey by the ACMD, open to all drug and alcohol misuse commissioners in England.
 - Statements from two professional bodies on recommissioning.
 - The annual ‘State of the Sector’ surveys of drug and alcohol misuse treatment and recovery service providers.
 - Evidence gathering sessions and presentations from:
 - Public Health England;
 - drug misuse treatment commissioners and directors of public health;
 - drug and alcohol misuse treatment service providers;
 - United Kingdom Drug Policy Commission (UKDPC) work on commissioning; and
 - PbR pilot areas commissioners.
 - Information from Scotland, Wales and Northern Ireland officials on:
 - how their countries differ to England regarding arrangements for funding and providing drug misuse treatment; and
 - the impact of those arrangements

1.3 Quality of evidence for this report

The evidence collected for this report was largely descriptive (for example, outlining commissioning structures) or qualitative (for example, surveys and expert opinions). The financial data cited had been published for a range of purposes, used different methodologies and had different stakeholder interests. As a result, all the evidence had stakeholder biases and limitations.

Although there were discrepancies in the evidence (particularly between official statistics and stakeholder evidence around drug misuse treatment funding), this was around the scale of reduction – not whether there had been financial reductions. There was good consistency across data from a range of drug misuse treatment provider and commissioner surveys and expert witness evidence.

However, the evidence (cited in previous ACMD reports) is strong that drug misuse treatment has a positive impact on a range of individual and community outcome measures.

2. SHIFTING PUBLIC SERVICES LANDSCAPE IN UK COUNTRIES

2.1. Significant changes in drug and alcohol misuse treatment structures and processes, including devolution

The commissioning of drug and alcohol misuse treatment and wider health and social care has undergone major change in the last 20 years, particularly in England. Under the various devolution arrangements currently in place in the UK, health is now a devolved matter and is the responsibility of England, Scotland, Wales and Northern Ireland. Each country has developed their own health system and supporting structures, and this is reflected in the current arrangements for the commissioning of drug misuse treatment services.

2.2. England

2.2.1. Public sector commissioning is the mechanism used to plan, design and procure services according to local priorities and needs, to achieve value for money and improve outcomes for local residents. Services are provided by the NHS, voluntary (also known as 'third') and independent sector providers.

2.2.2. Drug and alcohol misuse services in England were at the forefront of services for those with complex needs that were to be locally commissioned and performance managed. From 2001 to 2013, the National Treatment Agency for Substance Misuse (NTA) oversaw the expansion of drug misuse treatment services and significant national investment of resources by the Government. NTA was tasked with:

- expanding treatment for drug misuse;
- improving the quality of the provision; and
- commissioning drug and alcohol misuse treatment services in England.

NTA regional teams undertook a 'delivery assurance' role of local strategic partnerships' (Drug and Alcohol Action Teams or DAATs) delivery of the drug strategy for adults and young people. During this time DAATs were normally underpinned by dedicated local drug and alcohol misuse commissioners and were located in a mixture of local authority and primary care trusts (PCTs). Each local area was required to submit annual commissioning plans that were scrutinised by the NTA.

2.2.3. In 2012 the Health and Social Care Act (Department of Health, 2012) devolved greater power and responsibility to local decision-makers and elected council members, and enabled greater focus on harmonising different funding streams to maximise efficient and effective responses to local or 'place' needs and shared priorities (Department of Health, 2012). County councils, unitary authorities and London boroughs established health and wellbeing boards (HWBs) with minimum membership drawn from the local authority, clinical commissioning groups (CCGs) and local branches of Healthwatch (the consumer champion for health and social care). DAATs were replaced or subsumed by the new structures. HWBs have narrower membership than the multi-agency DAATs, although some HWBs invite a wider range of local stakeholders.

2.2.4. In 2013 the responsibility for commissioning drug and alcohol misuse treatment became one of local government's new public health responsibilities. Combined drug and alcohol misuse financial spend was calculated and transferred into ring-fenced local authority public health grants. The NTA was dissolved and its functions moved into Public Health England (PHE).

2.2.5. PHE is an executive agency of the Department of Health and was created to bring together public health specialists from over 70 organisations. It has a broad remit, with national and international roles. In relation to substance misuse, PHE's relationship with substance misuse commissioners in local government is very different to that of the NTA. PHE's role has been designed to be one of support and advice without any remit for formal performance management or 'delivery assurance'.

2.2.5. Commissioning prison health services, primary care, some public health services (notably screening and immunisations) and specialist health services became the responsibility of the NHS Commissioning Board, now NHS England. The majority of local health service commissioning became the responsibility of CCGs, which are member organisations of general practices; these have governance arrangements that give a strong voice to local GPs.

2.2.6. In 2015 the probation trusts had been replaced by a single National Probation Service, responsible for high-risk offenders, and by 21 Community Rehabilitation Companies (CRCs) dealing with medium and lower level offending and with a new responsibility to supervise short-sentence (less than 12 months) prisoners. In 2012, 41 Police and Crime Commissioners (PCCs) were elected across England (and Wales) with responsibility to hold Chief Constables and police forces to account.

2.2.7. In recent years the Government has also funded a number of outcomes-based commissioning pilots including payment by results (PbR). PbR pilots started across eight sites in 2012 before additional pilot projects were embarked upon in England, which covered a number of health and social care areas including alcohol misuse treatment and generic employment programmes.

2.2.8. Previous ACMD reports have outlined that recovery from dependence involves improvement in a range of recovery outcome domains, in addition to overcoming dependence on drugs or alcohol. Recovery from dependence also involves:

- improvements in social and cultural capital such as housing and positive community involvements;
- better health and wellbeing;
- having economic capital, including a legitimate income; and
- no criminal involvement.

Many of these outcome areas are therefore significantly impacted by wider health and welfare systems and services.

2.2.9. While there are a host of national guidelines on commissioning for many aspects of health and social care, commissioning falls outside of the scope of regulatory and inspectorate bodies such as the Care Quality Commission and Monitor. However, in 2008 the Healthcare Commission and the NTA developed criteria and undertook a national review of commissioning to rate all local commissioning partnerships against these criteria (Healthcare Commission, 2008).

2.3. Scotland

2.3.1. In Scotland responsibility for commissioning has been devolved to 30 Alcohol and Drug Partnerships (ADPs). These are locally commissioned evidence-based, person-centred and recovery-focused treatment services to meet the needs of their resident populations. In 2009 the Framework for Local Alcohol and Drug Partnerships, (Scottish Government, 2009) signed jointly by Scottish

Government, the NHS and the Convention of Scottish Local Authorities (COSLA), set out the guidelines for local partnerships on misuse of alcohol and drugs, and aimed:

- to ensure that all bodies involved in tackling alcohol and problem drug misuse are clear about their responsibilities and their relationships with each other; and
- to focus activity on the identification, pursuit and achievement of agreed, shared outcomes.

2.3.2. ADPs are accountable to local Community Planning Partnerships (CPPs). An ADP is typically formed of representatives from the local NHS region (covering public health, mental health, addiction services and general hospital), local council (covering elected members, education, social work, and the Community Safety Partnership), the police, Community Justice Authority, and drug and alcohol misuse voluntary organisations. These representatives are required to be at a senior level within their organisation to ensure that the partnership has the ability to make strategic decisions that will be carried out across the partnership.

2.3.3. The Scottish Government provides earmarked funding to ADPs, as set out in the annual funding letter, to help them deliver against agreed core outcomes and key government priorities. Each year ADPs have to provide the Scottish Government with information on progress for the year against these outcomes and priorities.

2.3.4. Funding for ADPs is routed for administrative purposes via NHS Boards, but it is a partnership resource and the full allocation must be directed to ADPs. Investment decisions should be transparent and made on a partnership basis in pursuit of locally agreed strategies and delivery plans, which seek to deliver nationally agreed core outcomes and local outcomes.

2.3.5. It is also expected that ADP resources will be supplemented by investment from partners' core funding and that the partnership will be responsible for determining how all the available resource is invested. Partners are jointly accountable for delivery of the ADP outcomes within this financial framework.

2.3.6. Scotland's ADPs typically use commissioning principles recommended by the Social Care Inspectorate Scotland, taken from the Institute of Public Care (IPC), which links the commissioning and purchasing contracting cycles and is relevant across all public care services. The public, people who use services and those who support them are placed at the centre of this model.

2.3.7. Since 2013 Scotland has had a quality improvement framework including *The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services*, (Scottish Government, 2013) which are informed by recommendations from the *Essential Care and Quality Alcohol Treatment and Support* expert advisory reports on the development of 'recovery-orientated systems of care'.

2.4. Wales

2.4.1. In Wales, since 2009 the NHS has delivered services through seven local health boards and three NHS trusts. In 2010 substance misuse area planning boards (APBs) were established as part of the arrangements to deliver the Welsh Government substance misuse strategy, *Working Together to Reduce Harm* (Welsh Assembly Government, 2008). Commissioning executive groups allow 'responsible authorities' within a local health board region to discharge their statutory responsibilities under the UK Crime and Disorder Act 1998 for formulating and implementing a strategy for combating the misuse of drugs, alcohol and other substances.

2.4.2. In 2011 the Welsh Government reviewed APB development and to what extent they were delivering against their intended role and functions. As a consequence, revised guidance was published in August 2012 to support the planning, commissioning and performance management of substance misuse services at a regional (local health board) level (Welsh Assembly Government, 2013).

2.4.3. In 2013 the Welsh Government published guidance on 'recovery-orientated integrated systems of care' (ROISC) for APB commissioners, planners, service providers and service users, designed to enable the establishment of integrated systems of recovery-orientated service provision, and enabling the principles of recovery to be embedded in the culture of treatment provision across Wales (Welsh Assembly Government, 2014).

2.4.4. In 2015 the Welsh Government published revised commissioning guidance for substance misuse for APBs (Welsh Assembly Government, 2015). The revised guidance was designed to take into account emerging expertise on commissioning, the strengthened role of the APBs, requirements for an outcome-based commissioning strategy, and new national and local priorities (the increased availability of new psychoactive substances).

2.4.5. The APB commissioning process is now designed to take into account the Welsh Government priority of 'prudent healthcare'. Prudent healthcare is built around a set of principles that remodels the relationship between service users and providers on the basis of co-production, ensuring both are equal partners in any treatment delivered and ensuring "*the right service is intervening at the right time and in the right way using an evidence-based approach*" (*ibid.*).

2.5. Northern Ireland

2.5.1. Northern Ireland is unique in the UK in that it has a fully integrated system for both health and social care. New commissioning arrangements were put in place in 2009 (Health and Social Care Act (Northern Ireland), 2009) with:

- the establishment of the single regional Health and Social Care Board (HSCB) to replace the previous four Health and Social Services Boards;
- five local commissioning groups as sub-committees of the HSCB; and
- the regional Public Health Agency (PHA).

2.5.2. The HSCB, together with its five local commissioning groups, is responsible for commissioning the bulk of health and social care services in Northern Ireland. The HSCB is responsible for the commissioning of statutory Tier 3, and both statutory and community-based Tier 4 alcohol and drug misuse services, funded primarily through the mental health budget.

2.5.3. The HSCB is assisted by the PHA, which has responsibility for improving and protecting health and wellbeing, and provides public health advice to the commissioning process for those services commissioned by the HSCB. In addition, the PHA also directly commissions a range of services that fall within its areas of responsibility, for example, screening and immunisation programmes, obesity prevention, and services aimed at reducing drug misuse. The PHA commissions Tier 1 to Tier 3 alcohol and drug misuse services through its health Improvement budget.

2.5.4. The HSCB and the PHA have jointly developed a regional framework for the commissioning of alcohol and drug misuse services in Northern Ireland. This was being finalised at the time of writing (Health and Social Care Board/Public Health Agency, 2013).

3. CHANGES IN FINANCIAL RESOURCES FOR DRUG MISUSE TREATMENT IN ENGLAND

3.1. Challenges in tracking financial investment in drug and alcohol misuse treatment

The Advisory Council on the Misuse of Drugs (ACMD) Recovery Committee wished to track the changes in financial resourcing and expenditure on drug and alcohol misuse treatment from 2001 to 2015, focusing on England (following the shift in responsibility for commissioning of public health services to local authorities in 2013). This task proved challenging for a variety of reasons, not least that financial information on drug and alcohol misuse treatment has been recorded and reported using different systems and methodologies over the past ten years, and there is a lack of financial data published in a consistent way. However, there are some published reports, including National Treatment Agency for Substance Misuse (NTA) business plans and annual reports, and National Audit Office reports, which give financial data on selected aspects of funding allocations in England for some years. These are presented below. However, the ACMD has found that it has proven difficult to establish accurate trends in funding allocations and spending beyond ‘broad brush’ trends.

3.2. Drug misuse treatment funding in England, 1998–2003

In 1998 the Government launched a new drug strategy *Tackling Drugs to Build a Better Britain*. Following the 1998 comprehensive spending review, an extra £217 million extra resources were invested in drug misuse treatment over the next three years to complement the local ‘historic’ spending (this was around £59 million a year). By 2000–01, the total annual investment in drug misuse treatment (historic and new resources) was £234 million (National Treatment Agency, 2005).

The Government at the time made a further commitment to spending £401 million on drug misuse treatment by 2003–04 and streamline drug treatment funding mechanisms (National Audit Office, 2010).

3.3. Funding streams, 2003–13

From 2003–04, new funding streams were put in place for drug misuse treatment. These were the pooled treatment budgets that provided funding to local primary care trusts (PCTs), which were instructed to act on behalf of local strategic partnerships (Drug Action Teams or Drug and Alcohol Action Teams). Funding streams for drug and alcohol misuse treatment (including the costs of local commissioning teams, provider revenue and capital provider contracts) from 2003–04 to 2012–13 are outlined below.

a) The new or rationalised national funding streams given to local areas comprised:

- adult pooled treatment budget (APTB) that ring-fenced money for drug misuse treatment for adults;
- young people’s pooled treatment budget (YPPTB) that ring-fenced drug and alcohol misuse treatment for young people;
- Home Office/Department of Health funding streams for offenders, including drug testing on arrest and referral schemes, and prison and community drug and alcohol misuse treatment, such as funding for the Drug Interventions Programme (DIP).

b) Local funding to local areas comprised:

- contributions from local authorities and/or local health commissioners (then PCTs).

c) Miscellaneous funding to local areas came from:

- short-term government funding initiatives;
- charitable trust grants;
- EU funding streams;
- treatment ‘slots’ funded by research grants;
- private patients’ funding;
- health insurance schemes.

3.4. Drug misuse treatment funding allocations, 2004–09

3.4.1 The Government continued to invest large increases in funding to local areas in England from 2004–05 to 2008–09, to assist with the aim of the ten-year drug strategy to “*double the number of people in drug treatment*” and increase the quality of services (Cabinet Office, 1998). The main funding stream by which extra investment was made was the pooled treatment budget (PTB) allocations, which was meant to be complemented by increased local financial allocations. The National Audit Office report in 2010 (National Audit Office, 2010) showed this increased investment (Figure 1 below).

Figure 1: Drug misuse treatment budgets, activity and outcome data, 2004–05 to 2008–09

	2004-05	2005-06	2006-07	2007-08	2008-09
Adult Pooled Treatment Budget ¹	£255m	£300m	£380m	£383m	£373m
Local funding ¹	£226m	£226m	£224m	£207m	£208m
Total funding ¹	£481m	£526m	£604m	£590m	£581m
Number of adults in effective treatment ²	134,000	145,000	164,000	183,000	195,000
Total treatment funding per adult in effective treatment	£3,600	£3,600	£3,700	£3,200	£3,000

Source: National Audit Office analysis

NOTES

1 Funding figures are shown at 2008-09 prices.

2 Effective treatment: Adults who are discharged from treatment 12 weeks or more after triage, or who remain in treatment 12 weeks after triage, or who were discharged from treatment within 12 weeks in a planned way.

3.4.2. In 2004–05, total adult drug misuse treatment funding was £481 million (comprising £255 million PTB and £226 million local funding). Total funding reached a high of £604 million in 2006-07 before falling to £590 million in 2007-08. By 2008–09, total funding for adult drug misuse treatment was £581 million.

Due to increases of the numbers in drug misuse treatment, per capita treatment funding spending had reduced from £3,600 to £3,000 per annum. The National Audit Office noted that the proportion of funding from the PTB increased from 53 per cent to 64 per cent of total funding.

3.4.3. This analysis did not take into account the estimated £200 million additional funding from the Government for drug-using offenders in 2008–09, including the DIP and prison drug treatment.

3.5. Drug misuse treatment funding, 2008–09 to 2010–11

3.5.1. Published reports (National Treatment Agency, 2010) indicate that funding for drug and alcohol misuse treatment in the community in 2010–11 was £680 million. This comprised:

- £400 million APTB;
- £25 million YPPTB;
- £95 million DIP/funding for offenders;
- £160 million local drug treatment spending.

Prison substance misuse treatment funding was an additional £100 million (of which a proportion was for drug misuse treatment).

3.5.2 It is interesting to note that, although overall total spending for drug misuse treatment was broadly stable at around £800 million, there were reductions in local drug treatment spending, including reductions in ‘local funding’ of almost £50 million since 2008–09. Excluding prison treatment funding, drug misuse treatment funding appears to have fallen from £776 million to £680 million from 2008–09 to 2010–11, a fall of 12 per cent.

3.5.3. During this time, prison substance misuse treatment increased from £13 million for the Integrated Drug Treatment System (IDTS) in 2007–08 to £100 million in 2010–11.

3.5.4 The ACMD Recovery Committee was unable to find published reports on changes in drug misuse treatment funding between 2010–11 and 2013–14.

3.6. Funding structures and resources after 2013–14

3.6.1. Since 2013–14 substance misuse services commissioned by local areas in England have been funded from the local ring-fenced public health grant (PHG). The value of the grant in its first year was based upon public health expenditure from 2012 plus ‘growth and pace of change funding’. Drug and alcohol misuse funding is not ring-fenced within the grant.

The grant conditions specify that PHG-funded services are “*services which form part of the comprehensive health service*” and as such are subject to the same ‘rules’ as NHS services around payment and eligibility (Department of Health, 2014).

It is important to note that when the PHG was created, the expenditure on drug and alcohol misuse was around £800 million (around 30% of PHG funding), ahead of sexual health at around £640 million. In 2013–14 at the point of transfer this comprised:

- £532 million for adult drug misuse;
- £71 million for young people (substance misuse); and
- £190 million for alcohol misuse.

3.6.2. Local authority outturn data are available for 2013–14, (Department for Communities and Local Government, 2014) 2014–15 (Department for Communities and Local Government, 2015) and 2015–16 (Department for Local Government and the Communities, 2016). These data are recorded by drug misuse (adult), alcohol misuse (adult) and substance misuse (youth). Within each of these categories, financial data are subdivided into ‘running expenses’ (normally contracted services, and ‘employees’, usually the commissioning staff and sometimes specialist substance misuse social work staff.

3.6.3 Table 1 provides local authority substance misuse outturn data (actual net spend) for 2013–14, 2014–15 and 2015–16. Key points from these data show:

- a slight rise in adult drug misuse spend between 2013–14 and 2014–15 but an overall 8.0 per cent fall in spend over the 3 years;
- a reduction in substance misuse youth spend of 32.6 per cent over the 3 years;
- a 20.6 per cent increase in adult alcohol misuse spend over the 3 years.

Table 1: Local authority substance misuse outturn data (actual net spend), 2013–2016

	2013–14 (in £000s)	2014–15 (in £000s)	2015–16 (in £000s)
Drug misuse (adults)	532,376	541,313	489,986
Alcohol misuse (adults)	190,355	201,067	229,509
Substance misuse (youth)	70,839	66,715	47,771
Total expenditure	793,570	809,095	767,266

3.7. Conflicting evidence concerning drug misuse treatment resources

3.7.1 The ACMD found conflicting evidence and perceptions about the extent of drug misuse treatment spending cuts since 2013–14.

- Current or planned reductions (generally greater than those described in local authority outturn data) were reported by the majority of commissioners in the ACMD survey, the annual State of the Sector surveys and providers who gave evidence (see Section 5).
- The ACMD heard evidence of numerous examples of local area reductions in funding, enacted through either variations to existing contracts or re-procurement of local services. One example was Birmingham, which re-procured its substance misuse services (the largest single system in the country) and had a full system reconfiguration for much less resource; 32 per cent ‘cost efficiencies’ over a 5-year contract.^a
- Funding for local custody suite diversion services for drug misusers transferred to local crime commissioners from 2013–14. The ACMD could not find any published data on whether this funding had continued. Reports from providers suggested that most of this funding had been reduced or ceased by 2016.

3.8. Evidence that further reductions in substance misuse resources are imminent

3.8.1 The ACMD also received evidence that further reductions in resources were likely to occur in 2016–21.

^a Evidence presented to ACMD Recovery Committee: 17/09/15

- In November 2015 the Chief Executive of Public Health England outlined that future savings to the overall PHG would be phased in at:
 - 2.2 per cent in 2016–17;
 - 2.5 per cent in 2017–18;
 - 2.6 per cent in each of the two following years; and
 - no change or ‘flat cash’ in 2020–21.

The Health Foundation commented that this amounts to “*real term reductions from £3.47 billion to just under £3 billion by 2020–21*”, (Health Foundation, 2016) which equates to a 16 per cent reduction between 2016–17 and 2020–21.

- In a survey of local directors of public health, drugs and alcohol misuse services were cited as facing cuts in most local authorities, with 46 per cent planning cuts to alcohol services and 46 per cent planning to cut drug services in 2015–16 plus 72 per cent planning to cut funding to both drug and alcohol services in 2016–17 (Public Health England, 2014).
- Furthermore, analysis by the King’s Fund (Buck, 2016) on spending intentions of local authorities indicated that drug misuse treatment faced a higher percentage reduction than other public health areas in 2016–17 and this translated into larger absolute reductions in expected spend (as this comprised the largest funding stream to go into the PHG). Planned changes in 2016–17 compared with 2015–16 were reported as:
 - a 14 per cent reduction in drug misuse funding;
 - just over 9 per cent reduction in young people’s substance misuse services funding; and
 - an increase in planned alcohol misuse funding of around 7 per cent.

The King’s Fund also commented that “*Planned spending on some of the key determinants of our health in wider local government budgets is also falling; for example, culture and related services, which includes spending on open spaces, recreation and sport, is down by 6%, and housing services, which include homelessness, benefits and strategy, is down by 7.5% using the same data source*” (*ibid.*). The King’s Fund warned of the ‘false economy’ of these cuts.

3.9. Risks posed by changes to local public health grants

3.9.1. England has growing health inequality particularly between those living in areas of wealth and of social deprivation, and between the highest and lowest social classes. Reducing health inequalities is a national priority and central to the NHS *Five-Year Forward View* for reforming the NHS, health and social care services (NHS England, 2014).

3.9.2. There is evidence of very varied PHG allocations between different councils during the first year of the PHG. Benchmarking from the Chartered Institute of Public Finance and Accountancy (CIPFA) showed that 2013–14 net expenditure per head of population varied from under £20 to over £120 in different local authorities. Although some adjustments to allocation formulae have been made to address discrepancies, there is evidence that reallocation has only resulted in small variations (House of Commons Health Committee, 2016).

3.9.3. Local PHGs were ring-fenced for an initial two years; this was originally extended to 2015–16 and was recently extended further to 2017–18. However, while the total grant was ring-fenced, within the grant the substance misuse element of funding was not ring-fenced and has had to ‘compete’ against other public health priorities. Many authors have noted that drug misusers are highly stigmatised and face discrimination and may therefore ‘lose out’ to other service user groups who may be seen as ‘more deserving’ (UKDPC, 2008).

3.9.4 In addition, some public health services are ‘prescribed’ or mandated (local authorities must provide these within the PHG). Current public health mandated services include sexual health services (infection testing, treatment and contraception), the NHS Health Check programme, public health advice, the national child measurement programme, and services for 0–5 year olds. It is likely that mandated services will be prioritised for funding over non-mandated services – particularly if service users are stigmatised or seen as undeserving.

3.9.5. Against this backdrop of continuing reductions in local authority budgets, Simon Stevens, the head of the NHS, told the Health Select Committee in June 2016 that adequate investment in drugs and alcohol misuse services is vital to prevent unsustainable demands on scarce NHS resources in the future (Health Select Committee, 2016).

3.9.6 A House of Commons Health Committee report on public health post-2013 published in July 2016 (House of Commons Health Select Committee, 2016) concluded on public health funding:

“Local authorities are aiming to deliver more with less, giving rise to innovative practice, but they are now at the limit of the savings they can achieve without a detrimental impact on services and outcomes. There is clearly a mismatch between spending levels on public health – which are set to reduce – and the significance attached to prevention in the NHS Five-Year Forward View”.

Public health spending accounts for just 4.1 per cent of total health funding. The report concludes that cuts to public health funding are a false economy and the Government should commit to protecting funding for public health services or risk widening health inequalities and the sustainability of NHS services. Concern was expressed in the committee about the planned removal of PHG ring-fence and urged the Government to set out how this will be managed so as to not further disadvantage areas with higher deprivation and poorer outcomes. The health committee also committed to review variations in funding and outcomes.

3.10. Conclusions

3.10.1. The ACMD found clear evidence of a reduction in funding of drug misuse treatment between 2008–09 and 2010–11 of 12 per cent. There was a lack of published financial data available between 2011–12 and 2013–14. Local authority outturn reports showed an 8 per cent fall in adult drug misuse treatment spend between 2013–14 and 2015–16, and a 33 per cent fall in youth substance misuse spend over the same period.

3.10.2. There was a large increase in prison substance misuse treatment and alcohol treatment funding over this period.

3.10.3. The King’s Fund also reported large planned reductions in public health and particularly to drug and alcohol misuse treatment between 2016–17 and 2020–21.

3.10.4. The ACMD concluded that there is a likelihood that community drug misuse treatment will face greater reductions in more local authorities than other public health areas and may be

disproportionately impacted by future reductions. Those with drug (and alcohol) dependency were identified as 'unpopular' and likely to 'lose out' in local resource allocations compared with those using mandated services or other population groups.

3.10.5. A removal of the public health funding ring fence is likely to compound these issues and if the PHG is used for other purposes, funding for treatment of drug misuse could continue to fall.

4. COMMISSIONERS' VIEWS

Substance misuse commissioners in England were surveyed in June–August 2015 by the Advisory Council on the Misuse of Drugs (ACMD). This comprised an online anonymous survey and further qualitative interviews conducted with 14 invited commissioners.

4.1. Advisory Council on the Misuse of Drugs online commissioners survey 2015

A total of 106 responses were obtained from around 149 commissioning teams (71% response rate). However, response rates to individual questions varied, particularly in relation to questions about procurement.

4.1.1. In all, 100 out of 106 local areas gave responses about **strategic commissioning trends** (around 67% of all local commissioning areas). The following trends were identified.

- a) Over 91 per cent thought that they had strategic links to their health and wellbeing board (HWB) and the local police and criminal justice systems, but only 75 per cent reported strategic links to clinical commissioning groups (CCGs) responsible for health.
- b) Just under a quarter (22%) reported these strategic links to health and criminal justice as very good, 43 per cent as good, 7 per cent as neutral, 23 per cent as could be improved and 6 per cent as poor.
- c) When asked whether strategic links had improved with the move to HWB structures, a fifth (20%) said that they had improved, 10 per cent said slightly improved, 17 per cent said they had slightly worsened and 10 per cent said they had worsened.
- d) Just over half (58%) felt that the alignment of local drug and alcohol misuse treatment priorities with other local strategic priorities had improved, with 23 per cent saying that they could be improved and 18 per cent being neutral.
- e) Almost two-thirds (63%) rated service user involvement in commissioning as good or very good but 20 per cent felt that it could be improved or was poor. Carer involvement was rated as good or very good by only a quarter (25%), with 38 per cent reporting that it could be improved and 16 per cent saying that it was poor.
- f) Commissioning support from Public Health England (PHE) was seen as positive in just under half (23% very good, 26% good), with 22 per cent stating that it was OK or neutral, 17 per cent wanting improvement and 11 per cent rating it as poor.

4.1.2. Current and **projected resource allocation** questions had 55 responses (52% of respondents and 37% of local areas) and therefore only 'trend' data are reported as the detailed data may be unreliable.

- a) Commissioners predicted year-on-year reductions in resources for all types of drug and alcohol misuse treatment and for resourcing substance misuse commissioning teams between 2014–15 and 2017–18.
- b) When asked whether they thought they would have enough financial resources to meet the needs of the local population in 2015–16, 14 per cent said that they were well resourced, 50 per cent reported having adequate resources, and 37 per cent were under resourced (8% very under resourced). By 2016–17 over half (55%) were predicting that they would be

under resourced (including 14% who thought that they would be 'very' under resourced), 29 per cent adequately resourced and 10 per cent well resourced.

4.1.3. In all, 64 areas (60% of respondents and 43% of local areas) answered questions on **quality and performance** in commissioning. There were the following trends in responses.

- a) Most commissioners met with local providers either quarterly (62%) or monthly (35%).
- b) When asked what process measures are prioritised locally:
 - 95 per cent said Public Health Outcomes Framework measures;
 - 87 per cent said treatment completion;
 - 60 per cent said numbers in treatment;
 - 54 per cent said retention in treatment; and
 - just over a third said drug (36%) or alcohol (38%) misuse treatment penetration.
- c) Around a third (32%) of commissioners had a local workforce strategy and 60 per cent had provider-led workforce strategies.
- d) The vast majority (94%) had commissioner-led quality assurance programmes comprising:
 - safeguarding adults and children (100%);
 - serious incident reporting to commissioners (95%);
 - information governance (91%);
 - Care Quality Commission (CQC) compliance and service user satisfaction surveys (83%);
 - drug-related death review process (75%);
 - local medicines management systems (69%); and
 - case note audits (56%).

4.1.4. A minority of commissioners (n=24) had answers on **re-procurement** (partially due to some not having recently re-procured services). A number of questions were answered by less than a quarter of commissioners and have been excluded from this section. However, around 40 per cent of commissioners gave answers to systems requirement of new contracts and unintended consequences of re-procurement. The following trends were reported.

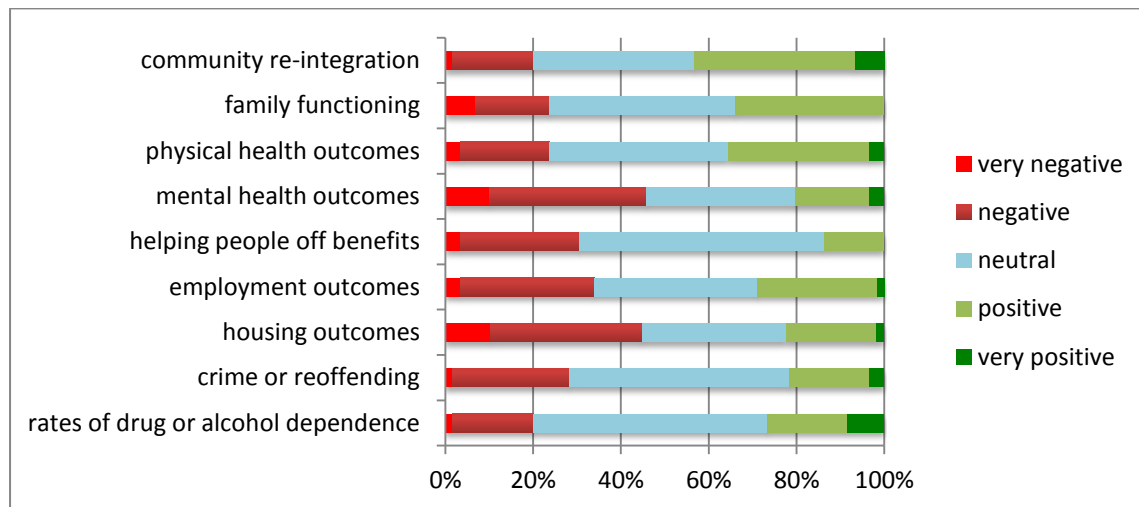
- a) The majority of new contracts had quality governance requirements including:
 - compliance with national clinical guidelines (100%);
 - CQC registration and compliance (95%);
 - information governance compliance (83%);
 - single-case management system (70%); and
 - shared clinical governance across the local system (65%).
- b) When asked what recovery outcomes were specifically commissioned:
 - around 95 per cent said reductions in dependence;
 - 79 per cent specified improvements in physical health and employment status;
 - 74 per cent improvements in housing;

- 66 per cent reductions in crime and improved mental health;
 - 47 per cent reductions in drug-related deaths;
 - 32 per cent reductions in numbers claiming benefits; and
 - 26 per cent reduced levels of use 'on top' among those in opioid substitution therapy.
- c) Many new contracts had 'recovery-orientated requirements' including:
- promotion of mutual aid (95%);
 - staff cultures that promote recovery (92%);
 - motivational recovery plan reviews (80%);
 - assessments that include strengths and deficits (72%); and
 - a 'phased and layered' approach (59%).
- d) The impact of re-procurement on local system performance on key indicators was reported to be negative by between 60 and 65 per cent of commissioners in the 3 months before and 6 months after new contracts started (with between 15 and 20% reporting no impact and 24% reporting some improvement 3 to 6 months after the start). Between 6 and 12 months after new contracts started 45 per cent still reported negative impacts on performance. Most commissioners (73%) reported a positive impact in the second year of new contracts but 23 per cent still reported a negative impact.
- e) Unintended consequences of re-procurement were reported by 58 per cent of respondents, including:
- negative reactions to Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) causing problems for months;
 - problematic behaviour by some outgoing providers;
 - difficulty in changing staff culture;
 - loss of key staff;
 - breakdown of links to mental health services;
 - problems in new partnership working; and
 - problems with estates or buildings (65% of respondents).
- f) Commissioners were asked about the approximate cost of a recent re-procurement. Most were unable to give a monetary value but instead gave answers such as "*drain of existing staff's time*".

4.1.5. Around 60 per cent of commissioners rated the **impact of overall local system change on recovery outcomes**. The majority thought that the impact would be neutral, but the results were mixed and varied. More than 40 per cent perceived negative impacts on mental health and housing outcomes, and more than a quarter thought that there were negative impacts on employment outcomes, helping people off benefits and away from crime. Conversely, more than 40 per cent thought that there was a positive impact on community re-integration outcomes, and more than 25

per cent perceived improvements in physical health outcomes, family functioning, employment, and rates of drug and alcohol dependence.

Figure 2: Commissioner ratings of the impact of local system change on recovery outcomes



4.2. Advisory Council on the Misuse of Drugs qualitative interviews with commissioners 2015

The online survey of commissioners across England asked for volunteers for further ‘deep dive’ qualitative interviews. A total of 14 selected commissioners (from all regions in England) were subsequently invited to be interviewed by telephone during July and August 2015. The interview questions were developed by the ACMD Recovery Committee based on gaps in responses to the online survey. Questions covered recent procurement, outcomes, financial considerations, workforce and strategic priorities.

Overall, the interviewed commissioners felt that the systems required a period of stability to develop the skills and services that are required to properly deliver the recovery agenda. They felt that commissioning knowledge and expertise were being lost, leading to uninformed strategic decisions being made and opening the door for poor practice and poor providers. The following overarching messages emerged from the interviews.

- a) Contracts needed to be a minimum of five years (three years with the option to extend for one year, plus another one year).
- b) System ‘churn’ and frequent re-procurement led to instability and had a notable negative impact on outcomes.
- c) The workforce in general was ‘not fit for purpose’ and this was one of the most significant barriers to recovery outcomes. Commissioners thought that the workforce required significant investment, and that clinical expertise was being eroded. Concerns were expressed on the ‘over reliance’ on volunteers, who seemed to provide the majority of the ‘recovery-based’ work in some areas.
- d) Drug and alcohol misuse strategic leadership was thought to be lacking at a local level.
- e) Financial disinvestment was a very significant concern.

- f) *“Poor provider behaviour and poor practice during re-procurement and service transfer”* was noted as having a negative impact on service user outcomes during re-procurement.
- g) For those areas that had shared care-based treatment (care shared between drug misuse treatment and primary care), it was felt that outcomes for heroin users were poorer due to ‘prescription-based’ treatment; this lacked psychosocial interventions and a subsequent move to reduce the shared care was described.
- h) Finally, some commissioners expressed concerns that ‘localism’ had meant that they lost some of the previous oversight and support from the National Treatment Agency for Substance Misuse (NTA) regional teams and national bodies and that this was a significant gap and a risk to achieving recovery outcomes.

5. PROVIDERS' PERSPECTIVES ON COMMISSIONING AND PROCUREMENT

5.1. State of the Sector survey, 2014–16^b

5.1.1. The State of the Sector survey is an online survey of managers of adult community and residential drug and alcohol misuse treatment services from across the England, followed up with in-depth interviews with senior staff and chief executives. The State of the Sector reports (Recovery Partnership, 2014; Recovery Partnership, 2015; Recovery Partnership, 2016) provide a detailed insight into the changing nature of drug and alcohol misuse treatment services from a provider perspective. The surveys were carried out by DrugScope and latterly Adfam on behalf of the Recovery Partnership.

5.1.2. The 2014 report said that areas of concern such as funding reductions and increasing caseload levels were evident, but did not find evidence of deep and widespread disinvestment that year “*at this early point*”, since the move to local authority health and wellbeing board commissioning.

5.1.3. However, responses in 2015 and then in 2016 for both community and residential services suggested that a decrease in funding had occurred.

5.1.4. An often cited example of the pressures being placed on the sector were reductions in funding for mental health and substance misuse services (dual diagnosis). Providers highlighted growing prevalence and severity of service user needs in this area, and the ongoing challenges of offering services and joined-up support to people affected by both substance misuse and mental health issues.

5.1.5. Respondents from the 2015 and 2016 reports indicate that they were working to contracts of three years or less. Comments from respondents were clear about this causing instability and anxiety among services and service users. Comments also suggested that frequent re-tendering can be resource intensive.

5.1.6. The latest State of the Sector data had fewer respondents reporting re-tendering, with 44 per cent of respondents having been through a re-tendering exercise since September 2014; this had been 54 per cent and 57 per cent in the previous two years. The proportion of respondents expecting to be re-tendered over the coming year had fallen across the reporting periods; in 2014, 63 per cent expected to be re-tendered, in 2015 this was 44 per cent, and 35 per cent in 2016 expected to be re-tendered or have a contract renegotiation.

5.1.7. In 2016, 78 per cent reported a standard contract length (not allowing for possible extensions) of three years or less; 14 per cent reported an increased contract length and 23 per cent a reduced contract length.

5.1.8. In 2016, 82 per cent of respondents said that guidance on the commissioning of substance misuse services was not useful.

5.1.9. In 2014 neither community nor residential services reported an in-year financial impact of reduced investment. However, by 2015, 55 per cent of community service respondents indicated a decrease in

^b Three State of the Sector reports were published in 2014, 2015 and 2016. While the State of the Sector report titles refer to different years (some of which overlap), this report will identify the reports by their publication dates: 2014, 2015 and 2016.

funding (average reduction of 16.5%), 29 per cent indicated no change, and 16 per cent indicated an increase in funding. By 2016, 58 per cent of respondents indicated a decrease in funding, 32 per cent indicated no change, and 10 per cent indicated an increase in funding.

5.1.10. In 2015, 53 per cent reported a reduction in frontline staff while 62 per cent reported an increase in the use of volunteer recovery champions.

5.1.11. The 2016 data show a worsening impact of reductions in funding on service delivery reported by the majority of providers, including on reductions in work force development, core services, and increased caseload levels per worker.

5.1.12. Around a fifth of participants in each of the three surveys (2014, 2015 and 2016) felt that access to mental health services for their client group had deteriorated in the preceding 12 months. Fewer than one in ten felt access had improved.

5.2. Providers' experience of procurement and contract transfer

5.2.1. The Advisory Council on the Misuse of Drugs (ACMD) Recovery Committee heard verbal submissions from third (voluntary) sector and NHS providers about their experiences of procurement and contract transfer as part of an evidence gathering session.

5.2.2. Third sector and NHS providers described their approaches to procurement, including the process of due diligence in procurement and comprehensive risk–benefit analysis, when considering tendering for new contracts. This process involved intelligence gathered on current providers, including outcomes of inspections they had, and quality and performance issues that could be 'inherited'. Providers felt that procurement processes could be helped by maintaining good dialogue between commissioner, provider and service user stakeholders.

5.2.3. Challenges during procurement and re-procurement included:

- financial envelopes that were considered too small to make a contract viable and that some contracts were *"not worth bidding for"*;
- coping with the scale of the tendering, which required significant resources and energy and could distract from day-to-day running of existing services – some large providers describe tendering for 15 to 20 contracts at any one time;
- timescales for re-procurement (to bid and then mobilise) were often described as *"tight"*;
- a range of staffing issues from complex and difficult Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE), staffing legacies (including large, well-paid teams needing to be reduced in size and cost), and changing cultures that could be difficult for staff; and
- unhelpful and/or uncommunicative outgoing agencies.

5.2.4. Providers' views of good practice in procurement – providers identified the following areas of practice that, if done well, could help with contract transfer.

- Staff transfer – to retain expertise and knowledge and maintain staff morale.
- Accommodation – this should not involve too much upheaval; a similar or the same location for operations is desirable.

- Case note and data transfer, with information governance procedures and information sharing – retaining organisational memory in a consistent way.
- Continuity of care – clients should not have to ‘start again’ with a new keyworker.
- Maintaining performance during transition.
- Project management of service transfers and transformations.
- When the new contract begins, the new provider should welcome staff and explain the service model to them from the outset. A change programme should be outlined, which includes induction and training options for all levels of staff. Service user groups should also be involved as part of a ‘deep dive’ into what the service really looks like.
- The transformation phase will take place between 6 and 18 months after the contract begins and should include:
 - the completion of consultations with human resources;
 - the establishment of any redundancies or change in job roles; and
 - the identification of management structures.
- Medical leadership is vital to shift the focus to recovery, and medical reviews of all clients whose receive prescribed treatment should take place in order to understand their risks and how to optimise their treatment.
- New contract lengths were thought to be best and most effective when longer (longer than three years); the most common contract lengths were described as two- to three-year contracts with options for up to three one-year extensions.
- Providers felt that mobilisation phases (to prepare for change) that began three months prior to contract start was optimal. This enabled service transfer and stakeholder work with partners, commissioners, service users and local clinical commissioning groups (CCGs).

5.3. Evidence from professional bodies

5.3.1. The ACMD called for evidence on this topic from professional bodies involved in substance misuse treatment. Responses were received from the Faculty of Addictions at the British Psychological Society (BPS) and the Faculty of Addictions Psychiatry of the Royal College of Psychiatrists (RCPsych).

5.3.2. Some members of the BPS said that since drug and alcohol misuse services transferred to public health in local authorities, *“the effects of austerity and cuts to funding have become increasingly apparent”*. They reported *“rapid re-tendering cycles are leading to a lack of stability in treatment systems and rapid changes in treatment approaches which act against the fundamental principle of high-quality training and supervision of frontline staff”*. Some members of the BPS stated that *“this lends itself to a highly competitive market of providers who need to drive down costs”*.

They noted that the level of inclusion of clinical psychologists in provider infrastructures varied widely from one provider to another. In 2012 a BPS publication (BPS, 2012) said making successful changes to drug and alcohol problems requires changes to behaviour, thinking and environment.

Clinical psychologists are unique among drug and alcohol misuse treatment professionals in having high-level expertise to assist clients to make these changes. The BPS also highlights publications from the National Treatment Agency for Substance Misuse (NTA), which stressed the need for high-quality psychosocial treatment and good clinical governance. Some members of the BPS stated that *“there has been a significant decrease in the number of clinical psychology posts in addictions over recent years and not all clinical psychology training courses include training specifically on working with substance misuse”*.

Finally, members of the BPS commented that *“as commissioners and CCGs have a different set of organising issues, there has been a separation of mental health and substance misuse priorities on the ground, making effective joint working and expert input for people with complex needs, ever more difficult to achieve”*.

5.3.3. The Faculty of Addictions Psychiatry of the RCPsych stated the view that, in the last few years, changes to commissioning of addiction services have resulted in a reduction of quality and long-term sustainability of services. The Faculty identified the following problems.

- Multiple and frequent re-tendering of services resulting in unstable treatment systems and poor continuity of care for patients. This particularly impacts on patients with co-existing substance misuse and mental health problems (dual diagnosis) and complex needs requiring extended clinical care.
- Loss of NHS treatment services to the voluntary sector – so that many NHS health trusts no longer provide addiction services. In these instances, the RCPsych reported that general psychiatry, acute and primary care medical colleagues are concerned about the loss of joined-up care for those with complex health needs and/or dual diagnosis, resulting in negative impacts on patient care.
- Increased workload and costs caused by frequent re-tendering, which detracts from frontline service productivity and resources.
- Poor transition (and drop-out) of patients as a consequence of re-tendering including increased drug overdoses, increase in use of accident and emergency and acute hospitals, and increases in crime.

The RCPsych stated that another biggest impact of multiple frequent re-tendering was the negative impact on the professional workforce – especially doctors, nurses and psychologists. It noted a loss of local systems led by addiction psychiatrists and cited a recent survey of faculty members. The survey identified a loss of 33 consultant addiction psychiatry posts, and a loss of half of addiction psychiatry training posts as a direct consequence of re-procurement and loss of NHS services.

The RCPsych noted that, although the Health and Social Care Act 2012 obliges local authorities to maintain training positions, *“few chose to do so”*. The impact of the loss is threefold:

- reduced capacity to fill addiction psychiatrist training posts;
- addictions are seen as an unattractive career due to re-tendering creating difficulties in recruiting; and
- the significant loss of expertise in addictions among general psychiatrists not receiving placements in this area – which impacts on patient care.

The RCPsych also comments on the change in commissioning policy where commissioners are *“overly focused on limiting the length of treatment irrespective of patient need”* – leading to treatment ‘fall-out’ of those with complex needs.

In relation to reductions to resources, the RCPsych stated that it had examples of re-procurement of services for at least 30 per cent less resources and says that these reductions are at the expense of quality as less resource is stretched over the same number of patients. It draws attention to the loss of more expensive professional staff, *“e.g. clinical assistants rather than consultant psychiatrists, and peer mentors rather than nurses or psychologists”*. The RCPsych reported that while the Care Quality Commission has expressed concerns about the competency of staff and quality of care in some instances, some commissioners *“appear to have no accountability for decisions to downgrade services”*.

The RCPsych stated *“In summary, the recent changes in commissioning of addiction services have had a negative impact on the quality and continuity of care for patients, and the loss of addiction psychiatry training posts will have a negative impact on recruitment into the speciality. We are keen to highlight the impact on the whole treatment sector as well as the wider NHS, and seek to work with appropriate bodies to find solutions”*.

6. CONCLUSIONS AND RECOMMENDATIONS

The ACMD concludes that there is evidence that there have been reductions in resources for drug misuse treatment services (including young people's substance misuse services). ACMD also considered the Kings Fund report that suggested further reductions are planned to all substance misuse treatment services.

The ACMD is concerned that a system that has been seen nationally and internationally as highly successful is at risk of being undermined. The ACMD is concerned that loss of funding will result in the dismantling of a drug misuse treatment system that has brought huge improvement to the lives of people with drug and alcohol problems.

A loss of funding could lead to decreased treatment penetration and increased levels of blood-borne viruses, drug-related deaths and drug-driven crime in communities. Furthermore, reductions in drug misuse treatment funding are likely to result in reduced capacity and coverage of drug treatment services and/or the quality and effectiveness of drug treatment will be severely compromised if resources are spread too thinly – especially where service users have significant and complex long-term treatment needs. The clinical guidelines on drug misuse and dependence (Department of Health, 2017) include recommendations on clinical practice and competence. The ACMD is concerned that there could be a mismatch between these national guidelines and what underfunded local drug misuse treatment systems are able to deliver.

The effects of reduced resources appear to be compounded by services at risk of disruptive and frequent re-procurement that drains vital resources and creates a 'churn', resulting in poorer service user recovery outcomes, at least in the short term.

Moving drug and alcohol misuse treatment into local authority public health structures appears to have been detrimental to treatment in the context of the financial challenges faced by local authorities. In this complex and changing context it is difficult to see how current levels of drug (and alcohol) misuse treatment coverage and outcomes will be maintained over the next few years without significant extra efforts to protect investment and quality.

The ACMD has reviewed and assessed the report in light of the Government's recently published 2017 Drug Strategy. While the ACMD welcomes the strategy's recognition that "effectively funded and commissioned services, targeted at helping people fully recover from dependence" are crucial, decreasing local budgets and a lack of levers make it difficult to see how this aspiration can be delivered.

Conclusion 1

Despite the continuation of the ring-fenced Public Health Grant to local authorities until April 2019, reductions in local funding are the single biggest threat to drug misuse treatment recovery outcomes being achieved in local areas.

Recommendations

National and local government should give serious consideration to how current levels of investment can be protected, including mandating drug and alcohol misuse services within local authority budgets and/or placing the commissioning of drug and alcohol treatment within NHS commissioning structures.

National government should ensure more transparent and clear financial reporting on local drug misuse treatment services, together with new mechanisms to challenge local disinvestment or falls in treatment penetration.

National government's commitment to develop a range of measures which will deliver greater transparency on local performance, outcomes and spend should include a review of key performance indicators for drug misuse treatment, particularly those in the Public Health Outcomes Framework (PHOF), to provide levers to maintain drug treatment penetration and the quality of treatment and achieve reductions in drug-related deaths.

Conclusion 2

The quality and effectiveness of drug misuse treatment is being compromised by under-resourcing.

Recommendations

National bodies should develop clear standards, setting out benchmarks for service costs and staffing to prevent a 'drive to the bottom' and potentially under-resourced and ineffective services.

The Government's new Drug Strategy Implementation Board should ask PHE and the Care Quality Commission to lead or commission a national review of the drug misuse treatment workforce. This should establish the optimal balance of qualified staff (including nurses, doctors and psychologists) and unqualified staff and volunteers required for effective drug misuse treatment services. This review should also benchmark the situation in England against other comparable EU countries.

Conclusion 3

There is an increasing disconnection between drug misuse treatment and other health structures, resulting in fragmentation of drug treatment pathways (particularly for those with more complex needs).

Recommendation

Local and national government should consider strengthening links between local health systems and drug misuse treatment. In particular, drug misuse treatment should be included in clinical commissioning group commissioning and planning initiatives, such as local Sustainability and Transformation Plans (STPs).

Conclusion 4

Frequent re-procurement of drug misuse treatment is costly, disruptive and mitigates drug treatment recovery outcomes.

Recommendation

Commissioners should ensure that recommissioning drug misuse treatment services is normally undertaken in cycles of five to ten years, with longer contracts (longer than three years) and careful consideration of the unintended consequences of recommissioning. PHE and the Local Government Association (LGA) should consider the mechanisms by which they can enable local authorities to

avoid re-procurement before contracts end in systems that are meeting quality and performance indicators.

Conclusion 5

The ACMD is concerned that the current commissioning practice is having a negative impact on clinical research into drug misuse treatment across NHS and third (voluntary) sector providers. Many treatment providers are third sector and current research structures are not designed to recognise them. System churn due to recommissioning and reduced resources mitigates the stability and infrastructure required for research.

Recommendation

The Government's new Drug Strategy Implementation Board should address research infrastructure and capacity within the drugs misuse field. Any group set up to work on this should include:

- government departments;
- research bodies such as the Medical Research Council (MRC) and the National Institute for Health Research (NIHR); and
- other stakeholders.

APPENDIX A: MEMBERSHIP AND SECRETARIAT

Members of the Advisory Council on the Misuse of Drugs Recovery Committee (August 2017)

Ms Annette Dale-Perera	Chair, ACMD member
Dr Kostas Agath	ACMD member
Mr Mike Ashton	Editor, <i>Drug and Alcohol Findings</i>
Ms Fiona Bauermeister	ACMD member
Professor David Best	Professor of Criminology, Sheffield Hallam University
Ms Vivienne Evans	Chief Executive, Adfam
Dr Emily Finch	ACMD member
Mr Mark Gilman	Managing Director, Discovering Health
Mr Simon Jenkins	Director, Recovery-Now
Mr Chris Lee	Public Health Specialist, Lancashire County Council
Mr Tim Leighton	Director, Centre for Addiction Treatment Studies
Ms Joanna Manning	Programme Manager, Children & Young People Division, Nottingham, Children's Society
Ms Jo Melling	ACMD member
Dr Tim Millar	ACMD member
Mr Richard Phillips	ACMD member
Mr Rob Phipps	ACMD member
Mr Alistair Sinclair	Director, UK Recovery Federation
Mr Martin Smith	Recovery Lead, Derbyshire Healthcare NHS Foundation Trust
Dr Melanie Smith	Director of Public Health, Brent Council
Professor Harry Sumnall	ACMD member
Ms April Wareham	Independent consultant

Members of the Advisory Council on the Misuse of Drugs (August 2017)

Dr Owen Bowden-Jones (Chair of ACMD)	Consultant in addiction psychiatry and Honorary Senior Lecturer at Imperial College
Dr Kostas Agath	Medical Director of Addaction
Ms Gillian Arr-Jones	Pharmacist and expert reviewer and pharmacist consultant in health and social care
Mr Simon Bray	Commander in the Metropolitan Police, Specialist Operations
Dr Roger Brimblecombe	Pharmacologist
Ms Annette Dale-Perera	Independent consultant
Professor Paul Dargan	Consultant physician and clinical toxicologist, clinical director, Guy's and St Thomas' NHS Foundation Trust and Professor of Clinical Toxicology, King's College London

Dr Emily Finch	Clinical director of the Addictions Clinical Academic Group and Consultant psychiatrist for South London and Maudsley NHS Trust
Professor Simon Gibbons	Professor of Medicinal Phytochemistry, Research Department of Pharmaceutical and Biological Chemistry, UCL School of Pharmacy
Professor Raymond Hill	Neuropharmacologist and Visiting Professor of Pharmacology, Imperial College London
Mr David Liddell	Chief Executive Officer at the Scottish Drugs Forum
Professor Fiona Measham	Professor of Criminology in the School of Applied Social Sciences, Durham University
Mrs Jo Melling	Head of Performance and Delivery, NHS England (Midlands)
Dr Tim Millar	Senior Research Fellow and Addiction Research Strategy Lead, University of Manchester
Mr Richard Phillips	Independent consultant in substance misuse
Mr Rob Phipps	Former senior policy official (drugs and alcohol), Department of Health, Social Services and Public Safety in Northern Ireland
Dr Steve Pleasance	Analytical chemist and Head of Industry at the Royal Society of Chemistry
Professor Fabrizio Schifano	Consultant psychiatrist (addictions), Change, Grow, Live (cgl) Hertfordshire Drug and Alcohol Recovery Services and Professor of Clinical Pharmacology and Therapeutics, University of Hertfordshire
Professor Alex Stevens	Professor of Criminal Justice and Deputy Head of the School of Social Policy, Sociology and Social Research, University of Kent
Professor Harry Sumnall	Professor in Substance Use, Liverpool John Moores University
Dr Ben Whalley	Director of Discovery Research, GW Pharmaceuticals

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