

**RICHARD: STANDBY TEXT ONLY, IGNORE THIS PAGE. TO BE USED/ADAPTED ONLY IF SOMEONE DOES NOT SUBMIT THEIR COPY. BY IAIN DUNCAN SMITH. THANKS, DEIRDRE**

#### STRUCTURAL REFORM REPLACE THE NATIONAL TREATMENT AGENCY WITH AN ADDICTION RECOVERY BOARD.

- This will shift culture from maintenance and harm reduction as an end-goal to full recovery. The new board will be chaired by a minister and led by an individual committed to full recovery and evidence-based treatment.

- Alcohol treatment is patchy and managed by Primary Care Trusts with little central direction. The ARB would rectify this by bringing alcohol treatment on a level with drug treatment and providing an integrated strategy.

- Treatment of dependency on prescribed and over-the-counter drugs is negligible. This would also be strategised by the ARB.

#### ABSTINENCE-BASED TREATMENT VOUCHERS.

Personalised treatment vouchers will more quickly enable addicts who want to enter residential treatment and break free of dependency. With some provision made for the unstable nature of recovery, vouchers will be available on a time-scaled system.

#### TREATMENT REFORM STANDARDS OF RECOVERY.

The system of tiered models of care and the setting of targets should be replaced with new standards of recovery. This would be a needs-led system, monitored and measured in terms of real outcomes – including abstinence, improved mental health, employment and housing.

#### RESIDENTIAL REHABILITATION EXPANSION.

Expansion should be undertaken to move from 2,400 beds to 10,000. In time, it should be compulsory for addicts to be offered a residential place should they be available, preventing beds being left empty. We cannot continue to use residential rehabilitation as a last resort.

#### GREATER RECOGNITION AND USE OF PEER SUPPORT GROUPS.

Drug and Alcohol Action Teams will develop close contact with local groups and direct clients to them, to take advantage of the sponsorship, mentoring and peer support offered. Compulsory signposting (not attendance) to meetings will enable recovering addicts to access services.

#### EXPAND RESIDENTIAL TREATMENT FOR FAMILIES AND YOUNG PEOPLE.

Families and children must be actively prioritised for treatment in order to break the cycle of addiction. Social workers, drugs counsellors and child-protection services must work together to identify and help families where children are at risk from parental substance abuse, and would otherwise be likely to enter the care system.

#### PRISON TREATMENT REFORM.

We will end the present government's fatalistic approach to addiction. A strategy for drug and alcohol reforms in prison will complement those undertaken in communities. It will include robust enforcement, a review of detection and testing regimes – including the introduction of innovative voluntary drug-testing regimes, rebalanced treatment provision to move from harm reduction and maintenance to recovery, new approaches to judicial review, and sensible measures to assist stable resettlement.

#### PROTECTING COMMUNITIES

REPLACE THE ADVISORY COUNCIL ON THE MISUSE OF DRUGS (ACMD) WITH A NEW ADVISORY COUNCIL ON

#### ADDICTION.

A new council will include social scientists, child psychologists, psychiatrists and experienced recovery-based treatment practitioners.

#### AN EVALUATION OF CURRENT DRUG AND ALCOHOL PREVENTION.

An independent evaluation of existing prevention provision will be commissioned.

#### OVERALL-ENFORCEMENT SPENDING REVIEW.

An urgent and independent review of current enforcement policy should be undertaken, making full consideration of international models and good practice.

## PREPARE FOR THE OPPORTUNITIES AND CHALLENGES OF 2012.

*Leading personalities in the field of addiction treatment and recovery use their insights and inside information to predict what they consider will be the major opportunities and threats of the year to come. Start your preparation now.*



**DAVID BURROWES MP.**

2012 will be a year with great challenges and opportunities. The *Drugs Strategy* has meant that recovery is now on everyone's lips and we will see this year how far recovery is transforming people's lives.

The *Alcohol Strategy* will no doubt reaffirm the government's commitment to tackle the main drug which damages lives in the UK. It is an issue of public health but will need to cut across all of government: Health, Education, Home Office, Justice, Communities and Local Government and, of course, the Treasury. I was part of the 2007 Social Justice Policy Group's *Breakthrough Britain* report which identified the strong evidence linking the price of alcohol to levels of harmful alcohol consumption. Given the scale of the alcohol problem, solutions will need to be bold.

The Payment by Results pilots going live in April are the most radical and innovative reforms to drug treatment. I predict that the pilots will drive many addicts to the path of full recovery who would otherwise be parked on methadone. 2012 will demonstrate a fundamental shift to outcome-based commissioning where the outcome is living a drug-free life. How quality residential rehabs can thrive in this new PbR environment is a challenge which, as chair of the Recovery Partnership's expert group, I am determined to meet.

This year will see a significant change in governance. It will be the last year for the National Treatment Agency as Public Health England takes the national reins and Health and Well Being Boards take local reins. Any criticism or praise for drug treatment will lie not with the NTA but with ministers and local councillors. The opportunity is that drugs misuse will be one of the biggest fishes in the new Public Health England fishbowl and well placed to receive both funds and strategic support. The challenge is the likely significant variations across the country in local areas providing additional support.

2010 was the year when the *Drugs Strategy* changed the tide in favour of recovery. 2011 was the year when the tanker of drug treatment began to change course. 2012 will see it negotiate some choppy waters but head firmly to the port where drug-free lives are rewarded, supported and celebrated.



**Dr OWEN BOWDEN-JONES**

is chair of the Faculty of Addictions, Royal College of Psychiatrists, honorary senior lecturer at Imperial College London and

consultant psychiatrist/lead clinician for Club Drug Clinic, Addictions Directorate, Central and NW London NHS Foundation Trust.

After a period of rapid, disruptive change across healthcare in general, and substance misuse provision in particular, I predict that 2012 will see the treatment system begin to catch up and adapt. The next year will see the delivery of:

1. Initial results from the payment by results pilots – you can read more about this at [www.nta.nhs.uk/healthcare-pbr.aspx](http://www.nta.nhs.uk/healthcare-pbr.aspx)
2. Final report of the Recovery Oriented Drug Treatment expert group – visit [www.nta.nhs.uk/recovery-orientated-drug-treatment.aspx](http://www.nta.nhs.uk/recovery-orientated-drug-treatment.aspx)
3. NICE Quality Standards for drug misuse, to complement the existing Quality Standards for Alcohol – details at [www.nice.org.uk/guidance/qualitystandards/alcoholdependence/home.jsp](http://www.nice.org.uk/guidance/qualitystandards/alcoholdependence/home.jsp)
4. Ongoing development of the 'skills hub' by the Skills Consortium – [www.skillsconsortium.org.uk/skillshub.asp](http://www.skillsconsortium.org.uk/skillshub.asp)
5. Guidance for substance-misuse commissioners from the Joint Commissioning Panel for Mental Health – updates will be at [www.rcpsych.ac.uk/policy/policyandparliamentary/projects/live/commissioning.aspx](http://www.rcpsych.ac.uk/policy/policyandparliamentary/projects/live/commissioning.aspx)
6. Details of Public Health England transition – visit [www.dh.gov.uk/en/MediaCentre/Pressreleases/DH\\_122249](http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_122249).

These documents will begin to describe the framework in which care can be delivered and standards set.

Within this framework, recovery will rightly continue to be the focus, underlying the culture change that is now underway. Service users will increasingly collaborate with staff to improve the quality and effectiveness of treatment...



Services must continue to be commissioned to meet the full range of needs of the community, from harmful use to complex, severe dependence. At a time of unprecedented change, commissioners have a huge responsibility to make sure that the most vulnerable are not left behind.

Excitingly, the evidence describing the 'active ingredients' of treatment and recovery will continue to emerge, helping services to offer the right treatment, to the right person, at the right time.



**MARTIN BARNES** is CEO of DrugScope, a membership organisation for the drug field in the UK.

There are positives for the drug sector: a continuing strong political commitment to tackling drug misuse; central-government funding for drug treatment, so far relatively protected; and the outward face of the sector to government and others is increasingly coherent and collaborative. The *Drug Strategy* is an aspirational, balanced and sensible framework for policy and practice.

But it is hard to feel optimistic. The economy, deficit reduction and spending cuts cast a shadow: the drug sector, despite a nominal ringfence round the pooled treatment budget, is not immune. Disinvestment has started, particularly in young people's treatment, drug education/prevention, and in services key to delivering a genuinely recovery-oriented system and the high-level ambitions and outcomes in the drug strategy.

The biggest challenge facing the sector is the new public-health service. From April 2013, responsibility for drug and alcohol treatment will transfer to local authorities, directors of public health and the new Health and Wellbeing Boards. Up to half of the likely £2billion public-health budget will represent current spending on drug and alcohol treatment. Drug and alcohol treatment will compete – at a time when local authorities are managing unprecedented spending

cuts – with other needs, including tobacco control, obesity, winter deaths and so on.

The omens for how local authorities will approach investment in treatment and recovery are not encouraging, but there is time to influence the local and national agenda. The new Crime and Police commissioners, elected in November, are an unknown commodity but will have a stake in investment to tackle drug- and alcohol-related offending and antisocial behaviour. The government's (re)new(ed) focus on 'troubled families' is an opportunity to emphasise the multiple relevance of treatment and recovery.

The role of Public Health England, after the National Treatment Agency, will be crucial for influencing investment. Service users, people in recovery and others will be key to champion this.

Despite the commitment to 'localism', there must be clear, consistent and bold leadership from government. There must be pragmatism at the centre if local disinvestment in drug treatment is to be avoided.



**GAVIN COOPER** is managing director of Trust The Process, alongside Tom Kirkwood who is director of development. They offer over 200 'recovery beds' and services across tiers 3 and 4.

For many it has been another tough year, with the closure of some long-standing and respected facilities. Have we learnt from this? Or are we set to continue doing the same thing with the expectation of a different result?

I am sure we've all heard how the National Treatment Agency is going to be disbanded and swallowed up into the NHS – and at the same time how it is going from strength to strength and going to be around for ever.

I have been told about an extra "£billions" for the system, a fair proportion of which is ring-fenced for alcohol treatment – yet at the same

time heard that it is likely to be funnelled into central coffers and used to offer family support and address consequences rather than to treat the root cause of the problem, the addict/alcoholic!

So what changes do I see?

Continuing to disburse a significant part of the budget on methadone? Or practicing client choice which includes an offering of structured daycare, detox and rehabilitation?

Continuing to commission providers with little or no experience of the assessed need? Or opening the door to service providers who have embraced true "recovery" all along?

Continuing to commission providers and pump taxpayers' money into services with little or no experience in the true requirement but 'happen' to be part of the same PCT area, albeit at a higher cost and producing lesser outcomes?

Further changes and challenges that await us in 2012 are the threat of abuse of controlled drugs acquired on the internet, the need for providers to find partnerships outside our sector and the fact that we will now be in direct competition for funding from other more mainstream health services, such as children's health, smoking, etc.

I choose to concentrate on the effects on our industry, particularly residential units, of the Care Quality Commission. Much has been said, or nervously whispered, of the negative effects of the stringent requisites of accreditation, including the closing of many smaller units. But many positive changes will come, once the dust settles.

We are being forced to professionalise as an industry, and in many right places, particularly round safeguarding, clinical governance, risk management, care planning and the respect and advocacy of our clients and staff.

Very high standard and appropriate training and qualifications in the areas we work in will help shift away from the traditional need of workers in our sector to make up for deficiencies of local services in areas such as housing, benefits, employment and education towards a more multi-agency approach to the care of our clients.

For workers 'on the ground', a more pervasive change is the need for more paperwork at ever-higher levels. If managed well in organisations, it will not mark the death of traditional addiction workers spending treatment time talking about feelings. Instead, I believe a new breed of worker will emerge, able – through skills in MI, FRAMES, ITEP, etc – to turn the filling-in of a care or risk management plan into a truly inclusive, realistic, significant and inspiring therapeutic event.



**DEIRDRE BOYD** is CEO of the Addiction Recovery Foundation, the charity which publishes *Addiction Today*, and runs the UK/European Symposia on Addictive Disorders. She is convener/spokesperson for the Concordat of rehabs.

Many factors in the coming year have been predicted already in this article. Others come from central and local government, and from newcomers trying to exploit the recovery movement.

As an example of the first, the Department of Communities and local government ministers will use the *Localism Act* to reform social housing, aiming for more flexibility in the way people access social housing, and types of tenancies. There should be chances to integrate housing into local frameworks supporting recovery programmes.

Payment by Results is the great hope of this government but there is anxiety about the practice and quality of commissioning, the impact of PbR on providers' cashflow, and the lack of nationally approved recovery outcomes. We are concerned about the lack of a drug-free goal, to sustain recovery, but ministers tell of incentivising payment using a weighting mechanism to encourage full recovery. There is a desire that at least 80% of the money in the "freedom from drugs of dependence" domain be paid on the two measures that require the cessation of dependence on drugs – including substitute prescriptions.

The *Public Health Outcomes Framework* will be important in keeping local areas focussed on issues round drugs and alcohol dependence. So, too, should be local areas' *Strategic Needs Assessments* to include drug and alcohol users.

The Work Programme now operates across 18 contract areas where prime providers engage with about 850 subcontractors. Work Programme prime providers and subcontractors are to work closely with and support drugs PbR sites.

Amid challenges will be work on stigma around drug users – *Addiction Today's* concern is the stigma round recovery, the greatest stigma being not denial but disinformation of what it is.

This brings me to the fact that 2011 was a roller coaster year for the recovery movement. We saw people claiming to represent us publicly attack others in our movement. This in turn threatened to polarise us because it was impossible to deny what we witnessed. The tactics and style of the attacks were brutal, unnecessary and unfounded and not something we could support in a recovery movement. But we learned from this, so that those who really do support recovery in the UK

are now more cautious about what we support, more critical in our assessments of people and organisations who claim to be recovery advocates and claim to represent us. It was a testing time but what happened next confirmed that we are a strong movement. Those who were on the receiving end of the attacks found support from people and organisations in a way that they had not previously experienced. We came together in our support of them. As a collective, it made us stronger and more protective. This strength will grow in 2012.

Grassroots organisations will bloom. When others in our field will be affected by the economic climate, the organisations driven by the passion of individuals will carry on regardless. Organisations excluded from mainstream funding will remain recession-proof. When bigger national services will become more competitive with each other to stay afloat, local grassroots organisations will continue to encourage other diverse recovery organisations, driven by their willingness to connect and inspire in order to grow communities of recovery across the UK. 2012 promises to be an exciting time – anything and everything is possible!



Image: Phil Good