**Independent report**

**Review of drugs part two: prevention, treatment, and recovery**

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## Foreword

This is Part 2 of my independent review for government, setting out a way forward on drug treatment and recovery. Part 1 laid bare the extent of the illicit drugs market in the UK, worth almost £10 billion a year, with 3 million users and a supply chain that has become increasingly violent and exploitative. Drug deaths are at an all-time high and drug addiction fuels many costly social problems, including homelessness and rising demands on children's social care. The drugs market is driving most of the nation's crimes: half of all homicides and half of acquisitive crimes are linked to drugs. People with serious drug addiction occupy one in 3 prison places.

Part 1 also showed how entrenched drug use and premature deaths occur disproportionately more in deprived areas and the north of the country. It is highly likely that the pandemic has widened inequalities and that any recession would further drive trends in drug use and deaths in the wrong direction. So, the problem is almost certainly worse than when we reported in Part 1 and a major barrier to 'levelling up'.

All these issues are examined in depth in Part 2, which concludes that the public provision we currently have for prevention, treatment and recovery is not fit for purpose, and urgently needs repair.

Government faces an unavoidable choice: invest in tackling the problem or keep paying for the consequences. A whole-system approach is needed, with demand reduction a key component, to drive down the profitability of the market. This part of my review offers concrete proposals, deliverable within this Parliament, to achieve this.

For problem drug users, including an estimated 300,000 opiate and crack users, we cannot expect a reduction in demand without reversing the recent disinvestment in treatment and recovery services. To achieve and sustain recovery people need, alongside treatment, somewhere safe to live and something meaningful to do (a job, education or training). Too many people are in and out of treatment for years or even decades, without turning their lives around for good.

This problem can only be solved through coordinated action by multiple departments including the Home Office (HO), Department of Health and Social Care (DHSC), Department for Work and Pensions (DWP), Ministry of Housing, Communities and Local Government

(MHCLG) and the Ministry of Justice (MoJ). To move forward, these departments must work together to invest in and improve treatment, employment, housing support and the way that people with addictions are treated in the criminal justice system. Every department will have competing priorities, and funding allocation processes do not easily support cross-departmental priorities. The Prime Minister should therefore appoint a single, responsible minister on drug policy to hold all of government to account, supported by a central team to monitor and report upon relevant social and criminal justice outcomes.

Increased funding is necessary, but not sufficient. Greater co-ordination and accountability at national level must also flow through to the local level, where responsibility sits for the delivery of drug treatment and wider recovery outcomes. If government invests more in treatment, this money should be ring-fenced, and local authorities must be required to work with wider health, employment support, housing and criminal justice partners to develop joint commissioning plans and be held to account for these plans and their outcomes.

It must be recognised that addiction is a chronic health condition, and like diabetes, hypertension or rheumatoid arthritis, it will require long-term follow-up. Discharge after short-term treatment is currently used as a measure of success, but should be stopped, as it ignores the fundamental relapsing and remitting nature of the condition. Trauma (physical, sexual or psychological) and mental ill-health are the drivers and accompaniment of much addiction. They are co-morbidities rather than separate problems for a ‘dual diagnosis’. Commissioners of substance misuse services and NHS mental health services must ensure that individuals do not fall between the cracks.

Too many drug users are cycling in and out of prison. Rarely are prison sentences a restorative experience. Our prisons are overcrowded, with limited meaningful activity, drugs easily available, and insufficient treatment. Discharge brings little hope of an alternative way of life. Diversions from prison, and meaningful aftercare, have both been severely diminished and this trend must be reversed to break the costly cycle of addiction and offending.

Achieving these improvements in treatment and wider recovery will require significant rebuilding of capacity, including recruiting many more professionally qualified staff and trained support workers. Services which have diminished over the years, such as inpatient detoxification and residential rehabilitation, will need to be re-commissioned in a way that ensures national coverage.

Finally, we can no longer, as a society, turn a blind eye to recreational drug use. A million people use powder cocaine each year and the market is worth around £2 billion. The vast majority of users do not see themselves as having a drug problem and they are unlikely to come forward for treatment. However, they are causing considerable harm to others through the supply chain, both here and abroad. This is a difficult group to influence but, as the COVID-19 pandemic has so clearly shown, behavioural and attitudinal shifts in health

behaviour are possible. We need to invest now in an innovation fund to test out which marketing and behavioural interventions could work in the UK, building on evidence from abroad.

This review makes recommendations for change across many departments and other organisations, which reflects the complex nature of the problem. It calls for significant investment, but the payoff is handsome: currently each £1 spent on treatment will save £4 from reduced demands on health, prison, law enforcement and emergency services. I am hopeful that the recommendations will be welcomed by this government as they strongly support its crime reduction and 'levelling up' agendas. My aim is to bring hope and real change to the many individuals, families and communities whose lives are blighted by drug addiction and by the criminals who exploit it.

Rich contributions to this review were made by many people (who are listed in Annex B). The review could not have been completed without backing by a team of highly competent civil servants: Pete Burkinshaw, Jon Knight, Nino Maddalena, Jez Stannard, Julia Thomas, Fizz Annand, Tracey Mwaniki and Emilie Rapport Munro, ably and tirelessly led by Tabitha Brufal. I wish to acknowledge the unstinting support and hard work, particularly on policy and drafting, contributed by Donna Ward of DWP, Dr Ed Day of Birmingham University and the UK government's Drug Recovery Champion and Professor Keith Humphreys of Stanford University. The expert reference group kept my feet firmly to the fire and on the ground. The voices of those with lived experience of drugs have been urging us forward throughout, I hope not in vain, and I thank them for their invaluable testimony.

Arising from such collaborative teamwork, the review recommendations take the form, "We recommend…" but I take full responsibility for them and their every word.

Dame Carol Black

## Executive summary

### What this review set out to achieve

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

system. For recreational drug users, we need to find ways to change attitudes and behaviour.

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

**Reform of central government leadership**

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

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

**Increased funding for drug treatment and wider recovery support**

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

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

- year 1: £119 million
- year 2: £231 million
- year 3: £396 million

- year 4: £484 million
- year 5: £552 million

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

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

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

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

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

**Allocating and protecting funding**

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

**Commissioning**

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

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

**Strengthening local authority accountability**

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

**Rebuilding services: workforce**

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

**Rebuilding services: treatment**

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

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

**Rebuilding services: recovery support**

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

**Diverting more offenders into treatment and recovery services**

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

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

**Employment support**

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

**Housing**

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

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

**Mental health**

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

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

**Physical healthcare**

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

**Prevention and early intervention**

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

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

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

**Research**

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

We recommend that DHSC and the Department for Business, Energy & Industrial Strategy (BEIS) encourage and facilitate research into what works to combat substance misuse, across supply, prevention, treatment and recovery. DHSC should promote innovative

research on addiction and its implementation in practice by offering incentives or rewards to companies and other organisations for effective developments in this field. For example, pharmaceutical advances.

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

**List of recommendations**

**Recommendation 1**

The government should establish a central Drugs Unit with strong analytical capacity which would develop a National Outcomes Framework and hold departments to account. The sponsoring minister should report annually to Parliament on progress in tackling drug misuse, including publication of relevant data.

**Recommendation 2**

We recommend that the government invests, by the end of year 5 of this programme, an additional £552 million in the treatment system through DHSC and an additional £15 million in employment support through DWP. MHCLG will also need to bid for additional funds for housing support at the next Spending Review.

**Recommendation 3**

We recommend that from 2022 to 2023, DHSC require local authorities to spend drug treatment funding, current and additional, on these services and not on other things.

Similarly, we recommend that DWP and MHCLG protect any future additional funding provided for employment services and housing support for people dependent on drugs.

**Recommendation 4**

We recommend that DHSC, DWP and MHCLG make sure that funding for treatment, employment and housing support is distributed fairly on the basis of need.

**Recommendation 5**

We recommend that DHSC introduce a national Commissioning Quality Standard and require local authorities, as a condition of funding, to work with health, housing and employment support, and criminal justice partners to develop a joint needs assessment and publish a commissioning plan to direct spending from 2022 to 2023. Government should make provision for budgets to be aligned or pooled at local level and each department should use its policy levers to require a strong partnership approach locally.

**Recommendation 6**

We recommend that DHSC and the Office for Health Promotion review the effect of frequent retendering on quality and cost-effectiveness of substance misuse treatment services.

**Recommendation 7**

We recommend that DHSC introduce, for 2022 to 2023 and beyond, a Local Outcomes Framework to increase transparency and local authorities' accountability for their treatment and recovery outcomes. DHSC should consider introducing incentive payments for local authorities to deliver improved outcomes.

**Recommendation 8**

We recommend that DHSC ensure that the Office for Health Promotion has the capacity and capability to monitor local performance against the Local Outcomes Framework, and report to the new central cross-government Drugs Unit to:

- hold local areas to account for meeting the new Commissioning Quality Standard
- improve outcomes
- work with the Local Government Association (LGA) to provide a comprehensive improvement support offer for local authorities

**Recommendation 9**

We recommend that DHSC commission HEE to devise by the end of 2021 a comprehensive strategy to increase the number of professionally qualified drug treatment staff (psychiatrists and other doctors, psychologists and other therapists, nurses and social workers), and set occupational standards, competency and training requirements for drug workers and peer recovery workers. Government should also fund HEE to cover the costs of training the workforce.

**Recommendation 10**

We recommend that the Academy of Medical Royal Colleges, working with appropriate other bodies, be commissioned to develop a professional body, a Centre for Addictions, for all members of the substance misuse workforce. DHSC should provide seed funding to enable this.

**Recommendation 11**

We recommend that local authorities commission a full range of evidence-based harm reduction and treatment services to meet the needs of their local population in line with the new national Commissioning Quality Standard.

**Recommendation 12**

We recommend that DHSC, NHSE and the Office for Health Promotion review by the end of 2021 to 2022 the commissioning and funding mechanisms for high-cost but low-volume services such as inpatient detoxification and residential rehabilitation. DHSC should introduce a regional or sub-regional approach to commissioning these services to ensure national coverage.

**Recommendation 13**

We recommend that DHSC make increased funding available to specialist substance misuse services for young people to improve the capacity and quality of these services, and also through the national Commissioning Quality Standard ensure that these services are linked with other local services for vulnerable young people and that family interventions are more widely available.

**Recommendation 14**

We recommend that DHSC and the Office for Health Promotion support local areas to ensure that thriving communities of recovery are linked to every drug treatment system. The government's Drug Recovery Champion should work with the Office for Health Promotion to develop standards to raise the quality and improve the governance of the recovery sector.

**Recommendation 15**

We recommend that MoJ, HO and DHSC, with the support of NHSE and the Office for Health Promotion, work together to ensure that the additional funding for drug treatment announced in January 2021 contributes to improved treatment pathways from criminal justice settings. In particular, action should be taken to divert drug users from the criminal justice system into treatment, and maximise the use of Community Sentence Treatment Requirements (CSTRs).

**Recommendation 16**

We recommend that DHSC and NHSE expand their CSTR programme to 100% of the country by the end of this Parliament. NHSE and HMPPS should work closely with local commissioners of substance misuse treatment to seize the opportunity presented by the recently announced increase in funding for such treatment in 2021 and 2022.

**Recommendation 17**

We recommend that MoJ, DHSC and NHSE work together to improve by the end of 2021 to 2022 the transparency and accountability of the commissioning and delivery of substance misuse services in prisons, including through publishing how much money is spent each year on these services. HM Prison Service should make sure that enough staff are available to take prisoners to their treatment appointments within the prison.

**Recommendation 18**

We recommend that MoJ ensure that everyone leaving prison has identification and a bank account and that those who cannot claim benefits online get the opportunity, from the day of release, to access DWP's telephony service. MoJ and its partners should make sure that prisoners with drug dependence can access and receive drug treatment in the community as soon as possible after release.

**Recommendation 19**

We recommend that MoJ fund their new health and justice partnership co-ordinator role within the probation service, so that it covers all local probation areas in England, in tandem with the introduction by the NHS of new integrated care systems.

**Recommendation 20**

We recommend that DWP work with the Office for Health Promotion to roll out IPS to all areas in England within the forthcoming Spending Review period.

**Recommendation 21**

We recommend that DWP recruit peer mentors (one in each Jobcentre Plus area), to encourage people dependent on drugs to claim all relevant benefits and access employment support, with funding for the posts agreed at the Spending Review.

**Recommendation 22**

We recommend that DWP augment Jobcentre Plus support by equipping staff to reach out into the community and work more intensively with those with complex needs, including working in drug and alcohol treatment services with people with addictions.

**Recommendation 23**

We recommend that MHCLG and DHSC work together to gain better understanding of the types and levels of housing-related need among people with a substance misuse problem, with early findings feeding into the next Spending Review.

**Recommendation 24**

We recommend that DHSC and NHSE develop, publish and implement by the end of 2021 an action plan that improves the provision of mental health treatment to people with drug dependence. This should include consideration of the introduction of contractual requirements or incentives so that NHS mental services target dependent drug users. Consideration should also be given to commissioning substance misuse services to treat some mental health co-morbidities without referring people on to specialist mental health services.

**Recommendation 25**

Linked to recommendations 9 and 10, we recommend that DHSC commission Health Education England to develop competency and training requirements for all staff working with people with co-existing mental health problems and drug dependence. Resources and

standards should be applicable and applied across the mental health and substance misuse workforces.

**Recommendation 26**

We recommend that DHSC, NHSE and the Office for Health Promotion ensure that opportunities for integrated commissioning of mental health and substance misuse services are explored proactively and articulated as part of the next stages of integrated care system development. This includes ensuring that proposed legislation facilitates integrated commissioning and provision.

**Recommendation 27**

We recommend that DHSC and NHSE develop, publish and implement by the end of 2021 an action plan for improving the provision of physical healthcare to people with drug dependence, which should be an integral part of local integrated care systems.

**Recommendation 28**

We recommend that DfE make an assessment of the support available to teachers in rolling out the new Relationship, Health and Sex Education (RSHE) curriculum, and continue to monitor implementation, with a view to more detailed evaluation after 2 years of full curriculum delivery.

**Recommendation 29**

We recommend that DfE and DCMS, with support from DHSC and the Office for Health Promotion, invest in age-appropriate evidence-based services and support all young people to build resilience and to avoid substance misuse. Local authorities should identify, and provide additional support to, those young people most at risk of being drawn into using illicit substances or involvement in supply.

**Recommendation 30**

We recommend that the government (either HO or DHSC) establish an innovation fund to research which interventions are most effective at changing the behaviour of recreational drug users.

**Recommendation 31**

We recommend that DHSC and BEIS encourage more research into what works to combat substance misuse, across supply, prevention, treatment and recovery.

**Recommendation 32**

We recommend that the government promote greater innovation in research, for example in pharmaceuticals, by offering incentives or rewards to companies or organisations whose developments prove beneficial in practice in the addiction field.

## 1. Introduction

In February 2020, Part 1 of this independent review laid bare that drug misuse is at tragically destructive levels in this country. The review highlighted the severe damage to public health and safety inflicted by the flood of drugs entering the UK market and deep cuts to prevention, treatment and recovery programmes. The trends in prevalence of drug use and the associated harms presented in Part 1 of this review are summarised in Annex A.

Recognising the need for swift action, the DHSC commissioned Part 2 of the review. This focused on how to improve the funding, commissioning, quality and accountability of drug prevention, treatment and recovery services in England. The methodology adopted in carrying out this commission is set out in Annex B.

The findings have been disturbing, even shocking. Funding cuts have left treatment and recovery services on their knees. Commissioning has been fragmented, with little accountability for outcomes. And partnerships between local authorities, health, housing, employment support and criminal justice agencies have deteriorated. The workforce is depleted, especially of professionally qualified people, and demoralised. Vital services have

been cut back, particularly inpatient detoxification, residential rehabilitation, specialist services for young people, and treatment for cannabis and stimulant users.

Areas of the country with the highest rates of drug deaths or the poorest treatment services are the very same areas where the need to level up is greatest. These communities want to see urgent and effective action to tackle the violent drugs market, alongside purposeful efforts to rebuild treatment services and recovery support so that people can get the help they need.

The current situation is intolerable. Accordingly, this review has pursued 3 main objectives:

1. To increase the proportion of people misusing drugs who access treatment and recovery support, including more young people, and earlier interventions for offenders to divert them away from the criminal justice system, particularly prison.
2. To ensure that the treatment and recovery package offered is of high quality and includes evidence-based drug treatment, mental and physical health interventions, and employment and housing support.
3. To reduce the demand for drugs and prevent problematic drug use, including use by vulnerable and minority groups and by recreational drug users.

To achieve these objectives, significant changes need to be made in 4 areas.

1. Radical reform of leadership, funding and commissioning.
2. Rebuilding of services.
3. Increased focus on prevention and early intervention.
4. Improvements to research and how science informs policy, commissioning and practice.

This report sets out a vison for change in these areas with recommendations.

**2. Radical reform of leadership, funding and commissioning**

The priority, protection and increased funding given to the NHS have not been applied to services for drug dependence. A lower standard of care for this vulnerable and stigmatised

population is not acceptable. Bringing treatment and recovery services for drug dependence up to parity with other health services will require fiscal investment as well as improvements in coordination and accountability.

Two welcome developments are the £80 million additional funding for drug treatment in 2021 and 2022, as part of a broader crime package, and the additional £126 million over 3 years invested into drug and alcohol treatment for people who sleep rough. This demonstrates the importance that government places on reducing drug deaths and harms, and drug-related crime and violence. This funding provides a strong foundation for further structural investment at the next Spending Review, to enable urgent reforms across the entire system of enforcement, prevention, treatment and recovery.

Addiction is a chronic condition experienced within the social environment. Clinical treatment on its own is rarely enough. Many people will also need services to help them with family challenges, mental health, housing and employment support. These services must be coordinated at the local level, but now commonly exist in separate silos or are missing altogether. The difficulties experienced at local level are mirrored at national level. Ministers and departments have not worked sufficiently well together in a determined and sustained way.

Responsibility for treatment and recovery is cross-departmental. In addition to funding the NHS, DHSC funds local authorities for treatment of substance misuse and recovery through the Public Health Grant, but the MHCLG funds housing and housing support, and DWP funds employment support. Many opiate users cycle in and out of the courts, prison and probation, bringing into the picture 2 further departments, the MoJ and the HO.

Since 2012, the government has entrusted all decision making on drug treatment services to local authorities, with virtually no accountability or recognised standards. The current system of local commissioning is fractured, with different bodies responsible for different services and no real incentive for them to work together. These challenges have exacerbated the impact of cuts in local authority budgets. Because the impact of drug misuse is felt most acutely in the most deprived areas of the country, addressing these problems is central to the government's ambition for 'levelling up'.

The next 5 sub-sections of the report grapple with these long-standing challenges and make recommendations to government on leadership and encouragement from the centre, funding and its allocation, local arrangements for commissioning, and accountability.

### 2.1 Making sure central government departments are held to account

The Prime Minister's Crime and Justice Taskforce, and the government's strong commitment to reducing crime, have made drug misuse a priority. The Taskforce has brought ministers together, and the Cabinet Office has secured cross-departmental commitment and a coordinated approach. This early success should be built upon.

An effective government response requires strong and co-ordinated action from multiple departments. Previous drug strategies have suffered from sporadic cross-government engagement, with attention waxing and waning.

Introduction of a new central Drugs Unit is essential to coordinate and monitor this cross-departmental work, including to ensure that it focuses on delivering real world outcomes and that the work develops alongside the priorities of No. 10 and the government. The Unit, sitting in whatever department or joint arrangement seems appropriate, needs to secure commitment and action from multiple secretaries of state, making sure that momentum is maintained in all relevant departments. A cross-government National Prevention Board, which the government is considering setting up to tackle obesity, could also be used to strengthen the coordinated response to this strategy.

This new central unit should have adequate analytical capacity. It should develop a new National Outcomes Framework, and the sponsoring minister should publish data annually within a report to Parliament so that departments are held individually and collectively to account for progress. The unit should have ready access to senior scientific advice, to ensure that drug policy decisions are informed by the best available research.

This National Outcomes Framework should cover all aspects of the illicit use of drugs, including:

- the impact of enforcement action to reduce supply
- measures of drug-related harm and deaths
- drug-related crime
- the number of people (particularly offenders) in treatment
- the number of people with drug dependence accessing mental health services
- measures of progress on housing and employment

For substance misuse services, measures of service quality and effectiveness, recovery capital and quality of life in the longer term, should be included as well as numerical measures.

The government should convene a long-term representative group of external stakeholders, including drug addiction scientists and people with personal experience of drug dependence, to assist the central unit in evaluating the new structures and holding relevant departments to account. Extensive stakeholder engagement should also be integral to the development of new outcomes frameworks and standards.

Responsibility for policy and resulting action should be explicitly demarcated. The HO should focus on controlling the supply of drugs, drug trafficking, gangs, and drug-related violence, and would continue to lead on legislation. DHSC would focus primarily on harm reduction, treatment and recovery, and DfE would lead on prevention initiatives targeted at young people.

**Recommendation 1**

The government should establish a central Drugs Unit with strong analytical capacity which would develop a National Outcomes Framework and hold departments to account. The sponsoring minister should report annually to Parliament on progress in tackling drug misuse, including publication of relevant data.

### 2.2 Significantly increasing the funding for drug treatment and wider support

Part 1 of the review showed that funding for treatment fell by 17% overall between 2014 to 2015 and 2018 to 2019. The reduction in funding for young people's specialist substance misuse services was even worse at 28% over the same period. Meanwhile increased prevalence of drug use, harm, drug-related violence and mortality now affects every area of the country, fuelled by county line drug supply. The amount of unmet need for treatment is growing, but the treatment workforce is declining in number and quality.

There's a strong 'invest to save' case for drug treatment, all the more important given the pressure on government finances caused by the pandemic. Although Part 1 of the review showed that the societal costs of drug misuse are £20 billion each year, in 2020 to 2021 only £650 million was spent on drug treatment. Every £1 currently spent on harm reduction and treatment gives a combined health and justice return on investment of £4. Failure to invest will inevitably lead to increased future pressures on the criminal justice system, health services, employment services and the welfare system.

On current estimates of prevalence, in order to provide a full range of high-quality treatment and recovery services for adults and young people with a drug dependence, significant investment is needed on top of the current expenditure, rising from £119 million in year one to £552 million in year 5.

This additional investment is urgently needed to provide:

- increased treatment capacity to meet need, including to respond to newer non-opiate patterns of drug use, and to expand and improve services for children and young people
- increased drug treatment capacity to respond to criminal justice priorities set out in the sentencing white paper, including increased use of community sentences with a requirement for drug treatment, and getting more prisoners into treatment within three weeks of release
- expansion in the number of professionally qualified workers (psychiatrists, psychologists, nurses and social workers), and development of training to improve the skills of drug workers and peer recovery workers
- increased provision of inpatient detoxification and residential rehabilitation
- expansion of local areas' support for peer-led grass-roots recovery communities and peer mentoring, complementing professionally led services
- increased overdose prevention, harm reduction and syringe exchange programmes
- an innovation fund for research into what interventions, and what methods of delivery, are most effective at deterring recreational drug users

Improved treatment services will not be enough on their own to help people achieve and maintain recovery. A broader package of services is needed, involving also well-coordinated housing and housing support, employment support, and mental health services.

In addition to the mainstream support provided by Jobcentre Plus, DWP should provide additional investment, estimated at £6 million in year one rising to £16.5 million from year 3, to roll out nationally a dedicated employment support programme for people in drug treatment.

MHCLG and DHSC have secured welcome substantial additional funding to improve treatment services for people who sleep rough. We know that housing and housing support have a crucial role to play in the success of drug treatment and that many of those entering treatment report a housing need.

As evidence on the scale and nature of unmet need is limited, provision of additional housing-related support for those in treatment should be used to assist better understanding of need as well as impact on treatment outcomes. We estimate that an additional investment of £150 million over a 5-year period would be needed to provide housing support services to

individuals in treatment alongside the expansion of Individual Placement and Support. These estimates are based on assumptions about the current need for housing support among individuals in treatment and are subject to refinement through further testing and piloting. MHCLG should work with DHSC to assess the types and levels of housing related needs among people with substance misuse problems.

An extra £5 million per year is needed by MoJ for probation health and justice co-ordinators so that they can play a full part in local area partnerships. Although this is out of scope of this review, additional prison staff are also needed to ensure that prisoners experience an improved regime and can also be escorted to substance misuse appointments.

NHSE is improving mental health services by additional investment of £2.3 billion per year. Part of this should be used to increase the specialist mental health support available to people with drug dependence.

These new investments should be guided by research on the effectiveness and accessibility of the various services.

Increased funding for treatment and recovery does not diminish the importance, highlighted in Part 1 of this review, of taking action to stem supply of drugs. This remains an important objective of law enforcement agencies including the National Crime Agency, Border Force, British Transport Police and terrestrial police forces, and must also be resourced appropriately.

A detailed breakdown of these costs, as well as estimates of the benefits that would accrue from this additional investment, can be found in Annex C.

**Recommendation 2**

We recommend that the government invests, by the end of year 5 of this programme, an additional £552 million in the treatment system through DHSC and an additional £15 million in employment support through DWP. MHCLG will also need to bid for additional funds for housing support at the next Spending Review.

### 2.3 Making sure treatment funding is protected and is allocated fairly

Responsibility for commissioning substance misuse services was passed from the NHS to local authorities under the Health and Social Care Act 2012. Local authorities are well placed, with responsibility and local knowledge, to commission substance misuse treatment for their local populations and areas.

However, a number of challenges stem from locating these services outside NHS structures, including reduced parity with other NHS-led clinical services, competition for scarce professional staff, detachment from wider NHS professional training and development structures, and some increased costs. After careful consideration, this review has concluded that funding should continue to be distributed by DHSC to local authorities.

Local authority efforts have been hampered by steep cuts in their funding, including a fall in real terms in the allocation for public health from £4 billion in 2015 to 2016 to £3.2 billion in 2020 to 2021. National incentives and accountability measures should be introduced to ensure that drug treatment and recovery services receive adequate financial and other support right across the country.

Financial incentives for local authorities should be explored as a possible component of an accountability framework. Care should be taken to avoid generating unintended consequences. Previous payment-by-results pilots in the sector have shown that it is difficult to attach incentives to complex and long-term outcomes. However, there is evidence that the approach can work for more process-focused measures such as numbers in treatment.

Funding should be distributed to local authorities fairly, taking into account the:

- level of deprivation
- prevalence of drug use
- rate of drug-related deaths
- number of people requiring treatment who are not receiving a service

**Recommendation 3**

We recommend that from 2022 to 2023, DHSC require local authorities to spend drug treatment funding, current and additional, on these services and not on other things. Similarly, we recommend that DWP and MHCLG protect any future additional funding provided for employment services and housing support for people dependent on drugs.

**Recommendation 4**

We recommend that DHSC, DWP and MHCLG make sure that funding for treatment, employment and housing support is distributed fairly on the basis of need.

### 2.4 Improving commissioning, including introducing a national Commissioning Quality Standard and a focus on local partnerships

Increased funding will not improve services unless the commissioning process is strengthened. In many local authorities commissioning structures and processes are not sufficiently robust or effective. The capacity, experience and specialist competence of local authority commissioners have declined in recent years. As funding increases, local authorities must take immediate action to bolster this function and resource it properly.

Many local authorities do not commission the full range of services required by their local population. The most significant cuts have been made to inpatient detoxification and residential rehabilitation services, outreach programmes, comprehensive recovery support, and psychosocial interventions, particularly for non-opiate drug users. The Care Quality Commission's (CQC) regulation of services assesses the quality of only those services which are being provided, but does not consider, as it should, whether extended or different services are needed.

To address these problems, DHSC should develop a national Commissioning Quality Standard, based on the UK clinical guidelines on drug treatment, to clarify the commissioning process that local authorities should follow and the full range of drug prevention and treatment services that should be available to their local population, for adults and young people. Annex D summarises what should be included.

This process will be enhanced by co-production with people with lived experience of addiction, and so the national Commissioning Quality Standard should sit comfortably alongside the quality standard for recovery support services which is currently being developed by the College of Lived Experience Recovery Organisations (LEROs).

This national Commissioning Quality Standard can and should exist alongside local leadership and innovation so that services are tailored to local needs within a strong partnership approach. Many successful treatment and recovery systems include smaller, locally led voluntary-sector organisations. These are often well placed to engage minority populations and underserved groups.

Partnerships are needed to meet the multi-faceted needs of drug dependent people. The development of integrated care systems (ICS) provides a vehicle for strengthening the partnership between local authorities and NHS organisations to improve the health of the population (including those addicted). Police and crime commissioners, and the probation and prison services, must also establish effective partnerships to support diversion of offenders away from the criminal justice system and into local treatment, where interventions may be more cost-effective.

Local partnerships should involve collaboration on needs assessment and commissioning plans. Local plans for the required package of services (including treatment, recovery support, mental health services, care of physical co-morbidities, and support for housing and employment) should be produced and published jointly, in collaboration between all those agencies responsible for providing services for drug users in a given local authority area.

National government should use policy levers and incentives to promote improved collaboration. For example, DHSC should ensure that conditions attached to funding require local authority commissioners of substance misuse services to work in effective partnership with other local agencies. MoJ, HO, MHCLG and DWP should identify appropriate levers to reinforce this approach for the services which they commission or oversee. Provision of additional funding should be conditional on the production and continuing implementation of a comprehensive local plan.

Departments should require budgets to be aligned or pooled at local level, removing any barriers and deploying incentives where appropriate.

Retendering services as frequently as every 3 years hampers the creation of a stable network of services. Commissioning is often little more than a procurement exercise, placing undue emphasis on price at the expense of quality. DHSC and the new Office for Health Promotion should undertake a review of service retendering as a mechanism to drive quality and cost effectiveness, with close scrutiny of the current market.

In many local authorities, active engagement with treatment providers and ongoing management of contracts is minimal. In some cases, the contract is awarded to a prime provider with further commissioning responsibility delegated to this provider, including for inpatient detoxification and residential rehabilitation. The prime provider may seek to retain its share of the funding at the expense of the smaller, more local or specialist providers.

Commissioners should work collaboratively with treatment providers and introduce longer commissioning cycles of at least 5 years to reduce service disruption and discontinuity. This would bring local authority commissioning more into line with NHS practice where there is a move away from competition in favour of collaboration.

**Recommendation 5**

We recommend that DHSC introduce a national Commissioning Quality Standard and require local authorities, as a condition of funding, to work with health, housing and employment support, and criminal justice partners to develop a joint needs assessment and publish a commissioning plan to direct spending from 2022 to 2023. Government should make provision for budgets to be aligned or pooled at local level and each department should use its policy levers to require a strong partnership approach locally.

**Recommendation 6**

We recommend that DHSC and the Office for Health Promotion review the effect of frequent retendering on the quality and cost-effectiveness of substance misuse treatment services.

### 2.5 Strengthening local authority accountability for spending and improvement support

If local authorities receive additional funding for drug treatment and recovery services, they should be held to account for this spend. Because of the marginalised and stigmatised nature of drug dependence, relying on a local authority's accountability to the local electorate may not be an effective mechanism to drive service improvement. This is rarely a priority 'doorstep' issue for local politicians.

The National Outcomes Framework will be used to hold government departments to account. This should be developed further to create a Local Outcomes Framework to be used by the Office for Health Promotion to hold local authorities and their partner agencies to account. This Local Outcomes Framework will consist of indicators drawn from the national framework most relevant to local delivery of treatment and recovery systems. It must be developed in partnership with people working throughout the system to make sure that it includes the right measures of local performance and does not introduce perverse incentives.

Outcome measures in the framework should cover the performance of all the local partners with a role in providing care and support for people with drug problems. Given that drug problems are concentrated in more deprived areas, these measures will show what progress is being made to level up. Annual publication will promote transparency and encourage community engagement in local implementation.

The Office for Health Promotion must have the staff and resources needed to monitor local area performance against the Local Outcomes Framework and report to the new central Drugs Unit and hold local areas to account for meeting the new Commissioning Quality Standard.

Local authorities with poor outcomes should be obliged to work with the Office for Health Promotion to improve their services. As suggested in the paragraph above, DHSC should consider providing local authorities with a financial incentive for improved performance and outcomes, perhaps delivered in partnership with the Local Government Association. Support for local authorities should include regional improvement networks, facilitated by the Office for Health Promotion and aligned with the new NHS integrated care system structures.

DHSC should commission the CQC to undertake a thematic review of commissioning practice to see whether local areas have in place comprehensive and integrated treatment and recovery-orientated systems of care (ROSC). Because tackling substance misuse requires strong partnerships between local agencies, joint inspections between CQC and other inspectorates such as Her Majesty's Probation Inspectorate and Her Majesty's Inspectorate of Constabulary should also be considered.

**Recommendation 7**

We recommend that DHSC introduce, for 2022 to 2023 and beyond, a Local Outcomes Framework to increase transparency and local authorities' accountability for their treatment and recovery outcomes. DHSC should consider the introduction of incentive payments for local authorities to deliver improved outcomes.

**Recommendation 8**

We recommend that DHSC ensures that the Office for Health Promotion has the capacity and capability to monitor local performance against the Local Outcomes Framework and report to the new central cross-government Drugs Unit to:

- hold local areas to account for meeting the new Commissioning Quality Standard
- improve outcomes
- work with the LGA to provide a comprehensive improvement support offer for local authorities.

### 2.6 Proposed new accountability framework between government and responsible local partners

The review makes several recommendations which, taken together, form the basis of a new and strengthened accountability framework between national government and local partnerships of the local authority, health, and criminal justice—working together to deliver integrated recovery-orientated systems of care for dependent drug users.

There are 4 main ways in which local partnerships will be held to account.

1. The central cross-government Drugs Unit will draw up a National Outcomes Framework, which will be developed further into a Local Outcomes Framework.

The Local Outcomes Framework will contain locally relevant indicators to monitor local authority delivery of treatment and recovery systems.

2. Poorly performing local authorities and health and criminal justice partnerships will be obliged to work with the Office for Health Promotion.
3. Local authorities will be subject to a thematic review of their commissioning practices by CQC, delivering the results to the central cross-government Drugs Unit.
4. Local authorities will receive financial incentives for improved performance.

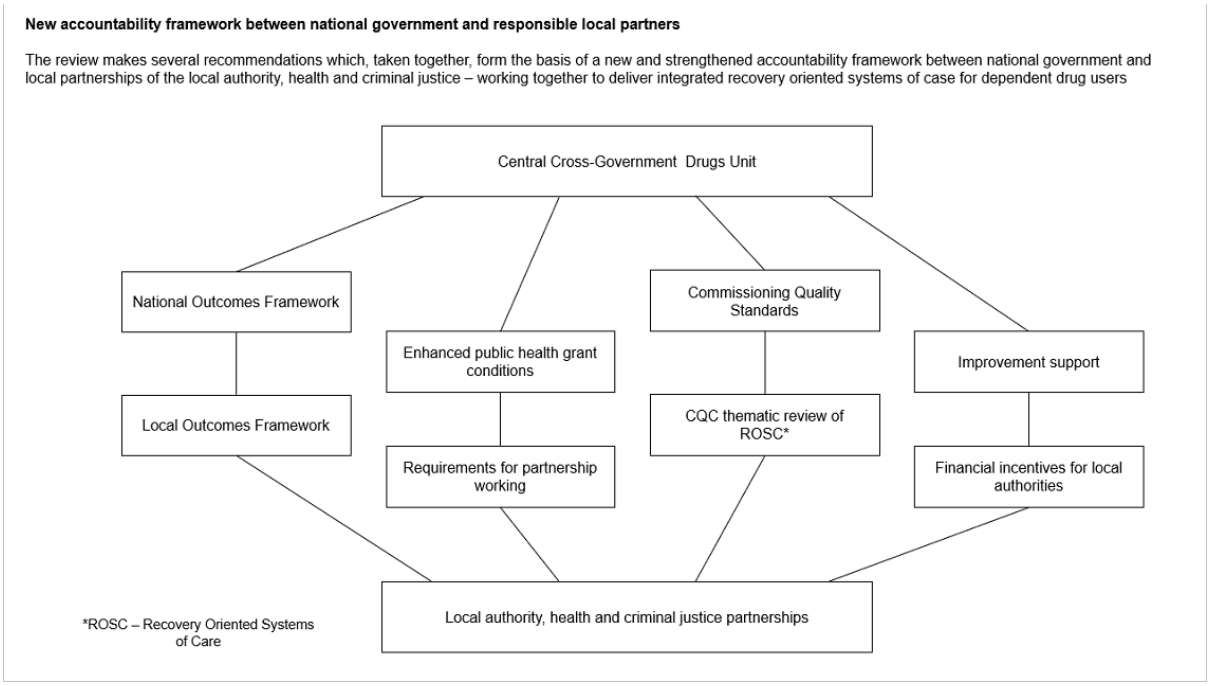

Figure 1: Accountability framework example

### 3. Rebuilding services

People with drug dependence often find it hard to access many of the services they need, including mental and physical healthcare from the NHS. Housing support and employment support are rarely there when needed, and their absence makes recovery less likely. This section of the report makes recommendations aimed at rebuilding those services which are essential to successful treatment and recovery, which necessarily involves rebuilding the workforce. A complex set of public services are often required to help people address their drug dependence and achieve recovery.

### 3.1 Workforce

The drug treatment and recovery workforce has deteriorated significantly in quantity, quality and morale in recent years, due to excessive caseloads, decreased training and lack of clinical supervision. A recent workforce survey showed that drug workers had caseloads of between 50 and 80, sometimes rising as high as 100 people. Good practice suggests a caseload of 40 or less, depending on complexity of need. Such high caseloads reduce the quality of care provided and the effectiveness of treatment. Focus should be on providing high-quality personalised care, rather than paperwork.

The availability of training placements for the next generation of specialists has reduced, and so too has professionals' capacity to train and support drug workers and peer workers. The number of psychiatrists in specialist substance misuse training has fallen steeply. The only effective treatments for people dependent on non-opioid drugs are psychosocial interventions including cognitive behavioural therapy, yet people with professional skills in these areas are in very short supply. Dedicated social work teams for drugs and alcohol are also disappearing.

Services are increasingly reliant on drug workers who often have minimal professional qualifications or none. Drug workers are not always properly trained or supervised and 10% of them are volunteers. Similar issues affect peer workers although people with lived experience, working as peer supporters or mentors, have a critical role to play in any well-developed drug and alcohol treatment service.

The disruption caused by frequent retendering of drug treatment services has made recruitment difficult and has caused many to leave, particularly professionally trained staff such as psychiatrists, psychologists, and nurses. Job security and access to professional development are more readily available within NHS mental health services, so are more attractive to many healthcare workers.

Rebuilding the workforce is going to require sustained focus and financial investment over the medium to longer-term. DHSC and HEE should take urgent action to expand the substance misuse workforce and rebuild its professional base. This requires development of a workforce strategy that complements HEE's workforce strategy for mental health services. Clear occupational standards for drug workers and peer recovery workers are also needed, including a competency and training framework.

Creating a professional body, a Centre for Addictions, should be explored, to permit members of the substance misuse workforce to work together in a more co-ordinated network. This body should develop specialist training for the workforce and provide accreditation. In Australia the Chapter of Addiction Medicine within the Australian College of Physicians carries out this function, though only for clinicians. The Academy of Medical

Royal Colleges should be requested to take the lead on this, working with appropriate other bodies, with the government providing some seed funding.

The addiction research workforce is important for ensuring that the UK is aware of emerging treatments, recovery supports, and drug trends. Government research funders, professional bodies and scientific societies should actively commission research on addiction and support the careers of addiction researchers.

**Recommendation 9**

We recommend that DHSC commission HEE to devise by the end of 2021 a comprehensive strategy to increase the number of professionally qualified drug treatment staff (psychiatrists and other doctors, psychologists and other therapists, nurses and social workers), and set occupational standards, competency and training requirements for drug workers and peer recovery workers. Government should also fund HEE to cover the costs of training the workforce.

**Recommendation 10**

We recommend that the Academy of Royal Medical Colleges, working with appropriate other bodies, be commissioned to develop a professional body, a Centre for Addictions, for all members of the substance misuse workforce. DHSC should provide seed funding to enable this.

### 3.2 Treatment for adults

In line with recommendation 5, local authorities should ensure that a full range of drug prevention and treatment services is available to their local population. These evidence-based harm-reduction and treatment services should include:

- needle and syringe programmes
- the provision of naloxone
- pharmacological and psychosocial treatments
- outreach services
- residential rehabilitation
- inpatient detoxification

There should also be a strong focus on early intervention and the treatment needs of offenders. Current clinical management of drug misuse and dependence does not always match the guidance laid out in the 2017 UK clinical guidelines on drug treatment. The package of reforms recommended in this review will help bring practice into line with these evidence-based guidelines.

In many local areas psychosocial interventions are limited and their delivery is substandard, frequently amounting to little more than a chat with a drug worker. Yet psychosocial interventions are critical, particularly for non-opioid users for whom there are no effective pharmacological interventions. This is a major defect in current services and every local authority area must ensure that it has a programme of psychosocial interventions, led by trained professionals.

Some very vulnerable groups, such as crack cocaine users, people who use image- or performance-enhancing drugs or people engaged in 'chemsex', do not receive an adequate or any service, but are at great risk. In addition, outreach and harm-reduction services, including specialist needle and syringe programmes, have been cut back in many areas.

Local commissioning of inpatient detoxification and residential rehabilitation has decreased substantially in recent years, despite evidence of their effectiveness and importance for people with particularly complex needs. Local commissioning of such high-cost but low-volume services should be replaced with a regional or sub-regional approach.

**Recommendation 11**

We recommend that local authorities commission a full range of evidence-based harm reduction and treatment services to meet the needs of their local population in line with the new national Commissioning Quality Standard.

**Recommendation 12**

We recommend that DHSC, NHSE and the Office for Health Promotion review by the end of 2021 to 2022 the commissioning and funding mechanisms for high-cost but low-volume services such as inpatient detoxification and residential rehabilitation. DHSC should introduce a regional or sub-regional approach to commissioning these services to ensure national coverage.

### 3.3 Treatment for young people

The Smoking, Drinking and Drug Use survey has shown that drug use among children (aged 11 to 15) has increased by over 40% since 2014, reversing a previous long-term downward trend. This increase is seen across a wide range of substances and most socio-economic groups. The most alarming development is the widespread involvement of vulnerable children and young people in drug supply, often through 'county lines'.

Young people with treatment requirements coming into services have increasingly complex needs, often involving poor mental health and self-harm, and sometimes criminal or sexual exploitation. Targeted early identification of young people at risk, and brief and early intervention, need to be strengthened. Services need to be trauma-informed and treatment should be family-based if necessary, particularly for young people whose parents are themselves dependent on drugs or alcohol.

Like adults, young people with drug-use problems need a broad treatment package, with a combination of specialist treatment and wider health and social care services. The challenges they face include their family circumstances and mental health difficulties. Commissioning structures at national and local level must ensure that these different services work together.

The Office for Health Promotion should undertake more work on defining and promoting effective drug and alcohol services and practice for young people. It should also ensure that there is better prevalence data to support planning for local areas.

**Recommendation 13**

We recommend that DHSC make increased funding available to specialist substance misuse services for young people to improve the capacity and quality of these services. Also, through the national Commissioning Quality Standard, DHSC should ensure that these services are linked with other local services for vulnerable young people and that family interventions are more widely available.

### 3.4 Recovery support

Recovery is a process that often takes time to achieve, and effort to maintain. In May 2019 Dr Ed Day was appointed as the UK government's Drug Recovery Champion, to promote the best treatment and support for those recovering from drug misuse. The first annual report from the UK Recovery Champion stated:

the creation of a Recovery-Orientated System of Care (ROSC) offers the best chance of helping people move on from drug dependence. At its best ROSC is built on person-centred services and supports multiple non-linear pathways to recovery.

The added funding and accountability recommended in this report should support the expansion of ROSC.

Services should include people with lived experience of drug dependence working as recovery champions and recovery coaches. They should also provide networks of peer-based recovery support and establish communities of recovery and mutual aid groups. The passion and commitment of people in these roles made a strong and positive impression on the review team.

Peer supporters should not be left to do the work of professionals without appropriate training, pay or support. This is exploitative and underlines the need for a comprehensive workforce strategy.

Smaller providers have been forced out of the market, resulting in the closure of many grassroots organisations and local charities. This has adversely affected women and people from minority groups, including black, Asian and minority ethnic (BAME) communities, because local organisations (including lived experience recovery organisations) are better at understanding and responding to their needs.

The government's appointment of a recovery champion is a welcome development, but for this to have impact, there is an urgent need to develop a flexible and innovative network of peer-recovery organisations and also standards to raise quality and improve governance.

**Recommendation 14**

We recommend that DHSC and the Office for Health Promotion support local areas to ensure that thriving communities of recovery are linked to every drug treatment system. The government's Drug Recovery Champion should work with the Office for Health Promotion to develop standards to raise the quality and improve the governance of the recovery sector.

### 3.5 Diverting more offenders into treatment and recovery services

The Crime and Justice Taskforce, chaired by the Prime Minister, is committed to reducing crime and reoffending, much of which is driven by drug dependence. The phase one report showed that a cohort of around 300,000 heroin and crack users drive nearly half of all acquisitive crime and homicides. Spending an average of £40 to £50 per day on drugs,

these users cycle in and out of prison. Initiating treatment for this group has a rapid effect on reducing offending and alleviating some of the pressure on our prison system. Yet referrals from the criminal justice system into drug treatment have fallen sharply, particularly for crack users.

Police-led out of court disposal and drug diversion schemes, like Checkpoint in Durham, Turning Point in the West Midlands, and DEP in Avon and Somerset, have delivered early interventions that divert individuals away from the criminal justice system and into drug education, support, and treatment. These schemes should be expanded.

Use of community sentences with drug rehabilitation requirements (DRR) and alcohol treatment requirements (ATR) has decreased significantly, even though they offer a more cost-effective therapeutic alternative to short prison sentences for drug-related offending. Same-day sentencing requirements in court and ineffective probation supervision have contributed to a fall in the number of these sentences because there is often neither the time nor the expertise available to help arrange such a disposal. In these circumstances, the judiciary inclines towards custodial sentences, particularly when the availability and quality of local treatment and recovery services are in question.

NHSE's pilot programme to rebuild community treatment sentences is making progress. The programme covers mental health treatment requirements (MHTRs), DRRs, ATRs and combined orders, and now covers 20% of the country. Funding has been committed in the NHS Long Term Plan to expand coverage to 50% of England by 2023. However, before 100% coverage is achieved many offenders will not benefit from this approach, and the high use of prison in the remaining uncovered areas will continue.

The recent sentencing white paper announced a commitment to increase use of police diversion schemes, and community sentences with treatment requirements, as alternatives to custody. These initiatives are very positive, but they all place significant additional pressure on the drug treatment system, reinforcing the earlier call for substantial additional investment (recommendation 2). The drug-related crime and criminal justice costs that stem from a failure to provide offenders with an adequate treatment system are annually over 10 times the proposed additional investment (in year 5).

**Recommendation 15**

We recommend that the MoJ, HO and DHSC, with the support of NHSE and the Office for Health Promotion, work together to ensure that the additional funding for drug treatment announced in January 2021 contributes to improved treatment pathways from criminal justice settings. In particular, action should be taken to divert drug users from the criminal justice system into treatment and maximise the use of Community Sentence Treatment Requirements (CSTRs).

**Recommendation 16**

We recommend that DHSC and NHSE expand their CSTR programme to 100% of the country by the end of this Parliament. NHSE and HMPPS should work closely with local commissioners of substance misuse treatment to seize the opportunity presented by the recently announced increase in funding for such treatment funding in 2021 and 2022.

### 3.6 Substance misuse services in prisons

Details of the regime inside prison are outside the scope of this review. However, it is clear that efforts to address drug misuse in custody are consistently undermined by the widespread availability across the prison estate of illicit drugs, especially spice. Evidence suggests that demand is driven by a widespread sense of boredom, hopelessness and lack of purposeful activity in custody.

The Health and Social Care Act 2012 transferred to NHSE responsibility for commissioning healthcare services in custody. Funding for prison healthcare and substance misuse services has fared relatively well compared to local authority funded services in the community, benefiting from increases to the NHS's spending settlement.

This increased funding is thought to have improved healthcare services in custodial settings. However, there has been criticism of NHSE's often arm's-length approach to commissioning substance misuse services in prisons. Contracts are often placed with a large prime provider of general healthcare, which is then left to sub-contract specialist substance misuse services. Some decline has been reported in the range of provision, particularly of recovery-orientated services. There is also a perception that many prison governors feel less involved in healthcare provision in their establishments.

**Recommendation 17**

We recommend that MoJ, DHSC and NHSE work together to improve by the end of 2021to 2022 the transparency and accountability of the commissioning and delivery of substance misuse services in prisons, including through publishing how much money is spent each year on these services. HM Prison Service should make sure that enough staff are available to take prisoners to their treatment appointments within the prison.

### 3.7 Continuity of care

The period immediately after release from prison is challenging. People released, often driven by renewed desire for drugs, are at high risk of overdose and reoffending. PHE's Public Health Outcome Framework indictor C20 has shown that only a third of those referred for further community treatment post-release go on to receive it within 3 weeks.

The introduction of RECONNECT (an NHS programme for care after custody) and Enhanced RECONNECT should help more prisoners on release make contact with health and substance misuse services. The role of peer mentors in helping people get into treatment should also be considered by commissioners.

Delays in accessing benefits also contribute significantly to an individual's vulnerability to re-offending and relapse. Prisoners are often released on a Friday afternoon, facing a long wait before their first benefit payment comes through, with nowhere to live, and without viable proof of identity. Jobcentre Plus staff now come into prisons to enable prisoners to start the benefit claim process before release. This is welcome but needs to be more consistent and better resourced.

**Recommendation 18**

We recommend that MoJ ensures that everyone leaving prison has identification and a bank account and that those who cannot claim benefits online get the opportunity, from the day of release, to access DWP's telephony service. MoJ and its partners should make sure that prisoners with drug dependence can access and receive treatment in the community.

### 3.8 Probation services

The probation system has a crucial role to play in implementing the recommendations of this review, but currently has major shortcomings. Government should ensure that the ongoing reforms result in getting offenders into treatment and keeping them there. More resources should be dedicated to identifying, assessing and referring offenders into treatment from court, and in advising the court on treatment-sentencing options. A requirement to attend drug appointments could be imposed through licence conditions on offenders at release. Probation officers should work with treatment providers to agree a joint plan to support offenders identified as needing drug treatment.

We welcome the new health and justice partnership co-ordinator role in the probation service, now being tested in 5 areas. The co-ordinator will have the skills and knowledge needed to promote understanding and collaboration between local partners. The new NHS integrated care systems (ICS) provide an opportunity for these co-ordinators to liaise across health and care services, as well as drug and alcohol treatment. If the testing is successful

the MoJ should expand this approach to cover all probation local delivery units, linked with the anticipated introduction of ICS.

After multiple successful pilot studies MoJ has rolled out mandatory sobriety programmes for offenders where crime is driven by alcohol. Other countries use this same model for other substances and this approach should be trialled in the UK justice system for drugs as well.

**Recommendation 19**

We recommend that MoJ fund their new health and justice partnership co-ordinator role within the probation service, so that it covers all local probation areas in England, in tandem with the introduction by the NHS of new ICS.

### 3.9 Employment support

Employment has been demonstrated to improve treatment outcomes. Having work or something meaningful to do is an essential part of recovery and builds self-esteem. The increased stability and financial security that comes from employment greatly assist individuals, families and communities. However, few people in treatment receive the employment support that they need or move into employment.

People in treatment and recovery frequently experience stigma, and employers are often wary of hiring people with histories of drug and alcohol misuse.

Individual placement and support (IPS) is an intensive employment support intervention that has an established evidence base in the mental health sector. There is a strong focus in IPS on finding out people's own preferences for work. A recent trial within treatment services in 7 areas has shown that this IPS model is also successful in getting people in drug and alcohol treatment back into work. The IPS model should be rolled out in treatment settings across the whole of England.

Introducing the peer-mentor model into Jobcentre Plus will help people who have a drug dependence to receive more tailored support. Peer mentors have been through a similar drug-dependence journey, and can provide support and advice to claimants, drawing on personal experience. Peer mentors can:

- encourage safe disclosure of substance-related needs
- encourage people to engage with the appropriate support

- show that it is possible to move into employment

Good results have been obtained by having Jobcentre Plus work coaches provide outreach employment support in GP surgeries. DWP should consider extending this disability employment adviser (DEA) model so that Job Centre plus staff also work within drug and alcohol treatment services.

**Recommendation 20**

We recommend that DWP work with the Office for Health Promotion to roll out IPS to all areas in England within the forthcoming Spending Review period.

**Recommendation 21**

We recommend that DWP recruit peer mentors (one in each Jobcentre Plus area) to encourage people dependent on drugs to claim all relevant benefits and access employment support, with funding for the posts agreed at the Spending Review.

**Recommendation 22**

We recommend that DWP augment Jobcentre Plus support by equipping staff to reach out into the community and work more intensively with those with complex needs, including working in drug and alcohol treatment services with people with addictions.

### 3.10 Housing support

Drug dependence can be both a cause and a consequence of homelessness and rough sleeping. People who are dependent on drugs may struggle to retain accommodation due to financial difficulties, problems with behaviour or family relationship breakdown.

Homelessness and rough sleeping can also be the route to becoming drug and alcohol dependent. Findings from the MHCLG's rough sleeping questionnaire indicate that almost two-thirds of people who sleep rough have a current drug or alcohol problem, with almost one-third reporting a problem with heroin, many for over 10 years.

Public Health England's (PHE) statistics report on substance misuse treatment found that one-fifth of adults starting treatment in 2019 to 2020 reported a housing problem, increasing to one-third of people in treatment for opiates. It also found 16% of opiate clients reported this as 'urgent' (mainly as being of 'no fixed abode'). Nearly a quarter of opiate clients

reported living in ‘unsuitable housing’ of such poor quality or condition as to be likely to have a negative impact on the person’s likelihood of achieving recovery.

Having a healthy home is key to recovery. In 2019, the Advisory Council on the Misuse of Drugs (ACMD) report into homelessness and drug misuse found that treating homeless people for drug misuse is exceptionally difficult unless their housing needs are addressed at the same time. ACMD state that safe, stable housing is essential for people who are homeless and who have problematic drug use, and that it is associated with increased engagement with services.

Currently local authority housing services do not systematically provide the support that is needed, and there are shortcomings in the availability of specialist housing support (for example ‘supported housing’, ‘recovery housing’ or ‘floating support’) tailored to meet the specific needs of the population in drug treatment.

The government has committed to ending rough sleeping by 2024, with substantial new funding announced in 2020 to improve provision of drug and alcohol treatment for people who are sleeping rough. The ‘Everyone In’ initiative in operation during the COVID-19 pandemic has provided some positive experience of flexible collaboration between accommodation and health services, including drug treatment services, with lessons for the future. Government should build on this and work towards having integrated, flexible and trauma-informed services across housing and health become the norm for people who sleep rough.

Housing First has proved to be an effective evidence-based model for people with complex needs who sleep rough, providing a secure stable platform from which other issues can be addressed. Housing First should be scaled up and rolled out more widely, and MHCLG should continue to work with DHSC and the Office for Health Promotion to secure additional funding at the next Spending Review for drug and alcohol treatment for people who sleep rough.

However, in spite of the positive work being done to tackle rough sleeping, for other people in treatment and recovery we need clearer understanding of the level of housing need, and the gaps in housing-related services, so as to form a strategy to address them.

**Recommendation 23**

We recommend that MHCLG and DHSC work together to gain better understanding of the types and levels of housing-related need among people with a substance misuse problem, with early findings feeding into the next Spending Review.

### 3.11 Mental health support

Many people with drug dependence also have a mental health problem. Such individuals are often passed from one service to the other, excluded from mental health services until they resolve their drug problem, and excluded from drug services until their mental health problems have been addressed. Time and resources are wasted, and opportunities to address both drug and mental health problems are lost. People with any other set of chronic conditions would not be treated like this.

In 2012 the Improving Access to Psychological Therapies (IAPT) programme for people with milder mental health problems published a positive practice guide for working with people who use drugs and alcohol, and in 2017 PHE developed guidance on commissioning and providing better care for people with co-occurring mental health, and alcohol and drug use conditions, which stressed that there should be 'no wrong door' and this issue is 'everyone's business'. Both sets of guidance have been poorly implemented, and access to services remains deeply inadequate.

For many people, mental health problems and trauma lie at the heart of their drug and alcohol dependence. Commissioners of substance misuse services and NHS mental health services must either provide a better pathway between the services or integrate their services. Above all, the workforce in both services need to be trained to deliver more and higher-quality psychosocial interventions.

It is encouraging that the 2020 NHS mental health implementation plans to expand community services include a commitment to improve access for people with drug dependence. However, the new central Drugs Unit should keep this commitment under close scrutiny.

DHSC and NHSE should work together on how they will meet the mental health needs of people dependent on illicit drugs and alcohol. They should consider introducing contractual requirements or incentives such as the NHS's CQUIN scheme (Commissioning for Quality and Innovation).

NHSE, with the support of DHSC, should explore how substance misuse services could be commissioned to assess and treat some comorbidities, including giving psychological interventions for trauma, anxiety and depression.

HEE's workforce strategy should consider what training is needed for the substance misuse workforce to build their skills and ability to treat the mild to moderate mental health difficulties which are very common in people with drug dependence.

**Recommendation 24**

We recommend that DHSC and NHSE develop, publish and implement by the end of 2021 an action plan that improves the provision of mental health treatment to people with drug and dependence. This should include consideration of the introduction of contractual requirements or incentives so that NHS mental services target dependent drug users. Consideration should also be given to commissioning substance misuse services to treat some mental health co-morbidities themselves without referring people on to specialist mental health services.

**Recommendation 25**

Linked to recommendations 9 and 10, we recommend that DHSC commission HEE to develop competency and training requirements for all staff working with people with co-existing mental health problems and drug dependence. Resources and standards should be applicable and applied across the mental health and substance misuse workforces.

**Recommendation 26**

We recommend that DHSC, NHSE and the Office for Health Promotion ensure that opportunities for integrated commissioning of mental health and substance misuse services are explored proactively and articulated as part of the next stages of integrated care system development. This includes ensuring that proposed legislation facilitates integrated commissioning and provision.

### 3.12 Physical healthcare

Many drug users have poor overall health. Sixty per cent of deaths of opiate users in treatment are from causes other than drug-misuse poisoning, with respiratory disease, cardiovascular disease and cancer the leading immediate causes.

The NHS is poor at engaging with the wider health needs of drug users with medical co-morbidities (for example, hepatitis C, HIV, heart and lung disease), many of whom have very high need for health services but are ill-equipped to navigate complex pathways. This must change, particularly to meet commitments to level up and to increase healthy life expectancy by 5 years by 2035.

Stigma often limits access to healthcare services, with drug users feeling unwelcome in many mainstream health and care settings. The healthcare system needs to find ways to reach these vulnerable patients to provide screening and treatment. Several models are available for consideration, including specialist clinics within substance misuse services and assertive outreach for repeat attenders at emergency departments, which has proved

promising for people with alcohol problems. In most models, peer mentors can potentially play a useful role in helping people get to NHS appointments, which may otherwise appear daunting.

DHSC and NHSE should work together to develop an action plan on improving access to physical healthcare. Use of contractual requirements and incentives should be explored, as for mental health services.

**Recommendation 27**

We recommend that DHSC and NHSE develop, publish and implement by the end of 2021 an action plan for improving the provision of physical healthcare to people with drug dependence, which should be an integral part of local integrated care systems.

## 4. Increased focus on primary prevention and early intervention

As no one can become addicted to drugs without using them regularly, society benefits enormously when people can be persuaded not to use drugs in the first place (primary prevention) or to stop occasional drug use before it becomes a problem (early intervention). Government policy in this area should comprise drug-focused prevention programmes in schools, non-drug focused support for young people to reduce their risk for many problems including but not limited to drugs, and population-wide approaches to reduce recreational drug use.

### 4.1 Drug-focused prevention programmes in schools

A major prevention opportunity is created by the statutory guidance for RSHE that came into force in England on 1 September 2020, with schools having to commence first teaching of the subjects no later than the start of the summer term 2021. The statutory guidance sets out requirements in relation to teaching about tobacco, alcohol, prescription medicines and illicit drugs.

The international experience with prevention shows that support for front-line workers and evaluation of outcomes is critical for success. Teachers will need high-quality training programmes to deliver the new drug prevention curriculum effectively. Further, because good intentions do not guarantee good results, the new prevention effort should be subject to scientific evaluation fed back in a fashion that promotes continuous improvement.

Teachers are being supported to deliver the new curriculum through teacher training materials designed to build confidence as well as quality of teaching. The implementation of the RSHE curriculum will be monitored through periodic school snapshot surveys and Ofsted inspections.

**Recommendation 28**

We recommend that DfE make an assessment of the support available to teachers in rolling out the new Relationship, Health and Sex Education (RSHE) curriculum, and continue to monitor implementation, with a view to more detailed evaluation after 2 years of full curriculum delivery.

### 4.2 Non-drug-focused programmes that build youth resilience

Evidence shows that the same factors that increase childhood risk for drug use also increase risk of alcohol and tobacco use, poor academic performance, mental health problems, and harm to self and others. These problems cause immediate and long-term harm to individuals and wider society. Risk factors include chaotic, unrewarding environments, unremitting stress, social exclusion, and individual risk factors such as having difficulty managing emotions, coping with challenges, and exercising behavioural self-control. Prevention programmes which target these core risk factors in schools, in the community and in the family, can reduce drug use as well as many other problems that blight the lives of young people.

Dame Andrea Leadsom MP has been leading a review, commissioned by the Prime Minister, into improving health outcomes of babies and young children. Her review has looked at reducing inequalities from conception to age 2, aiming to ensure that every baby is given the best possible start in life. The findings should be integrated into the government's drug strategy, and also into the government's thinking on reforming alternative provision in education including the focus on earlier, more preventative intervention.

Positive activities for young people outside of school hours are also important. The DCMS provide funding direct to the third sector through the Youth Investment Fund. In future this should be focused on the most vulnerable children.

Some groups of children are exposed to additional risk around drug taking or selling, including children who are outside mainstream education. Each local authority should have a fair access protocol, agreed with the majority of the mainstream state-funded schools in its area, to maximise the protection that education gives to vulnerable children. This will help ensure that children who don't have a school place, especially the most vulnerable, are

offered a place at a suitable school as quickly as possible. All admission authorities, including those of academy and free schools, should be required to participate in the fair access protocol for their area.

Addressing children's mental health issues early is also a protective factor, and the government is committed to putting in place additional support at school level. This includes introducing new mental health support teams for all schools and colleges and providing training for senior mental health leads in schools and colleges.

In its response to the online harms white paper consultation, the government set out its ambition to make the UK the safest place in the world to be online. Drug dealers have a significant online presence, using social media to push drugs to children and young people. Decisive action is needed to curtail online harm and introduce legislation which places greater responsibility on technology companies to address these issues.

Families with parental drug misuse need specific support which must be co-ordinated at a local level. There is promising emerging evidence of the outcomes of programmes such as the Children of Alcohol Dependent Parents (CADeP) programme. This support should be expanded to drug misuse and, depending on results, rolled out across England.

**Recommendation 29**

We recommend that DfE and DCMS, with support from DHSC and the Office for Health Promotion, invest in age-appropriate evidence-based services and support all young people to build resilience and to avoid substance misuse. Local authorities should identify, and provide additional support to, those young people most at risk of being drawn into using illicit substances or involvement in supply.

### 4.3 Reducing recreational drug use across the population

The rise in the use of recreational drugs, such as cannabis, powder cocaine and ecstasy, is a further pressing issue that was exposed in Part 1 of this review. Many young people in treatment are there because they are struggling with cannabis harms, and there is a further worrying trend of increasing use of powder cocaine by young, often well-educated, males.

Although many recreational drug users do not consider their use to be problematic, recreational use carries risks and it fuels the illicit drug market. The risks include dependence, health harms, overdose, the health risks associated with a contaminated or adulterated or unusually strong batch, and negative impacts on users' everyday lives and families.

Government should look to understand better the drivers for recreational drug use and what measures can be taken to influence behaviour. This will include accurate and clear information to users on the risks (including the information provided by the Talk to Frank drug information service), broader prevention work to build resilience in young people and reduce certain kinds of risk-taking behaviour, and support to engage drug users with any underlying causes such as adverse childhood experiences or exposure to gangs.

There is little research, either in the UK or internationally, which shows what can be done to put this rising trend of recreational drug use into reverse. Mass communications based on anti-drug messaging have been shown to be ineffective and can compound user attitudes and behaviour.

Innovation is needed to identify new ways of influencing the behaviour and attitudes of recreational drug users. Any campaign should be grounded in behavioural science and include a package of targeted interventions that complement the broader drug prevention and treatment system.

**Recommendation 30**

We recommend that the government (either HO or DHSC) establish an innovation fund to research which interventions are most effective at changing the behaviour of recreational drug users.

## 5. Improvements to research and how science informs policy, commissioning and practice

There are several obvious research and evidence gaps, listed below, which need to be addressed as a matter of priority, with support from research funders such as NIHR.

The National Drug Treatment and Monitoring System (NDTMS) is a valuable resource that should continually be reviewed and updated, and routinely linked to other relevant data sets to create an extensive drugs data warehouse. This would allow better evaluation of treatment and the effectiveness of innovations. Long-term cohort studies would identify those interventions that best help people to respond well to treatment and achieve recovery.

There is a lack of research on psychosocial interventions, particularly for cocaine use and for other non-opioid substances. More research should be conducted into which interventions are most effective, particularly for people who may have cognitive deficits due to past or current drug use, and for people with co-occurring mental illness. Funding should be available for service providers to support this activity.

Research on substance misuse should extend to look at the factors which promote recovery, a priority area flagged in the government's Drug Recovery Champion's recent annual report. Research should be broad based, draw on different disciplines and bring practitioners and researchers together. More research is required into the effectiveness of peer-led interventions and how these can be encouraged and facilitated by the treatment system. Drug use in ethnic minority communities, and its prevention and treatment, also need particular attention.

Pharmacological research has made few recent advances other than the introduction of long-acting forms of buprenorphine. However, neuroscientists have argued that there is scope to develop agonist and antagonist therapies to help prevent relapse.

DHSC should promote innovative research on addiction and its implementation in practice by offering incentives, rewards or prizes to companies and other organisations for effective developments in this field - for example, pharmaceutical advances.

Training to improve the calibre of UK addictions research is essential, both to improve the quality and value of the research undertaken and to create the next generation of researchers. Training fellowships are desirable to support development of skills in areas of research relevant to policy and practice.

**Recommendation 31**

We recommend that DHSC and BEIS encourage more research into what works to combat substance misuse, across supply, prevention, treatment and recovery.

**Recommendation 32**

We recommend that the government promote greater innovation in research, for example in pharmaceuticals, by offering incentives or rewards to companies or organisations whose developments prove beneficial in practice in the addiction field.

2 of my independent review for government, setting out a way forward on drug treatment and recovery. Part 1 laid bare the extent of the illicit drugs market in the UK, worth almost £10 billion a year, with 3 million users and a supply chain that has become increasingly violent and exploitative. Drug deaths are at an all-time high and drug addiction fuels many costly social problems, including homelessness and rising demands on children's social care. The drugs market is driving most of the nation's crimes: half of all homicides and half of acquisitive crimes are linked to drugs. People with serious drug addiction occupy one in 3 prison places.

Part 1 also showed how entrenched drug use and premature deaths occur disproportionately more in deprived areas and the north of the country. It is highly likely that the pandemic has

widened inequalities and that any recession would further drive trends in drug use and deaths in the wrong direction. So, the problem is almost certainly worse than when we reported in Part 1 and a major barrier to ‘levelling up’.

All these issues are examined in depth in Part 2, which concludes that the public provision we currently have for prevention, treatment and recovery is not fit for purpose, and urgently needs repair.

Government faces an unavoidable choice: invest in tackling the problem or keep paying for the consequences. A whole-system approach is needed, with demand reduction a key component, to drive down the profitability of the market. This part of my review offers concrete proposals, deliverable within this Parliament, to achieve this.

For problem drug users, including an estimated 300,000 opiate and crack users, we cannot expect a reduction in demand without reversing the recent disinvestment in treatment and recovery services. To achieve and sustain recovery people need, alongside treatment, somewhere safe to live and something meaningful to do (a job, education or training). Too many people are in and out of treatment for years or even decades, without turning their lives around for good.

This problem can only be solved through coordinated action by multiple departments including the Home Office (HO), Department of Health and Social Care (DHSC), Department for Work and Pensions (DWP), Ministry of Housing, Communities and Local Government (MHCLG) and the Ministry of Justice (MoJ). To move forward, these departments must work together to invest in and improve treatment, employment, housing support and the way that people with addictions are treated in the criminal justice system. Every department will have competing priorities, and funding allocation processes do not easily support cross-departmental priorities. The Prime Minister should therefore appoint a single, responsible minister on drug policy to hold all of government to account, supported by a central team to monitor and report upon relevant social and criminal justice outcomes.

Increased funding is necessary, but not sufficient. Greater co-ordination and accountability at national level must also flow through to the local level, where responsibility sits for the delivery of drug treatment and wider recovery outcomes. If government invests more in treatment, this money should be ring-fenced, and local authorities must be required to work with wider health, employment support, housing and criminal justice partners to develop joint commissioning plans and be held to account for these plans and their outcomes.

It must be recognised that addiction is a chronic health condition, and like diabetes, hypertension or rheumatoid arthritis, it will require long-term follow-up. Discharge after short-term treatment is currently used as a measure of success, but should be stopped, as it ignores the fundamental relapsing and remitting nature of the condition. Trauma (physical,

sexual or psychological) and mental ill-health are the drivers and accompaniment of much addiction. They are co-morbidities rather than separate problems for a ‘dual diagnosis’. Commissioners of substance misuse services and NHS mental health services must ensure that individuals do not fall between the cracks.

Too many drug users are cycling in and out of prison. Rarely are prison sentences a restorative experience. Our prisons are overcrowded, with limited meaningful activity, drugs easily available, and insufficient treatment. Discharge brings little hope of an alternative way of life. Diversions from prison, and meaningful aftercare, have both been severely diminished and this trend must be reversed to break the costly cycle of addiction and offending.

Achieving these improvements in treatment and wider recovery will require significant rebuilding of capacity, including recruiting many more professionally qualified staff and trained support workers. Services which have diminished over the years, such as inpatient detoxification and residential rehabilitation, will need to be re-commissioned in a way that ensures national coverage.

Finally, we can no longer, as a society, turn a blind eye to recreational drug use. A million people use powder cocaine each year and the market is worth around £2 billion. The vast majority of users do not see themselves as having a drug problem and they are unlikely to come forward for treatment. However, they are causing considerable harm to others through the supply chain, both here and abroad. This is a difficult group to influence but, as the COVID-19 pandemic has so clearly shown, behavioural and attitudinal shifts in health behaviour are possible. We need to invest now in an innovation fund to test out which marketing and behavioural interventions could work in the UK, building on evidence from abroad.

This review makes recommendations for change across many departments and other organisations, which reflects the complex nature of the problem. It calls for significant investment, but the payoff is handsome: currently each £1 spent on treatment will save £4 from reduced demands on health, prison, law enforcement and emergency services. I am hopeful that the recommendations will be welcomed by this government as they strongly support its crime reduction and ‘levelling up’ agendas. My aim is to bring hope and real change to the many individuals, families and communities whose lives are blighted by drug addiction and by the criminals who exploit it.

Rich contributions to this review were made by many people (who are listed in Annex B). The review could not have been completed without backing by a team of highly competent civil servants: Pete Burkinshaw, Jon Knight, Nino Maddalena, Jez Stannard, Julia Thomas, Fizz Annand, Tracey Mwaniki and Emilie Rapport Munro, ably and tirelessly led by Tabitha Brufal. I wish to acknowledge the unstinting support and hard work, particularly on policy and drafting, contributed by Donna Ward of DWP, Dr Ed Day of Birmingham University and the

UK government's Drug Recovery Champion and Professor Keith Humphreys of Stanford University. The expert reference group kept my feet firmly to the fire and on the ground. The voices of those with lived experience of drugs have been urging us forward throughout, I hope not in vain, and I thank them for their invaluable testimony.

Arising from such collaborative teamwork, the review recommendations take the form, "We recommend…" but I take full responsibility for them and their every word.

Dame Carol Black

## Executive summary

### What this review set out to achieve

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

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

### Reform of central government leadership

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

We recommend the formation of a central Drugs Unit, sitting in whatever department or joint arrangement seems appropriate, with clear ministerial sponsorship. This unit should take the

lead in setting clear objectives and targets for the rest of government, and translate these into a new National Outcomes Framework, with the sponsoring minister reporting annually to Parliament on progress.

**Increased funding for drug treatment and wider recovery support**

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

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

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

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

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

This would allow for increased capacity for under-served groups, including non-opiate users and young people, and for larger numbers to be diverted away from the criminal justice system. Further work needs to be carried out by MHCLG before the next Spending Review

to identify how much additional funding is required to provide housing support to people in treatment who lack adequate housing.

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

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

**Allocating and protecting funding**

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

**Commissioning**

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

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

**Strengthening local authority accountability**

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

**Rebuilding services: workforce**

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

**Rebuilding services: treatment**

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

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

**Rebuilding services: recovery support**

DHSC and the Office for Health Promotion should support local areas to ensure that thriving communities of recovery are linked to every drug treatment system, working to standards on

quality and governance developed by the government's Drug Recovery Champion and the Office for Health Promotion.

**Diverting more offenders into treatment and recovery services**

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

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

**Employment support**

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

**Housing**

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

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

**Mental health**

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

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

**Physical healthcare**

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

**Prevention and early intervention**

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

The Department for Education (DfE) must ensure that schools seize the major prevention opportunity presented by the statutory guidance for Relationships, Sex and Health Education

(RSHE). This guidance came into force in England from September 2020 and sets out requirements in relation to teaching about tobacco, alcohol, prescription drugs and illicit drugs.

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

**Research**

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

We recommend that DHSC and the Department for Business, Energy & Industrial Strategy (BEIS) encourage and facilitate research into what works to combat substance misuse, across supply, prevention, treatment and recovery. DHSC should promote innovative research on addiction and its implementation in practice by offering incentives or rewards to companies and other organisations for effective developments in this field. For example, pharmaceutical advances.

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

**List of recommendations**

**Recommendation 1**

The government should establish a central Drugs Unit with strong analytical capacity which would develop a National Outcomes Framework and hold departments to account. The sponsoring minister should report annually to Parliament on progress in tackling drug misuse, including publication of relevant data.

**Recommendation 2**

We recommend that the government invests, by the end of year 5 of this programme, an additional £552 million in the treatment system through DHSC and an additional £15 million in employment support through DWP. MHCLG will also need to bid for additional funds for housing support at the next Spending Review.

**Recommendation 3**

We recommend that from 2022 to 2023, DHSC require local authorities to spend drug treatment funding, current and additional, on these services and not on other things. Similarly, we recommend that DWP and MHCLG protect any future additional funding provided for employment services and housing support for people dependent on drugs.

**Recommendation 4**

We recommend that DHSC, DWP and MHCLG make sure that funding for treatment, employment and housing support is distributed fairly on the basis of need.

**Recommendation 5**

We recommend that DHSC introduce a national Commissioning Quality Standard and require local authorities, as a condition of funding, to work with health, housing and employment support, and criminal justice partners to develop a joint needs assessment and publish a commissioning plan to direct spending from 2022 to 2023. Government should

make provision for budgets to be aligned or pooled at local level and each department should use its policy levers to require a strong partnership approach locally.

**Recommendation 6**

We recommend that DHSC and the Office for Health Promotion review the effect of frequent retendering on quality and cost-effectiveness of substance misuse treatment services.

**Recommendation 7**

We recommend that DHSC introduce, for 2022 to 2023 and beyond, a Local Outcomes Framework to increase transparency and local authorities' accountability for their treatment and recovery outcomes. DHSC should consider introducing incentive payments for local authorities to deliver improved outcomes.

**Recommendation 8**

We recommend that DHSC ensure that the Office for Health Promotion has the capacity and capability to monitor local performance against the Local Outcomes Framework, and report to the new central cross-government Drugs Unit to:

- hold local areas to account for meeting the new Commissioning Quality Standard
- improve outcomes
- work with the Local Government Association (LGA) to provide a comprehensive improvement support offer for local authorities

**Recommendation 9**

We recommend that DHSC commission HEE to devise by the end of 2021 a comprehensive strategy to increase the number of professionally qualified drug treatment staff (psychiatrists and other doctors, psychologists and other therapists, nurses and social workers), and set

occupational standards, competency and training requirements for drug workers and peer recovery workers. Government should also fund HEE to cover the costs of training the workforce.

**Recommendation 10**

We recommend that the Academy of Medical Royal Colleges, working with appropriate other bodies, be commissioned to develop a professional body, a Centre for Addictions, for all members of the substance misuse workforce. DHSC should provide seed funding to enable this.

**Recommendation 11**

We recommend that local authorities commission a full range of evidence-based harm reduction and treatment services to meet the needs of their local population in line with the new national Commissioning Quality Standard.

**Recommendation 12**

We recommend that DHSC, NHSE and the Office for Health Promotion review by the end of 2021 to 2022 the commissioning and funding mechanisms for high-cost but low-volume services such as inpatient detoxification and residential rehabilitation. DHSC should introduce a regional or sub-regional approach to commissioning these services to ensure national coverage.

**Recommendation 13**

We recommend that DHSC make increased funding available to specialist substance misuse services for young people to improve the capacity and quality of these services, and also through the national Commissioning Quality Standard ensure that these services are linked with other local services for vulnerable young people and that family interventions are more widely available.

**Recommendation 14**

We recommend that DHSC and the Office for Health Promotion support local areas to ensure that thriving communities of recovery are linked to every drug treatment system. The government's Drug Recovery Champion should work with the Office for Health Promotion to develop standards to raise the quality and improve the governance of the recovery sector.

**Recommendation 15**

We recommend that MoJ, HO and DHSC, with the support of NHSE and the Office for Health Promotion, work together to ensure that the additional funding for drug treatment announced in January 2021 contributes to improved treatment pathways from criminal justice settings. In particular, action should be taken to divert drug users from the criminal justice system into treatment, and maximise the use of Community Sentence Treatment Requirements (CSTRs).

**Recommendation 16**

We recommend that DHSC and NHSE expand their CSTR programme to 100% of the country by the end of this Parliament. NHSE and HMPPS should work closely with local commissioners of substance misuse treatment to seize the opportunity presented by the recently announced increase in funding for such treatment in 2021 and 2022.

**Recommendation 17**

We recommend that MoJ, DHSC and NHSE work together to improve by the end of 2021 to 2022 the transparency and accountability of the commissioning and delivery of substance misuse services in prisons, including through publishing how much money is spent each year on these services. HM Prison Service should make sure that enough staff are available to take prisoners to their treatment appointments within the prison.

**Recommendation 18**

We recommend that MoJ ensure that everyone leaving prison has identification and a bank account and that those who cannot claim benefits online get the opportunity, from the day of release, to access DWP's telephony service. MoJ and its partners should make sure that prisoners with drug dependence can access and receive drug treatment in the community as soon as possible after release.

**Recommendation 19**

We recommend that MoJ fund their new health and justice partnership co-ordinator role within the probation service, so that it covers all local probation areas in England, in tandem with the introduction by the NHS of new integrated care systems.

**Recommendation 20**

We recommend that DWP work with the Office for Health Promotion to roll out IPS to all areas in England within the forthcoming Spending Review period.

**Recommendation 21**

We recommend that DWP recruit peer mentors (one in each Jobcentre Plus area), to encourage people dependent on drugs to claim all relevant benefits and access employment support, with funding for the posts agreed at the Spending Review.

**Recommendation 22**

We recommend that DWP augment Jobcentre Plus support by equipping staff to reach out into the community and work more intensively with those with complex needs, including working in drug and alcohol treatment services with people with addictions.

**Recommendation 23**

We recommend that MHCLG and DHSC work together to gain better understanding of the types and levels of housing-related need among people with a substance misuse problem, with early findings feeding into the next Spending Review.

**Recommendation 24**

We recommend that DHSC and NHSE develop, publish and implement by the end of 2021 an action plan that improves the provision of mental health treatment to people with drug dependence. This should include consideration of the introduction of contractual requirements or incentives so that NHS mental services target dependent drug users. Consideration should also be given to commissioning substance misuse services to treat some mental health co-morbidities without referring people on to specialist mental health services.

**Recommendation 25**

Linked to recommendations 9 and 10, we recommend that DHSC commission Health Education England to develop competency and training requirements for all staff working with people with co-existing mental health problems and drug dependence. Resources and standards should be applicable and applied across the mental health and substance misuse workforces.

**Recommendation 26**

We recommend that DHSC, NHSE and the Office for Health Promotion ensure that opportunities for integrated commissioning of mental health and substance misuse services are explored proactively and articulated as part of the next stages of integrated care system development. This includes ensuring that proposed legislation facilitates integrated commissioning and provision.

**Recommendation 27**

We recommend that DHSC and NHSE develop, publish and implement by the end of 2021 an action plan for improving the provision of physical healthcare to people with drug dependence, which should be an integral part of local integrated care systems.

**Recommendation 28**

We recommend that DfE make an assessment of the support available to teachers in rolling out the new Relationship, Health and Sex Education (RSHE) curriculum, and continue to monitor implementation, with a view to more detailed evaluation after 2 years of full curriculum delivery.

**Recommendation 29**

We recommend that DfE and DCMS, with support from DHSC and the Office for Health Promotion, invest in age-appropriate evidence-based services and support all young people to build resilience and to avoid substance misuse. Local authorities should identify, and provide additional support to, those young people most at risk of being drawn into using illicit substances or involvement in supply.

**Recommendation 30**

We recommend that the government (either HO or DHSC) establish an innovation fund to research which interventions are most effective at changing the behaviour of recreational drug users.

**Recommendation 31**

We recommend that DHSC and BEIS encourage more research into what works to combat substance misuse, across supply, prevention, treatment and recovery.

**Recommendation 32**

We recommend that the government promote greater innovation in research, for example in pharmaceuticals, by offering incentives or rewards to companies or organisations whose developments prove beneficial in practice in the addiction field.

## 1. Introduction

In February 2020, Part 1 of this independent review laid bare that drug misuse is at tragically destructive levels in this country. The review highlighted the severe damage to public health and safety inflicted by the flood of drugs entering the UK market and deep cuts to prevention, treatment and recovery programmes. The trends in prevalence of drug use and the associated harms presented in Part 1 of this review are summarised in Annex A.

Recognising the need for swift action, the DHSC commissioned Part 2 of the review. This focused on how to improve the funding, commissioning, quality and accountability of drug prevention, treatment and recovery services in England. The methodology adopted in carrying out this commission is set out in Annex B.

The findings have been disturbing, even shocking. Funding cuts have left treatment and recovery services on their knees. Commissioning has been fragmented, with little accountability for outcomes. And partnerships between local authorities, health, housing, employment support and criminal justice agencies have deteriorated. The workforce is depleted, especially of professionally qualified people, and demoralised. Vital services have been cut back, particularly inpatient detoxification, residential rehabilitation, specialist services for young people, and treatment for cannabis and stimulant users.

Areas of the country with the highest rates of drug deaths or the poorest treatment services are the very same areas where the need to level up is greatest. These communities want to see urgent and effective action to tackle the violent drugs market, alongside purposeful efforts to rebuild treatment services and recovery support so that people can get the help they need.

The current situation is intolerable. Accordingly, this review has pursued 3 main objectives:

1. To increase the proportion of people misusing drugs who access treatment and recovery support, including more young people, and earlier interventions for offenders to divert them away from the criminal justice system, particularly prison.

2. To ensure that the treatment and recovery package offered is of high quality and includes evidence-based drug treatment, mental and physical health interventions, and employment and housing support.
3. To reduce the demand for drugs and prevent problematic drug use, including use by vulnerable and minority groups and by recreational drug users.

To achieve these objectives, significant changes need to be made in 4 areas.

1. Radical reform of leadership, funding and commissioning.
2. Rebuilding of services.
3. Increased focus on prevention and early intervention.
4. Improvements to research and how science informs policy, commissioning and practice.

This report sets out a vison for change in these areas with recommendations.

**2. Radical reform of leadership, funding and commissioning**

The priority, protection and increased funding given to the NHS have not been applied to services for drug dependence. A lower standard of care for this vulnerable and stigmatised population is not acceptable. Bringing treatment and recovery services for drug dependence up to parity with other health services will require fiscal investment as well as improvements in coordination and accountability.

Two welcome developments are the £80 million additional funding for drug treatment in 2021 and 2022, as part of a broader crime package, and the additional £126 million over 3 years invested into drug and alcohol treatment for people who sleep rough. This demonstrates the importance that government places on reducing drug deaths and harms, and drug-related crime and violence. This funding provides a strong foundation for further structural investment at the next Spending Review, to enable urgent reforms across the entire system of enforcement, prevention, treatment and recovery.

Addiction is a chronic condition experienced within the social environment. Clinical treatment on its own is rarely enough. Many people will also need services to help them with family challenges, mental health, housing and employment support. These services must be

coordinated at the local level, but now commonly exist in separate silos or are missing altogether. The difficulties experienced at local level are mirrored at national level. Ministers and departments have not worked sufficiently well together in a determined and sustained way.

Responsibility for treatment and recovery is cross-departmental. In addition to funding the NHS, DHSC funds local authorities for treatment of substance misuse and recovery through the Public Health Grant, but the MHCLG funds housing and housing support, and DWP funds employment support. Many opiate users cycle in and out of the courts, prison and probation, bringing into the picture 2 further departments, the MoJ and the HO.

Since 2012, the government has entrusted all decision making on drug treatment services to local authorities, with virtually no accountability or recognised standards. The current system of local commissioning is fractured, with different bodies responsible for different services and no real incentive for them to work together. These challenges have exacerbated the impact of cuts in local authority budgets. Because the impact of drug misuse is felt most acutely in the most deprived areas of the country, addressing these problems is central to the government's ambition for 'levelling up'.

The next 5 sub-sections of the report grapple with these long-standing challenges and make recommendations to government on leadership and encouragement from the centre, funding and its allocation, local arrangements for commissioning, and accountability.

### 2.1 Making sure central government departments are held to account

The Prime Minister's Crime and Justice Taskforce, and the government's strong commitment to reducing crime, have made drug misuse a priority. The Taskforce has brought ministers together, and the Cabinet Office has secured cross-departmental commitment and a coordinated approach. This early success should be built upon.

An effective government response requires strong and co-ordinated action from multiple departments. Previous drug strategies have suffered from sporadic cross-government engagement, with attention waxing and waning.

Introduction of a new central Drugs Unit is essential to coordinate and monitor this cross-departmental work, including to ensure that it focuses on delivering real world outcomes and that the work develops alongside the priorities of No. 10 and the government. The Unit, sitting in whatever department or joint arrangement seems appropriate, needs to secure commitment and action from multiple secretaries of state, making sure that momentum is maintained in all relevant departments. A cross-government National Prevention Board,

which the government is considering setting up to tackle obesity, could also be used to strengthen the coordinated response to this strategy.

This new central unit should have adequate analytical capacity. It should develop a new National Outcomes Framework, and the sponsoring minister should publish data annually within a report to Parliament so that departments are held individually and collectively to account for progress. The unit should have ready access to senior scientific advice, to ensure that drug policy decisions are informed by the best available research.

This National Outcomes Framework should cover all aspects of the illicit use of drugs, including:

- the impact of enforcement action to reduce supply
- measures of drug-related harm and deaths
- drug-related crime
- the number of people (particularly offenders) in treatment
- the number of people with drug dependence accessing mental health services
- measures of progress on housing and employment

For substance misuse services, measures of service quality and effectiveness, recovery capital and quality of life in the longer term, should be included as well as numerical measures.

The government should convene a long-term representative group of external stakeholders, including drug addiction scientists and people with personal experience of drug dependence, to assist the central unit in evaluating the new structures and holding relevant departments to account. Extensive stakeholder engagement should also be integral to the development of new outcomes frameworks and standards.

Responsibility for policy and resulting action should be explicitly demarcated. The HO should focus on controlling the supply of drugs, drug trafficking, gangs, and drug-related violence, and would continue to lead on legislation. DHSC would focus primarily on harm reduction, treatment and recovery, and DfE would lead on prevention initiatives targeted at young people.

**Recommendation 1**

The government should establish a central Drugs Unit with strong analytical capacity which would develop a National Outcomes Framework and hold departments to account. The sponsoring minister should report annually to Parliament on progress in tackling drug misuse, including publication of relevant data.

### 2.2 Significantly increasing the funding for drug treatment and wider support

Part 1 of the review showed that funding for treatment fell by 17% overall between 2014 to 2015 and 2018 to 2019. The reduction in funding for young people's specialist substance misuse services was even worse at 28% over the same period. Meanwhile increased prevalence of drug use, harm, drug-related violence and mortality now affects every area of the country, fuelled by county line drug supply. The amount of unmet need for treatment is growing, but the treatment workforce is declining in number and quality.

There's a strong 'invest to save' case for drug treatment, all the more important given the pressure on government finances caused by the pandemic. Although Part 1 of the review showed that the societal costs of drug misuse are £20 billion each year, in 2020 to 2021 only £650 million was spent on drug treatment. Every £1 currently spent on harm reduction and treatment gives a combined health and justice return on investment of £4. Failure to invest will inevitably lead to increased future pressures on the criminal justice system, health services, employment services and the welfare system.

On current estimates of prevalence, in order to provide a full range of high-quality treatment and recovery services for adults and young people with a drug dependence, significant investment is needed on top of the current expenditure, rising from £119 million in year one to £552 million in year 5.

This additional investment is urgently needed to provide:

- increased treatment capacity to meet need, including to respond to newer non-opiate patterns of drug use, and to expand and improve services for children and young people
- increased drug treatment capacity to respond to criminal justice priorities set out in the sentencing white paper, including increased use of community sentences with a requirement for drug treatment, and getting more prisoners into treatment within three weeks of release

- expansion in the number of professionally qualified workers (psychiatrists, psychologists, nurses and social workers), and development of training to improve the skills of drug workers and peer recovery workers
- increased provision of inpatient detoxification and residential rehabilitation
- expansion of local areas' support for peer-led grass-roots recovery communities and peer mentoring, complementing professionally led services
- increased overdose prevention, harm reduction and syringe exchange programmes
- an innovation fund for research into what interventions, and what methods of delivery, are most effective at deterring recreational drug users

Improved treatment services will not be enough on their own to help people achieve and maintain recovery. A broader package of services is needed, involving also well-coordinated housing and housing support, employment support, and mental health services.

In addition to the mainstream support provided by Jobcentre Plus, DWP should provide additional investment, estimated at £6 million in year one rising to £16.5 million from year 3, to roll out nationally a dedicated employment support programme for people in drug treatment.

MHCLG and DHSC have secured welcome substantial additional funding to improve treatment services for people who sleep rough. We know that housing and housing support have a crucial role to play in the success of drug treatment and that many of those entering treatment report a housing need.

As evidence on the scale and nature of unmet need is limited, provision of additional housing-related support for those in treatment should be used to assist better understanding of need as well as impact on treatment outcomes. We estimate that an additional investment of £150 million over a 5-year period would be needed to provide housing support services to individuals in treatment alongside the expansion of Individual Placement and Support. These estimates are based on assumptions about the current need for housing support among individuals in treatment and are subject to refinement through further testing and piloting. MHCLG should work with DHSC to assess the types and levels of housing related needs among people with substance misuse problems.

An extra £5 million per year is needed by MoJ for probation health and justice co-ordinators so that they can play a full part in local area partnerships. Although this is out of scope of this review, additional prison staff are also needed to ensure that prisoners experience an improved regime and can also be escorted to substance misuse appointments.

NHSE is improving mental health services by additional investment of £2.3 billion per year. Part of this should be used to increase the specialist mental health support available to people with drug dependence.

These new investments should be guided by research on the effectiveness and accessibility of the various services.

Increased funding for treatment and recovery does not diminish the importance, highlighted in Part 1 of this review, of taking action to stem supply of drugs. This remains an important objective of law enforcement agencies including the National Crime Agency, Border Force, British Transport Police and terrestrial police forces, and must also be resourced appropriately.

A detailed breakdown of these costs, as well as estimates of the benefits that would accrue from this additional investment, can be found in Annex C.

**Recommendation 2**

We recommend that the government invests, by the end of year 5 of this programme, an additional £552 million in the treatment system through DHSC and an additional £15 million in employment support through DWP. MHCLG will also need to bid for additional funds for housing support at the next Spending Review.

### 2.3 Making sure treatment funding is protected and is allocated fairly

Responsibility for commissioning substance misuse services was passed from the NHS to local authorities under the Health and Social Care Act 2012. Local authorities are well placed, with responsibility and local knowledge, to commission substance misuse treatment for their local populations and areas.

However, a number of challenges stem from locating these services outside NHS structures, including reduced parity with other NHS-led clinical services, competition for scarce professional staff, detachment from wider NHS professional training and development structures, and some increased costs. After careful consideration, this review has concluded that funding should continue to be distributed by DHSC to local authorities.

Local authority efforts have been hampered by steep cuts in their funding, including a fall in real terms in the allocation for public health from £4 billion in 2015 to 2016 to £3.2 billion in 2020 to 2021. National incentives and accountability measures should be introduced to

ensure that drug treatment and recovery services receive adequate financial and other support right across the country.

Financial incentives for local authorities should be explored as a possible component of an accountability framework. Care should be taken to avoid generating unintended consequences. Previous payment-by-results pilots in the sector have shown that it is difficult to attach incentives to complex and long-term outcomes. However, there is evidence that the approach can work for more process-focused measures such as numbers in treatment.

Funding should be distributed to local authorities fairly, taking into account the:

- level of deprivation
- prevalence of drug use
- rate of drug-related deaths
- number of people requiring treatment who are not receiving a service

**Recommendation 3**

We recommend that from 2022 to 2023, DHSC require local authorities to spend drug treatment funding, current and additional, on these services and not on other things. Similarly, we recommend that DWP and MHCLG protect any future additional funding provided for employment services and housing support for people dependent on drugs.

**Recommendation 4**

We recommend that DHSC, DWP and MHCLG make sure that funding for treatment, employment and housing support is distributed fairly on the basis of need.

### 2.4 Improving commissioning, including introducing a national Commissioning Quality Standard and a focus on local partnerships

Increased funding will not improve services unless the commissioning process is strengthened. In many local authorities commissioning structures and processes are not sufficiently robust or effective. The capacity, experience and specialist competence of local authority commissioners have declined in recent years. As funding increases, local authorities must take immediate action to bolster this function and resource it properly.

Many local authorities do not commission the full range of services required by their local population. The most significant cuts have been made to inpatient detoxification and residential rehabilitation services, outreach programmes, comprehensive recovery support, and psychosocial interventions, particularly for non-opiate drug users. The Care Quality Commission's (CQC) regulation of services assesses the quality of only those services which are being provided, but does not consider, as it should, whether extended or different services are needed.

To address these problems, DHSC should develop a national Commissioning Quality Standard, based on the UK clinical guidelines on drug treatment, to clarify the commissioning process that local authorities should follow and the full range of drug prevention and treatment services that should be available to their local population, for adults and young people. Annex D summarises what should be included.

This process will be enhanced by co-production with people with lived experience of addiction, and so the national Commissioning Quality Standard should sit comfortably alongside the quality standard for recovery support services which is currently being developed by the College of Lived Experience Recovery Organisations (LEROs).

This national Commissioning Quality Standard can and should exist alongside local leadership and innovation so that services are tailored to local needs within a strong partnership approach. Many successful treatment and recovery systems include smaller, locally led voluntary-sector organisations. These are often well placed to engage minority populations and underserved groups.

Partnerships are needed to meet the multi-faceted needs of drug dependent people. The development of integrated care systems (ICS) provides a vehicle for strengthening the partnership between local authorities and NHS organisations to improve the health of the population (including those addicted). Police and crime commissioners, and the probation and prison services, must also establish effective partnerships to support diversion of offenders away from the criminal justice system and into local treatment, where interventions may be more cost-effective.

Local partnerships should involve collaboration on needs assessment and commissioning plans. Local plans for the required package of services (including treatment, recovery support, mental health services, care of physical co-morbidities, and support for housing and employment) should be produced and published jointly, in collaboration between all those agencies responsible for providing services for drug users in a given local authority area.

National government should use policy levers and incentives to promote improved collaboration. For example, DHSC should ensure that conditions attached to funding require local authority commissioners of substance misuse services to work in effective partnership

with other local agencies. MoJ, HO, MHCLG and DWP should identify appropriate levers to reinforce this approach for the services which they commission or oversee. Provision of additional funding should be conditional on the production and continuing implementation of a comprehensive local plan.

Departments should require budgets to be aligned or pooled at local level, removing any barriers and deploying incentives where appropriate.

Retendering services as frequently as every 3 years hampers the creation of a stable network of services. Commissioning is often little more than a procurement exercise, placing undue emphasis on price at the expense of quality. DHSC and the new Office for Health Promotion should undertake a review of service retendering as a mechanism to drive quality and cost effectiveness, with close scrutiny of the current market.

In many local authorities, active engagement with treatment providers and ongoing management of contracts is minimal. In some cases, the contract is awarded to a prime provider with further commissioning responsibility delegated to this provider, including for inpatient detoxification and residential rehabilitation. The prime provider may seek to retain its share of the funding at the expense of the smaller, more local or specialist providers.

Commissioners should work collaboratively with treatment providers and introduce longer commissioning cycles of at least 5 years to reduce service disruption and discontinuity. This would bring local authority commissioning more into line with NHS practice where there is a move away from competition in favour of collaboration.

**Recommendation 5**

We recommend that DHSC introduce a national Commissioning Quality Standard and require local authorities, as a condition of funding, to work with health, housing and employment support, and criminal justice partners to develop a joint needs assessment and publish a commissioning plan to direct spending from 2022 to 2023. Government should make provision for budgets to be aligned or pooled at local level and each department should use its policy levers to require a strong partnership approach locally.

**Recommendation 6**

We recommend that DHSC and the Office for Health Promotion review the effect of frequent retendering on the quality and cost-effectiveness of substance misuse treatment services.

**2.5 Strengthening local authority accountability for spending and improvement support**

If local authorities receive additional funding for drug treatment and recovery services, they should be held to account for this spend. Because of the marginalised and stigmatised nature of drug dependence, relying on a local authority's accountability to the local electorate may not be an effective mechanism to drive service improvement. This is rarely a priority 'doorstep' issue for local politicians.

The National Outcomes Framework will be used to hold government departments to account. This should be developed further to create a Local Outcomes Framework to be used by the Office for Health Promotion to hold local authorities and their partner agencies to account. This Local Outcomes Framework will consist of indicators drawn from the national framework most relevant to local delivery of treatment and recovery systems. It must be developed in partnership with people working throughout the system to make sure that it includes the right measures of local performance and does not introduce perverse incentives.

Outcome measures in the framework should cover the performance of all the local partners with a role in providing care and support for people with drug problems. Given that drug problems are concentrated in more deprived areas, these measures will show what progress is being made to level up. Annual publication will promote transparency and encourage community engagement in local implementation.

The Office for Health Promotion must have the staff and resources needed to monitor local area performance against the Local Outcomes Framework and report to the new central Drugs Unit and hold local areas to account for meeting the new Commissioning Quality Standard.

Local authorities with poor outcomes should be obliged to work with the Office for Health Promotion to improve their services. As suggested in the paragraph above, DHSC should consider providing local authorities with a financial incentive for improved performance and outcomes, perhaps delivered in partnership with the Local Government Association. Support for local authorities should include regional improvement networks, facilitated by the Office for Health Promotion and aligned with the new NHS integrated care system structures.

DHSC should commission the CQC to undertake a thematic review of commissioning practice to see whether local areas have in place comprehensive and integrated treatment and recovery-orientated systems of care (ROSC). Because tackling substance misuse requires strong partnerships between local agencies, joint inspections between CQC and other inspectorates such as Her Majesty's Probation Inspectorate and Her Majesty's Inspectorate of Constabulary should also be considered.

**Recommendation 7**

We recommend that DHSC introduce, for 2022 to 2023 and beyond, a Local Outcomes Framework to increase transparency and local authorities' accountability for their treatment and recovery outcomes. DHSC should consider the introduction of incentive payments for local authorities to deliver improved outcomes.

**Recommendation 8**

We recommend that DHSC ensures that the Office for Health Promotion has the capacity and capability to monitor local performance against the Local Outcomes Framework and report to the new central cross-government Drugs Unit to:

- hold local areas to account for meeting the new Commissioning Quality Standard
- improve outcomes
- work with the LGA to provide a comprehensive improvement support offer for local authorities.

### 2.6 Proposed new accountability framework between government and responsible local partners

The review makes several recommendations which, taken together, form the basis of a new and strengthened accountability framework between national government and local partnerships of the local authority, health, and criminal justice—working together to deliver integrated recovery-orientated systems of care for dependent drug users.

There are 4 main ways in which local partnerships will be held to account.

1. The central cross-government Drugs Unit will draw up a National Outcomes Framework, which will be developed further into a Local Outcomes Framework. The Local Outcomes Framework will contain locally relevant indicators to monitor local authority delivery of treatment and recovery systems.
2. Poorly performing local authorities and health and criminal justice partnerships will be obliged to work with the Office for Health Promotion.
3. Local authorities will be subject to a thematic review of their commissioning practices by CQC, delivering the results to the central cross-government Drugs Unit.

4. Local authorities will receive financial incentives for improved performance.

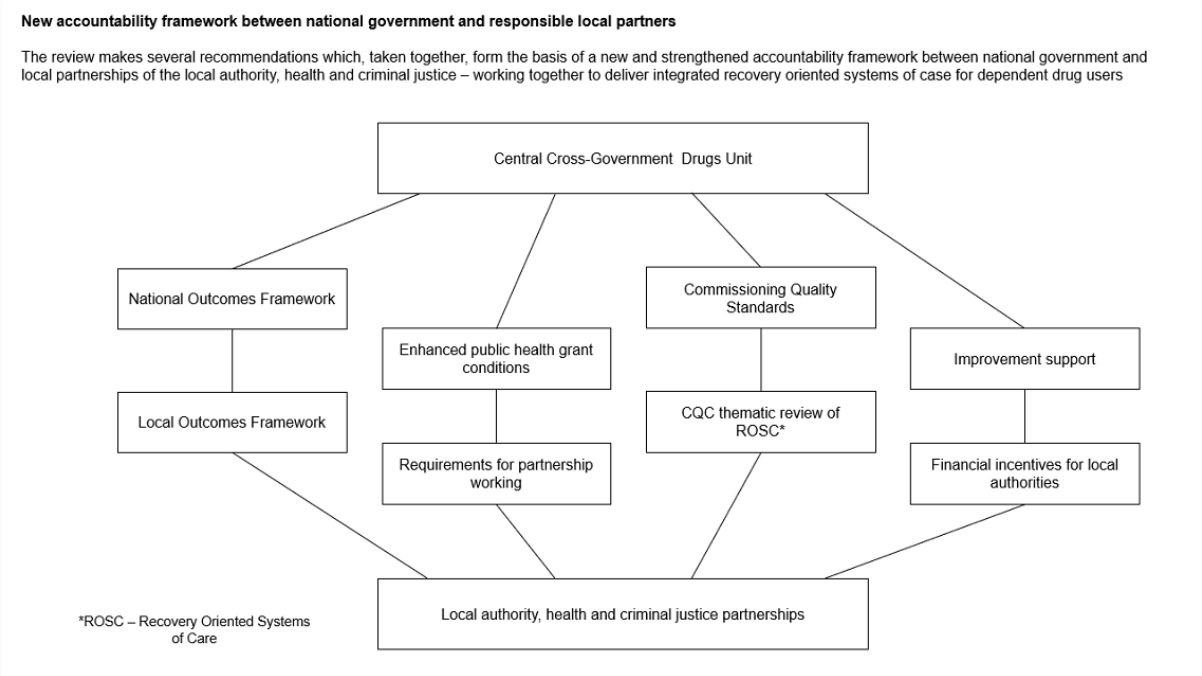

Figure 1: Accountability framework example

## 3. Rebuilding services

People with drug dependence often find it hard to access many of the services they need, including mental and physical healthcare from the NHS. Housing support and employment support are rarely there when needed, and their absence makes recovery less likely. This section of the report makes recommendations aimed at rebuilding those services which are essential to successful treatment and recovery, which necessarily involves rebuilding the workforce. A complex set of public services are often required to help people address their drug dependence and achieve recovery.

### 3.1 Workforce

The drug treatment and recovery workforce has deteriorated significantly in quantity, quality and morale in recent years, due to excessive caseloads, decreased training and lack of clinical supervision. A recent workforce survey showed that drug workers had caseloads of between 50 and 80, sometimes rising as high as 100 people. Good practice suggests a

caseload of 40 or less, depending on complexity of need. Such high caseloads reduce the quality of care provided and the effectiveness of treatment. Focus should be on providing high-quality personalised care, rather than paperwork.

The availability of training placements for the next generation of specialists has reduced, and so too has professionals' capacity to train and support drug workers and peer workers. The number of psychiatrists in specialist substance misuse training has fallen steeply. The only effective treatments for people dependent on non-opioid drugs are psychosocial interventions including cognitive behavioural therapy, yet people with professional skills in these areas are in very short supply. Dedicated social work teams for drugs and alcohol are also disappearing.

Services are increasingly reliant on drug workers who often have minimal professional qualifications or none. Drug workers are not always properly trained or supervised and 10% of them are volunteers. Similar issues affect peer workers although people with lived experience, working as peer supporters or mentors, have a critical role to play in any well-developed drug and alcohol treatment service.

The disruption caused by frequent retendering of drug treatment services has made recruitment difficult and has caused many to leave, particularly professionally trained staff such as psychiatrists, psychologists, and nurses. Job security and access to professional development are more readily available within NHS mental health services, so are more attractive to many healthcare workers.

Rebuilding the workforce is going to require sustained focus and financial investment over the medium to longer-term. DHSC and HEE should take urgent action to expand the substance misuse workforce and rebuild its professional base. This requires development of a workforce strategy that complements HEE's workforce strategy for mental health services. Clear occupational standards for drug workers and peer recovery workers are also needed, including a competency and training framework.

Creating a professional body, a Centre for Addictions, should be explored, to permit members of the substance misuse workforce to work together in a more co-ordinated network. This body should develop specialist training for the workforce and provide accreditation. In Australia the Chapter of Addiction Medicine within the Australian College of Physicians carries out this function, though only for clinicians. The Academy of Medical Royal Colleges should be requested to take the lead on this, working with appropriate other bodies, with the government providing some seed funding.

The addiction research workforce is important for ensuring that the UK is aware of emerging treatments, recovery supports, and drug trends. Government research funders, professional

bodies and scientific societies should actively commission research on addiction and support the careers of addiction researchers.

**Recommendation 9**

We recommend that DHSC commission HEE to devise by the end of 2021 a comprehensive strategy to increase the number of professionally qualified drug treatment staff (psychiatrists and other doctors, psychologists and other therapists, nurses and social workers), and set occupational standards, competency and training requirements for drug workers and peer recovery workers. Government should also fund HEE to cover the costs of training the workforce.

**Recommendation 10**

We recommend that the Academy of Royal Medical Colleges, working with appropriate other bodies, be commissioned to develop a professional body, a Centre for Addictions, for all members of the substance misuse workforce. DHSC should provide seed funding to enable this.

### 3.2 Treatment for adults

In line with recommendation 5, local authorities should ensure that a full range of drug prevention and treatment services is available to their local population. These evidence-based harm-reduction and treatment services should include:

- needle and syringe programmes
- the provision of naloxone
- pharmacological and psychosocial treatments
- outreach services
- residential rehabilitation
- inpatient detoxification

There should also be a strong focus on early intervention and the treatment needs of offenders. Current clinical management of drug misuse and dependence does not always match the guidance laid out in the 2017 UK clinical guidelines on drug treatment. The

package of reforms recommended in this review will help bring practice into line with these evidence-based guidelines.

In many local areas psychosocial interventions are limited and their delivery is substandard, frequently amounting to little more than a chat with a drug worker. Yet psychosocial interventions are critical, particularly for non-opioid users for whom there are no effective pharmacological interventions. This is a major defect in current services and every local authority area must ensure that it has a programme of psychosocial interventions, led by trained professionals.

Some very vulnerable groups, such as crack cocaine users, people who use image- or performance-enhancing drugs or people engaged in 'chemsex', do not receive an adequate or any service, but are at great risk. In addition, outreach and harm-reduction services, including specialist needle and syringe programmes, have been cut back in many areas.

Local commissioning of inpatient detoxification and residential rehabilitation has decreased substantially in recent years, despite evidence of their effectiveness and importance for people with particularly complex needs. Local commissioning of such high-cost but low-volume services should be replaced with a regional or sub-regional approach.

**Recommendation 11**

We recommend that local authorities commission a full range of evidence-based harm reduction and treatment services to meet the needs of their local population in line with the new national Commissioning Quality Standard.

**Recommendation 12**

We recommend that DHSC, NHSE and the Office for Health Promotion review by the end of 2021 to 2022 the commissioning and funding mechanisms for high-cost but low-volume services such as inpatient detoxification and residential rehabilitation. DHSC should introduce a regional or sub-regional approach to commissioning these services to ensure national coverage.

### 3.3 Treatment for young people

The Smoking, Drinking and Drug Use survey has shown that drug use among children (aged 11 to 15) has increased by over 40% since 2014, reversing a previous long-term downward trend. This increase is seen across a wide range of substances and most socio-economic

groups. The most alarming development is the widespread involvement of vulnerable children and young people in drug supply, often through ‘county lines’.

Young people with treatment requirements coming into services have increasingly complex needs, often involving poor mental health and self-harm, and sometimes criminal or sexual exploitation. Targeted early identification of young people at risk, and brief and early intervention, need to be strengthened. Services need to be trauma-informed and treatment should be family-based if necessary, particularly for young people whose parents are themselves dependent on drugs or alcohol.

Like adults, young people with drug-use problems need a broad treatment package, with a combination of specialist treatment and wider health and social care services. The challenges they face include their family circumstances and mental health difficulties. Commissioning structures at national and local level must ensure that these different services work together.

The Office for Health Promotion should undertake more work on defining and promoting effective drug and alcohol services and practice for young people. It should also ensure that there is better prevalence data to support planning for local areas.

**Recommendation 13**

We recommend that DHSC make increased funding available to specialist substance misuse services for young people to improve the capacity and quality of these services. Also, through the national Commissioning Quality Standard, DHSC should ensure that these services are linked with other local services for vulnerable young people and that family interventions are more widely available.

### 3.4 Recovery support

Recovery is a process that often takes time to achieve, and effort to maintain. In May 2019 Dr Ed Day was appointed as the UK government’s Drug Recovery Champion, to promote the best treatment and support for those recovering from drug misuse. The first annual report from the UK Recovery Champion stated:

the creation of a Recovery-Orientated System of Care (ROSC) offers the best chance of helping people move on from drug dependence. At its best ROSC is built on person-centred services and supports multiple non-linear pathways to recovery.

The added funding and accountability recommended in this report should support the expansion of ROSC.

Services should include people with lived experience of drug dependence working as recovery champions and recovery coaches. They should also provide networks of peer-based recovery support and establish communities of recovery and mutual aid groups. The passion and commitment of people in these roles made a strong and positive impression on the review team.

Peer supporters should not be left to do the work of professionals without appropriate training, pay or support. This is exploitative and underlines the need for a comprehensive workforce strategy.

Smaller providers have been forced out of the market, resulting in the closure of many grassroots organisations and local charities. This has adversely affected women and people from minority groups, including black, Asian and minority ethnic (BAME) communities, because local organisations (including lived experience recovery organisations) are better at understanding and responding to their needs.

The government's appointment of a recovery champion is a welcome development, but for this to have impact, there is an urgent need to develop a flexible and innovative network of peer-recovery organisations and also standards to raise quality and improve governance.

**Recommendation 14**

We recommend that DHSC and the Office for Health Promotion support local areas to ensure that thriving communities of recovery are linked to every drug treatment system. The government's Drug Recovery Champion should work with the Office for Health Promotion to develop standards to raise the quality and improve the governance of the recovery sector.

### 3.5 Diverting more offenders into treatment and recovery services

The Crime and Justice Taskforce, chaired by the Prime Minister, is committed to reducing crime and reoffending, much of which is driven by drug dependence. The phase one report showed that a cohort of around 300,000 heroin and crack users drive nearly half of all acquisitive crime and homicides. Spending an average of £40 to £50 per day on drugs, these users cycle in and out of prison. Initiating treatment for this group has a rapid effect on reducing offending and alleviating some of the pressure on our prison system. Yet referrals from the criminal justice system into drug treatment have fallen sharply, particularly for crack users.

Police-led out of court disposal and drug diversion schemes, like Checkpoint in Durham, Turning Point in the West Midlands, and DEP in Avon and Somerset, have delivered early interventions that divert individuals away from the criminal justice system and into drug education, support, and treatment. These schemes should be expanded.

Use of community sentences with drug rehabilitation requirements (DRR) and alcohol treatment requirements (ATR) has decreased significantly, even though they offer a more cost-effective therapeutic alternative to short prison sentences for drug-related offending. Same-day sentencing requirements in court and ineffective probation supervision have contributed to a fall in the number of these sentences because there is often neither the time nor the expertise available to help arrange such a disposal. In these circumstances, the judiciary inclines towards custodial sentences, particularly when the availability and quality of local treatment and recovery services are in question.

NHSE's pilot programme to rebuild community treatment sentences is making progress. The programme covers mental health treatment requirements (MHTRs), DRRs, ATRs and combined orders, and now covers 20% of the country. Funding has been committed in the NHS Long Term Plan to expand coverage to 50% of England by 2023. However, before 100% coverage is achieved many offenders will not benefit from this approach, and the high use of prison in the remaining uncovered areas will continue.

The recent sentencing white paper announced a commitment to increase use of police diversion schemes, and community sentences with treatment requirements, as alternatives to custody. These initiatives are very positive, but they all place significant additional pressure on the drug treatment system, reinforcing the earlier call for substantial additional investment (recommendation 2). The drug-related crime and criminal justice costs that stem from a failure to provide offenders with an adequate treatment system are annually over 10 times the proposed additional investment (in year 5).

**Recommendation 15**

We recommend that the MoJ, HO and DHSC, with the support of NHSE and the Office for Health Promotion, work together to ensure that the additional funding for drug treatment announced in January 2021 contributes to improved treatment pathways from criminal justice settings. In particular, action should be taken to divert drug users from the criminal justice system into treatment and maximise the use of Community Sentence Treatment Requirements (CSTRs).

**Recommendation 16**

We recommend that DHSC and NHSE expand their CSTR programme to 100% of the country by the end of this Parliament. NHSE and HMPPS should work closely with local

commissioners of substance misuse treatment to seize the opportunity presented by the recently announced increase in funding for such treatment funding in 2021 and 2022.

### 3.6 Substance misuse services in prisons

Details of the regime inside prison are outside the scope of this review. However, it is clear that efforts to address drug misuse in custody are consistently undermined by the widespread availability across the prison estate of illicit drugs, especially spice. Evidence suggests that demand is driven by a widespread sense of boredom, hopelessness and lack of purposeful activity in custody.

The Health and Social Care Act 2012 transferred to NHSE responsibility for commissioning healthcare services in custody. Funding for prison healthcare and substance misuse services has fared relatively well compared to local authority funded services in the community, benefiting from increases to the NHS's spending settlement.

This increased funding is thought to have improved healthcare services in custodial settings. However, there has been criticism of NHSE's often arm's-length approach to commissioning substance misuse services in prisons. Contracts are often placed with a large prime provider of general healthcare, which is then left to sub-contract specialist substance misuse services. Some decline has been reported in the range of provision, particularly of recovery-orientated services. There is also a perception that many prison governors feel less involved in healthcare provision in their establishments.

**Recommendation 17**

We recommend that MoJ, DHSC and NHSE work together to improve by the end of 2021to 2022 the transparency and accountability of the commissioning and delivery of substance misuse services in prisons, including through publishing how much money is spent each year on these services. HM Prison Service should make sure that enough staff are available to take prisoners to their treatment appointments within the prison.

### 3.7 Continuity of care

The period immediately after release from prison is challenging. People released, often driven by renewed desire for drugs, are at high risk of overdose and reoffending. PHE's

Public Health Outcome Framework indictor C20 has shown that only a third of those referred for further community treatment post-release go on to receive it within 3 weeks.

The introduction of RECONNECT (an NHS programme for care after custody) and Enhanced RECONNECT should help more prisoners on release make contact with health and substance misuse services. The role of peer mentors in helping people get into treatment should also be considered by commissioners.

Delays in accessing benefits also contribute significantly to an individual's vulnerability to re-offending and relapse. Prisoners are often released on a Friday afternoon, facing a long wait before their first benefit payment comes through, with nowhere to live, and without viable proof of identity. Jobcentre Plus staff now come into prisons to enable prisoners to start the benefit claim process before release. This is welcome but needs to be more consistent and better resourced.

**Recommendation 18**

We recommend that MoJ ensures that everyone leaving prison has identification and a bank account and that those who cannot claim benefits online get the opportunity, from the day of release, to access DWP's telephony service. MoJ and its partners should make sure that prisoners with drug dependence can access and receive treatment in the community.

### 3.8 Probation services

The probation system has a crucial role to play in implementing the recommendations of this review, but currently has major shortcomings. Government should ensure that the ongoing reforms result in getting offenders into treatment and keeping them there. More resources should be dedicated to identifying, assessing and referring offenders into treatment from court, and in advising the court on treatment-sentencing options. A requirement to attend drug appointments could be imposed through licence conditions on offenders at release. Probation officers should work with treatment providers to agree a joint plan to support offenders identified as needing drug treatment.

We welcome the new health and justice partnership co-ordinator role in the probation service, now being tested in 5 areas. The co-ordinator will have the skills and knowledge needed to promote understanding and collaboration between local partners. The new NHS integrated care systems (ICS) provide an opportunity for these co-ordinators to liaise across health and care services, as well as drug and alcohol treatment. If the testing is successful the MoJ should expand this approach to cover all probation local delivery units, linked with the anticipated introduction of ICS.

After multiple successful pilot studies MoJ has rolled out mandatory sobriety programmes for offenders where crime is driven by alcohol. Other countries use this same model for other substances and this approach should be trialled in the UK justice system for drugs as well.

**Recommendation 19**

We recommend that MoJ fund their new health and justice partnership co-ordinator role within the probation service, so that it covers all local probation areas in England, in tandem with the introduction by the NHS of new ICS.

### 3.9 Employment support

Employment has been demonstrated to improve treatment outcomes. Having work or something meaningful to do is an essential part of recovery and builds self-esteem. The increased stability and financial security that comes from employment greatly assist individuals, families and communities. However, few people in treatment receive the employment support that they need or move into employment.

People in treatment and recovery frequently experience stigma, and employers are often wary of hiring people with histories of drug and alcohol misuse.

Individual placement and support (IPS) is an intensive employment support intervention that has an established evidence base in the mental health sector. There is a strong focus in IPS on finding out people's own preferences for work. A recent trial within treatment services in 7 areas has shown that this IPS model is also successful in getting people in drug and alcohol treatment back into work. The IPS model should be rolled out in treatment settings across the whole of England.

Introducing the peer-mentor model into Jobcentre Plus will help people who have a drug dependence to receive more tailored support. Peer mentors have been through a similar drug-dependence journey, and can provide support and advice to claimants, drawing on personal experience. Peer mentors can:

- encourage safe disclosure of substance-related needs
- encourage people to engage with the appropriate support
- show that it is possible to move into employment

Good results have been obtained by having Jobcentre Plus work coaches provide outreach employment support in GP surgeries. DWP should consider extending this disability employment adviser (DEA) model so that Job Centre plus staff also work within drug and alcohol treatment services.

**Recommendation 20**

We recommend that DWP work with the Office for Health Promotion to roll out IPS to all areas in England within the forthcoming Spending Review period.

**Recommendation 21**

We recommend that DWP recruit peer mentors (one in each Jobcentre Plus area) to encourage people dependent on drugs to claim all relevant benefits and access employment support, with funding for the posts agreed at the Spending Review.

**Recommendation 22**

We recommend that DWP augment Jobcentre Plus support by equipping staff to reach out into the community and work more intensively with those with complex needs, including working in drug and alcohol treatment services with people with addictions.

### 3.10 Housing support

Drug dependence can be both a cause and a consequence of homelessness and rough sleeping. People who are dependent on drugs may struggle to retain accommodation due to financial difficulties, problems with behaviour or family relationship breakdown.

Homelessness and rough sleeping can also be the route to becoming drug and alcohol dependent. Findings from the MHCLG's rough sleeping questionnaire indicate that almost two-thirds of people who sleep rough have a current drug or alcohol problem, with almost one-third reporting a problem with heroin, many for over 10 years.

Public Health England's (PHE) statistics report on substance misuse treatment found that one-fifth of adults starting treatment in 2019 to 2020 reported a housing problem, increasing to one-third of people in treatment for opiates. It also found 16% of opiate clients reported this as 'urgent' (mainly as being of 'no fixed abode'). Nearly a quarter of opiate clients reported living in 'unsuitable housing' of such poor quality or condition as to be likely to have a negative impact on the person's likelihood of achieving recovery.

Having a healthy home is key to recovery. In 2019, the Advisory Council on the Misuse of Drugs (ACMD) report into homelessness and drug misuse found that treating homeless people for drug misuse is exceptionally difficult unless their housing needs are addressed at the same time. ACMD state that safe, stable housing is essential for people who are homeless and who have problematic drug use, and that it is associated with increased engagement with services.

Currently local authority housing services do not systematically provide the support that is needed, and there are shortcomings in the availability of specialist housing support (for example 'supported housing', 'recovery housing' or 'floating support') tailored to meet the specific needs of the population in drug treatment.

The government has committed to ending rough sleeping by 2024, with substantial new funding announced in 2020 to improve provision of drug and alcohol treatment for people who are sleeping rough. The 'Everyone In' initiative in operation during the COVID-19 pandemic has provided some positive experience of flexible collaboration between accommodation and health services, including drug treatment services, with lessons for the future. Government should build on this and work towards having integrated, flexible and trauma-informed services across housing and health become the norm for people who sleep rough.

Housing First has proved to be an effective evidence-based model for people with complex needs who sleep rough, providing a secure stable platform from which other issues can be addressed. Housing First should be scaled up and rolled out more widely, and MHCLG should continue to work with DHSC and the Office for Health Promotion to secure additional funding at the next Spending Review for drug and alcohol treatment for people who sleep rough.

However, in spite of the positive work being done to tackle rough sleeping, for other people in treatment and recovery we need clearer understanding of the level of housing need, and the gaps in housing-related services, so as to form a strategy to address them.

**Recommendation 23**

We recommend that MHCLG and DHSC work together to gain better understanding of the types and levels of housing-related need among people with a substance misuse problem, with early findings feeding into the next Spending Review.

### 3.11 Mental health support

Many people with drug dependence also have a mental health problem. Such individuals are often passed from one service to the other, excluded from mental health services until they resolve their drug problem, and excluded from drug services until their mental health problems have been addressed. Time and resources are wasted, and opportunities to address both drug and mental health problems are lost. People with any other set of chronic conditions would not be treated like this.

In 2012 the Improving Access to Psychological Therapies (IAPT) programme for people with milder mental health problems published a positive practice guide for working with people who use drugs and alcohol, and in 2017 PHE developed guidance on commissioning and providing better care for people with co-occurring mental health, and alcohol and drug use conditions, which stressed that there should be 'no wrong door' and this issue is 'everyone's business'. Both sets of guidance have been poorly implemented, and access to services remains deeply inadequate.

For many people, mental health problems and trauma lie at the heart of their drug and alcohol dependence. Commissioners of substance misuse services and NHS mental health services must either provide a better pathway between the services or integrate their services. Above all, the workforce in both services need to be trained to deliver more and higher-quality psychosocial interventions.

It is encouraging that the 2020 NHS mental health implementation plans to expand community services include a commitment to improve access for people with drug dependence. However, the new central Drugs Unit should keep this commitment under close scrutiny.

DHSC and NHSE should work together on how they will meet the mental health needs of people dependent on illicit drugs and alcohol. They should consider introducing contractual requirements or incentives such as the NHS's CQUIN scheme (Commissioning for Quality and Innovation).

NHSE, with the support of DHSC, should explore how substance misuse services could be commissioned to assess and treat some comorbidities, including giving psychological interventions for trauma, anxiety and depression.

HEE's workforce strategy should consider what training is needed for the substance misuse workforce to build their skills and ability to treat the mild to moderate mental health difficulties which are very common in people with drug dependence.

**Recommendation 24**

We recommend that DHSC and NHSE develop, publish and implement by the end of 2021 an action plan that improves the provision of mental health treatment to people with drug and dependence. This should include consideration of the introduction of contractual requirements or incentives so that NHS mental services target dependent drug users. Consideration should also be given to commissioning substance misuse services to treat some mental health co-morbidities themselves without referring people on to specialist mental health services.

**Recommendation 25**

Linked to recommendations 9 and 10, we recommend that DHSC commission HEE to develop competency and training requirements for all staff working with people with co-existing mental health problems and drug dependence. Resources and standards should be applicable and applied across the mental health and substance misuse workforces.

**Recommendation 26**

We recommend that DHSC, NHSE and the Office for Health Promotion ensure that opportunities for integrated commissioning of mental health and substance misuse services are explored proactively and articulated as part of the next stages of integrated care system development. This includes ensuring that proposed legislation facilitates integrated commissioning and provision.

### 3.12 Physical healthcare

Many drug users have poor overall health. Sixty per cent of deaths of opiate users in treatment are from causes other than drug-misuse poisoning, with respiratory disease, cardiovascular disease and cancer the leading immediate causes.

The NHS is poor at engaging with the wider health needs of drug users with medical co-morbidities (for example, hepatitis C, HIV, heart and lung disease), many of whom have very high need for health services but are ill-equipped to navigate complex pathways. This must change, particularly to meet commitments to level up and to increase healthy life expectancy by 5 years by 2035.

Stigma often limits access to healthcare services, with drug users feeling unwelcome in many mainstream health and care settings. The healthcare system needs to find ways to reach these vulnerable patients to provide screening and treatment. Several models are available for consideration, including specialist clinics within substance misuse services and assertive outreach for repeat attenders at emergency departments, which has proved

promising for people with alcohol problems. In most models, peer mentors can potentially play a useful role in helping people get to NHS appointments, which may otherwise appear daunting.

DHSC and NHSE should work together to develop an action plan on improving access to physical healthcare. Use of contractual requirements and incentives should be explored, as for mental health services.

**Recommendation 27**

We recommend that DHSC and NHSE develop, publish and implement by the end of 2021 an action plan for improving the provision of physical healthcare to people with drug dependence, which should be an integral part of local integrated care systems.

## 4. Increased focus on primary prevention and early intervention

As no one can become addicted to drugs without using them regularly, society benefits enormously when people can be persuaded not to use drugs in the first place (primary prevention) or to stop occasional drug use before it becomes a problem (early intervention). Government policy in this area should comprise drug-focused prevention programmes in schools, non-drug focused support for young people to reduce their risk for many problems including but not limited to drugs, and population-wide approaches to reduce recreational drug use.

### 4.1 Drug-focused prevention programmes in schools

A major prevention opportunity is created by the statutory guidance for RSHE that came into force in England on 1 September 2020, with schools having to commence first teaching of the subjects no later than the start of the summer term 2021. The statutory guidance sets out requirements in relation to teaching about tobacco, alcohol, prescription medicines and illicit drugs.

The international experience with prevention shows that support for front-line workers and evaluation of outcomes is critical for success. Teachers will need high-quality training programmes to deliver the new drug prevention curriculum effectively. Further, because good intentions do not guarantee good results, the new prevention effort should be subject to scientific evaluation fed back in a fashion that promotes continuous improvement.

Teachers are being supported to deliver the new curriculum through teacher training materials designed to build confidence as well as quality of teaching. The implementation of the RSHE curriculum will be monitored through periodic school snapshot surveys and Ofsted inspections.

**Recommendation 28**

We recommend that DfE make an assessment of the support available to teachers in rolling out the new Relationship, Health and Sex Education (RSHE) curriculum, and continue to monitor implementation, with a view to more detailed evaluation after 2 years of full curriculum delivery.

### 4.2 Non-drug-focused programmes that build youth resilience

Evidence shows that the same factors that increase childhood risk for drug use also increase risk of alcohol and tobacco use, poor academic performance, mental health problems, and harm to self and others. These problems cause immediate and long-term harm to individuals and wider society. Risk factors include chaotic, unrewarding environments, unremitting stress, social exclusion, and individual risk factors such as having difficulty managing emotions, coping with challenges, and exercising behavioural self-control. Prevention programmes which target these core risk factors in schools, in the community and in the family, can reduce drug use as well as many other problems that blight the lives of young people.

Dame Andrea Leadsom MP has been leading a review, commissioned by the Prime Minister, into improving health outcomes of babies and young children. Her review has looked at reducing inequalities from conception to age 2, aiming to ensure that every baby is given the best possible start in life. The findings should be integrated into the government's drug strategy, and also into the government's thinking on reforming alternative provision in education including the focus on earlier, more preventative intervention.

Positive activities for young people outside of school hours are also important. The DCMS provide funding direct to the third sector through the Youth Investment Fund. In future this should be focused on the most vulnerable children.

Some groups of children are exposed to additional risk around drug taking or selling, including children who are outside mainstream education. Each local authority should have a fair access protocol, agreed with the majority of the mainstream state-funded schools in its area, to maximise the protection that education gives to vulnerable children. This will help ensure that children who don't have a school place, especially the most vulnerable, are

offered a place at a suitable school as quickly as possible. All admission authorities, including those of academy and free schools, should be required to participate in the fair access protocol for their area.

Addressing children's mental health issues early is also a protective factor, and the government is committed to putting in place additional support at school level. This includes introducing new mental health support teams for all schools and colleges and providing training for senior mental health leads in schools and colleges.

In its response to the online harms white paper consultation, the government set out its ambition to make the UK the safest place in the world to be online. Drug dealers have a significant online presence, using social media to push drugs to children and young people. Decisive action is needed to curtail online harm and introduce legislation which places greater responsibility on technology companies to address these issues.

Families with parental drug misuse need specific support which must be co-ordinated at a local level. There is promising emerging evidence of the outcomes of programmes such as the Children of Alcohol Dependent Parents (CADeP) programme. This support should be expanded to drug misuse and, depending on results, rolled out across England.

**Recommendation 29**

We recommend that DfE and DCMS, with support from DHSC and the Office for Health Promotion, invest in age-appropriate evidence-based services and support all young people to build resilience and to avoid substance misuse. Local authorities should identify, and provide additional support to, those young people most at risk of being drawn into using illicit substances or involvement in supply.

### 4.3 Reducing recreational drug use across the population

The rise in the use of recreational drugs, such as cannabis, powder cocaine and ecstasy, is a further pressing issue that was exposed in Part 1 of this review. Many young people in treatment are there because they are struggling with cannabis harms, and there is a further worrying trend of increasing use of powder cocaine by young, often well-educated, males.

Although many recreational drug users do not consider their use to be problematic, recreational use carries risks and it fuels the illicit drug market. The risks include dependence, health harms, overdose, the health risks associated with a contaminated or adulterated or unusually strong batch, and negative impacts on users' everyday lives and families.

Government should look to understand better the drivers for recreational drug use and what measures can be taken to influence behaviour. This will include accurate and clear information to users on the risks (including the information provided by the Talk to Frank drug information service), broader prevention work to build resilience in young people and reduce certain kinds of risk-taking behaviour, and support to engage drug users with any underlying causes such as adverse childhood experiences or exposure to gangs.

There is little research, either in the UK or internationally, which shows what can be done to put this rising trend of recreational drug use into reverse. Mass communications based on anti-drug messaging have been shown to be ineffective and can compound user attitudes and behaviour.

Innovation is needed to identify new ways of influencing the behaviour and attitudes of recreational drug users. Any campaign should be grounded in behavioural science and include a package of targeted interventions that complement the broader drug prevention and treatment system.

**Recommendation 30**

We recommend that the government (either HO or DHSC) establish an innovation fund to research which interventions are most effective at changing the behaviour of recreational drug users.

## 5. Improvements to research and how science informs policy, commissioning and practice

There are several obvious research and evidence gaps, listed below, which need to be addressed as a matter of priority, with support from research funders such as NIHR.

The National Drug Treatment and Monitoring System (NDTMS) is a valuable resource that should continually be reviewed and updated, and routinely linked to other relevant data sets to create an extensive drugs data warehouse. This would allow better evaluation of treatment and the effectiveness of innovations. Long-term cohort studies would identify those interventions that best help people to respond well to treatment and achieve recovery.

There is a lack of research on psychosocial interventions, particularly for cocaine use and for other non-opioid substances. More research should be conducted into which interventions are most effective, particularly for people who may have cognitive deficits due to past or current drug use, and for people with co-occurring mental illness. Funding should be available for service providers to support this activity.

Research on substance misuse should extend to look at the factors which promote recovery, a priority area flagged in the government's Drug Recovery Champion's recent annual report. Research should be broad based, draw on different disciplines and bring practitioners and researchers together. More research is required into the effectiveness of peer-led interventions and how these can be encouraged and facilitated by the treatment system. Drug use in ethnic minority communities, and its prevention and treatment, also need particular attention.

Pharmacological research has made few recent advances other than the introduction of long-acting forms of buprenorphine. However, neuroscientists have argued that there is scope to develop agonist and antagonist therapies to help prevent relapse.

DHSC should promote innovative research on addiction and its implementation in practice by offering incentives, rewards or prizes to companies and other organisations for effective developments in this field - for example, pharmaceutical advances.

Training to improve the calibre of UK addictions research is essential, both to improve the quality and value of the research undertaken and to create the next generation of researchers. Training fellowships are desirable to support development of skills in areas of research relevant to policy and practice.

**Recommendation 31**

We recommend that DHSC and BEIS encourage more research into what works to combat substance misuse, across supply, prevention, treatment and recovery.

**Recommendation 32**

We recommend that the government promote greater innovation in research, for example in pharmaceuticals, by offering incentives or rewards to companies or organisations whose developments prove beneficial in practice in the addiction field.