we are withyou

Dame Carol Black, part two consultation – WithYou response

Prevention and harm reduction

1) What interventions are the most effective at preventing problematic drug use? Universal or targeted for both adults and young people. Include good practise examples. What helps and what makes it difficult?

As Part 1 of the Black review explored, many people who need support don't access drug and alcohol treatment. At With You, our research has shown that fear of judgement, lack of awareness of services and issues with access are all barriers to people seeking support. As a charity, we have explored ways to engage more and different people in treatment, including changing our name (from Addaction to With You) to be more inclusive and developing new online and self-support services. Since then we've seen a 25% increase in use of web chat and 42,000 visits to our online advice; this demonstrates an appetite from people to access non-judgemental support in different ways.

There is a significant evidence base behind effective interventions for preventing problematic drug use, and our experience shows us key principles for what works.

To prevent drug use from becoming problematic, there needs to be effective early intervention and engagement. This means better awareness for people of the support that is out there, and multiple routes into accessing services. Currently the primary route into services is through referral to in-person services, however we know from our research that some groups of people are unlikely to access support in this way. By the time people access services through referral, people have often experienced problems for some time.

The data from our anonymous web chat service reinforces this. Chat is accessed by people different to those who access our in-person services; generally they have an existing support network and employment, but a recent life event has made them look for support with drugs or alcohol. Web chat is usually their first

interaction with an organisation offering support - the first time they have reached out for help - and we hear from people at a much earlier stage.

Working together with the National Lottery Community Fund, we are testing approaches to learn more about who might need support to access services, and whether we can reach more people and underrepresented groups through different approaches and targeting.

Given the barriers to seeking help, when people do engage in treatment, they need to feel that services are for them, and that they have a range of options in how they engage - in person, online, on the phone and a mix of these. Changing our delivery model during the pandemic (see qu.24) has shown that providing clients with flexibility and channel choice improves attendance and engagement.

As drug service providers we need to respond to different clinical and user needs from diverse cohorts. At With You we are developing new tools and practices to segment people who use our services into cohorts, and using 'personas' to design pathways that can offer the best chance supporting recovery. This uses clinical best practice to target client groups - and will give staff a much clearer understanding of the evidence of which types of people require what support. We have been piloting this approach in our service in Scunthorpe; initial data shows it is effective to help long-term opiate users progress through treatment.

There is also a clear evidence base that shows relationships between practitioners and clients are an important factor in supporting people's recovery (see our recommendations in Q.16).

Working with young people requires a different approach to working with adults. Our experience and recommendations are in questions 4-8.

2) What interventions are most successful at reducing harm, particularly within vulnerable groups?

Keeping people safe is a key part of a person-centred approach to drugs, alongside engagement, treatment including clinical interventions, and recovery.

For the wider population, the best way to reduce harm is by normalising getting help and advice, for people to get on their own terms. Our new website provides this in a range of ways - for example getting back in control of chemsex use, the impacts of what happens when you take cocaine and alcohol, whether you can get addicted to cannabis. This advice is non-judgemental and written in everyday language that people use. Accessible, relevant advice allows people to

be informed about their decisions, and the impact of their choices on their health. 42,000 people have read our advice pages since their launch in March 2020.

This is also central to our approach with young people. Young people engage with our support and services because we focus education on risks and harm reduction rather than on being abstinent. See questions 4-8 for more on our approach to young people.

For more vulnerable groups, successfully reducing harm and staying safe can be measured in a number of ways - using drugs less often or in a safer way, receiving substitute medication, finding secure housing, engaging in education or employment, or being able to see your children again.

For these vulnerable groups, there still needs to be a person-centred approach in harm reduction measures, to understand people's barriers to engagement. We know that many people feel alienated by clinical environments, and there is an important role of community and people with lived experience in health.

At With You we have seen success when we take a proactive approach, reaching people in the spaces they already use. In Redcar and Cleveland, we were the first national treatment provider to run a pilot project of Peer to Peer naloxone. We trained a team of six 'peers' with lived experience to supply naloxone to people at risk of dying in the community, as well as local businesses and charities. As a result of the pilot, 43 Naloxone kits were issued in Redcar and Cleveland in January 2020 alone. This was a 40% increase in packs given out when compared with an average month in the service. 60% of people who received a naloxone pack in January were not known to With You, and 81% were introduced to naloxone for the first time.

This approach - focused on using communities and going to where people are, not expecting them to come to us - means that we can better reach people who need our help, and help save lives. At the same time it empowers the peers and supports their own recovery journey.

Another example is our work on hepatitis C in Cornwall, Wigan, Lincolnshire and other areas. Hepatitis C is a symptomless blood borne virus, but more than 90% of infections in the UK come from injecting drugs. We understood that vulnerable people found it difficult to engage with clinical services, and this was a factor in why testing was low. Our response has been to take testing and other blood borne virus testing out of hospitals to the community - we trained our workers in dry blood spot testing, and offered this to people free of charge. In Cornwall we used a community bus, and during lockdown worked with homeless people in emergency housing to test them for hepatitis C. In Lincolnshire we conducted a

two week testing and treatment drive in November 2018 where we incentivised testing with vouchers. As a result, 97% of people who were offered to be treated in Gainsborough and Louth were tested, with a high number of positive tests.

Another key harm reduction measure is needle syringe provision, to prevent the spread of diseases including HIV, hepatitis C, other blood borne viruses and reduce associated harm. Where we are commissioned to, we run needle syringe provision - the important factor is that these need to be judgement-free and safe environments for people to get fresh equipment and advice. We are also currently piloting with the National Lottery Community Fund the roll out of a 'click and collect' equipment service, and testing a 'direct to door' service - digital services launched during lockdown - to explore if this increases the number of people accessing fresh equipment. For example, we want to understand if iped and chemsex users, who may not use a traditional in-person drug services, may use this approach to keeping safe instead.

The role of people with lived experience is hugely important to give people hope that change is possible, and to normalise these issues. One example is in Wigan, where we work with a community farm to provide recovery, peer support, training and volunteering opportunities. Working alongside the community either on the farm itself or in a shop or cafe, people are able to develop the skills and confidence to integrate back into their community. Our experience shows that an active recovery community - such as in Wigan - gives visibility of those in recovery and living differently. The role of hope and lived experience shouldn't be underestimated in keeping people safe - and the development of these hyper-local communities is something that the third sector can and does play a unique role in developing.

3) What do you think the government could do to support the implementation of harm reduction interventions?

Based on our evidence in question 1 and 2, we would like to see government applying a range of different approaches:

Commissioning models that allows for flexibility and client choice within drug and alcohol treatment. This could include a mix of remote services such as an information and advice website, phone appointments, video groups and the option to talk to a trained advisor online, as well as more traditional in-person services. This would allow people to engage with drug treatment services in a way they prefer, and provides opportunity to engage at an earlier stage of their journey as well.

Help to normalise getting advice and harm reduction measures - there should be no shame or judgement in seeking advice - whether that is changing behaviour in chemsex, understanding the impact of using cannabis, or obtaining fresh equipment.

Encourage harm reduction measures to be from and in the community, as opposed to in drug and alcohol services buildings. This may encourage a wider range of people to engage.

Provide whole person treatment for physical and mental health. At With You we know it works to give physical health checks as part of assessment but we are not funded to do this (we have discussed more on physical health in question 17).

Invest in developing the workforce, in particular in applying different and tailored approaches to different people who use services. See question 16 for more on this.

Given the lack of diversity in those who access services, prioritise support and funding for projects that reach people in different ways - especially groups that don't engage with the traditional model. This includes in particular, women, BAME groups, and families. We are testing new approaches with this with LGBTQ+ groups (see more on question 14). Commissioners could try incentivising diversity through targets or financial incentives.

Young people

4) What do you think has caused the recent increase in drug use amongst children and young people? **What do you think can be done to reduce drug use among children and young people?**

At With You we know from our work with young people that the vast majority will experiment with drugs without any issues. Evidence is clear that traditional 'just say no' and fear arousal approaches are ineffective and can leave young people sceptical of advice given to them by professionals. We will not reduce young people's drug use by using these approaches, and need to provide confidential judgement free education on harm from drugs and how they might reduce it.

Young people also tell us they don't know that support from a safe and confidential drug and alcohol service is available to them. Although the government has made it mandatory for schools to provide drug and alcohol education, there is no guidance provided to schools on how, and teachers often don't have the expertise to deliver it. Our experience is that schools are often

concerned about approaching young people's drug and alcohol services for support as it might reflect badly on them and they might be seen as having 'a drug problem' in school.

Through our Amy Winehouse Foundation programme - funded by the National Lottery - we were able to engage 25,000 young people in alcohol and drug education sessions through assemblies and workshops. Young people's knowledge of the effects of alcohol and drugs improved with 78% of pupils saying they would be more likely to avoid risky behaviours following and 82% saying they would seek out support for alcohol and drug issues if they needed to.

Another example of good practice is from our young people's service in Kent, where we work with schools and youth groups as part of our Young Person Early Intervention Service. With this service, schools and youth groups approach us when they have identified a young person or group of young people they think may be using drugs. We meet with the young person or group of young people, build a trusted relationship based on respect and without judgement.

100% of young people we reach in this way have said that they are able to make safer, better informed choices about drugs than they were before.

Learning from our experiences, we would recommend that the government encourage schools to engage with and work together with local young people's drugs and alcohol services as trained experts in how to have these conversations, and to provide drug and alcohol education.

5) Please tell us about any types of drug and alcohol services or inventions for young people that work well. We'd particularly like to hear about services or interventions for types of drug and alcohol use which are increasing such as alprazolam (Xanax), cocaine or Ketamine.

At With You our research shows 22% of young people feel overwhelmed all the time. At the same time, we know they're struggling to access mental health support as thresholds are high and waiting lists are long. Young people tell us that they look to drugs like Xanax to meet their emotional support needs and reduce their paranoia and anxiety instead.

Creating environments where young people don't feel comfortable talking about drugs compounds this - we see this in the lack of high quality drugs and alcohol education in schools for young people on how to reduce harm from drug use (as mentioned in our response to question 4). By providing judgement-free advice and support, and working with young people to understand risks and their choices, we help them to make better informed decisions.

6) What are the gaps in interventions and services for young people using drugs and alcohol?

The important approach with young people's drug and alcohol services is to understand they are different to adult services - the recovery agenda and adult pathways do not apply. The focus needs to be on taking a rounded view of the young person - on them as individuals not on their 'drug' of choice. Drug trends will always change, so service providers should focus on young people's wellbeing and their ability to make informed, safe choices.

The majority of young people need good advice, education and the space to have open conversations to reduce the harm from drugs.

For some young people, they will need more specialist support. Life events, family, and trauma can lead to problematic use of drugs and alcohol. For this group, the role of partnership working with social services or other providers is fundamental, to prevent young people falling through the gap between services.

In Shropshire we work with young people at risk of criminal exploitation, mainly through county lines drug dealing, where the number of young people at risk of exploitation has increased dramatically in the past four years. Our work is effective due to our strong partnerships with other organisations. We sit on an Exploitation Triage Meeting which convenes twice a week, with young people who display issues around substances fast tracked into the service. We also work closely with Pupil Referral Units as those excluded from mainstream education are at greater risk of exploitation. When a young person becomes a victim of exploitation one of the key protective factors is an adult who they can talk to without judgment. Our staff offer that non-time limited, person centred support.

Using surveys and screening tools can help to identify vulnerable young people who are not on the radar of specialist drug, mental health or criminal justice services. Our RisKit programme - developed in collaboration with Kent University - takes this approach and has been consistently effective in reaching and supporting young people before they hit a crisis point.

The most effective way to work with young people is through exploring wider behaviours and consequential thinking. Using motivational interviewing and cognitive behavioural approaches can help them understand their decisions. The evidence base from RisKit also shows the importance of having skilled and knowledgeable practitioners delivering interventions if they are to be successful.

A more complete approach, combined with this specialist knowledge of drugs and ways to reduce risk, are an important combination.

In recent years that has also been a significant reduction nationally in young people's services - which creates a big gap in some areas.

7) How well do specialist drug and alcohol services for young people work with wider children's services and mental health services? What stops them working well together? How could this be improved?

Cognitive Behavioural Therapy (CBT) is an effective form of therapy to help young people make better informed decisions. However, if a young person is actively engaging in drug use, the CBT support they are able to access through Child and Adolescent Mental Health Services (CAMHS) can often vary or be denied.

In Shropshire, we have partnered with both CAMHS and the Clinical Commissioning Group (CCG) Safeguarding Lead to co-create joint care plans for any young person with dual diagnosis of mental health and drug issues. In the last 12 months we have seen five referrals into our service as a result of this partnership. This approach works to ensure no young person is cut off from mental health support because of their drug use.

This multi-agency response tailored to each individual young person being used in Shropshire is not nationwide. We would like to see a more joined up approach between young people's mental health and drug services being commissioned in every local authority across the country, learning from this model.

8) What could the government do to help improve specialist drug and alcohol services and interventions for young people?

Given our responses in questions 4-7, we recommend that the government does the following:

- Design and run services for young people with the understanding of them as a specific group with different needs, not as an 'add on' to adult services. At With You our experience of young persons' services being able to support individuals after they have turned 18 is also positive and can mitigate the risk of people disengaging from treatment if they otherwise would need to transfer to a separate adult service.
- Commission with longer commissioning cycles. This will help support stronger working partnerships between young people's drug and alcohol providers and other young people's services, such as CAMHS, to prevent young people from slipping through any gaps.
- Encourage funding only to be awarded to evidence-based programmes. In our experience at With You, a significant amount of money for young

people's support goes to projects that do not have a strong evidence base or clarity about the outcomes. This means service providers do not know if projects are effective. All young people's services should be using or contributing to developing our understanding of what works.

- Encourage schools to engage with and work together with local young people's drugs and alcohol services as trained experts in how to have these conversations, and to provide drug and alcohol education.
- Encourage authorities to remove barriers to mental health support, and to find ways to join up working between mental health and drug and alcohol services.

Treatment and recovery

9) What are the barriers to implementing evidence-based drug treatment guidelines and interventions? Answers can relate to specific interventions or services, such as in-patient detoxification or residential rehabilitation.

There is a strong existing evidence base for what works in supporting prevention, treatment and recovery from problems with drugs and alcohol. Practitioners are able to draw on a range of clinical and psychosocial interventions, in the context of structured work in one to one and group settings with clients. The barriers to this evidence-base being used and embedded in treatment are due to a range of factors, including constraints of time, pressures on funding and the availability of specialist support such as in-patient detox and residential treatment.

It is well documented that there has been a decrease in spending on drug and alcohol treatment services over the past few years; phase 1 of the Black Review noted that some local authorities have reduced spending by up to 40%. Though funding alone is not an enabler of evidence-based practice, increasingly tight budgets have resulted in higher caseloads and more pressure on frontline workers which can limit creativity and the space to tailor treatment provision.

To increase time available for frontline staff to spend with clients, not managing administration, at With You we are investing in tools and systems to support delivery as well as making the evidence base easy to use and accessible. We provide all staff with core psychosocial training, and we are developing clear pathways and personas to help practitioners apply the evidence in practice based on the needs of specific cohorts. Segmentation is using recognised clinical best practice to target client groups in the most effective way - and we

expect this to give staff a much clearer understanding of the evidence of which types of people require what support.

The role of a trained workforce and continual learning is also key. Drug and alcohol service providers need greater investment in workforce and training to ensure staff are supported to use up to date evidence in their work - see our recommendations on this in question 16.

Access and availability of specialist interventions can be another barrier to implementing effective treatment. We know from our work in Stoke on Trent that in-patient detox is most successful when it is integrated within a local drug and alcohol service provision. This allows us to provide continuous, wrap-around support and consistency of care before, during and after treatment. However in other areas of the country, if a person we work with requires in-patient detox we have to either provide them with home detox or seek additional budget from the commissioner to source an external in-patient provider.

There are few in-patient detox providers in the country, so not only do people have to travel far for the treatment, but the cost can be high due to this lack of competition in the market. By passing on the care to another provider it risks the continuity and consistency of care pre, during and post detox. In-patient detox should be integrated into commissioning models, as in Stoke on Trent, to prevent drug providers from having to seek external provision.

10) What could the government do to better support the implementation of evidence-based guidelines and improve the effectiveness of drug treatment and recovery interventions to help it realise its ambition to 'level-up' communities?

PHE guidance makes clear that providing well funded drug and alcohol services is good value for money because it cuts crime, improves health, helps community wellbeing and prevents harm. (PHE report: Alcohol and drug prevention, treatment and recovery: why invest? Feb 2018). Drug and alcohol issues are strongly correlated with areas of deprivation and poverty, therefore ensuring people can access care and support for recovery should be a key part of the Government's commitment to levelling up communities.

Local authorities are best placed to commission and support the implementation of effective, evidence-based drug treatment and recovery interventions, and the forthcoming Addiction strategy is a key opportunity to provide wider direction, investment and context for this delivery at a national level. Practically, this is an opportunity for the Government to demonstrate the value of effective treatment across a broad range of policy areas, and shape local provision within a set of national standards that create incentives for

quality improvement, partnerships and innovation outside of local commissioning priorities and procurement cycles.

11) What are the best models for commissioning and providing drug treatment and recovery services? What are the best ways to secure effective accountability for those services across different organisations at a national and local level? What levers or mechanisms could be introduced to ensure that services are effective and respond to the needs of local populations?

Though local authorities operate under pressure, commissioners working within a local system are best placed to understand the wide and diverse needs of a given community and articulate the priorities for local services and treatment systems. In our experience, a strong place-based strategy and culture of collaboration between different types of providers can support treatment and recovery, as well as a broad range of wider outcomes and social value. Local authorities can also broker partnerships and support integrated commissioning models, for example to support joint working between charities and the NHS.

At With You we have seen this model work well in Wigan, where the Council has committed to a model of partnership with the local community - the 'Wigan Deal' - and encourages providers to work together and collaborate towards shared outcomes. We provide drug and alcohol treatment services, but work in partnership with housing, domestic violence, mental health and NHS services to make sure that people are able to get the support they need in a joined up way. This means services work around and for people and provide for a range of different outcomes, instead of disjointed or exposing gaps between provision

We would also support commissioning models that allow for longer contract lengths, with strong incentives for partnership working and time to build real working relationships, as we see in our services in Cornwall. This means we can develop strong working relationships over a long timeframe, working in partnership with the commissioner to respond to trends and evolve and innovate new services in response to needs, rather than contract constraints.

Outcomes-based commissioning models and funding that supports innovation or service development can also give commissioners more scope to find and invest in new approaches, for example in reducing preventable alcohol admissions as we are exploring in our service in Cornwall.

12) What are the most effective ways of commissioning, designing, and providing integrated services for people with multiple and complex needs? Particularly for those who experience rough sleeping and co-occurring substance misuse and mental health conditions.

Integrated services for people with multiple and complex needs work best when they are designed for the service to be taken directly to the people that need it. At With You, our experience is that this group doesn't tend to proactively engage with treatment so drug and alcohol service providers have to go to them.

A good example of this approach is our Fulfilling Lives programme which is run in partnership with a range of statutory and voluntary agencies in Blackpool, funded by the National Lottery Community Fund. It targets people who are experiencing at least two issues out of homelessness, reoffending, substance misuse and mental ill health. People who are deemed eligible for support have their own 'Navigator' who works with them to help them access the support they need from other organisations. 'Navigators' have small caseloads, allowing them to offer intensive, person centred support. A study of the first four years of the project found that the programme doesn't just help to reduce homelessness and substance misuse, it also helps people to feel more relaxed, increased their confidence and boosted people's self esteem.

In many areas of the country there is not an integrated approach to drug treatment provision for people with multiple and complex needs. The Drug Intervention Programme (DIP) as previously funded and delivered by the Home Office was an integrated service that supported a person with all areas of their life to get them to a point where they are ready for drug treatment; brokering connections with housing, policing, probation and prison services is an opportunity for future investment. This is an area where charities are particularly well placed to respond given local networks and community knowledge, as demonstrated by Fulfilling Lives.

13) How does the way the drug treatment market, in terms of the tendering of services and contracts, impact on outcomes for people and effective service delivery? What measures could improve how the market works?

In part due to reductions in spending, as well as the cycle and structure of procurement processes, the drug treatment market is very competitive. There are many benefits to this dynamic: as treatment providers we strive to learn from each other, deliver best practice and demonstrate quality against local and national standards. However, the downside of this marketisation is the time and investment in the procurement process - with a view to retaining and winning contracts - which can distract from investment in workforce development or service improvement in response to changing local needs or people's feedback.

There are three measures that could help improve this:

Firstly, changing the way PHE shares and reports on performance data, moving away from a 'stacked' chart of comparative performance between providers

towards more open data and the ability to compare services against a range of measures. This would help to understand trends and changes in performance and help providers use data for their own service improvement, as well as compare performance against others in the market.

Secondly, supporting commissioners to engage with local community groups and networks and establishing stronger levers for user feedback and scrutiny of service provision, for example mystery shopping, online feedback and local peer research. This would also be a way of supporting changes in delivery and system design outside of a procurement process.

Finally, commissioners could encourage greater learning and sharing between providers with funding for cross-cutting research and development projects, the learning from which could become part of national guidelines. Currently, providers have a disincentive to share insights and findings from research as this may be a competitive advantage in a tender; investment in programmes and research that provide opportunities outside of local service provision, building on examples such as PHE's funding of the Individual Placement and Support scheme, are a route to supporting improved outcomes across the country.

14) Why do some drug users who need treatment not access it? What can be done to address this? We'd particularly like to hear answers about specific groups such as black, Asian and minority ethnic (BAME) communities and women.

Many people who need support don't access drug and alcohol treatment.

PHE data shows that primarily those in treatment are white, opiate-using, men aged 35-50. In order to encourage more people to access treatment, particularly those who are under-represented currently, we need to be much more focused and targeted in our approach as a sector.

For particular groups or communities - for example BAME drug users who are not accessing support - partnership working with community organisations plays a fundamental role. Our sector can learn from other sectors such as domestic violence, where the role of very small hyper-local community organisations are fundamental in helping women understand the options available to them, and making connections to larger organisations who can offer structured support. In depth partnership work takes time to build relationships, and this can be difficult in the short term contract environment.

At With You we run a weekly women's group in our North Somerset service - a safe space strictly for women affected by drugs and/or alcohol to discuss how they are feeling, their experiences and coping strategies, and facilitated by a trained female practitioner. Many of the women develop friendships and support

one another outside of the group, showing how specific groups and approaches can create strong recovery communities that help longer term recovery.

Our experience has also shown that LGBTQ+ communities affected by problematic drug use are much more likely to engage with a service specifically designed for LGBTQ+ people rather than a mainstream service. We are currently working in partnership with expert partners - LGBT Foundation, London Friend and Stonewall - to understand how we can improve our approach. We have created specific weekly LGBTQ+ sessions - an online webchat advice service on Wednesdays 11am - 7pm, and we're working on training up regular webchat staff so they're better able to answer LGBTQ+ specific questions. We are also changing staff training to reflect a more contemporary understanding of LGBTQ+ issues.

Finally - language is important for encouraging people to access treatment. Our research shows that language around addiction can in itself be a huge barrier to people seeking help. In February this year we changed our name. When tested, three times as many people surveyed said they would choose We Are With You compared to our previous org name Addaction, with many describing the new name as 'inclusive', 'approachable' and 'reassuring'. This shows that the way we (as a sector and a country) talk about these issues as a nation and as a sector is either stigmatising - 'addict' - or dehumanising - 'service users'.

We'd like to see:

Support for testing new approaches to working with minority groups to bring them into treatment - such as our LGBTQ+ webchat approach - and sharing lessons with the wider sector about effectiveness.

Increased emphasis on long term partnership building - particularly with other organisations that work with minority or community groups - as a more effective way of helping more people from diverse communities to access treatment.

Non-stigmatising and non-shameful language adopted in services focusing on the help offered and not the problem or issue. This also needs to be role modelled by government and the media.

Given the nature of the sector, if commissioners really want to change the demographics of people using services to be more representative of the population as a whole, consider setting targets and potentially using financial incentives within contracts.

15) How well do drug treatment and recovery services meet the needs of parents who are drug users and their children? How could this be improved?

We are not going to answer this question.

16) How could the capacity and competence of the drug treatment and recovery workforce (both providers and commissioners) be improved?

There is a clear evidence base that shows that relationships between practitioners and clients is an important factor in supporting people's recovery.

Skilled recovery workers are trained in using a range of psychosocial techniques to support these relationships. However, as part 1 of this review found, there could be greater consistency in the role of recovery worker.

There are key areas where investment can improve the capacity and competence of this workforce - development, training and better tools.

As a sector, we need to seek to keep good practitioners in client-facing roles, to encourage expertise and specialist practice. For most frontline staff, the current route to develop is into management. Clear professional standards are needed to allow progression and routes to higher pay, that recognise practitioner skill sets, for example routes to progress through experience level, qualification of practitioner, or practitioners that specialise in particular segments like street homeless opiate users, working with chemsex clients, or women and alcohol.

In training and qualifications, greater consistency could be achieved through introducing a universal standard for recovery worker roles through qualification or accreditation - this already exists in Scotland. To ensure this is effective, this qualification should be designed with full understanding of how to work with different types of people to meet future needs of drug users. This means drawing on the clear evidence base of how to work with different types of groups or segments, and the development of specialisms.

Providing structured opportunities for reflecting on practice also helps improve the competence of frontline staff. Learning from good clinical practice, we have introduced reflective practice for all frontline staff. This provides a regular space outside of line management, with a trained facilitator, for staff to have self-directed and highly structured space to reflect on practice, and we have seen a positive impact on the level of care in our pilot services. In order to implement a full practice supervision model for all frontline staff, as we see elsewhere in health and social care, one solution is for commissioners to build this role into their service models. This would be a significant driver of quality.

There is also an important role for developing staff skills in specialist areas such as co-design, engagement and facilitation. We know that these skills have a significant impact on how well a practitioner engages and works with a client, and we would like to see these recognised and valued as core skills within treatment, to help improve outcomes.

Secondly, clearer tools to support recovery workers can improve capacity. Our staff tell us that administrative processes take much of their time, and we need to remove barriers that prevent staff from focusing on clients and relationships. An example is our work on the first four weeks of people's engagement. Our data shows that people we help are most likely to disengage after four weeks of engagement, which means that the early interactions and conversations we have with clients are important for improving outcomes. The evidence shows that these conversations should focus on building relationships, however, NDTMS requires our frontline staff to answer 60 questions during an assessment with a new service use, so the focus is on understanding problems rather than identifying strengths. We are currently developing tools to support frontline workers, and we would like to see investment in better systems that give workers more scope to respond to need and strengths, and use their judgement, rather than process people.

For certain groups in particular, the role of volunteers and lived experience is particularly important in terms of people's long term recovery process in communities - to give people hope that change is possible, and to normalise these issues. Charities are particularly good at building these as we can develop wiganand play an active role in communities.

17) What are the most effective ways of meeting the physical health needs of people in drug treatment? What can prevent their physical health needs being met?

The entire health of a person should be considered as part of drug treatment as it can ultimately affect the success of a person's outcomes. However, current funding doesn't cover all physical health checks that might be necessary as part of the initial treatment assessment.

At With You we know that vulnerable people find it difficult to engage with clinical services and therefore their physical health can often get overlooked, so an important part of our work is outreach. We actively work to seek out people who don't know that they might have physical health issues and try to take diagnosis and treatment into the community and away from clinical spaces, like hospitals.

As hepatitis C is often symptomless until it reaches the chronic stage, testing is often low. At the same time we know that more than 90% of hepatitis C infections in the UK are through injecting drugs.

As part of our work in Cornwall, Wigan and other areas we have trained our drug and alcohol workers in dry blood spot testing, and offered this to people free of charge. In Cornwall our Lead Clinical Nurse has an honorary prescribing contract with the local hospital which allows us to treat hepatitis C in the community,

outside of the hospital setting. In Lincolnshire we conducted a two week testing and treatment drive in November 2018 where we incentivised testing with vouchers. As a result, 97% of people who were offered to be treated in Gainsborough and Louth were tested, with a high number of positive tests.

In addition to our hepatitis C work, in 2016 we ran a pilot testing opiate users for respiratory problems such as Chronic Obstructive Pulmonary Disease (COPD) in our Liverpool services. We know that people who use drugs problematically are much more likely to smoke cigarettes meaning they are more likely to contract COPD. The likelihood increases for people who smoke heroin with hospital admissions for COPD three times more common in patients on methadone. A person who has COPD is more likely to suffer a fatal overdose due to having a compromised respiratory system.

We offered testing to 1,100 people who had a methadone or buprenorphine prescription. We found that offering spirometry tests at prescribing clinics provided an opportunity to improve access to COPD diagnosis and treatment for drug-users. It reduced hospital admissions and dramatically improved quality of life. Just under half (47%) of participants had COPD and for 59% this was a new diagnosis. Those diagnosed were referred onto their GP for further management.

We would like to see all relevant health checks become part of the initial assessment stage of drug treatment. Commissioning should include provision as standard, as well as follow up healthcare tailored to each individual's specialist needs.

18) What are the most effective ways of meeting the mental health needs of people in drug treatment? What can prevent their mental health needs being met?

Similar to our response to question 17, the entire health of a person including mental health should be considered as part of drug treatment as it can ultimately affect the success of a person's outcomes. However, current funding doesn't cover mental health checks as part of the initial treatment assessment.

In line with our recommendations in question 17, we would like to see drug treatment and mental health providers work closer together to create joint, personalised care plans for clients with dual diagnosis.

However, the biggest barrier to meeting the mental health needs of people in drug treatment is that mental health services often refuse people who are still currently using drugs. In our service in South Lanarkshire in Scotland we employ counsellors to specifically support people who've experienced childhood trauma. This work goes beyond that of a normal recovery worker, with one on one sessions designed to help people work through the issues in their past that

continue to drive their drug use.

We would like to see a more joined up working approach between mental health and drug services being commissioned - or direct resourcing for drug and alcohol services to provide this mental health support - to ensure that no one who needs it is denied mental health care.

19) What current approaches are effective in meeting the employment and housing needs of those in treatment, including people experiencing rough sleeping? What barriers are there to good practice?

Drug treatment is most successful when the wider needs of a person are considered and met and being allocated one key or group worker that is consistent throughout the treatment.

In Cornwall, our Building Blocks programme works with unemployed adults with the aim of increasing their chances of finding employment. People don't have to be in treatment to be eligible but around half of referrals come through this route.

The support offered differs from that of similar government agencies such as the Job Centre. Rather than setting agendas and targets and using sanctions as a means to motivate certain behaviours, the programme works in a way that meets the wider range of needs of a person. Often clients have experienced significant trauma in the past so initial support is based around increasing their self-esteem and abilities. Support is offered at a pace that is comfortable for them with very little conditions and is not time limited. This kind of approach is most effective in helping people with a history of drug or alcohol use find work.

Since 2017 when the programme started, 642 people have successfully participated resulting in many job searching and engaging with voluntary work and more specifically, 113 people moving onto education or training and 91 into paid employment, including some people who have built their own businesses.

Another example is our project Blackpool Fulfilling Lives - working in partnership with statutory and voluntary agencies in Blackpool and funded by National Lottery Community Fund. This is targeted at people experiencing at least two issues of homelessness, reoffending, substance misuse and mental ill health. The people we support have a 'Navigator' who works with them to help access the support they need from organisations. Navigators have small workloads, allowing them to offer intensive, person centred support.

A study of the first four years of the project found that it doesn't just help reduce homelessness and substance misuse, but it also helps people to feel more relaxed, increased their confidence and boosted people's self esteem.

20) How can peer support/mentoring, mutual aid and recovery communities be better supported and improved?

The role of community and people with lived experience is hugely important in supporting recovery, particularly with drugs and alcohol. They give people hope that change is possible, and help to normalise these issues. At With You, our experience shows that an active recovery community - such as in Wigan or Stoke - give visibility of those in recovery and living differently.

As with frontline staff, people with lived experience and recovery communities work best when they have support, and are recognised and invested in. Investment in this varies significantly through commissioning, and in many areas there is underinvestment in doing this work well over the longer term.

We should prioritise two areas - giving communities support to develop themselves, and much clearer pathways into education and employment, for those that want it. One example of how we do the former is through advice on how to start safe mutual aid groups, through our mutual aid programme. This is trying to encourage people to use the tools to set up recovery groups based on evidence and best practice of what works.

In our work in Cornwall through the Building Better Opportunities employability programme (which works in tandem with our substance misuse treatment), we have seen that connecting employability with substance misuse programmes helps people better reintegrate into the community. Doing this in tandem with treatment means that people leave treatment with good employability skills, which increases the effectiveness of the care package overall.

The Scottish model has more active recovery communities, where they are funded by government over the long term. In order to really use and develop recovery communities well in England, they need a similar level of investment.

The other issue we need to consider with recovery communities is safeguarding, and minimum standards of training around safeguarding, as they are often unregulated communities that can be taken advantage of.

21) What other barriers are there to people achieving and sustaining recovery? How could they be addressed?

We are not going to answer this question.

22) What needs to be done to help those in custody address their drug misuse and continue their recovery? How can we improve the pathways between prison and community-based drug treatment, including 'through the gate' services when people are released?

For people currently in custody, there are a range of ways we can help them to address problematic use of drugs.

We need to increase the opportunities people have to engage in treatment. People need multiple opportunities to get support to address their relationship with drugs or alcohol - at the point of entry and throughout their time in custody. This should be through a trained specialist, a drug and alcohol practitioner or peer. This should be part of a wider prison support for recovery, to give people positive structure with mental health therapy, and a listening environment.

Incentives are another effective way to support people to enter and remain in treatment and recovery. There are a number of ways to do this: engaging families as part of individuals treatment, and involving them particularly in celebration or reward; giving people privileges such as personalisation funds as part of resettlement, or the ability to volunteer or become a mentor; and opening prison reward schemes for drug and alcohol treatment.

Environment is important for recovery, particularly in prisons. There needs to be a safe space to have psychologically informed therapeutic conversations. The wider environment should also support this, for example independent living or recovery wings.

When it comes to healthcare for people in prison, different health providers should sequence care to make best use of the time people have in prison. To help prevent drug related deaths, all prison staff should be trained to administer Naloxone.

The continuity of care moving between prison and community also needs to be improved. Often these services are commissioned separately, which can lead to different timescales, making consistent delivery hard. At With You we are commissioned in Lincoln to provide both prison and drug and alcohol treatment services. Our experience has shown that we can have much greater consistency from prison into the community, with one resettlement appointment, safer transition, and time to invest in a trusted relationship. Good partnerships can also lead to these outcomes.

At With You we also know that people leaving prison are more likely to be ready for drug treatment if their wider needs have been met - such as housing and employment - and their environment is more stable as a result. There are a number of ways to do this. In our services in HMP Lincoln and HMP Berwyn we

run ‘departure lounge’ spaces, to offer advice and practical support from a range of services like housing, as well as refreshment and a space to listen. We also offer inreach where a range of community providers come to prisons to support people with transition, through market days, clinics, and transfer appointments (in person and video link). Our evidence shows this helps people with the transition, and continued recovery. More can be done about transitional rehabilitation pathways, for people leaving prison to enter rehab or supported living programmes with community rehab to transition to community.

Finally, appropriately using release on temporary licence (ROTL) to test what will work and ease transition can also support people with their drug use, particularly with female releases where family connection and relationships are often critical. In Herefordshire, we provide volunteering opportunities in our community service for people ROTL, for example in our needle exchange, which means they are able to reestablish themselves in their community.

23) How can treatment work better with the criminal justice system? Including through diversion by police using out of court disposals and community sentence treatment requirements as an alternative to custody?

The drug interventions programme (DIP) was successful in making the criminal justice system and treatment health system work together. Since the termination of DIP, in our experience the pathways between criminal justice and drug treatment have been less effective.

At With You we would welcome the government introducing a formal approach to closer working between the criminal justice system and drug service providers. This would help to reinstate these partnerships ultimately resulting in a better drug treatment and outcomes for people in the criminal justice system.

Cross-cutting issues

24) What lessons can be learned from the way that drug prevention, treatment and recovery services have responded to coronavirus (COVID-19)? Looking to the future, how do they need to respond to the impact of the pandemic?

At With You our experience of delivering services during the pandemic - and the quick move to remote delivery - has shown that some people have engaged much more with a mixed-delivery model. Our data shows that many people have checked in more regularly with their recovery worker on the phone, as they’ve found it to be easier to attend these appointments than previous face to face.

We’ve moved our group work online and had high attendance. And overall while

referrals are down across the sector, our overall appointment attendance rate has increased. We also saw an increase in people looking for support online, especially family and friends of people affected by drug issues. Our help and advice website which also includes a webchat function to speak to a trained advisor free of charge provided additional channels to reach people during lockdown who reported they wouldn't normally attend our physical services.

However, for around 14% of surveyed clients, we know they are not able to engage with remote models of delivery. This varied picture shows that flexibility of approach, with personal choice of how to engage, could encourage more people to access services, and to stay engaged.

In addition, during the pandemic people who have slept rough for many years were given stable good quality temporary housing such as hotels. People who are homeless often struggle to properly engage with drug services but in one hotel in Shropshire where we partnered with housing services to provide drug and alcohol services during the pandemic we saw 100% engagement with treatment from people who had issues with drugs and alcohol.

We therefore would suggest that:

Services should provide mixed-approach models - offering choice and flexibility, based on people's needs. Commissioners should fund this as part of their model, particularly as they have leverage across the local system.

Service providers need support from commissioners to be innovative, find local solutions and build relationships with partners. There need to be incentives for innovation partnership working and joint delivery and a funding model that supports this flexibility.

25) How effective are drug treatment and recovery services at meeting the needs of black, Asian and minority ethnic (BAME) communities?

See our response to question 14.

26) The Public Sector Equality Duty requires public bodies to help make society fairer by tackling discrimination and providing equality of opportunity for all. How effectively do the commissioners and providers of drug prevention, treatment and recovery services do this and what improvements could be made? Responses can address any of the protected characters, specified in the duty, which are: race, religion or belief, sex, sexual orientation, age, disability, gender reassignment, pregnancy and maternity.

See our response to question 14.