

State of the Sector 2015

About Adfam and the Recovery Partnership

Adfam is the national umbrella organisation working to improve life for families affected by drugs and alcohol. Adfam is a registered charity (number 1067428). More information is available at: www.adfam.org.uk

The Recovery Partnership was formed by DrugScope, the Recovery Group UK and the Substance Misuse Skills Consortium in May 2011 to provide a new voice and channel for communication to ministers and officials on the achievement of the ambitions set out in the 2010 Drug Strategy. Following the closure of DrugScope in April 2015, Adfam took on the delivery of several elements of the Recovery Partnership's work, including the State of the Sector project. More information is available at: www.recovery-partnership.org

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Acknowledgements

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Most of all we'd like to thank all the people in our sector who supported this project by giving up their time to share information. The value of State of the Sector lies in its status as an independent, authentic piece of evidence that is 'by us, for us'.

To this end we would like to thank David Biddle of CRI, Karen Biggs of Phoenix Futures, Wendy Dawson of The Ley Community, Fern Hensley of Addaction, and Maggie Telfer of Bristol Drugs Project for participating in attributed interviews, and to the service managers who took part anonymously. We would also like to express our gratitude to those who gave up a significant amount of their limited time to participate in the online survey.

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Foreword

This report is the third iteration of the State of the Sector project conducted by the Recovery Partnership. The first survey was published in early 2014, and provided a snapshot of the experiences of drug and alcohol treatment services as they entered a new landscape characterised by the closure of the National Treatment Agency (NTA) and its absorption into Public Health England (PHE), and the transfer of budgets for drug and alcohol treatment, as well as commissioning responsibilities for substance use services, to local authorities.

The first two State of the Sector reports served as 'health checks' for our sector as it navigated this rapidly changing landscape, by drawing directly on the experiences of those involved in managing and delivering services. While the first found no evidence of deep and widespread disinvestment, in its second year the survey found that many respondents were experiencing or anticipating substantial funding reductions. This trend continues in 2015, with a considerable proportion of both community and residential providers reporting a reduction in funding. Given the announcement in the Autumn Spending Review that public health funding will be reduced by 3.9% per year for the rest of the current Parliament, challenges around resourcing safe and high quality services clearly remain.

Funding is not the only cause for concern evident in the three years of survey responses and telephone interviews. The challenge of offering effective, joined-up support to service users with multiple and complex needs, and in particular individuals with co-occurring substance use and mental health issues, is a thread which runs through the three reports.

However, consistent with previous years, the development of innovation and new ways of working to address these challenges, together with the enthusiasm of respondents to share examples of good practice is reassuring. Drug services, for instance, welcomed the introduction of the new naloxone legislation in October 2015, and many have plans to implement ambitious naloxone programmes over the coming year. Also encouraging is the commitment of management, staff and volunteers to deliver the highest quality services in their local communities, which shines through in many of the survey comments and telephone interviews. Collectively we support and empower some of the most vulnerable citizens in our society – and this wouldn't be possible without the hard work, passion and dedication that exist within our sector.

The impact that these services can have for individuals on their recovery journey is well documented. A new drug strategy will be published in spring 2016; it is my hope that this cornerstone of national guidance will recognise the hard work being done, paving the way for local authorities and in turn services across the country to continue and expand their important work with individuals, families and communities affected by alcohol and drugs.



Vivienne Evans OBE, Chief Executive, Adfam

February 2016

Executive Summary

In late 2013 DrugScope, on behalf of the Recovery Partnership, conducted the first State of the Sector survey, the findings of which were reported in January 2014. Consultation for the second report followed a year later, being published in early 2015¹.

This, the third State of the Sector report, has been produced by Adfam on behalf of the Recovery Partnership and draws on an online survey and series of telephone interviews conducted between September and December 2015. It uses the findings from a substantial online survey and a series of interviews with senior figures in the sector to evaluate the experiences of community drug and alcohol treatment services in England.

1. Key points

The 2015 State of the Sector survey for adult community and residential services includes responses from 176 services from across England. A survey of prison drug and alcohol services has also been conducted as part of the project. This will be published at a later date as an annexe to this report.

Funding

Over three times as many community services (40 services or 38%) reported a decrease in funding compared to those reporting an increase (12 services or 11%). Of residential services, six times as many (18 or 58%) reported a decrease in funding compared to those reporting an increase (3 or 10%). A significant proportion from both categories stated 'no change'.

Commissioning cycles and contract length

44% of services had been through tendering or contract re-negotiation in the previous year. Half (49%) expected to go through one of these processes during the year ahead.

The delivery of services

- A quarter (26%) of services reported an increase of 10% or more in numbers of clients accessing services and 8% reported a decrease of the same size.
- Beyond addressing substance use itself,

respondents indicated that the most significant support needs service users experience included issues around self-esteem, physical and mental health, employment support, and financial support and advice.

- A fifth of respondents feel that access to mental health services and housing/housing support has worsened over the last year – indicating that better joined-up support for people with dual diagnosis and multiple and complex needs is still required.
- 61% respondents were confident that their service has the skills, knowledge and support to engage with the new naloxone legislation which came into force in October 2015.
- At least 86% of respondents employ people with lived experience of the treatment system (known as “recovery champions”, “peer supporters” etc). 68% actively recruit people with lived experience of treatment as paid employees and 94% recruit former service users as volunteers.

2. Methodology

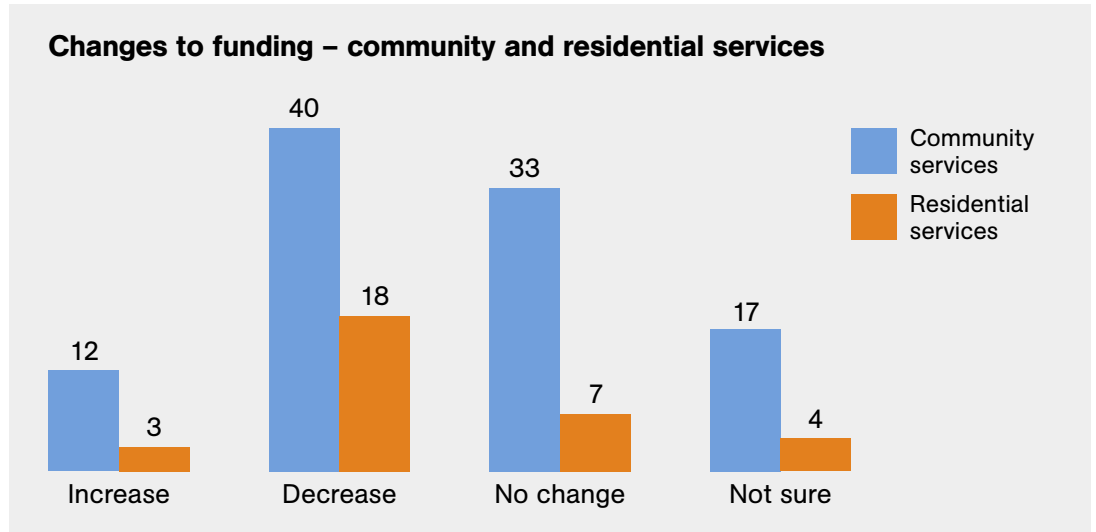
State of the Sector 2015 is based on three components: a large online survey for services delivering community and residential substance use treatment, using a convenience sample; a series of anonymised interviews with seven service managers; and attributed interviews with the Chief Executives of Bristol Drugs Project, CRI, The Ley Community, and Phoenix Futures, and a Contracts Manager at Addaction. One hundred and seventy six respondents completed or mostly completed the survey with a further 43 responses from prison services (which will be considered separately in an annexe).

Amongst the community and residential responses 18% identify as residential services, 79% as community services with the remainder being a mixture of mutual aid and 'other' services. Twenty per cent are NHS services, 55% are charities and 11% are private sector organisations.

¹ Both reports, and executive summaries, are available at: www.drugwise.org.uk/state-of-the-sector

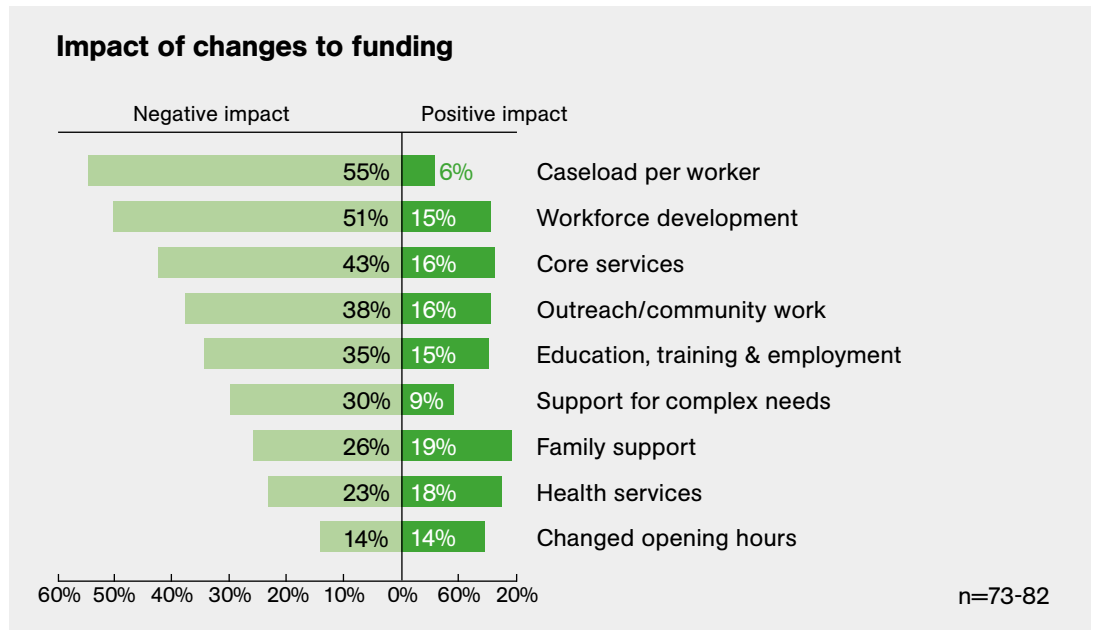
3. Key themes

a. Funding



Looking across responses to both this and last year's surveys, a continued trend towards reduced funding reported by both community and residential services is clearly identifiable. Though there are clear limitations to the scope of conclusions made due to sample size amongst other things, the fact that almost four times as many services have seen a decrease in funding in the last year as an increase is surely noteworthy.

Comparing these findings with an examination of local authority spending on treatment would be insightful, and could form a source of valuable auxiliary evidence for any future State of the Sector surveys.



Many respondents raised serious concerns about the impact of funding reductions on their services, service users and staff. This was felt particularly in regards to high worker caseloads, the lack of workforce development and, most importantly, the delivery of core services. Some respondents felt that the quality and safety of their services had been compromised in a bid to make savings. However, there were examples of both survey respondents and telephone interviewees who were clearly dedicated to mitigating as many of the negative impacts of funding reductions as possible by working in new and more effective ways.

“ The transition into different ways of working will take some time and there are some stresses throughout that process, but it is a situation that I recognise because it is fundamental to both staff wellbeing and to the quality of services that the people that use our services get. Funding challenges have to be seen as a spur to innovation. ”

David Biddle, CRI

2015 and September 2016. While these figures are indicative of considerable churn in local commissioning cycles, compared to the findings of last year’s survey (54% and 49% respectively) they could suggest that the pace of commissioning cycles is gradually slowing.

Concerns were expressed that frequent retendering can be destabilising for both service users and staff, and constitute a diversion of scarce resources away from the delivery of frontline services. Some smaller providers feel they are disadvantaged in the commissioning system, owing to their relative lack of resources to devote to tendering. Views of retendering, though, are far from universally negative. Encouragingly, considerable proportions of respondents believe that as a result of recent retendering, services: better reflect local need (40%); better reflect good practice (44%); and have prioritised quality (38%).

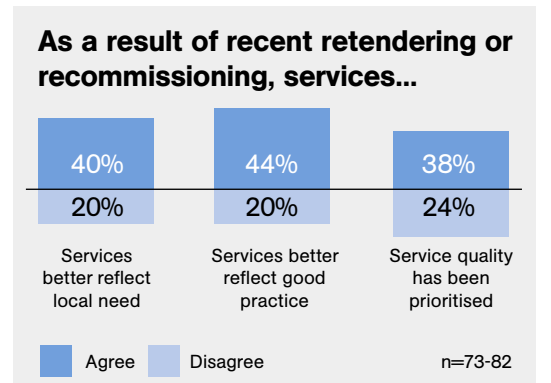
“Service users are fed up from the changes.”

“Services better reflect local need - on paper you can definitely see a trend for recovery communities, social enterprise and satellite working.”

b. Contract length and commissioning cycles

Survey responses suggest that in many local authorities commissioning cycles remain fairly compressed, with only 14% reporting a current contract of greater length than its predecessor, compared to 23% reporting the reverse.

44% of services have been through retendering or contract renegotiation in the previous year, and around half (49%) are expecting to go through retendering or contract renegotiation between September

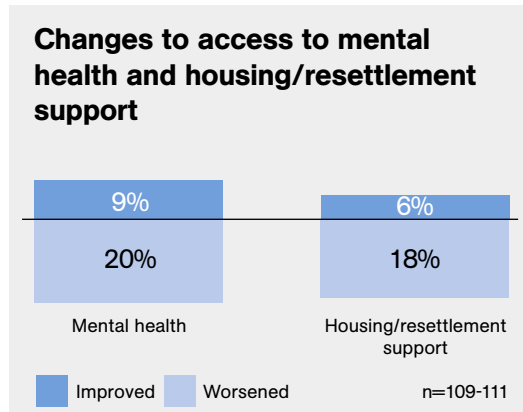


c. The delivery of services

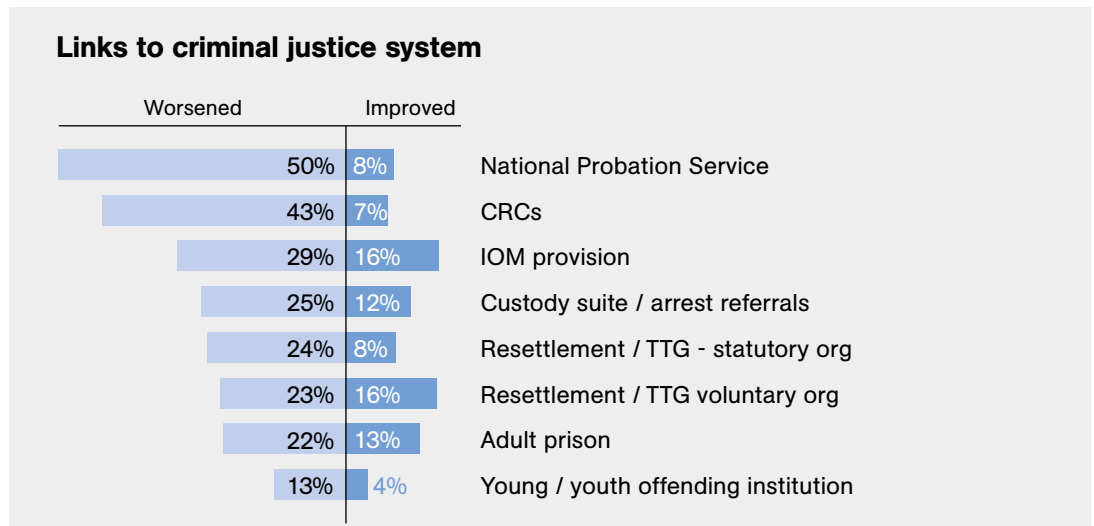
Multiple and complex need

Though not in any way a new issue for the sector, the challenge of providing joined-up support to service users with multiple and complex need, such as a 'dual diagnosis' of substance use and mental ill health, emerges as a prominent theme across the three years.

Though, encouragingly, a number of participants reported improved partnerships with mental health services, the survey as a whole paints a varied picture. A fifth of respondents feel that access to mental health provision has worsened, with only 9% reporting an improvement. The consistency with which access to mental health services has been flagged as an issue suggests that it remains a key challenge.



Access to suitable accommodation continues to be perceived as problematic. Three times as many feel that availability of housing/resettlement services has worsened over the last year as improved (18% vs 6%). Interviewees made it clear that there are some examples of new partnerships and in-house initiatives to improve access to housing, though regional variation was emphasised in the comments and interviews, particularly regarding access to the private rented sector.



For many, links with criminal justice services have remained relatively stable. However, 43% feel that links with Community Rehabilitation Companies (CRCs) are weaker than relationships held with their public sector predecessors - perhaps surprising given the new CRC providers were due to begin delivery in February 2015. Around a quarter of respondents report that both custody suite/arrest referral work and work with statutory and voluntary resettlement/'through the gates' organisations has reduced. Greater positive engagement might have been hoped for

given Transforming Rehabilitation's increased emphasis on providing offenders with holistic support.

Taken together, all this information articulates both the complexity and importance of working with people with complex and multiple need – as one of the interviewees eloquently put it:

“ Understanding how to deliver good quality services to people with complex needs is probably going to be one of the sector's biggest challenges over the next few years, not because we don't know how to do it, but because we're going to have to do it with less and less resources – and not just less resources for us, but less available support in those local areas from other sectors and agencies. ”

*Karen Biggs,
Phoenix Futures*

d. Harm reduction and naloxone

In October 2015, new legislation came into force allowing substance use services commissioned by a local authority or the NHS to supply naloxone without a prescription. As this survey was open from early September to mid-October 2015, a follow up in one year's time would better demonstrate any impact of this change. However it is encouraging that 61% respondents felt confident that their staff have the skills, knowledge and support to engage with naloxone provision, a modest increase on last year (55%).

“We are engaging with naloxone. Last year we had none! Since October it's so much easier, we have a target for each locality to hand out packs, everyone is talking about it, we want to improve the link in prisons.”

“ Since the changes from 1st October we can distribute more easily. In practice that means that instead of what was happening before – a training session with an individual around the safe use of naloxone, then having to pass that information on to the nurse who then has to physically hand over naloxone, we can do it there and then, so we can get naloxone out in a much more timely fashion and on a much bigger scale. ”

*Maggie Telfer,
Bristol Drugs Project*

Services continued to recognise the importance of harm reduction more broadly, including among many abstinence-based residential rehabilitation services. Eighty per cent of respondents felt that harm reduction needs were met through local provision, and comments provided suggest that in some areas testing, vaccination and pathways into treatment for blood-borne viruses (BBVs) are improving. Other comments indicate that variation between local areas and services remains.

Methodology and data

The State of the Sector 2015 comprises several elements:

- An online survey aimed at managers of adult drug and alcohol community treatment and residential rehabilitation services. 245 respondents started the survey. A qualifying question at the beginning of the survey was used to filter out participants who did not represent the service type in question; 32 respondents were not included as a result and a further 37 did not leave any meaningful responses, leaving 176 qualifying participants. While a large majority of respondents were service managers, a smaller number occupied other positions, including Chief Executive, Deputy Service Manager and Recovery Worker. These responses have been included in this report to ensure a variety of viewpoints are captured.
- An online survey aimed at managers of prison drug and alcohol services. 70 respondents began the survey, 27 participants were not included either because they did not pass the qualifying question or because they did not leave responses, leaving 43 qualifying respondents. The majority were representatives of adult prisons, though a smaller number represented youth offender institutions or immigration removal centres.
- Four attributed interviews with Chief Executives of drug and alcohol treatment providers. Attributed quotes from these interviews are included in this report. One attributed interview with a contracts manager was also conducted, and attributed quotes from this interview will be included in the prison's annexe. Those interviewed were:
 - **Karen Biggs**, Chief Executive of Phoenix Futures, a voluntary sector provider operating community, residential and prison services across England and Scotland. In addition to providing drug and alcohol services, Phoenix Futures is also a housing association.
 - **Maggie Telfer**, Chief Executive of Bristol Drugs Project (BDP), a voluntary sector treatment provider of community drug and alcohol services operating in Bristol. BDP offers a range of services, from substitute prescribing and shared care in GPs surgeries to training and employment programmes.
 - **Wendy Dawson**, Chief Executive of the Ley Community, a residential recovery programme located in Yarton near Oxford. The Ley Community offers a therapeutic intervention programme lasting up to 26 weeks, and a 12 week aftercare programme which involves support to access voluntary work placements, employment and housing.
 - **David Biddle**, Chief Executive of CRI, a voluntary sector organisation providing community and residential treatment and support across England and Wales. CRI also work in prisons and custody suites to support people in contact with the criminal justice system with substance use issues.
 - **Fern Hensley**, Contracts Manager at Addaction. Addaction is a voluntary sector organisation providing drug and alcohol services across England and Scotland, including in prisons. In addition to working with adults, young people and families affected by drugs and alcohol, Addaction also provides mental health services.
- Interviews with five managers of adult community and residential services and two managers of prison drug and alcohol services were also conducted, with interviewees selected from the online survey respondents. The service managers were selected to ensure, as far as was practicable, a diverse sample, with urban and rural areas, community and residential providers and the voluntary sector, NHS, and private organisations all represented. Some of the interviewees were selected on the basis of a particular focus, such as work

with Black and Minority Ethnic (BME) groups. Quotes from the anonymised interviews are included in the body of the report along with additional comments provided in response to the online survey.

- The responses from the prison services survey and interview comments regarding prison services have not been included in the main body of this report. They will be analysed separately and published as an annexe.

The online surveys were open to any organisation delivering substance use services. They were promoted through the networks of the Recovery Partnership, social media channels, DS Daily – the drug and alcohol information service, and Public Health England (PHE) at a regional level. In previous years, the survey had been circulated to the DrugScope membership list. As DrugScope closed in April 2015 it was not possible to repeat this process and there is a possibility therefore that the survey reached a slightly different audience. As with previous iterations, respondents are self-selecting and there is therefore a possibility of sample bias. There are a number of scenarios in which service managers may be more or less inclined to participate. This might include:

- A time-pressed service going through a busy period of rapid expansion due to taking on new services post-commissioning. This would potentially result in positive responses being under-represented;
- A service going through recommissioning where managers do not have the time to participate. This would potentially result in mixed responses being under-represented;
- A service that has unsuccessfully been through commissioning or a difficult process of contract renegotiation. This would potentially result in negative responses being under-represented.

- A manager from a service that has closed during the last year is unlikely to have taken part in the survey, again potentially resulting in an under-representation of negative responses.

It is difficult to quantify the relative probability of each of these scenarios. Consequently, no assumptions or adjustments have been made to the responses received. 26% (46) of respondents indicated that they or someone else from their service had participated last year, with a further 53% (94) respondents being unsure.

Participants were offered the opportunity to leave their contact details for a follow-up interview – and some did. The otherwise anonymous nature of the survey, however, makes it impossible to say what proportion of respondents completed previous versions. The information they provide is therefore best seen as indicative of what's going on in the wider sector – and that claims about commissioning, funding and other trends, based on direct comparisons over the three years, should be made with caution.

These responses should be taken as relating only to the period in question: survey respondents were asked to answer questions based on their experiences since September 2014, and therefore no inferences can be made about the time period before that. Nevertheless, when observed alongside the data from the previous two years it is possible to detect certain trends emerging.

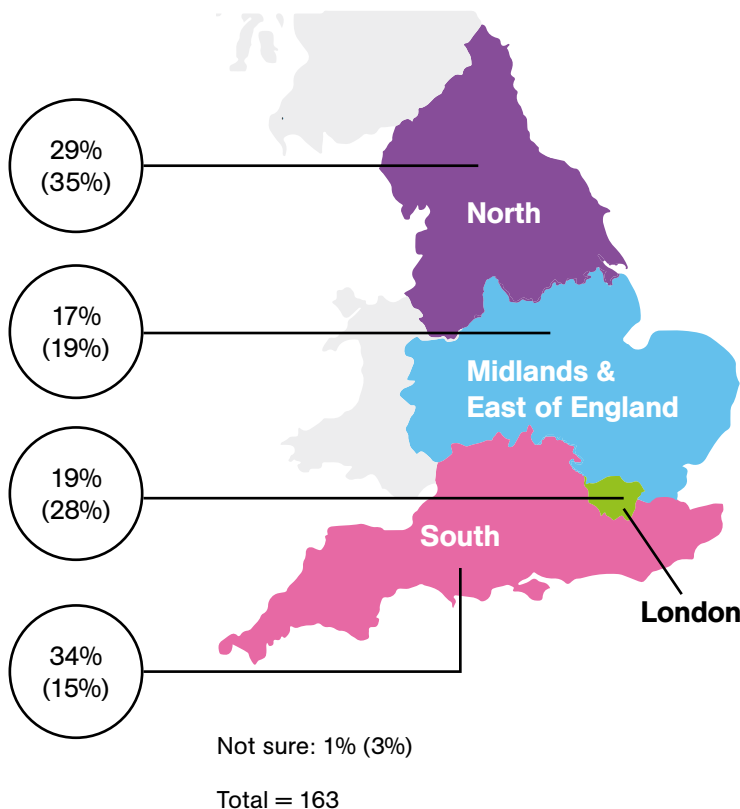
The anonymous nature of the survey also makes it impossible to tell whether more than one representative of a survey has taken part.

While 176 qualifying respondents began the survey, response rates for individual questions vary as participants were not required to answer every question. Sample size therefore varies by question, with questions with multiple parts having a mix of sample sizes. Sample size is clearly indicated on all graphs.

Charts either use actual numbers or percentages; whichever is more suitable to aid comprehension. Where percentages have been used this is clearly indicated. The online surveys and telephone interviews produced a substantial amount of narrative content; we have used the sections which best articulate what is happening in the sector. Views expressed by survey participants or interviewees do not necessarily reflect those of Adfam or the Recovery Partnership.

Respondents by region, type and sector

Respondents by PHE region (Last year's responses indicated in brackets)



Respondents were asked which Public Health England region they are based in. This year saw a substantial increase in respondents from the South of England, with moderate decreases in services in London, the North, and the Midlands and East of England. The reason for this shift is unclear.

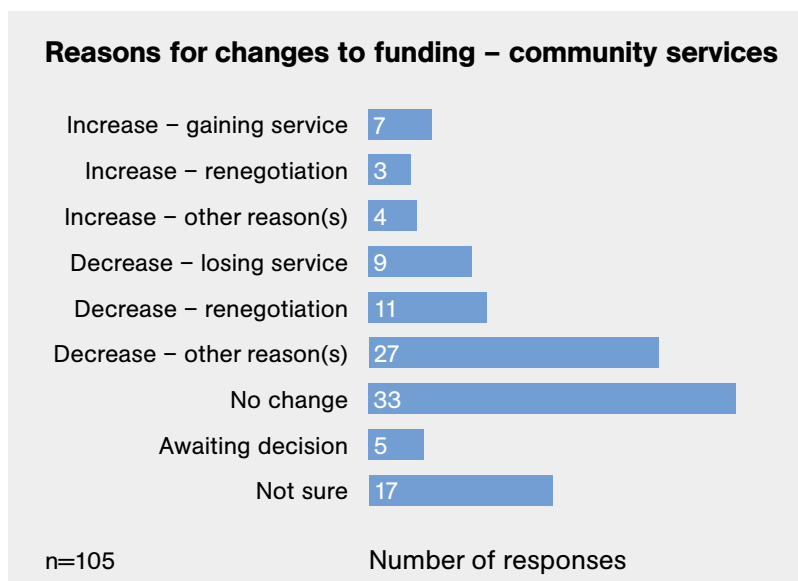
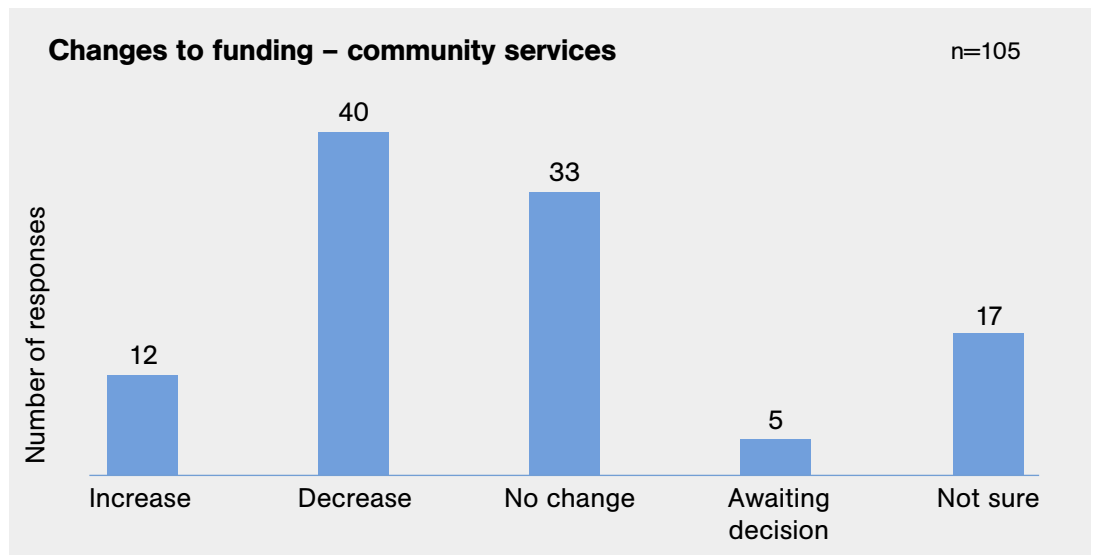
79% (125) of survey respondents describe their organisation as community services, with 18% (29) identifying as residential. Four respondents describe their organisation as mutual aid, and eight selected 'other'. These responses included education, training and employment providers, a hospital liaison service, and a criminal justice organisation. With the exception of the question on funding, responses from residential services have not been disaggregated from the responses of community services. The survey design does not allow the responses of drug services to be separated from answers provided by alcohol services.

Consistent with last year's survey, the majority (55%) of respondents represent voluntary sector organisations. 20% are from NHS providers and 11% are from private sector organisations. 4% of respondents represent social enterprises.

1. Funding

Summary

- Representatives from 58 services reported a decrease in funding over the time period considered, compared to 15 reporting an increase. 40 services said there had been no change to their level of funding.
- The impact of changes to funding over the last year were reported as mostly being negative, with a net deterioration in all aspects of service provision asked about in the survey with the exception of opening hours.



1. Funding Summary

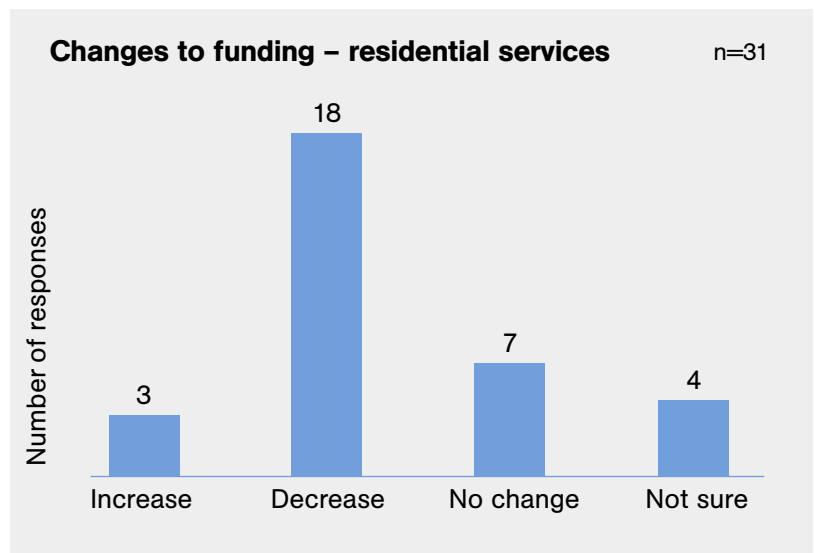
Representatives from 40 (38%) community services reported a decrease in funding during the last year, compared to 12 (11%) who had reported an increase. 33 community services (31%) said that there has been no change. As many services benefit from multiple funding streams, respondents were asked to select relevant answers. Of the community services reporting an increase, seven attribute this to gaining services through commissioning. Nine of those reporting a decrease have lost a service and 11 have been through a contract renegotiation. 27 cited other reasons, including changes to overall funding for substance use services locally.

“Local providers in the national HIV Prevention England programme experienced a 55% cut (the overall programme was cut by approximately 50%).”

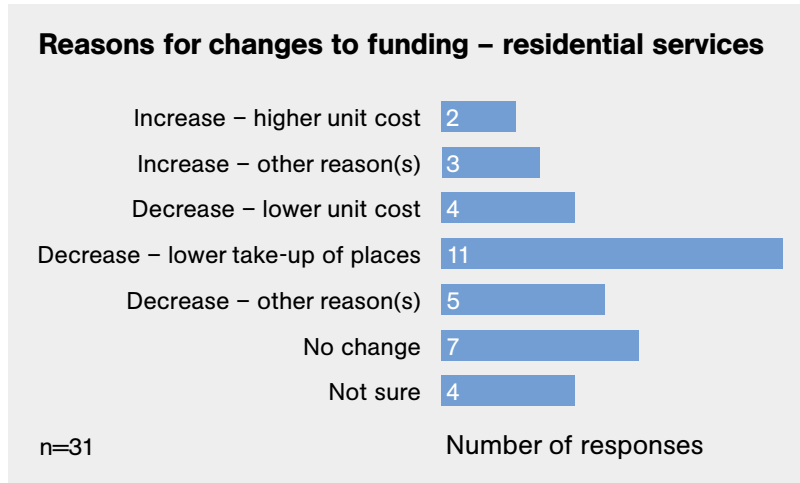
“Our main grant from Big Lottery Fund expired and we have only been able to replace some of this.”

“Due to being a lead provider of services with a commissioning responsibility for sub-contracting other organisations, funding increased by approximately £1.8 million.”

“We have faced ongoing reductions and don’t have anywhere near full cost recovery for most of our services, meaning core services and issues like IT are critically underfunded.”



1. Funding Summary



Of residential services, only three (10%) reported increased revenue and seven (23%) reported no change, compared to 18 (58%) respondents reporting a decrease.

“ Increasingly we are being told commissioners can only fund for 12 weeks. We’re commissioned by about 23 local authority areas, and more and more are saying, ‘we’ve only got money for 12 weeks.’ We still have a proportion that will pay the 26 weeks – we’ve just won three recent tenders, two for 26 weeks and one for 12+12, but my worry is that this will be a trend. The need to reduce the public purse, one needs to consider the social return on investment.... we break the cycle of addiction and welfare dependency - because our clients leave into full time employment. We’re cost effective. ”

Wendy Dawson, Ley Community

A majority (11) of the residential services reporting a decrease in funding attribute this to reduced take-up of places, with four services citing lower unit cost as the primary reason. In addition to the categories displayed on the chart, participants also had the option of indicating whether funding had increased because of a higher take up of places; however no respondents selected this option.

“ Our view is that there has been a consistent use of residential services over the last few years. Now, that might not be the view of everybody. There is starting to be a different pattern of commissioning of residential services...many would argue that residential services aren't commissioned, but the use of framework agreements creates processes not unlike tenders. Of course what you don't get is a guaranteed level of referrals as a result of that framework commissioning process. Some of us used to tender processes for community services probably don't feel like this is an area of concern, but others who are not used to going through this process will feel a strain.”

Karen Biggs, Phoenix Futures

“The Tier 4 budget for 2015/16 in our local authority has been capped at a lower level than 2014/15 - this represents a reduction in funding for Tier 4 of around a third or about £200,000. This has an impact on our overall funding as our rehab is spot funded by the DAAT, and we have had fewer referrals and admissions from the local authority so far this year. We are however still receiving business from outside our local authority.”

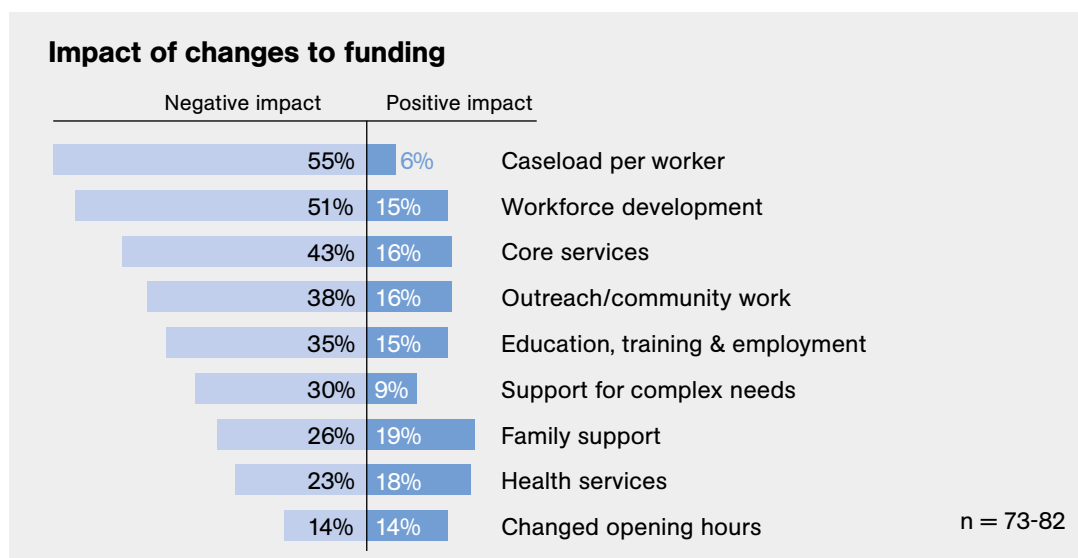
“We have met the shortfall by moving into providing treatment to private clients.”

“For the residential I manage...our funding generally comes from local authorities, so we need to make sure that we are promoting the service, raising the profile of the service, and maintaining the integrity of the relationships we have already got with local authorities so if they do want to refer clients in they will think of us. But we have definitely seen a drop in referrals, so it is appreciating that all local authorities have had their purses tightened. I would definitely say there has been a change, certainly over the last year.”

1. Funding

Impact of changes to funding

Impact of changes to funding



Whilst the levels of funding have been explored previously we need to know what the impact of these changes has actually been on the day to day delivery of key services for people in recovery.

With the exception of opening hours, which equal numbers of participants feel have both improved and worsened as a result of changes to funding, a net deterioration is reported across all areas of service provision considered. The areas that generated the most negative responses are related to staffing – over half (55%) believe that workers are under greater pressure with increased workloads, and a similar proportion feel that workforce development has suffered (51%) as a result of funding changes. Worryingly, the delivery of core services is also highlighted as an area of concern, with 43% reporting that changes to funding has had negative consequences. Those responses that indicated ‘no change’ have not been represented on the chart above.

Despite this almost uniformly negative picture some interviewees and survey respondents do feel confident in their ability to manage any damaging consequences that reductions in funding could bring about:

“We have put a contingency plan in place, the commissioners have been really helpful actually. We were informed probably two months ago about the decrease. Our contingency plan basically means there won’t be any effect on frontline delivery...we’re fortunate we’re in the situation of underspend over the last couple of years which we’ve kind of held back. So the short fall of 6% we can balance with the underspend that we’re holding and we’ve had permission from them to do that.”

1. Funding

Impact of changes to funding

“ My view is that if there are funding cuts you have to deliver services in different ways. You can't expect staff to continue to deliver in old key work/one-to-one ways. It is neither good for the service user nor for the staff. The transition into different ways of working will take some time and there are some stresses throughout that process, but it is a situation that I recognise because it is fundamental to both staff wellbeing and to the quality of services that the people that use our services get. Funding challenges have to be seen as a spur to innovation. ”

David Biddle, CRI

not enough management, admin time or fit for purpose IT.”

“We lost the outreach bus which supported hard to reach clients who didn't engage in treatment.”

“Really what we need to think about more is using more IT, virtual contact.”

Another issue is raised in the comments – one respondent pointed out that even where funding cuts have not occurred, several years without funding increases against inflation can present a challenge in itself:

“0% increase in funding against inflation since 2012 has obvious impact. For example we have six premises/direct access projects on costs to secure year on year.”

Many of the comments focus on the negative impact of funding changes to staffing levels, workloads, working hours and morale, but some emphasised also the commitment of staff:

“We are no longer funded to do in-depth work (Motivational Interviewing and counselling) related to HIV prevention under the HIV Prevention England programme, all of which was linked to chemsex with men who have sex with men (MSM). We have tried to maintain the same level of provision, but our volunteers are taking on larger caseloads.”

“Case managers have seen a doubling of caseloads and loss of certain outlying locality sites has reduced local access points.”

“We have tried very hard to ensure the cuts do not affect the people who use our services. However we are creaking with

“New contracts asking for flexible opening hours - evenings and weekends - despite staff structures containing less staff.”

“The reduction in funding had an impact directly on the management team, as this was reduced and not front line staff.”

1. Funding

Impact of changes to funding

“There is significant positivity among the staff, who are also very realistic about money – they all have suggestions. Where they do say we are doing less well is in training...because we are quite isolated we have to go out there and find out what others are doing, so that costs money. We do quite a bit of in-house training. We have lots of staff with lots of skills and knowledge”.

Specifically, a number of respondents highlight that their use of volunteers has increased, a theme which is examined further in the next section.

“ The general trend is that funding is continuing to decrease. In some areas we have decided not to retender. That’s an organisational decision in terms of the models that we use and our view around how we can apply our approach and our quality threshold. ”

Karen Biggs,
Phoenix Futures

“ Because we’ve got less clients in, that means we’ve had to make some redundancies. A residential management level post went, and the admissions manager asked for and took voluntary redundancy... Well, we’re financially as close to the budget as we possibly can be. We can’t take anything more from our operating budget, so we’re having to be very minimalist. The knock on effect of that is that it does affect our operating principles – we like to go that extra mile. So, for instance, if there’s anything extra-curricular, which isn’t part of our programme content...for example, taking a key working group into Oxford, to experience Oxford... We simply don’t have the money for these anymore. We do still fundraise... I mean, it’s not impacted on the core activity, because that’s built in to the cost price of a purchase... but we’re a tiny charity – I only have 16 staff. And the morale – having two managers leave the service, it leaves a sour taste. ”

Wendy Dawson, Ley Community

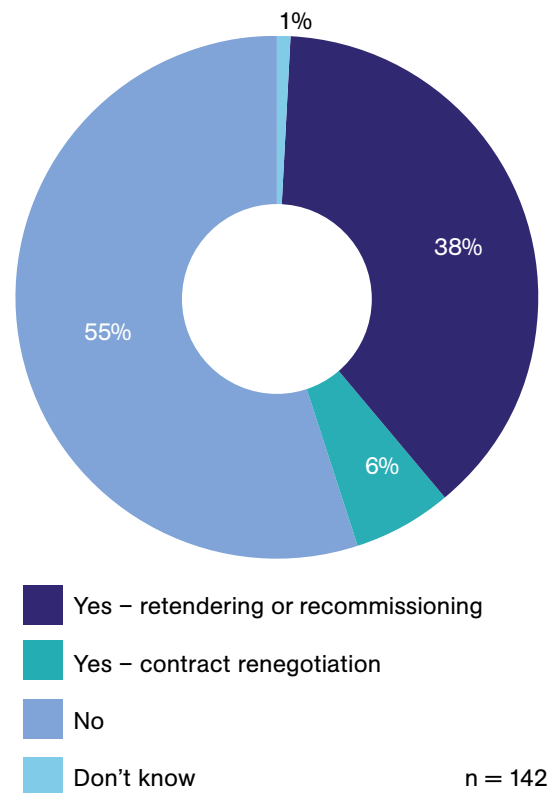
2. Commissioning cycles and contract length

Summary

- 44% of services have been through retendering or contract renegotiation since September 2014, and around half (49%) are expecting to go through retendering or contract renegotiation between September 2015 and September 2016.
- As a result of going through recommissioned or retendered 40% of respondents believe services better reflect local need, 44% that good practice has improved and 38% that service quality has been prioritised.
- Only 14% reported that their current contract is longer than their previous contract, compared to 23% who said it was shorter. These figures are similar to last year's survey and, combined with the comments and interview data, suggest that commissioning cycles remain fairly compressed. 78% of respondents reported a standard contract duration of three years or less (not including any potential extensions).
- 82% reported that through the tendering/retendering process they have not found any guidance on commissioning useful.

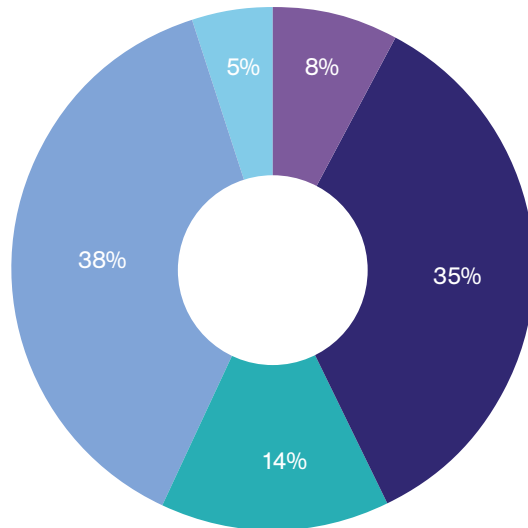
Retendering and contract negotiation

Services recommissioned or contracts renegotiated since September 2014



Forty four per cent of respondents have been through contract renegotiation or retendering between since September 2014, with half expecting to go through one of these processes again over the coming year. Of these, 35% respondents expect their service to go to tender and a further 14% anticipate a contract renegotiation.

Services anticipating recommissioning or renegotiation in 12 months from September 2015



- Yes - retendering or recommissioning
- Yes - renegotiation
- No
- Don't know
- Not applicable

n = 142

“ As a national provider, my view is that it is our responsibility to ensure that we can protect good quality local services that have found it increasingly hard to compete in the contracting / tendering environment. Just because you're not big enough to be able to submit a tender on your own does not mean you are not providing good, valuable services and providing something that's unique, that others can't provide. And it's important that those of us who do that tendering know that. Some of us do actually, you can look across the country and see really innovative partnerships across the voluntary sector. ”

Karen Biggs, Phoenix Futures

“ We're commissioned primarily through a tender framework, so we've won the tender for a geographical area and we're on their framework - that's the primary source. However, increasingly it seems to be that it's going back to spot purchases - so that's a commissioner ringing us up and asking if we have a placement. This is the preferred option, as tender processes are very lengthy and time consuming to complete, do not guarantee a head on a bed whereas a spot contract gives the service user more choice and enables a working relationship to be built up between provider and commissioning areas. ”

Wendy Dawson,
Ley Community

Several respondents commented that the commissioning system disadvantages smaller organisations that do not have the time or specialism in their staff team to complete tender bids.

“Because we are a small organisation we don’t have the knowhow, I have never filled in a tender form before...obviously we failed poorly at some of them because we don’t know how to fill in the form...we can’t afford to pay people lots of money to do them for us because we run quite a tight ship, because we are not an expensive rehab.”

Consistent with the findings of last year’s State of the Sector survey, there was a feeling among respondents that frequent retendering is destabilising for both service users and for staff, and the prospect of retendering can be a source of anxiety for services:

“ TUPE [Transfer of Undertakings (Protection of Employment)] is time consuming, it’s unsettling for staff...as they need to get used to another organisation, culture and team, and of course it is an expensive process, both in terms of cost if you have more staff than you are able to continue to employ in a new contract, and also it’s a major distraction from the day to day work.”

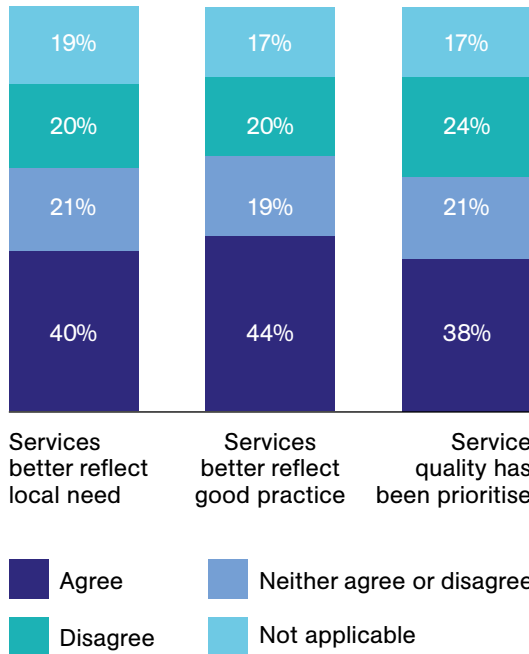
Maggie Telfer, Bristol Drugs Project

“Everyone is anticipating how much less we will have, the same as last year, we know probably that next year there will be more cuts, so there’s a slight anxiety on what that means for us. We have started looking at what we provide, what is effective, what’s working and not, trying to make ourselves leaner, just being good housekeepers really, but it depends on the size of cut. Rather than looking at it just as a risk we are also looking at being proactive.”

“Service users are fed up from the changes.”

“Our highly skilled team who have great experience are feeling undervalued and the non-NHS services seem to stick to the contract at the loss of innovation and flexibility (we currently are a seven days a week service because we are based in a NHS building open those hours).”

As result of recent retendering or recommissioning...



n = 80

This question provides some interesting and mixed insights into the effects of change on services.

40% felt that services better reflect local need as a result of recommissioning or contract renegotiation, although around a fifth (21%) of respondents feel that these processes have not brought about an improved local focus. Both positive and negative views are conveyed in the comments:

“Services better reflect local need - on paper you can definitely see a trend for recovery communities, social enterprise and satellite working.”

“Due to a protracted procurement process we have been forced to deliver a service that no longer represents the community’s needs, leaving the staff disillusioned and the service users receiving a service that wasn’t best suited.”

44% of survey respondents believe that services better reflect good practice as a result of recent recommissioning. However, this feeling is not universal; a fifth (20%) disagree. Contrary to the more positive picture that these figures suggest, comments provided by survey respondents on this issue were largely negative:

“Staff and service users agree that the quality and safety of service has been compromised.”

With regard to the quality of service provision, only 38% feel that it has been prioritised through these processes, leaving over three fifths of services deviating from this view, perhaps worryingly since so many have been recommissioned or through retendering. Of those who expressed a strong view, a greater proportion (15%) strongly disagree than strongly agree (10%) that service quality had been prioritised.

“Due to percentage weighing towards price on tenders I think that commissioners are choosing providers who offer cheaper options despite quality - the new provider came top on price and third for quality.”

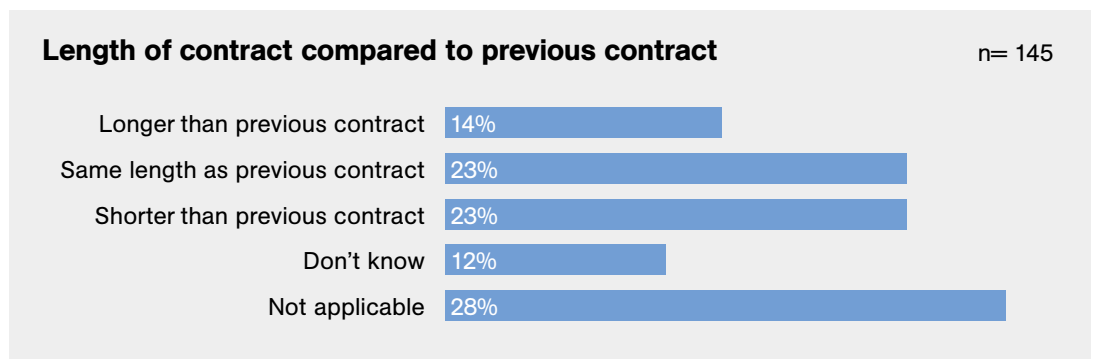
There is a strong feeling that existing guidance on the commissioning and tender process is lacking, with only 18% having found any guidance to be useful. Resources identified as useful include an NHS

commissioning conference, NICE guidance, Care Quality Commission (CQC) and NHS England joint paper on safer methadone prescribing, Alcohol Concern's Blue Light project for dependent, difficult to engage drinkers, and Asset Based Community Development (ABCD) commissioning guidance. Others note that their organisations have knowledgeable and experienced in-house tendering teams.

“We generally apply via e-tendering for residential services and the guidance is generally good. I just wish every authority would use the same tendering process.”

“We need more guidance on tendering as we often feel out of our depth.”

“Guidance would be useful – but then the other thing you have got is the time constraints.”



Where the length of the current contract differs to that of the one previously held, more services (23%) reported a reduction in contract length than an increase (14%). The majority of respondents who selected 'not applicable' are representatives of NHS services that have not been out to tender, residential services funded through spot purchase arrangements, or services awaiting tender decisions.

“ There has been a lot of tendering and retendering in the last 12 months. My view of it is that there are a number of contracts that have come in that have been of a longer duration, moving from 3+1+1 year to 5+1+1 years which is a welcome development... Longer contracts are important for financial planning, for stability, for quality, for service delivery, to put some investment into buildings and services over a period of time. It is just a more sensible and rational approach to delivering these kinds of services. **”**

David Biddle, CRI

Of those respondents who provided details of their service standard contract length, 78% are three years or shorter (not including any potential extensions). Only 23% are working to a standard contract length of over three years. Several services are operating to a two year contract, with a small number working to a yearly rolling contract.

“ My view, anecdotally, is that where commissioners can they are using the tender cycle to make the savings that they need to make, but without just top-slicing current provision... From a positive point of view it does allow both commissioners and providers to reconfigure a service, so rather than just saying you need to provide the same service for less money which obviously has risks in terms of quality and clinical delivery, it does allow providers to review how they're delivering services. That said, this in itself creates an unsettling feeling both for service users and for the sector as a whole. ”

Karen Biggs,
Phoenix Futures

“We are constantly having to tender for our service.”

“Shorter contracts with more treatment demands”

“ Short contracts are destabilising for people who work in services and who use services. It's time consuming and therefore it's expensive, for organisations but also for commissioners. Recommissioning takes a long period of time out of what might otherwise be normal business. Commissioning teams are quite small so obviously if they're taking on a recommissioning exercise then some of the development plans are slowed down inevitably. ”

Maggie Telfer,
Bristol Drugs Project

“ Commissioners are working in constrained and pressurised financial and political situations. And they're looking to provide solutions that answer a number of problems with the amount of money that's available. It comes down to the fact that we have to do things differently, because there isn't the money to continue doing things the same way. That said, I am not sure I would want to do things the same, because we should be improving the offer and the effectiveness of our services and broadening our vision. The sector has much to offer in respect of meeting those wider needs. ”

David Biddle, CRI

Service managers were asked about their relationship with commissioners. There is a recognition that commissioners as well as services have been through a difficult period of adjustment following the shift of commissioning to local authorities in April 2013, and that both are working under severe financial constraints. The responses provided suggest that the nature and quality of these interactions vary considerably, from extremely positive relationships with passionate and supportive individuals on one end of the scale to fractious relationships at the other.

“We’ve got a really good relationship with commissioners, we didn’t a couple of years ago but we’ve been doing a partnership for three years now, and the first year or so was just getting started, so the commissioners were asking for stuff all the time. We are now actively working with them, they want to see if we can be leaner, keep the service going but recognising there may be reductions in funding. If you look at the bigger picture, when public health came under the county council it was a huge change in the commissioning environment; everyone has taken a little while to settle down...we’re talking to Clinical Commissioning Group (CCG) commissioners. There’s no money but we’ve all talking to each other!”

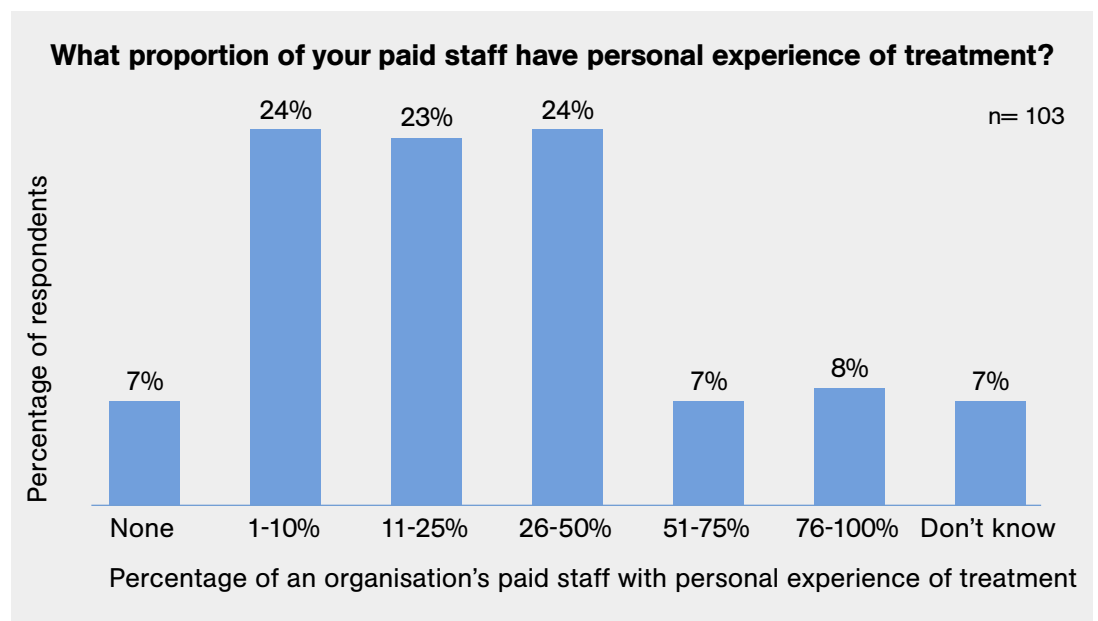
“Over the last 16 months our relationship with our commissioners was fractious. It’s non-existent now.”

3. The delivery of services

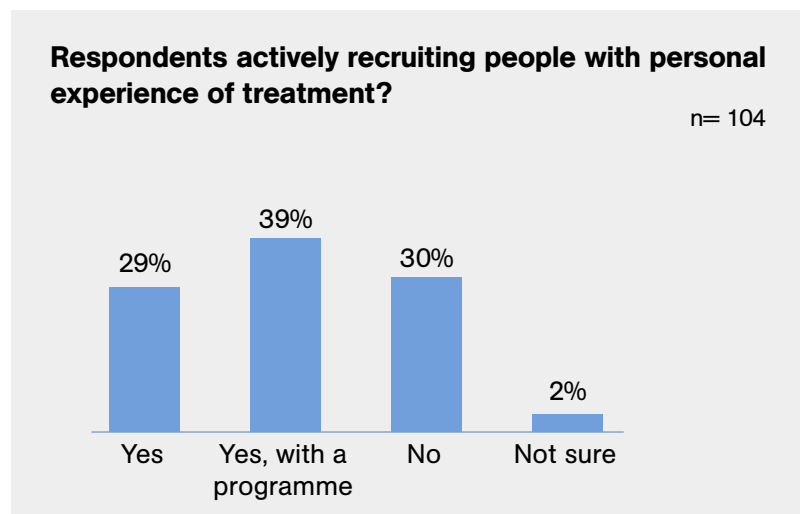
Staff and volunteers with personal experience of treatment

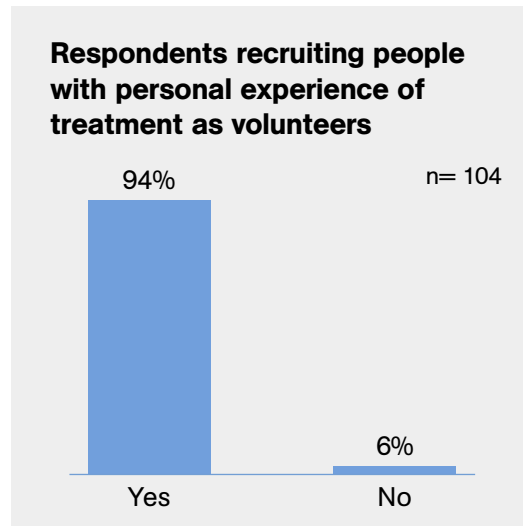
Summary

At least 86% of respondents employ people with personal experience of treatment. Sixty eight per cent actively recruit people with lived experience of treatment as paid employees and 94% recruit former service users as volunteers, in a range of different roles.



Similar to the picture cast by last year's State of the Sector survey, the vast majority of services employ people with experience of treatment for drug or alcohol use as paid members of staff, although the proportion varies markedly.





Nearly all (94%) respondents reported that their organisation recruits people who have personal experience of using drug or alcohol services as volunteers. The variety of the roles performed by volunteers is immense and varies between services. Roles stated include administrative duties, peer mentoring, acting as recovery champions, facilitating groups, and acting as recovery workers. This spectrum of activity extends into territory traditionally seen as that of the paid worker.

“DBS cleared volunteers have the same roles and responsibilities (within reason, time limits, their other responsibilities) as paid/contract staff.”

“Usually Peer Mentors first - then progression to volunteering and into paid work. This is of course dependent upon where they are in recovery - no ‘one-size-fits-all’ policy - each case taken individually.”

“To support the role of a paid worker and offer practical support for service users.”

“Employed as community recovery champions to engage with service users and tell their own story so that current service users can see what can be done with the right motivation and support.”

While the value of volunteers was widely recognised and appreciated, some participants also point out that relying too heavily on volunteers can bring about risks for service delivery:

“We’re commissioned to deliver a service and the design of the service has to stand. We can’t say we’re going to do a group on Tuesday and then it not happen. With volunteers, although often times they are really committed, you don’t have quite the same level of influence over their process of work because they are volunteering their time... We tend to use volunteers more on top of staff, to do the more flexible, social things, taking people to fellowship meetings, those kind of things. I think there is capacity to use volunteers, I think really with the spending cuts this is obviously going to increase rather than decrease over the next five years.”

Some respondents emphasise the value of infrastructure, support and training in successfully managing a substantial reliance on volunteers:

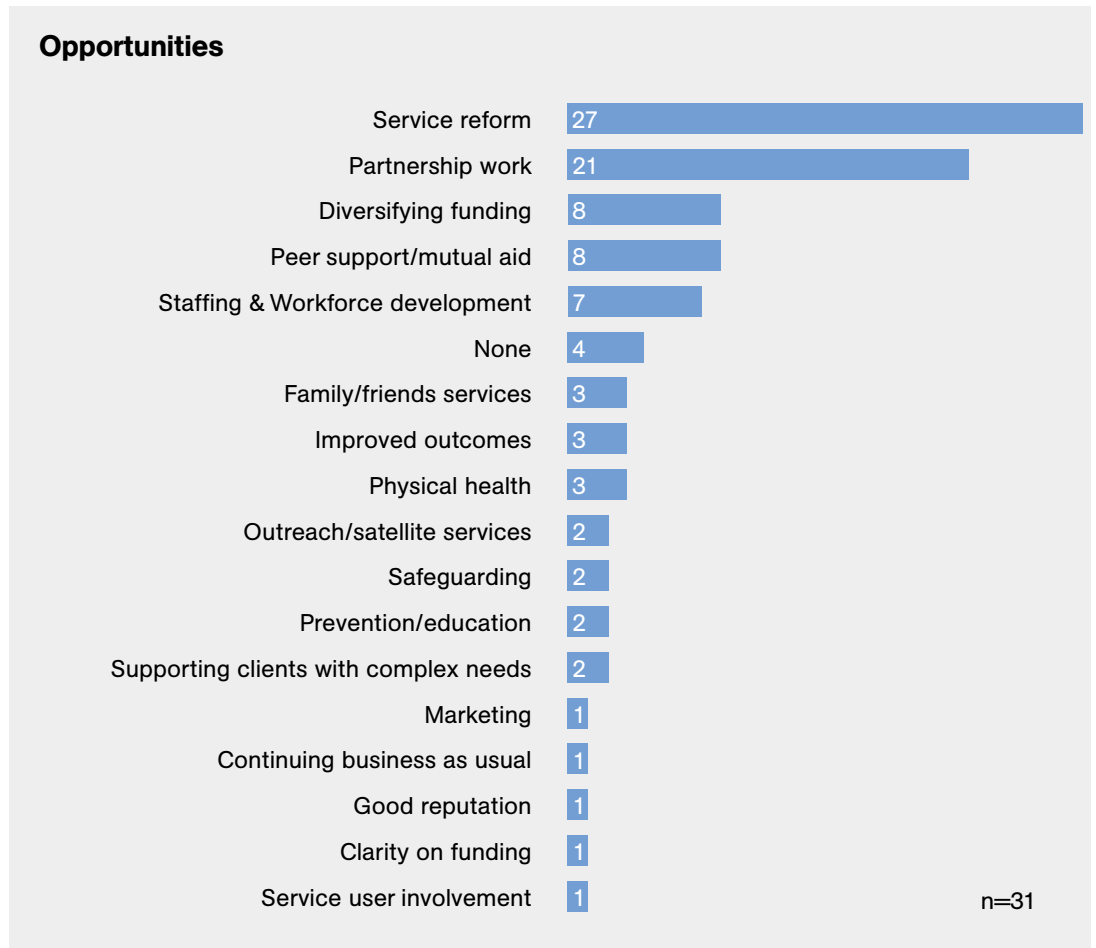
“We already rely exceptionally heavily on volunteers in our delivery model and they have taken on more work both with clients and in the back office supporting the service. Luckily we have good volunteering infrastructure to support this which enables us to provide supervision and support to volunteers. Services without this would struggle if they had to become more reliant on volunteers.”

Opportunities, challenges and innovation

Survey participants were asked to indicate what they saw as being the most significant opportunities and challenges in respect of the service(s) they manage, and to detail any innovative practice. This resulted in over 300 individual comments from 113 survey respondents, which have been coded and categorised thematically, and presented alongside some specific examples drawn from the comments.

Summary

- Areas such as partnership working and funding which have been recorded as challenges for some respondents are considered opportunities by others.
- Mostly commonly cited as opportunities are new ways of delivering services (service reform) and partnership working, as well as peer support and mutual aid and the chance to diversify funding streams. A small number of respondents suggest their service has had no opportunities for positive change in the 12 months preceding the survey.
- Key challenges include funding, staff caseloads, and maintaining the quality and safety of services.
- Areas of innovation most frequently cited include new approaches to service provision, the development of more efficient systems and practices, and partnership working.

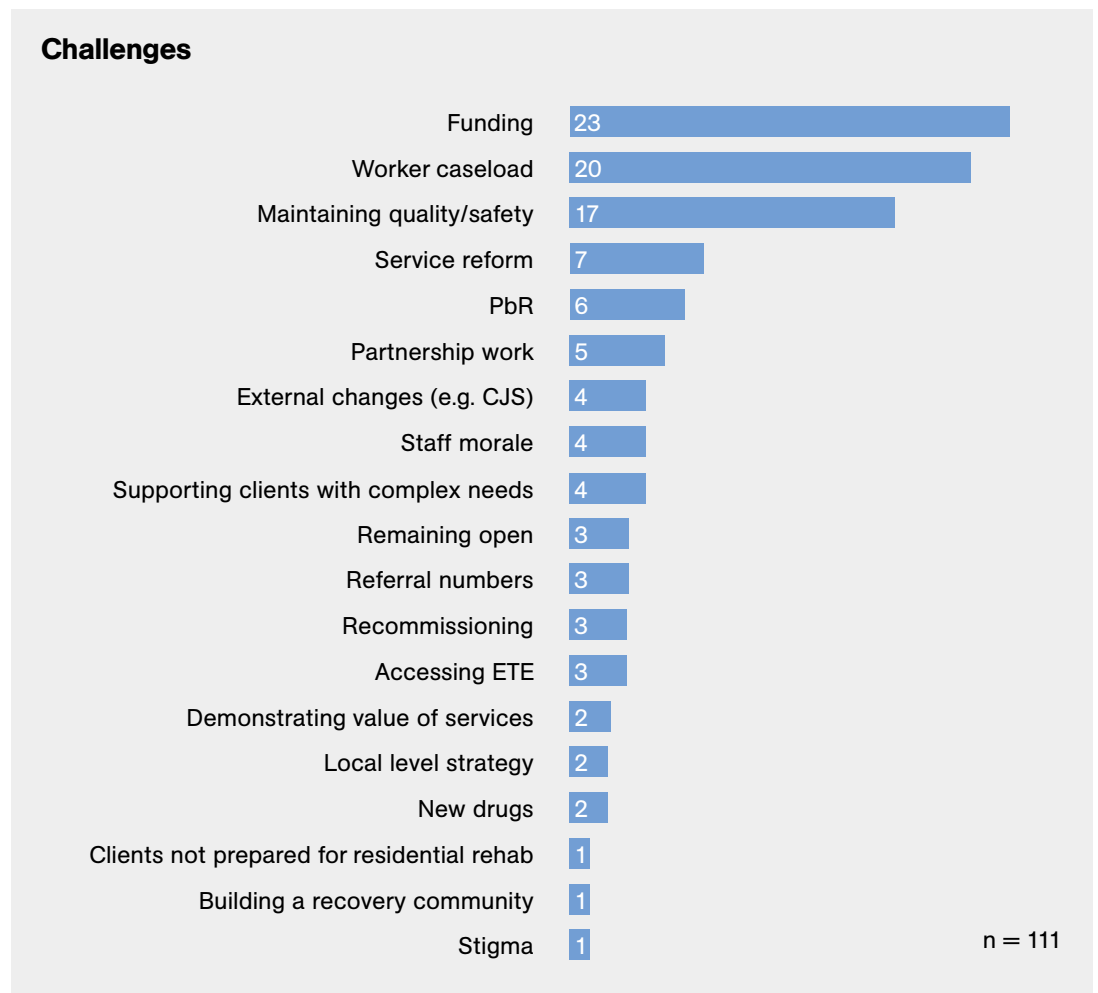


Examples of opportunities respondents feel their services had benefited from include:

Partnering with larger providers to subcontract specialist LGBT work - but we rarely get asked before tenders go in.”

“Working closely with other organisations, agencies, groups and individuals to ensure recovery opportunities for families, carers and individuals are robust and sustainable.”

“We were able to redesign the service having been given an extra building to work from, which has meant that we are able to provide a lot more for our service users.”



The areas identified as the greatest challenges facing services chime with issues discussed elsewhere: securing funding and worker caseloads. The fundamental issue of maintaining the quality and safety of services in a context of decreasing funding was understandably highlighted by some managers. Three respondents simply identify 'staying open' as their greatest challenge.

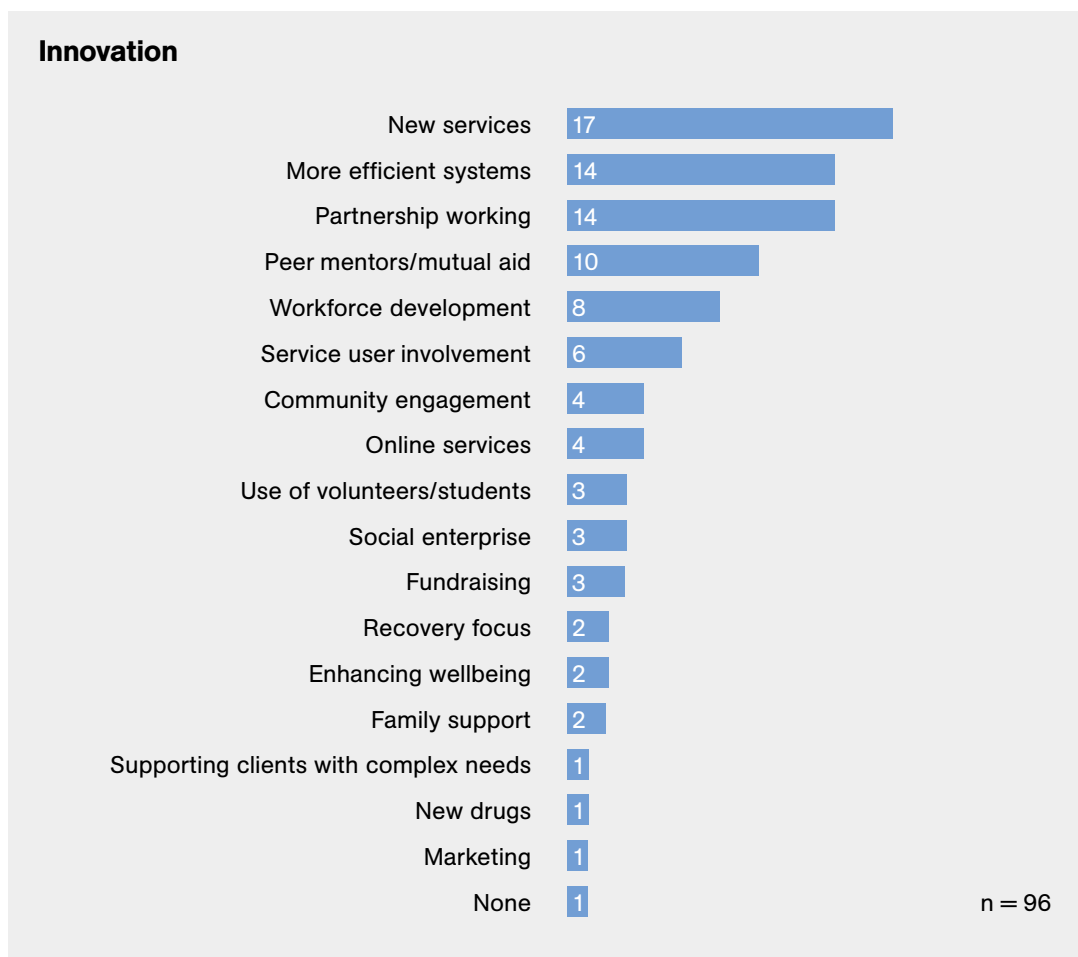
“Integrating four teams into one and changing previous cultures and poor practice.”

“Safe delivery of a service to complex vulnerable people requiring highly specialised interventions with significantly less money alongside expectations that both capacity and performance will remain unchanged.”

“Safe monitoring of all prescribed clients with only a small team of clinical staff.”

“Retaining only recently expanded Training Education Volunteering and Employment (TEVE) programmes with diverse community partners in context of Public Health overall budget reductions.”

“Maintaining funding. Maintaining the existence of the organisation post retendering. We will probably have to go in to a subcontracted arrangement, or if not successful with partnering run the very real risk of not existing.”



Despite the challenging financial environment identified by many, participants are also forthcoming in sharing innovative practice that emerged in spite of (or because of) financial tightening. New and more efficient services / practices, along with improved partnership working and the increased use of peer mentors and volunteers, are the most frequently cited types of innovation.

“ There has been a movement in the way services are delivered. Medical models are clearly not capturing the full needs of service users. We should incorporate the recovery agenda in a more fundamental way. We will make more use of self-help groups, much more use of volunteers, much more use of local communities to enable people not to receive their services direct but to engage in a much more asset-based approach in their communities. Substance misuse services aren't the only place that service users can get assistance. That's part of the process of delivering a service that encourages independence rather than dependence. ”

David Biddle,
CRI

However, a small number of respondents also noted that the opportunity to innovate is limited by funding levels:

“The nature of our service requires constant innovation, but this can be restricted by the fact that we are dependent on the skills and goodwill of volunteers, and are restricted in our ability to expand service delivery because we are unable to pay staff to undertake any new activities.”

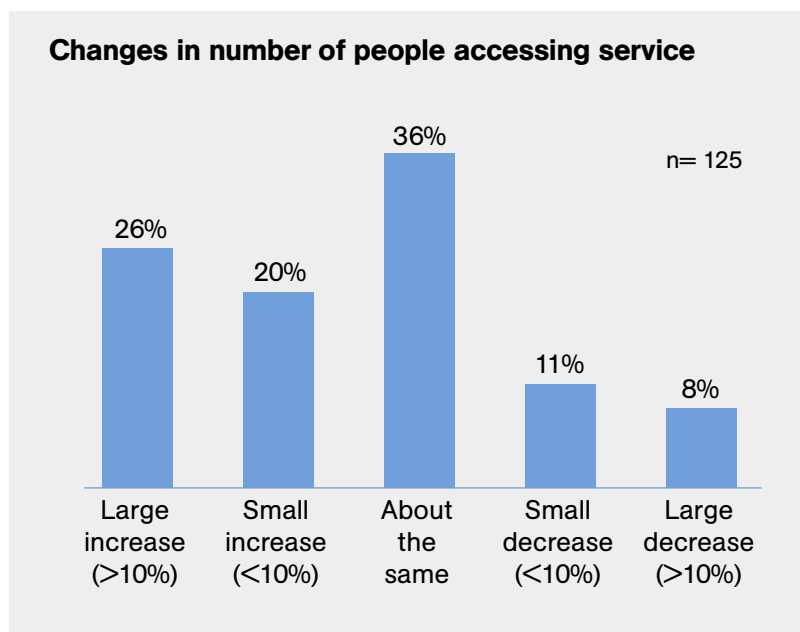
“Whilst we continue to be innovative in practice and delivery, funding is squeezing opportunities.”

Service user support needs

Summary

- The number of services reporting an increase in service user numbers has risen this year compared to previous figures. Around a quarter (26%) of services have seen a significant increase (of 10% or more) in client numbers, the most commonly cited reason for this being an increase in need around alcohol use and novel psychoactive substance (NPS) use. Only 8% reported a significant decrease in the number of service users.
- Some organisations reported delivering services, and supporting client groups, outside the boundaries of their funded programmes of work. The general exception was working with people with no recourse to public funds, though some services were able to support this group.
- 43% of services are funded to provide naloxone and accompanying training, with a further 19% able to do so without specific funding.
- Beyond addressing substance use itself, respondents indicated that the most significant support needs their service users experienced included issues around self-esteem, physical and mental health improvement, employment support, and support and financial advice.
- Similar to the findings of last year's survey, respondents feel that it was possible to meet most types of needs through current locally available provision, although several gaps stand out, including support for men involved in prostitution, people with mental health problems, and housing issues.

Number of people accessing drug and alcohol services



This year's survey results see a greater number of respondents reporting an increase in the number of clients accessing their service. One quarter reported an increase of over 10% in the overall number of service users, with a further 20% reporting a smaller increase. Half the number of last year's survey respondents (8% compared to 16% last year) reported a significant decrease in number of clients.

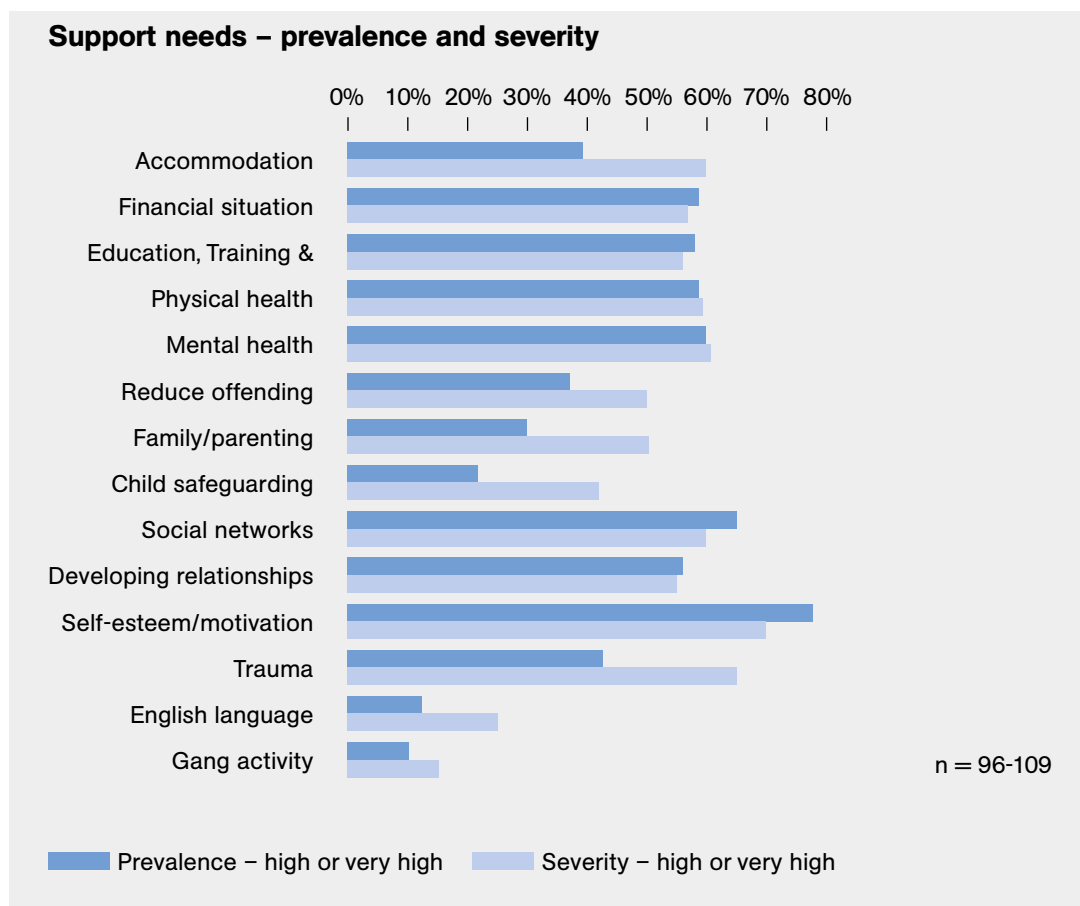
“Other services are limiting who they can see so we take on more service users. Mental health/social services not being able to see as many so we are seeing more with complex needs. We are keeping service users on for longer before rehab due to reduction in funding.”

“Fundraising to provide some free places has kept numbers up this year.”

“I believe the increase has come from more people accessing our service for debt/benefits/housing advice.”

“Some service users left the service complaining of another change.”

Support needs – prevalence and severity



Respondents were asked to indicate levels of severity and prevalence of service user need across 14 areas. The chart above displays the combined percentages for 'very prevalent' / 'prevalent' and 'very severe' / 'severe'. Addressing drug and/or alcohol use has been excluded from the list of needs since it is assumed to exist for all clients by definition.

speakers of other languages (ESOL) or involvement in gangs is lower, as is the level of the need.

Participants were invited to note other needs they encounter; examples provided include legal advice and bereavement support.

Many individual needs are significant in both degree of severity and prevalence, including physical health, mental health, self-esteem, and developing social networks. Accommodation and support following trauma are identified as among the most severe needs experienced. The number of clients requiring help with English for

In the spotlight:

‘Dual diagnosis’ and multiple and complex needs

Supporting clients with a ‘dual diagnosis’ of mental health and substance use issues, and multiple and complex needs more broadly, is a theme that runs through both survey responses and interviews. The responses make it clear that services are concerned with supporting individuals around a range of interrelated needs beyond their drug and alcohol use. A number of participants emphasised the importance of responding to multiple and complex needs as well as the associated challenges:

“ If you look holistically at what service users’ problems and issues are, substance use is frequently a consequence of those pressures, be it mental health, or accommodation or relationship breakdown, so on. Why would you not engage in that broader agenda in order to give people a stable platform from which to build their recovery?”

David Biddle,
CRI

“The reality is people are not just using drugs and alcohol, and anybody that is providing a service that doesn’t look at the whole person is naïve....you have to provide a broader service.”

“ Higher levels than national average of homelessness, higher levels of people who have never worked, through the roof levels of people in our services in prison that have been in care - that complex need is a consistent factor through all of our services. If you just ask the question you get the answer. What you're then left with is what do you do about it?

One of the reasons we opened Grace House (our service in London for women with complex needs) is a direct result of conversations I had with women in Holloway and the staff in Holloway. Some of the women going through Holloway are very complex...mental health issues can be created through being separated from their children, there is homelessness and a lack of suitable accommodation for those women...it was impossible for many of them to find accommodation when they leave prison, and what the prison staff have told me as well as the women is that they just want safe accommodation that supports their recovery. That's why we opened Grace House. It's not easy to run a service for women with complex needs, it's not easy to get those placements funded, it presents challenges in terms of ensuring that you've got that multiplicity of need supported. We're a drug and alcohol provider and we need to make sure that we get good expert support from other agencies to support the women with their other needs.

Complexity has been a lifelong factor of all of our services and all of the service users who access our services. It becomes more difficult for people to get support as statutory and voluntary agencies become more cash strapped, and there's a pressure for services to do more – it is going to be these people who fall through the net, the people who need a huge amount of input and support. Understanding how to deliver good quality services to people with complex needs is probably going to be one of the sector's biggest challenges over the next few years, not because we don't know how to do it, but because we're going to have to do it with less and less resources – and not just less resources for us, but less available support in those local areas from other sectors and agencies.”

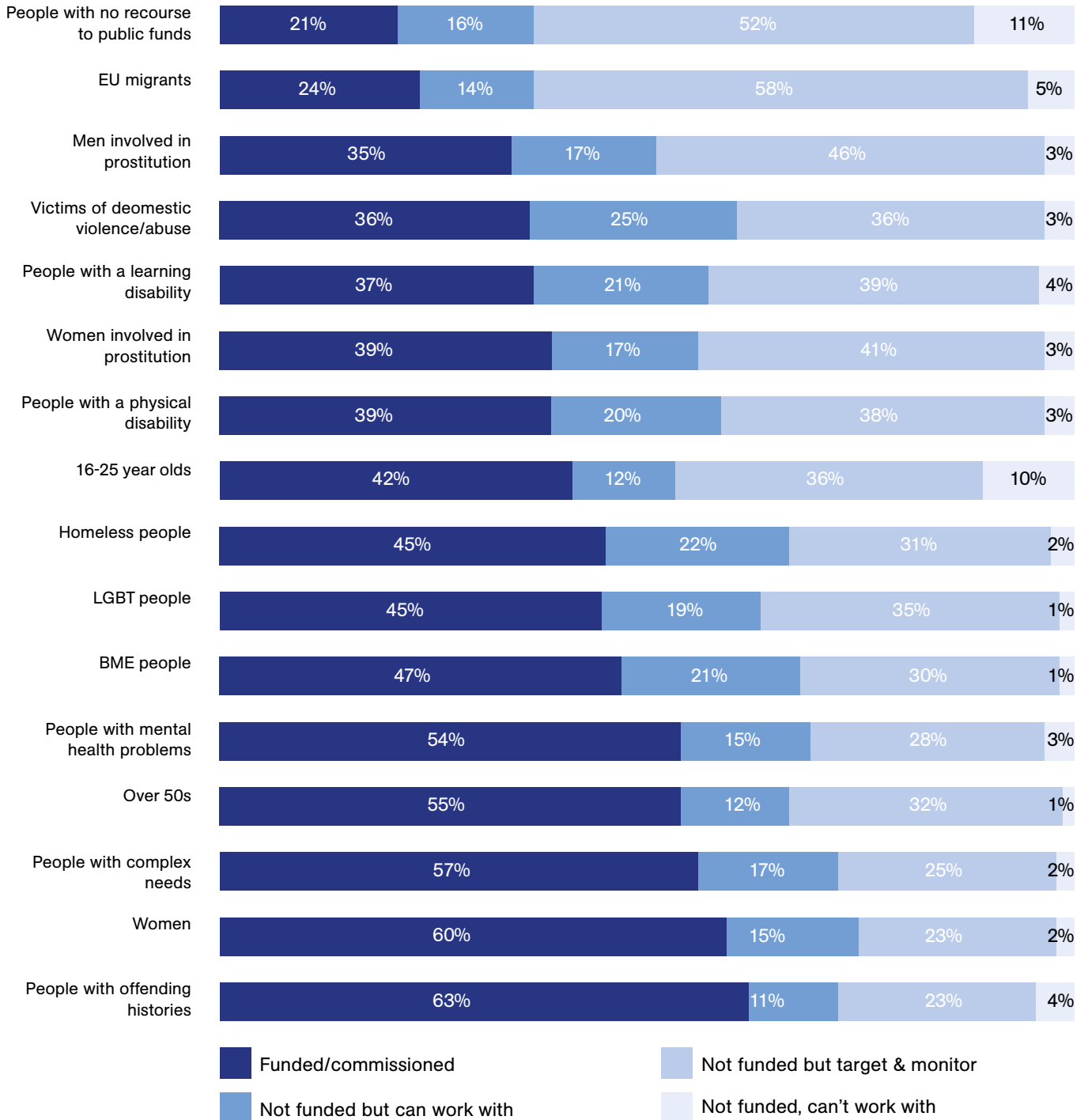
Karen Biggs, Phoenix Futures

The delivery of services

Services commissioned or funded to meet the needs of...

Availability of services to meet these needs

Services commissioned or funded to meet the needs of:



n = 100-118

The delivery of services

Services commissioned or funded to meet the needs of...

Participants were asked whether their services can meet the needs of specific groups of people and if they are funded to do so. Client groups have been ordered with the needs least frequently formally funded and commissioned at the top. A clear picture of a sector looking well beyond the limitations of directly funded work emerges. One respondent from a mutual aid organisation said:

“We will work with anyone who has a substance use problem provided we can manage the risk. Any individuals presenting with a problem that exceeds our capacity to work with effectively are referred to the nearest appropriate treatment service.”

Some respondents, however, are unable to work with certain cohorts, notably people with no recourse to public funds:

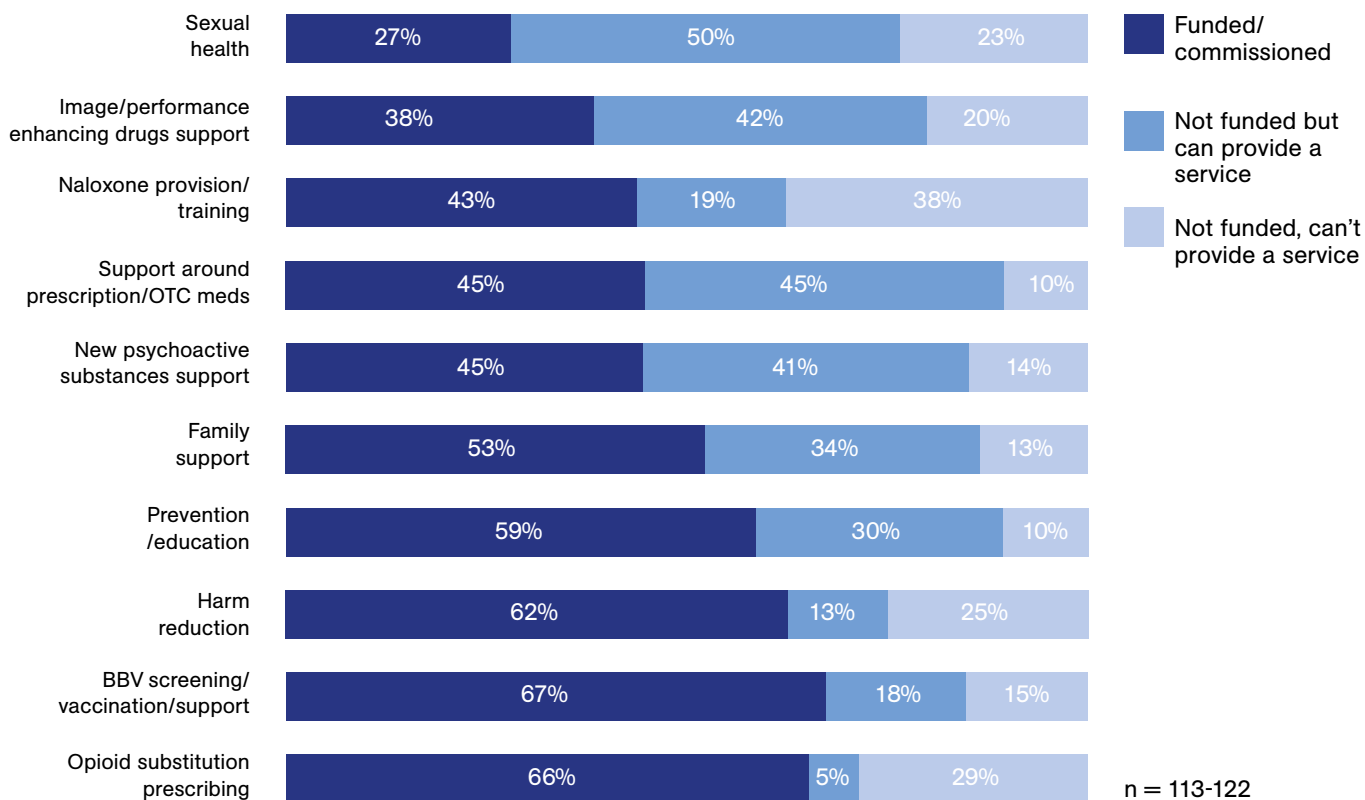
“We are expected to work with service users that require the service with the exception of people with no recourse to public funds.”

“Working with other services...people don’t always know about the rights of Eastern Europeans. Oftentimes they have a sort of blanket understanding... It’s a bit of a minefield, each individual case you have to look at the unique needs of this particular individual and then you have to look at where they’re from, what rights they have, have they got a right to be here, a right to work, and then present the case and argue the case.”

The delivery of services

Services funded or commissioned to provide...

Services funded or commissioned to provide:



“All services are provided but overstretched to the point where often need cannot genuinely be met, and triage becomes inevitable.”

It is worth noting that the survey was open from early September to mid-October 2015, with many respondents therefore participating before new legislation came into force on 1 October 2015 allowing drug services commissioned by a local authority or the NHS to supply naloxone without a prescription. A survey in one year's time would better show any impact of this change. The survey comments reveal that a number of services have plans to introduce take home naloxone programmes over the coming year:

“We are engaging with naloxone. Last year we had none! Since October it's so much easier, we have a target for each locality to hand out packs, everyone is talking about it, we want to improve the link in prisons, the prison drug service can provide the training but we're looking for health providers to prescribe on release. We are paying for it, we are being pragmatic, so it comes out of our

The delivery of services

Services funded or commissioned to provide...

prescribing budget. If we get to the point where I've exceeded certain moneys allocated then we'll have to talk to public health and the Clinical Commissioning Group (CCG)."

"The business case for provision of naloxone is now close to completion, and the new change in legislation makes it easier to supply."

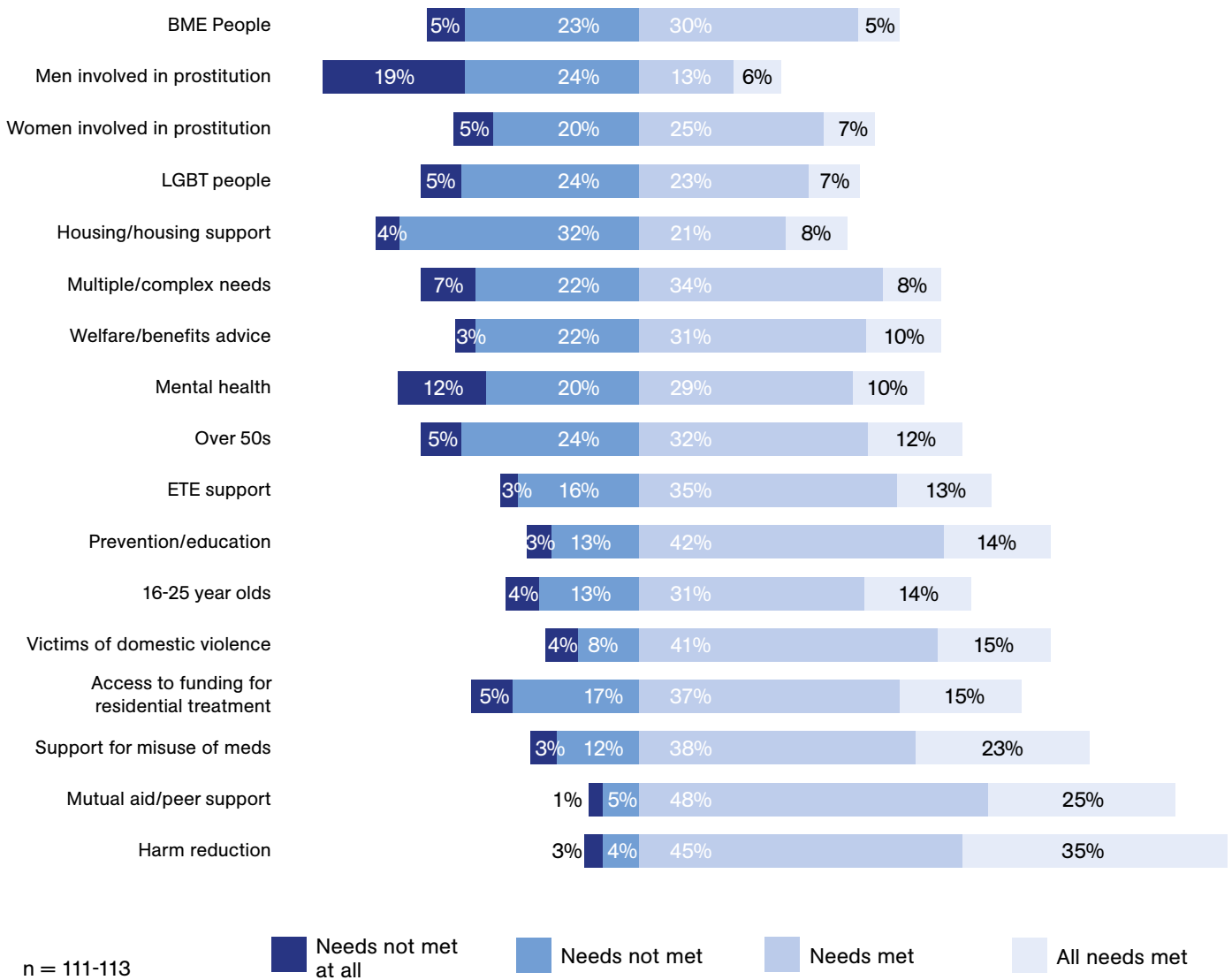
A number of respondents also noted that they work with and refer to other local agencies to provide services they are not able to provide:

"As the lead provider we work with anyone who accesses the service - this may involve referring onto specialist services."

“ Since the changes from 1st October we can distribute more easily. In practice that means that instead of what was happening before – a training session with an individual around the safe use of naloxone, then having to pass that information on to the nurse who then has to physically hand over naloxone, we can do it there and then, so we can get naloxone out in a much more timely fashion and on a much bigger scale.”

Maggie Telfer, Bristol Drugs Project

Other locally available provision



In general, respondents feel confident that a broad range of needs could be met through current locally available provision. Gaps in provision do stand out, including support for people with mental health problems, men involved in prostitution and housing issues. One person pointed out, crucially, that it is often not competence but capacity that decides whether these needs are met.

Partnership working and access to specialist services

Summary

- The questions in this section of the survey were split into two parts. The first part invited participants to indicate whether their clients had access to specialist services in allied sectors, and the second whether they felt access to, or partnership working with, that sector had changed. Participants were not required to answer both parts.
- Similar to last year's survey results, access to some form of mental health support is almost universal, be this in-house (30%), through joint working (39%) or onward referral (61%). However, while 9% feel that accessibility of mental health provision for their service users has improved over the last year, 20% reported a deterioration. Comments indicate lack of capacity and high admission thresholds are barriers, with reluctance of some mental health services to work with people still using substances remaining a real obstacle. This concern is a thread running through the three years of the State of the Sector project.
- Only 2% of respondents reported that their clients could not access physical health (including sexual health) services. Twice as many survey participants felt accessibility had improved (14%) than worsened (7%) over the last year.
- 65% of services responding to this year's survey work in partnership with Jobcentre Plus 65% and 47% have a partnership with Work Programme / Work Choice providers. Levels of engagement vary considerably, but for a number of respondents, failed attempts to engage with Jobcentre Plus and Work Programme providers are a cause of frustration. Education, Training and Employment (ETE) is widely available, although 9% respondents said that their clients do not have access to ETE services.
- Access to suitable accommodation continues to be problematic. While many services do report joint working with and referrals to housing services, three times as many feel that availability of housing/resettlement services has worsened (18%) over the last year has improved (6%). There are some examples of new partnerships and in-house initiatives to improve access to housing for clients of substance use services.
- Overall, there is a feeling that access to family support services continues to improve. Peer support and mutual aid are also widely available, with only 1% reporting that service users are unable to access peer support.

Working in Partnership

In addition to questions on joint working with specific sectors (see below), the survey asked how respondents feel partnership working in general could be improved. Increased communication and capacity were highlighted:

“Communication is key. An understanding of all services is vital, attendance at each other's team meetings, secure links within services. Training from each organisation to make others aware of what the specialist organisation provides.”

“Greater availability and more communication across services regarding service users. Joint working and shared care plans.”

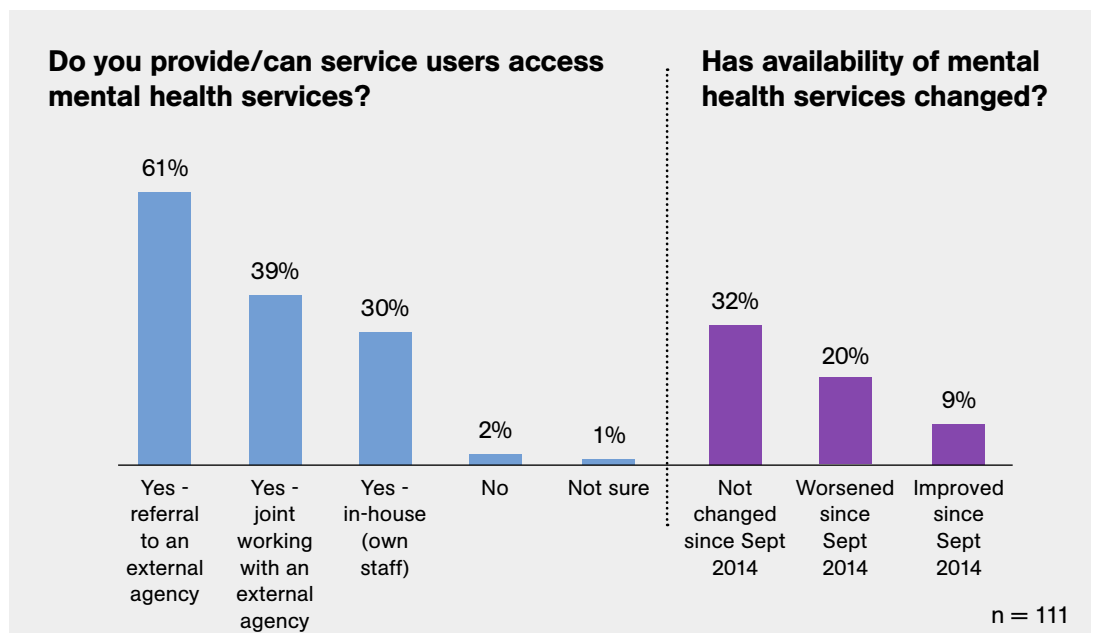
The delivery of services

Partnership working and access to specialist services

“The commissioning and funding environment has meant that services have little spare capacity for joint working. Although services are very willing to work together there is a lack of structure and management can only prioritise areas which directly impact on their performance management. As a consequence, the most vital suggestion is that commissioning ‘builds-in’ time for strategy, pathway and joint working development. It will be ironic if the search for efficiency and cost effectiveness actually destroys the integrated vision expressed in the [NHS] 5 Year Forward View!”

Mental Health

Both the survey data and telephone comments indicate that access to mental health provision for clients of drug and alcohol services remains a key concern. One in five (20%) respondents feel that access has worsened over the last year, compared to the 9% who believe it has improved.



“Availability of mental health services to our client group remains an area of concern even though we have been working in a sub-contract arrangement with the local NHS Trust. There still appears to be a barrier in engaging with substance misusing individuals.”

“Mental health services do not regularly see service users with an alcohol or drug problem, the majority of mental health support given is in-house, even though we are only commissioned to provide support to those with low intensity mental health problems.”

“Access is poor in the area although a local dual diagnosis working group has been established to help remove blockages for individual clients. Mental health services still however have a significant waiting time from assessment to allocation.”

“ Partnership working with mental health services remains a challenge. Bristol recommissioned its mental health services in 2014, so we’re about a year into what is a very different service. It involves about 10 sub-contracts, including small community organisations as well as larger ones. That has taken quite a lot of bedding in. And the issues that remain are the issues that were there before – resources, high thresholds for intervention, expectations of an individual’s situation in relation to their drug and alcohol use – so what is considered stable by a substance misuse service may not be considered sufficiently stable by a mental health service.”

Maggie Telfer,
Bristol Drugs Project

Several of the survey and telephone interview comments return to an issue prominent in both previous State of the Sector reports: barriers preventing drug or alcohol using clients from accessing mental health services. As in previous years, reasons cited for this include the perception that substance use issues should be addressed before mental health problems can be treated, capacity pressures within the mental health sector, and the failure of some service users to meet high clinical thresholds for access to mental health services. These issues have consistently been identified as problematic

The delivery of services

Partnership working and access to specialist services

by survey participants over the three years in which the survey has taken place.

One respondent highlighted the need for mental health services to respond to new patterns of drug use among LGBT service users:

“We feel mental health services will experience an increase in LGBT referrals as a result of the main chemsex drugs. There’s a noticeable increase in mental health impacts since these drugs have become more established, so some LGBT capacity building within these services would be useful.”

Despite these concerns, some feel more positive about access to mental health treatment, be that within their own service or via improved links to external mental health services:

“Within the service we have a complex needs team plus qualified mental health nurses who are care coordinators – but we also have pathways to mental health services. We have seen some improvement in how the pathways work. We are now doing some negotiations with the new wellbeing service.”
“Liaison and diversion schemes have improved access to mental health services.”

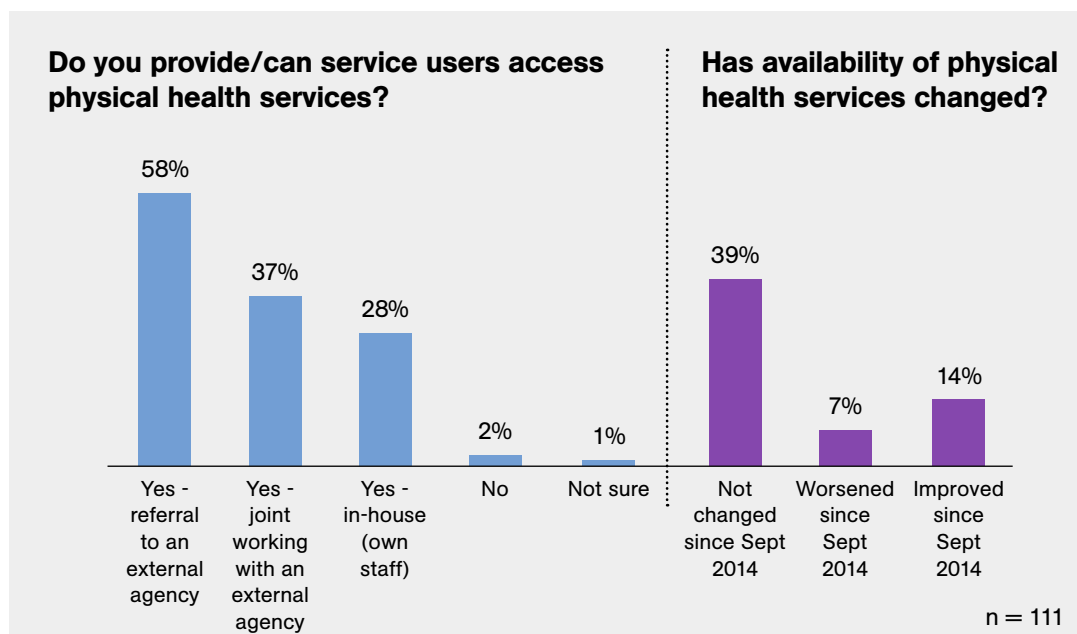
“We are able to offer CBT [Cognitive Behavioural Therapy] support which will then often improve the mental health and health and wellbeing of our residents. We also work closely with our dedicated in-house GPs who will make referrals to the local mental health service if they feel there is a need to do so.”

“ I think that partnership working with mental health has improved. Certainly for us, we are having more day-to-day contact with mental health services across the country. And there are other providers that are doing more of that, which is great in terms of being able to develop that learning. It’s still difficult though. I come across cases where it’s hard work to get that effective day-to-day shared responsibility for a client, particularly more complex clients. ”

Karen Biggs,
Phoenix Futures

Physical Health

The proportion reporting that access to physical health services (including sexual health services) had improved over the last year (14%) is twice as large as that indicating that things have got worse (7%), suggesting that there is some cause for optimism here despite variation between local areas.



Many of the comments focus on harm reduction and sexual health:

“General healthcare services have improved since we have begun to provide Health and Well-being clinics in-house. Provision of blood-borne virus (BBV) testing and vaccination has also been an area of focus which we continue to build and improve.”

“It’s actually more difficult accessing health services than it previously was; because we were part of the NHS before we

had a BBV clinic...it’s harder now to get BBV checks.”

“We’ve got a nurse who comes in regularly to see members of the community, and key workers will have discussions about BBVs during their initial key work sessions, so they can start encouraging residents to go and get screened... We have a number of people who have requested treatment. We have an in-house doctor who we would liaise with for anything like that.”

The delivery of services

Partnership working and access to specialist services

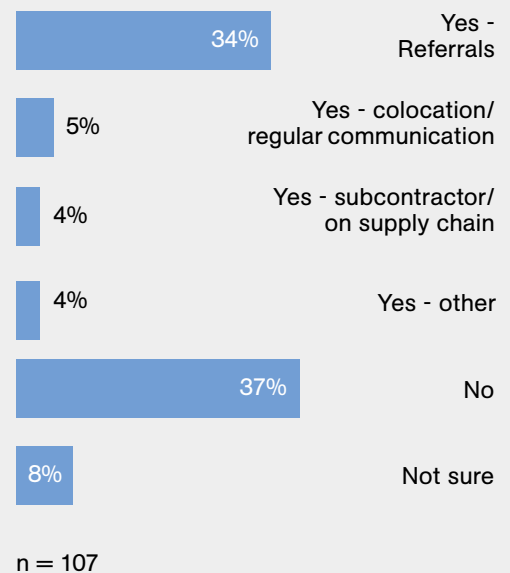
“ The take up rates of treatment and testing for BBVs are lower than they should be, so clearly there are barriers. Whether I think they are overcomeable? I do. I think the focus is making sure these services are simple to access for the service user, and ensuring that they understand why we want them to do it. We need to actually explain it better. I'm not sure we've been as good as we could've been on that, some services are very good and have very high levels of BBV vaccination and others less so. Part of that is down to culture, the service's culture, and some of that is managerially the organisation perhaps not pushing as hard as it should. ”

David Biddle,
CRI

Education, Training and Employment (ETE) services

The proportion reporting that access to physical health services (including sexual health services) had improved over the last year (14%) is twice as large as that indicating that things have got worse (7%), suggesting that there is some cause for optimism here despite variation between local areas.

Partnerships with Work Programme and Work Choice



Responses to this question closely mirror the results of last year's State of the Sector survey. Just under half of participants (47%) reported partnership working with Work Programme or Work Choice providers; most commonly engagement takes the form of referrals rather than colocation or substance use services being part of the supply chain.

The delivery of services

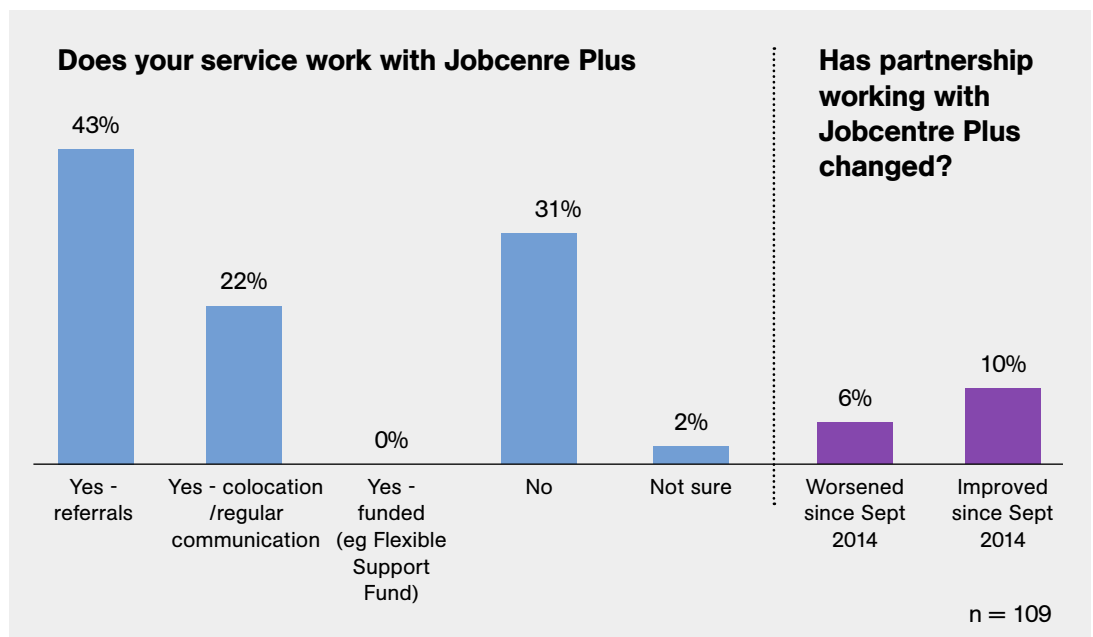
Partnership working and access to specialist services

Some services have been frustrated by failed attempts to engage with the Work Programme and Work Choice:

“Work Choice providers used to attend the service and meet with clients, but due to lack of staff they stopped coming in last year.”

“Doesn’t work well, very few referrals despite having an outreach drop-in in the job centre.”

“A poor working relationship despite numerous attempts to engage with them.”



Sixty five per cent of respondents to this year's survey reported any kind of partnership or relationship with Jobcentre Plus. A greater proportion feel that partnership working has improved (10%) than worsened (6%). The most commonly reported form of engagement is referrals (43%), with fewer services involved in colocation (23%) and none in receipt of funding from Jobcentre Plus.

Comments suggest that experiences of working with Jobcentre Plus have been mixed:

“We do liaise with Jobcentre Plus. However, depending on the management at the time they can be either very willing to work with us, or work with us on an ad hoc basis. Most of the time though, in fairness, they usually work proactively to protect our service users from being sanctioned whilst on ESA (Employment and Support Allowance).”

The delivery of services

Partnership working and access to specialist services

“Attempts to set up co-location have proved difficult - continuing to build relationships via satellite surgeries.”

“We set up a satellite within our local Jobcentre Plus, we have not seen any referrals as yet from Jobcentre Plus but we are hopeful that this will improve.”

In addition to the service provided by Jobcentre Plus, many providers give examples of ETE programmes run in partnership with local businesses, social enterprises, or voluntary sector organisations:

“We have a dedicated ETE worker who assists people in getting into college, work, runs groups and courses and liaises with external providers.”

“More input from local colleges, they seem to be falling over each other to register our clients for NVQs and apprenticeships.”

“We have an external partner based within our service who provides ETE two days a week.”

“We have a lot of partner relationships with local organisations because we do a lot of voluntary work in the community. We do lots of charity shops, local businesses, big businesses, small businesses, lots of different things.”

“ Everyone gets a job through our rehab - they complete in full time employment, so they're not on continued benefits - we break the cycle of addiction and welfare dependency, so that's the social return on investment. That's if people purchase the second part – the 12 week resettlement package. Clients complete our 26 weeks, then move on to the resettlement package for 12 weeks where they do a range of volunteering, then they get a job. They do what you and I do – they upskill their CVs, they get references from the eight weeks of voluntary work placements, then spend four weeks getting a job. They live on-site. We have semi-independent accommodation. Fortunately, in Oxfordshire, the retail trade has lots of jobs, so we encourage people to take them, initially, to get their feet in the door. That's usually within four-six weeks. ”

Wendy Dawson, Ley Community

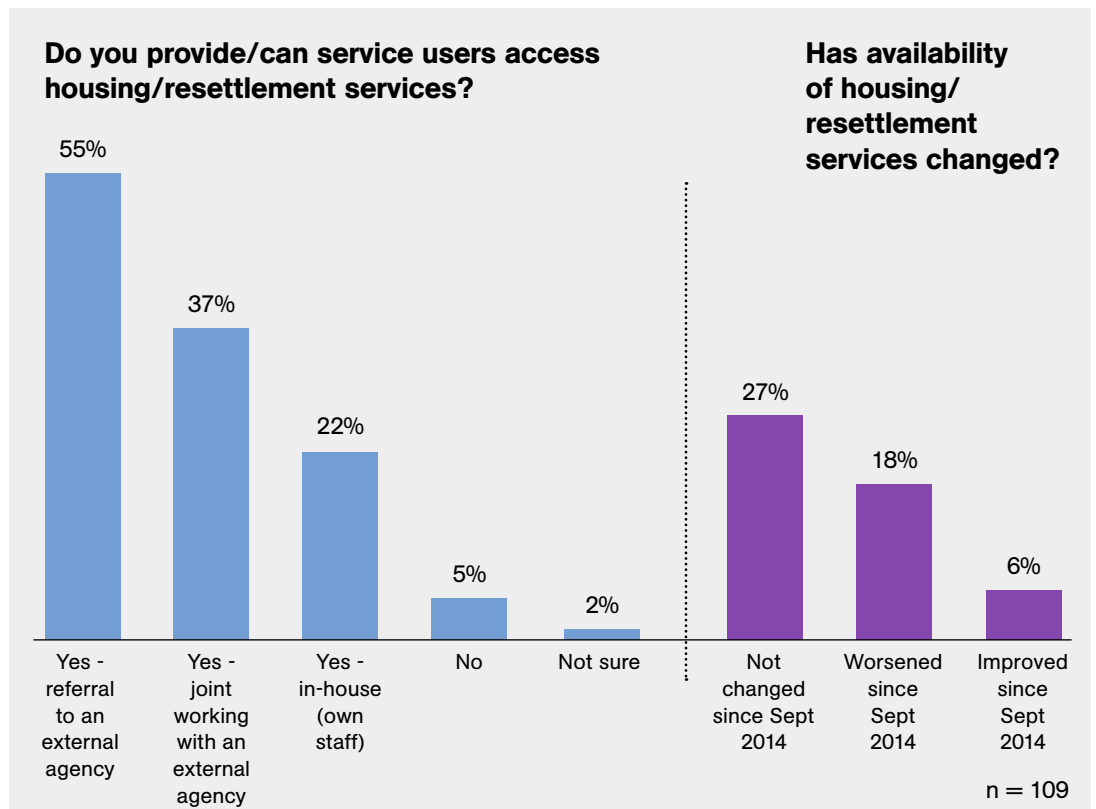
Some suggest that potential outcomes in this area are limited by lack of funding:

“Retendering resulted in the loss of one post so reduced capacity across service.”

“If our project received more funding we could employ someone to engage with employers. This would then create more job opportunities for our clients.”

22% of survey participants reported an improvement in the availability of ETE services over the last year, compared to only 5% who feel that availability has worsened.

Housing and housing support



Overall, availability of housing services is near universal, with only 5% reporting that their clients do not have access to these services. However, 18% feel that the availability of housing support and resettlement services has worsened, three times the number who indicated that it has improved (6%).

“ More people are recognising the need for recovery housing, the need for people, once they’ve moved through treatment, to be in a housing environment that’s supportive, and that includes peer support... If we put the same effort into understanding the appropriate housing for someone in recovery as well as what is the appropriate treatment programme then we’d be in a much better place - that’s what we’re trying to do. And I think from a national perspective there is an increased focus on that, a focus on housing, a focus on employability as a means to strengthen people’s recovery capital and ensure that completions remain successful. We are keen to push that agenda on and not just think about developing recovery housing that doesn’t cost very much, that’s not going to do the job.

Recovery housing requires a locally specific approach and we’re starting to look now at how we can compare it across the country and finding partners to be able to do that work with us, that’s why we called it ‘Building Recovery Friendly Communities’. We’re not saying that this pathway is going to work everywhere because housing associations have different appetites. In some areas you have fantastic housing associations that are so community minded. And you have good landlords – the Wirral has got some brilliant private landlords that work really well with us and understand what it is that we’re trying to do. It’s an entirely different situation in London – accessing the private rented market is incredibly difficult and expensive, but we have to think of a way to provide something for people on their recovery journey. In London we provide independent living, we are a landlord who understands the recovery journey and that can be incredibly important for some people. Many landlords wouldn’t take you if you told them you were in recovery, and to have to lie is really not helpful to someone’s recovery.”

Karen Biggs, Phoenix Futures

Comments suggest that there are concerns about the availability, suitability, cost and quality of housing for people accessing drug and alcohol services. Some respondents express particular concern about the cost and quality of accommodation in the private rented sector, with others noting the challenges brought about by cuts to the Supporting People/Housing Related Support programmes:

“It is harder to get to see a housing worker, most houses/flats are private lets and are expensive and often unsafe/shoddy.”

“Worsened with strict rules about drug use on premises with no system in place for people who are evicted for said use.”

“Our nominations have decreased over the past year: as yet our housing association has not given us a nomination for the year, we can access the rent deposit scheme, but again there is difficulty finding suitable properties within the local housing allowance for our clients.”

“Significant reduction in housing stock and available bed spaces locally - only one hostel available and has a continuous waiting list.”

“We work with various supported housing schemes across London, although this is becoming harder as funds have been cut from supporting people.”

“Appropriate housing for single males is non-existent.”

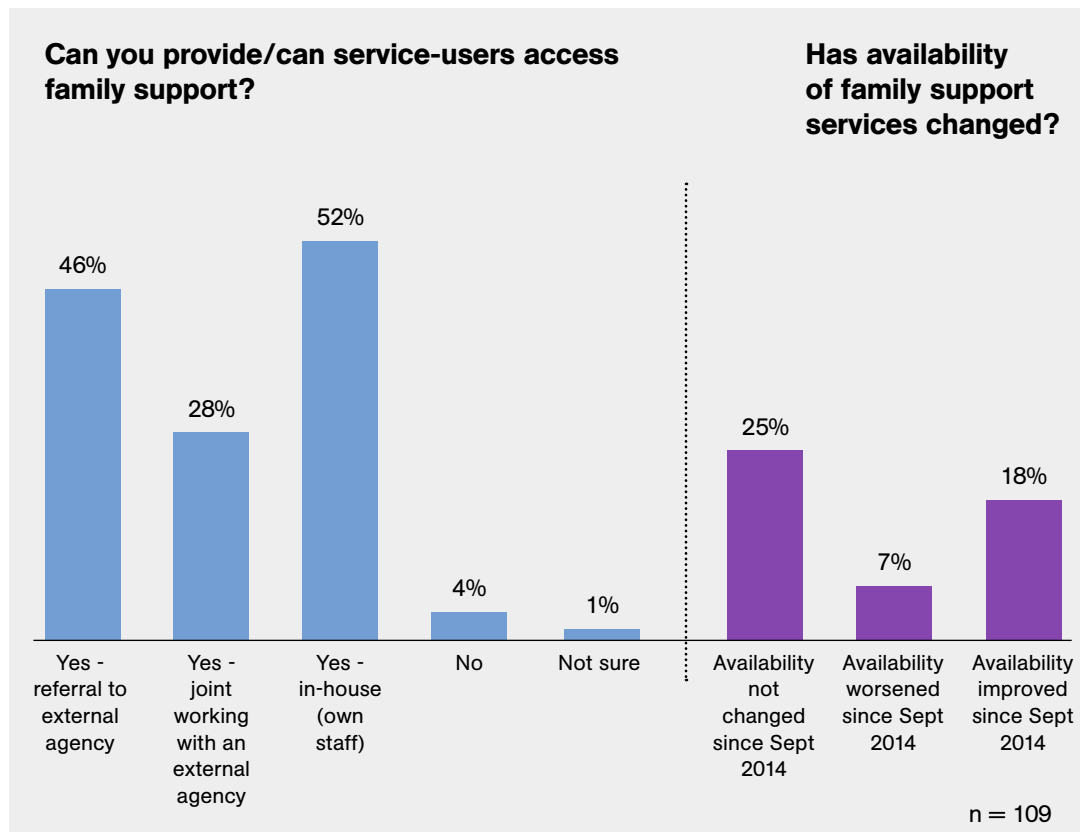
Despite these challenges, respondents emphasise efforts to engage with housing support services, from offering information and advice to building relationships with local housing providers:

“We are really lucky to have a great pathway into supported housing. From the outset the key workers will establish what the resident wants to do and often they will say ‘do you want to go into our supportive housing scheme?’, so the pathway is transparent then. There will still be opportunity to get some floating support, they’re not just going to be left on their own. If they do want to go back to their home town then that will be supported, or if they want to relocate to somewhere completely new a key worker will try and establish relationships with housing associations there. So it is very, very rare anyone ever finished treatment with nothing else.”

“We have links with housing charities, but access for re-settlement is stilted and difficult on occasion.”

“We have one member of our team whose expertise is housing. We have no funding to help people get private rented accommodation. But we can help and offer advice and information.”

Family support



Support for family members affected by a loved one's drug or alcohol use is widely available among services responding to the survey. More participants feel that access to family support had improved (18%) than deteriorated (7%).

A range of interventions and support are available for family members, made possible by several different funding streams:

“Family / Carer support group now facilitated in-house. M-PACT programme provided locally (funding for training by DAAT) as a multi-agency arrangement.”

“We provide services for children affected – support for other family members is via one of our partners. Our service is largely funded via a charitable trust.”

“Additional ‘troubled families’ resources now in place.”

“We offer family support groups throughout a resident’s six month stay with us.”

The delivery of services

Partnership working and access to specialist services

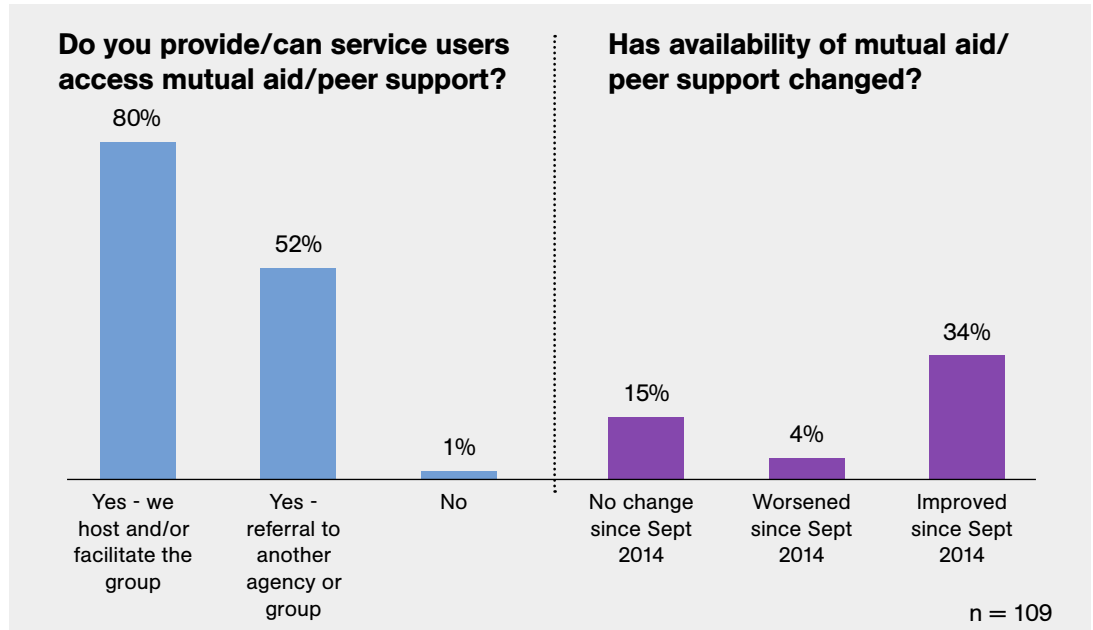
“Time limited funding has been granted to support the provision of a family worker for alcohol services in the city. Also all staff have received training to develop staffs knowledge and skills.”

“We’ve got an ‘affected others’ team which works with carers, linking to affected others organisations in mental health. We also have a family team that works with safeguarding issues, around social care, parenting, we link in where we can, we involve people who care for others in recovery plans and care plans.”

One service manager highlighted a gap in provision for people whose partners are involved with chemsex:

“We are experiencing an increase in demand for such support, mainly by telephone. We would like to see how we can improve this. The issues can be quite distinct and sensitive (e.g. same sex couples in an open relationship where one is engaged in chemsex and their use is impacting on the relationship). Partners tell us that they feel generic partner support services are not suitable places to discuss this.

Peer support and mutual aid



Responses to the survey suggest that peer support and mutual aid is widespread, with 34% reporting improved availability over the last year. Comments indicate a diversity of approaches are available:

“SMART Recovery, NA [Narcotics Anonymous], AA [Alcoholics Anonymous] groups all provided in our premises. Service user group also offers peer-led support. Peer mentors in-house.”

“Facilitate and hold groups within our service and also signpost to external groups. Speakers from peer led/mutual aid groups also speak and update staff and service users regularly at in-house training events.”

“We use the PHE Facilitated Access to Mutual Aid (FAMA) workbooks. We have SMART groups and co-located CA [Cocaine Anonymous] groups and we have our own recovery communities where service users can spend the day supported by accredited peer mentors”

A small number of participants noted the challenges associated with offering peer support in a rural setting:

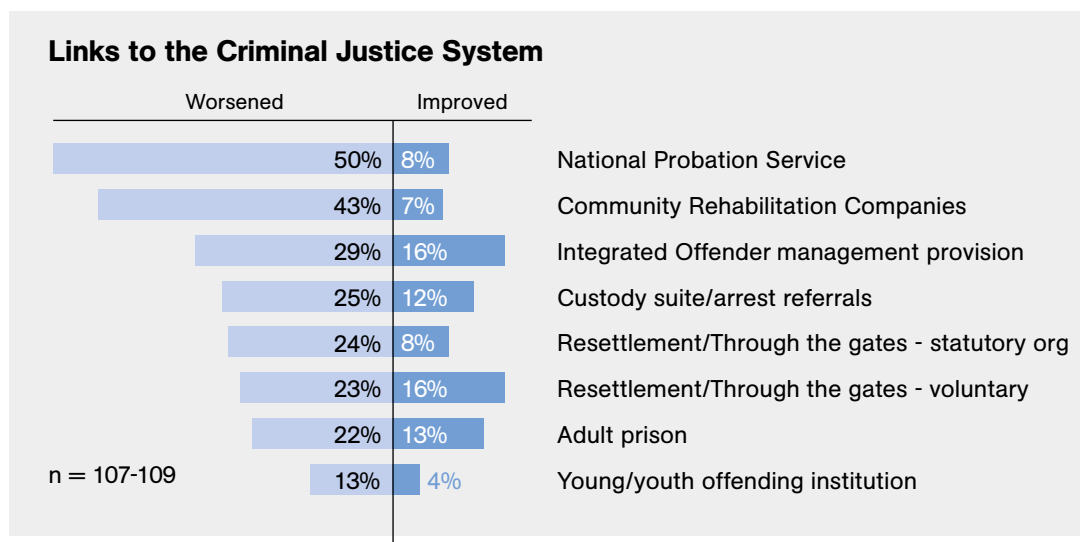
The delivery of services

Partnership working and access to specialist services

“We link in with community groups however there are limited resources in rural areas”.

“Linking people who live in rural areas up to peer support is time consuming! You’ve got people who live in small towns who don’t want to access community recovery in their town or village because everybody knows them. Transport wise we’ve got challenges, people can’t move around that easily, the larger towns have recovery communities or NA meetings etc, in other towns and small villages there’s nothing.

Criminal Justice



Respondents were asked to indicate whether or not they have experienced a change in links locally between their service and a series of criminal justice agencies, offender management, and prison services. The chart (above) displays that change.

For many respondents, links with criminal justice services have remained relatively stable. However, half of participants reported a deterioration in engagement with the National Probation Service, 43% feel that links with Community Rehabilitation Companies (CRCs) have weakened compared to relationships with their public sector predecessors. Around a quarter report that both custody suite/arrest referral work (25%) and work with statutory (25%) and voluntary (23%) resettlement / 'through the gates' organisations has reduced.

As noted last year, this is surprising given Transforming Rehabilitation’s increased emphasis on providing offenders with holistic support. Likewise, given that the new CRC providers were due to begin delivery in February 2015, increased engagement with CRCs would have been hoped for.

The delivery of services

Partnership working and access to specialist services

A picture of fragmentation is painted by the small numbers of people who did choose to comment:

“With the introduction of Liaison and Diversion services there has been an improvement. Changes in the probation/CRC service - concern about the risks increasing as there appears to be conflict and no joined up thinking.”

“Problems with getting information from courts/ probation in new arrangements and also problems with CRC expecting increased services while removing funding.”

“Negative impact since split between National Probation Service and CRC, reduced contact with IOM [Integrated Offender Management] staff, used to have good links, specialist staff and regular meetings. Staff numbers reduced, going through a period of voluntary and now compulsory redundancy.”

4. Current Issues

4. Current Issues

Recent developments and post-2013 structures

Recent developments and post-2013 structures

Summary

- Most services are confident or very confident that their staff have the skills, knowledge and support to engage with NPS, the wider availability of naloxone, image and performance enhancing drugs, and equalities issues.
- Overall, confidence in both Police and Crime Commissioners and Health and Wellbeing Boards has increased over the last year.

Confidence in engaging with current issues

Encouragingly, a sector with confidence in itself to deal with complex and emerging issues is apparent. Compared to last year's responses, more participants in this year's survey feel well equipped to engage with naloxone provision and training and equalities issues.

“No one has all the information on new psychoactive drugs.”

“We have contracted local equalities organisation to support training, engagement with targeted equalities communities e.g. South Asian communities in 2015.”

Confidence that own service has skills, knowledge and support to engage with...

Novel Psychoactive Substances

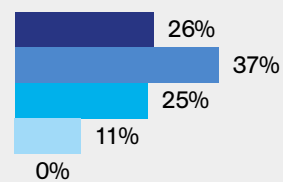
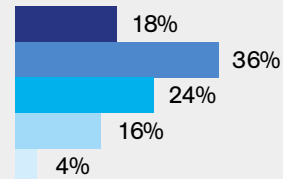
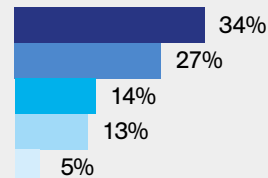


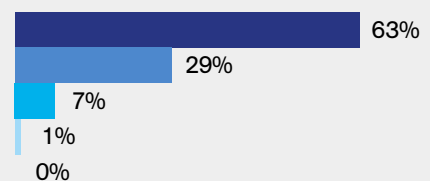
Image and Performance Enhancing Drugs



Wider availability of Naloxone post Oct 2015



Equality and diversity issues

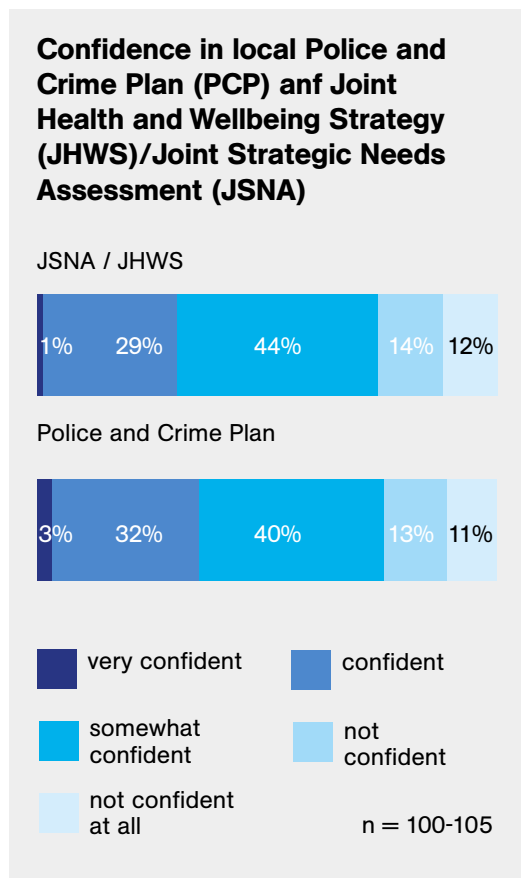


Post-2013 structures – Health and Wellbeing Boards and Police and Crime Commissioners

Following the April 2013 public health reforms, health and wellbeing boards (HWBs) now play a crucial role assessing need and setting local public health strategies, including local work around drugs and alcohol. Police and Crime Commissioners (PCCs) were also introduced in 2013. They are responsible for policing and community safety within individual police force areas, and are accountable to Police and Crime Panels. In London, the Mayor has overall responsibility for the Metropolitan Police while (appointed) Deputy Mayor for Police and Crime carries out the executive elements of the PCC role.

Overall confidence that Police and Crime Plans (PCPs), Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) meet local need has increased considerably compared to last year, perhaps given the additional time these structures have had to 'bed in'. Degrees of confidence do however remain mixed, and the comments provided reflect this:

“The JSNA did not directly address the needs of our service users; only referred to those experiencing mental health or dual diagnosis problems, which represent about 15-17% of our service users.”

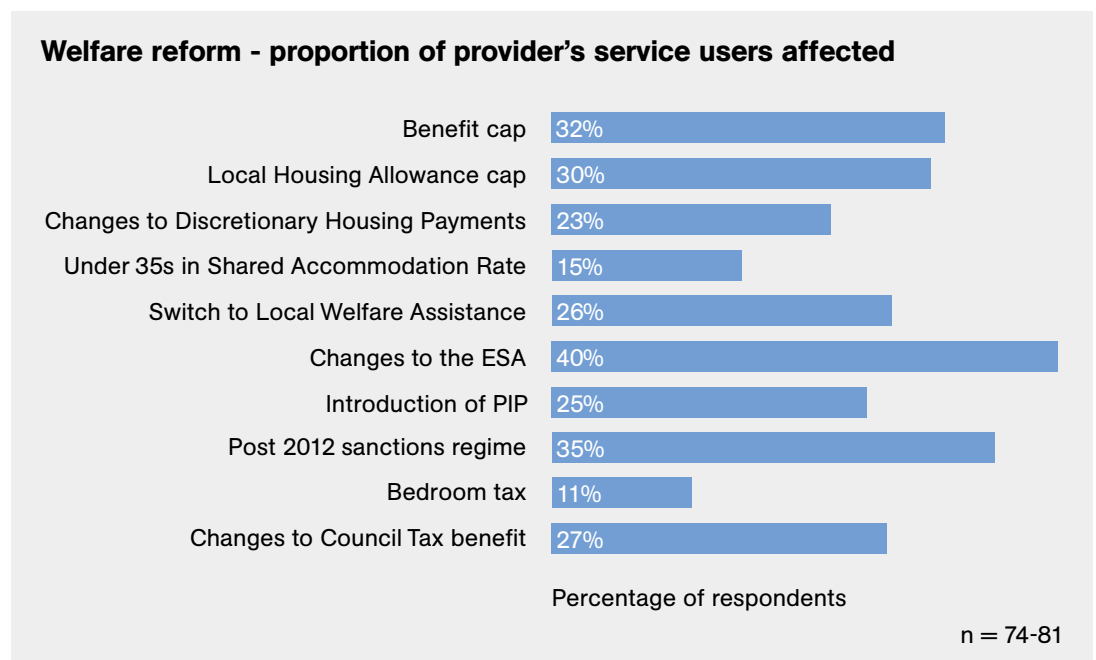


Impact of welfare reform

Summary

- Welfare reform is seen as having a negative impact overall, particularly changes to Employment and Support Allowance (ESA) and the sanctions regime. Some respondents however feel that certain reforms have had a positive impact.
- Several respondents emphasise that they do not collect data to measure the number of service users affected by welfare reforms and that their answers to these questions and the comments provided are therefore based on anecdotal evidence.

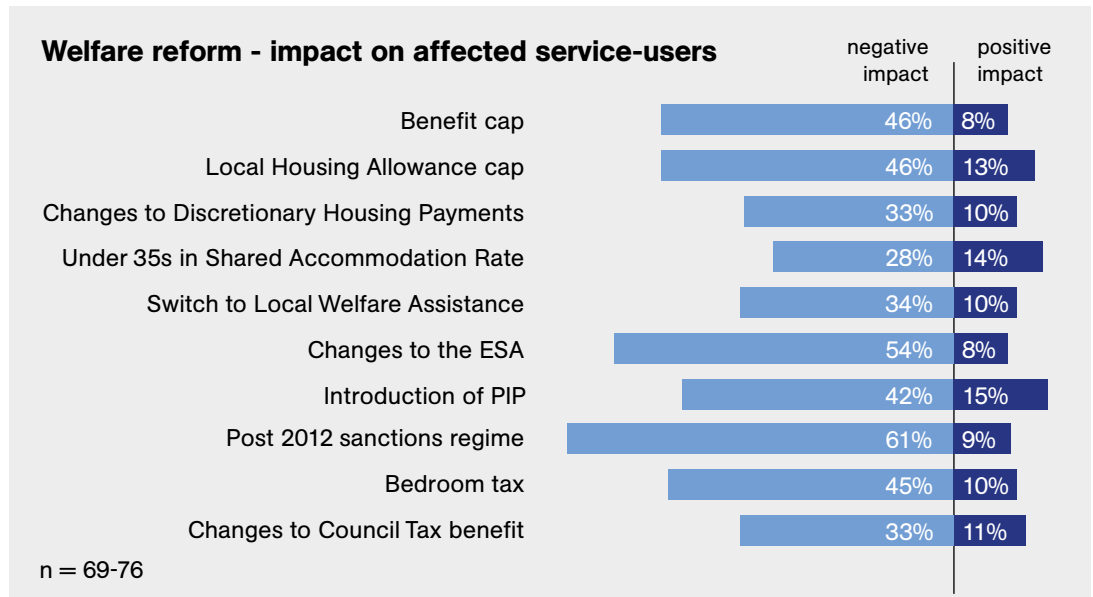
Respondents were asked to share the proportion of their clients affected by 10 areas of welfare reform, and whether each reform has had a positive or negative impact on their service users, or no notable impact.



Changes to the ESA, the sanctions regime and the benefit cap were seen as affecting the greatest proportion of respondents' service users and to have had the greatest negative impact.

While the net effect of all reforms listed is negative for each area of welfare reform, a smaller number of participants did state there has been a positive impact for service users, ranging from 8% for the benefit cap and changes to ESA, to 15% for the introduction of the Personal Independence Payment.

4. Current Issues
Impact on welfare reform



Some respondents made it clear that they collect no data on this topic, and that their submission was therefore based on anecdotal evidence only:

“We don’t really have enough data to be able to comment on this reliably, but we do feel that transgender clients in particular have been affected, which links to the generally much higher levels of discrimination experienced by this group, including around securing employment. There is also a general fear among clients on benefits that they will be pushed back into work before they are ready to do so safely.”

“Particular concerns regarding clients being sanctioned and the impact that has but sometimes even more so the issue of clients receiving high payments when sanctions are reversed. Several cases of clients who have used money for substances which has severely impacted upon their recovery.”

“ When people have had their benefits sanctioned that has also halted their housing benefit payments, and there was a recent central instruction to Local Authorities to stop doing that – as that’s something that’s been happening across the country and that gets people into arrears very rapidly – that’s a very real scenario for people. ”

Maggie Telfer, Bristol Drugs Project

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March 2016

