

Cross-Party Group on Drug and Alcohol Treatment and Harm Reduction



Chair: Lord David Ramsbotham
Secretary: Mike Wood MP

Vice Chairs: David Burrowes MP (Con); Paul Flynn MP (Lab); Paul Holmes MP (LD)

Parliamentary Digest (October 2008 - January 2009)

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Inaugural meeting

The Cross-Party Group on Drug and Alcohol Treatment and Harm Reduction held its inaugural meeting on Tuesday 28th October. The meeting was attended by twelve MPs and peers as well as representatives from the organisations that comprise the Conference Consortium.

The meeting explained the role of the new Group and the Conference Consortium. A full compliment of officers was elected:

- **Chair:** Lord David Ramsbotham (Crossbencher)
- **Vice Chairs:** David Burrowes MP (Conservative), Paul Flynn MP (Labour) and Paul Holmes (Liberal Democrat)
- **Secretary:** Mike Wood MP (Labour)

The meeting had a wide-ranging and lively discussion about drug and alcohol policy and about contemporary issues covering both policy and practice, and was a very useful beginning to our work. Parliamentarians were clearly impressed by the professionalism of the operation as well as the quality of the briefing material supplied and the opportunity to discuss the issues directly with those working in the field.

The next group meeting will be held on Tuesday 3rd February.

About the Conference Consortium

The Conference Consortium was established in 2005 by a group of non-governmental organisations, trade unions, professional associations and national bodies. This unique collaboration, a private company operating as a social enterprise, is dedicated to organising conferences and other events, promoting the adoption of the most appropriate, relevant and



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INTERNATIONAL HARM REDUCTION ASSOCIATION

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effective policies and practice, in response to the problems presented by drug and alcohol use.

To this end it provides a forum for the dissemination of information on research and good practice and fosters thinking and new ideas.

The Consortium is entirely owned by its members who are each shareholders in the company. Operating as a social enterprise no dividends are paid to any of the shareholders, with any and all profits made being reinvested in the business. One outcome from this is that it is able to offer free and subsidised delegate places at all of its events to those who use drugs and service users of drug and alcohol services.

The Consortium has recently organised events in collaboration with other organisations such as the Home Office, the Probation Boards' Association, the International Harm Reduction Association, and Drugscope.

The Conference Consortium, and the new Group in Parliament, is also supported by the Police Federation.

- **Conference, 25th June 2009**

On 25th June 2009, the Conference Consortium is hosting a conference, in conjunction with *Drink and Drugs News* (DDN), '**Drugs, Alcohol and Criminal Justice Interventions - how do we make a difference?**'. Both Group Chair Lord David Ramsbotham and Group vice chair David Burrowes MP have agreed to participate in a panel discussion in the afternoon session of the conference.

The Conference will focus attention on Criminal Justice interventions from arrest, arrest referral, assessment and pre-court work, health stabilisation, sentencing and the delivery of DRR through medium and high intensity (community and residential treatment) as well as working with prisoners through sentences, pre and post-release.

It will examine both 'what is working' and the 'pinch points' in the delivery of services within the context of often overlapping and sometimes contradictory strategies and frameworks created by different government bodies. The aim is for delegates to 'unpick' confusion and barriers where they exist, adopting a problem solving approach to identify ways to address them and improve their practice and delivery of services.

Objectives of the Group

To inform and influence parliamentarians and the public on all issues relevant to the provision of drug and alcohol services to offenders, the law and its application and consequences:



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- To promote best practice in the provision of drug and alcohol services, with the emphasis on quality rather than quantity;
- To promote strategies which would reduce dependency on drugs and alcohol and therefore crime and health budgets;
- To promote the influence of practitioners' views in the development of policy;
- To provide parliamentarians with briefings on all pertinent issues;
- To campaign to ensure that available resources for drug and alcohol resources meet need;
- The dissemination of information and research on good practice;
- To foster thinking and new ideas in the drug and alcohol fields.

Campaigning Issues

Detailed briefing papers were prepared on the issues below (Misuse of Drugs Act 1971 Section 9A, and Commissioning of Drug and Alcohol Services) and have been distributed to all members of the parliamentary group. Both issues will be discussed at subsequent group meetings; the next group meeting on 3rd February will focus upon the issue of Commissioning and we have already sent a letter on behalf of the group to the Home Secretary to request a meeting to discuss the revision or repeal of Section 9A of the Drugs Act.

- **Misuse of Drugs Act 1971 Section 9A**

Section 9A of the Misuse of Drugs Act 1971 was intended to prevent the commercial sale of kits and equipment for the preparation and consumption of illicit drugs. Not only is it failing to achieve this aim, but it is also having unintended consequences by preventing health services providing interventions that have the potential to reduce blood borne virus transmission.

Since 1986, there have only been a handful of prosecutions and convictions for Section 9A offences, with many vendors claiming that their goods are ornaments or for 'novelty use only'. A number of high-profile cases have failed to result in prosecution due to the difficulties in proving that the items were knowingly sold for 'illegal' purposes, and most forces have since abandoned enforcement.

Although provisions were made for the supply of syringes, no such allowances were made for other items that are essential to the preparation of a drug for injection – including widely available items such as matches, filters and foil. Subsequently, several amendments have been made to Section 9A to incorporate newly developed interventions, each involving a lengthy process of campaigning and legislative change. However, there are still a number of commonly available items that could provide significant public health benefits, but whose supply is technically prohibited.



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A number of products have been developed for needle exchanges – such as foil packs to discourage intravenous use – which have been shown to reduce harms, reduce injecting, improve client engagement (including the engagement of ‘naïve treatment users’). Because these items are not explicitly mentioned in Section 9A, many needle exchanges are unable to purchase or supply them, or technically face prosecution if they do. Although there has never been a conviction of a needle exchange or pharmacy worker under Section 9A, this threat of prosecution is a barrier to the supply of these products. Even in areas where the police have provided letters to indicate that the provision of such items is not a policing priority, local fundholders have refused permission for budgets to be spent on “illegal” products.

The Group will therefore be campaigning to change the law – either through the full repeal of Section 9A or to revise it to insert a general exemption for legitimate drug services to supply any items that have the potential to reduce drug-related harms.

The Group is now seeking a meeting with the Home Office to discuss options for revision of Section 9A. Group Secretary, Mike Wood MP, wrote to the Home Secretary in January 2009 asking for a meeting – and also sent a copy of the Health Secretary, given the implications for drug treatment policy.

- **Commissioning of Drug and Alcohol Treatment**

Accountability for the use of public funds is welcomed by the majority of treatment providers, as is the measurement of performance against targets as a means of being called to account. Performance monitoring helps to sustain investment in an important area of public policy and contributes to service improvement. Since the introduction of the internal health market in the early 1990s, targets have played an increasing part in service contracts, particularly for third sector organisations.

Historically, contract targets were negotiated between local purchasing agencies and providers, taking account of local needs and the local circumstances for delivery. Since the introduction of the National Treatment Agency (NTA) targets have been centrally set and they are now used to measure the performance of local Drug Action Teams (DAT’s) and providers. Recently, the NTA have matched a DAT’s performance data to unit cost data for its providers to support payment by results.

In order for targets to be effective they should be relevant and proportionate, reflecting service users needs and the type of care that is delivered as well as having a realistic expectation of inputs, outputs and outcomes.

Many providers believe that the current process for setting targets is contributing to a reduction in quality of provision and the flaws in the process rest on three things:

1) The rapid investment and equally rapid development of provision since 1999 has created an increase in volume but a paucity of quality, primarily because we still have a naïve



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workforce. Setting targets that apply to optimal conditions in circumstances that are sub optimal creates dangerously skewed expectations of performance and overloads the system.

The situation is made considerably worse because we have not invested in the evaluative research that would provide evidence not only that modalities in Models of Care work but would also give understanding, to commissioners and providers alike, of the factors that are critical to a modality being effectively applied.

There is a wealth of evidence on effectiveness for some treatment modalities, notably substitute prescribing and residential rehabilitation, and very little on others such as harm reduction and the low intensity talking therapies. Too little of the research addresses the quality factors in how modalities achieve the required outcomes. Much is made of the need for evidence based treatment, yet we are not investing in the research that will develop the evidence base for all the treatments on offer in the UK.

2) Commissioning has been poor for a very long time. It suffers from the same workforce weaknesses that affect providers but it has also been disrupted by continuous and badly managed reorganisation of the NHS and overburdened by a glut of policy initiatives. The NTA did little to address the workforce and process weaknesses in commissioning on its inception, relying on out of date and inadequate guidance from the Department of Health until midway through the last strategy before taking steps to tackle some of the problems. By the time the NTA acted, many of the performance problems had been built into the new development.

Commissioning by DATs has improved in recent years but not as a result of leadership from the centre; change has mostly occurred in areas where the DAT partners take an active interest in drug misuse and the DAT officers have a high level of expertise. Competitive tendering is increasingly used to iron out current poor performance or previously poor commissioning decisions but too often the tender process is inexpertly run. The use of competitive tendering to correct past mistakes and the frequency of tendering is creating a considerably unstable market.

Whilst increasingly many commissioners do follow EC Public Procurement guidelines the application of competitive tendering is hampered by their lack of knowledge about treatment. Guidance from the NTA relies upon process descriptions of modalities and the measurements of value rely too heavily on cost and output; as a consequence too many commissioners cannot properly evaluate tenders to purchase the outcomes and impact they look for.

3) Setting national targets centrally, in isolation from local delivery and without proper consultation with service users and providers has led to inappropriate targets, some of which are in conflict in certain circumstances. For example, where demand for care is high, such as in community prescribing, reducing waiting times and increasing retention can only be achieved with limitless investment to increase capacity.



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In loading unrealistic targets on DATs and linking their performance to Pooled Treatment Budget allocation, the NTA is putting greater pressure on those it considers to be slow or poor, without taking account of local conditions that may explain the slowness or paucity.

Payment by results has been introduced by stealth, on the back of unreliable data from the National Drug Treatment Monitoring System (NDTMS) and questionable data on unit costs.

Switching funds between DATs on this basis increases instability and exacerbates the impact of poorly set targets.

Setting payment tariffs for Problem Drug Users (£1440) and Non Problem Drug Users (£770), based on the premise that a problem drug user is a Class A heroin or cocaine (and crack) user, misunderstands problem drug use, which is not substance specific. The damage done by applying these tariffs may be serious and long lasting.

The solutions lay in significantly improving commissioning, taking steps to engineer a competent workforce and transparent and effective systems. Commissioning as a process entirely separate from purchasing, should engage service users and providers in working with commissioners to assess local need and respond by jointly designing the treatment system. It's only at the local level that the complexity of need and the circumstances that will affect provision can be understood and responded to both in terms of the nature of treatment, its volume and the expectations of what it will deliver.

Government has recognised with Local Area Agreements that it should have a light touch with the Local Strategic Partnerships, outlining only the areas of performance and not laying down detailed targets. The Drug Strategy needs the same arrangement but the barriers are the problems of commissioning, the lack of accountability in DATs and the failure by the NTA to address effectively the systemic weaknesses.

Parliamentary Interventions

- **Written Parliamentary Questions**

In relation to concerns about commissioning, the Group has tabled some questions about the role of the National Treatment Agency:

Paul Holmes: To ask the Secretary of State for Health (1) what the role and purpose is of the National Treatment Agency; (2) how many staff were employed at the National Treatment Agency (a) when it was first launched and (b) on the latest date for which figures are available; (3) what the budget was for the National Treatment Agency in (a) its first year of operation and (b) 2007-08.

Dawn Primarolo: The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001 to



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improve the availability, capacity and effectiveness of treatment for drug misuse in England. The NTA has achieved significant improvements in access to services and is now focusing on improving the quality of treatment in order to maximise the benefit to individuals, families and communities. The NTA also plays an important role in advice and guidance on the quality of and, since April 2008, monitoring access to alcohol treatment. In 2001-02, the NTA's first year of operation, it received a £2.1 million core grant in aid budget (from the Department) and employed an average number of 27¹ staff. In 2007-08, the NTA received a £11.59 million core grant in aid budget (from the Department) and employed an average of 173 staff." Note that although the NTA was established in April 2001, staff began to be appointed only from July 2001 onwards."

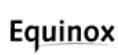
Paul Holmes: To ask the Secretary of State for Health what the total expenditure was by his Department on drug and alcohol treatment in 2007-08; and what percentage of the overall budget was spent on monitoring and management of the commissioning process.

Dawn Primarolo: The Department, in association with a small contribution from the Home Office and subsequently the Ministry of Justice, has provided specific resources to local partnerships for drug treatment since 2001. This has been through the pooled drug treatment budget (PTB), with £398 million of funding provided in 2007-08. At a local level, partnerships also make available funding for drug treatment from mainstream allocations in addition to the PTB. The cost of alcohol treatment is met through NHS mainstream expenditure in line with local needs and priorities and is not collected centrally. However, access to treatment is reported through a national alcohol treatment monitoring system. There is also an NHS vital signs indicator to reduce the rate of alcohol-related hospital admissions, which has been adopted by 99 primary care trusts in their operating plans for 2008-09 to 2010-11. Information on the percentage of the overall budget spent on monitoring and management of the commissioning process locally is not collected centrally. However, £11.457 million was allocated by the Department in 2008-09 to the National Treatment Agency for Substance Misuse (NTA) a special health authority with responsibility for improving the availability, capacity and effectiveness of treatment for drug misuse in England.

The Group has also asked questions about the Drug Change Programme pilots, and the implications for future commissioning strategy:

Paul Holmes: To ask the Secretary of State for Health what the purpose is of the Drug Change Programme pilots; and what assessment he has made of the implications of the pilots for levels of bureaucracy in the administration of drug and alcohol treatment.

Dawn Primarolo: The purpose of the Drug System Change Pilots programme is to test the potential to make improvements that can make a real difference in the way drug provision is delivered at a regional and local level. In the Drug Strategy, 'Drugs: protecting families and communities (2008)', the Government made a commitment to



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test out new approaches to delivering services, which ensures the drug treatment system and broader social support services work more closely together and become more focused on improved outcomes, including more personalised and innovative services. A copy of the strategy has already been placed in the Library. This pilot programme will give drug partnerships the opportunity to develop new approaches that allow them to reduce unnecessary bureaucracy and burdens. Funding will also be available to pilot areas to kick-start the pilots and help build capacity by funding the appointment of a project manager and administrative support.

Policing and Crime Bill

The Policing and Crime Bill was published in December 2008. Part 3 of the Bill is on 'Alcohol Misuse' – almost entirely focused on young people and alcohol. Schedule 4 of the Bill relates to licensing conditions relating to alcohol.

Although it is a law enforcement angle rather than treatment, the Group will be closely monitoring the provisions of the Bill – and providing briefings to parliamentarians where relevant. The Bill will have its second reading in the House of Commons on 19th January 2009.

Welfare Reform White Paper

In December 2008, the Government unveiled its new welfare reform white paper '*Raising expectations and increasing support: reforming welfare for the future*'. This formed the centrepiece of the legislation announced in the Queen's Speech and a Bill is expected around April 2009.

In the white paper, it is proposed that:

"We will also provide tailored support to help problem drug users to get off drugs and move into work. A new drug and employment programme will provide an integrated approach to drug treatment and employment support. This will give drug users the chance to turn their lives around. In return, we will expect drug users to take up this support, so that benefits are going to help people overcome their problems, not into the pockets of drug dealers."

[. . .]

"people who have declared they are, or who we think are, problem drug users, will be referred for an initial health assessment with a healthcare professional who will decide whether the individual has a heroin or cocaine problem, and will determine whether they should be referred to the new programme for problem drug users"

For full details see: <http://www.dwp.gov.uk/welfarereform/raisingexpectations/fullversion.pdf>



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