

# ROAD TO RECOVERY

Addiction in our society – the case for reform

August 2019



Road to Recovery  
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# About the Centre for Social Justice

Established in 2004, the Centre for Social Justice (CSJ) is an independent think tank that studies the root causes of Britain's social problems and addresses them by recommending practical, workable policy interventions. The CSJ's vision is to give people in the UK who are experiencing the worst disadvantage and injustice every possible opportunity to reach their full potential.

Since its inception, the CSJ has changed the landscape of our political discourse by putting social justice at the heart of British politics. This has led to a transformation in Government thinking and policy. The majority of the CSJ's work is organised around five 'pathways to poverty', first identified in our ground-breaking 2007 report, *Breakthrough Britain*. These are: family breakdown; educational failure; economic dependency and worklessness; addiction to drugs and alcohol; and severe personal debt.

In March 2013, the CSJ report *It Happens Here* shone a light on the horrific reality of human trafficking and modern slavery in the UK. As a direct result of this report, the Government passed the Modern Slavery Act 2015, one of the first pieces of legislation in the world to address slavery and trafficking in the 21st century.

The CSJ delivers empirical, practical, fully funded policy solutions to address the scale of the social justice problems facing the UK. Our research is informed by expert working groups comprising prominent academics, practitioners and policymakers. Furthermore, the CSJ Alliance is a unique group of charities, social enterprises and other grass-roots organisations that have a proven track record of reversing social breakdown across the UK.

The 13 years since the CSJ was founded has brought with it much success. But the social justice challenges facing Britain remain serious. Our response, therefore, must be equally serious. In 2019 and beyond, we will continue to advance the cause of social justice in this nation.



# Acknowledgements

With thanks to all the individuals and organisations that have advised and guided the conclusions and recommendations of this report. Please note that recommendations or statements of opinion made in this report should not be construed as perfectly representative of all named parties in all instances.

Experts in academia and service provision have provided invaluable perspective. Our pool of experts has included lived experience from people at many stages of recovery and their real-world insight has been invaluable. Some organisations and experts have provided a great deal of time and lent their considerable experience and knowledge. Some have challenged our thinking, many have shaped it. All have sought to contribute their time in the hope that they can improve the lives of some of our nation's most vulnerable.

Those charities, organisations and treatment providers that have provided their guidance are numerous but include Action on Addiction, Adfam, New Note, Road to Recovery Trust, The Forward Trust, Steps to Recovery, BAC O'Connor, Changing Lives, The Bridge Bradford, 1 North East and Trevi House.

**I am delighted to support the proposals. The proposed funding and commissioning model offers the right balance of central oversight and accountability to ensure a consistent approach and equitable access to high quality treatment. At the same time, it will incentivise local stakeholders to develop collaborative, joined up solutions based firmly on the principles of co-production.**

**Jon Royle, Chief Executive, Bridge, Bradford**

**We know that equitable access to good quality treatment saves lives. Simply put, the ongoing cuts to drug treatment funding is costing lives. People are dying. Those of us in the residential rehab sector are deeply concerned about what the future holds and we urge the government to invest in our sector. Personally, I am really pleased to see these clear recommendations as to how we can achieve better outcomes for those affected by addiction.**

**Hannah Shead, Chair of the Choices Rehab Consortium**

**At Steps2Recovery we believe that all those suffering from addiction have the right to long-term abstinent recovery. We believe our treatment model serves that purpose. The recommendations in this report are effective and efficient solutions to support the work that we do.**

**Chula Goonewardene MBACP, Steps2Recovery**

“

We are clear that no one should be left behind on the road to recovery. Effectively funded and commissioned services, targeted at helping people fully recover from dependence, is crucial to delivering this.

Home Office 2017

“

I slept on a bench and woke up shivering. I would sit and cry at night, I'd promise the world to get help.

Louis, Newcastle 2019

# Executive summary

**We are clear that no one should be left behind on the road to recovery. Effectively funded and commissioned services, targeted at helping people fully recover from dependence, is crucial to delivering this.**

Home Office 2017<sup>1</sup>

The government has recognised the fundamental principles which must surely be applied to any fair-minded approach to helping people from addiction into lasting recovery: ensuring equality of access; showing commitment through applying adequate resources in a fair and well-advised way; and staying the course until that person is helped out of dependence.

The above excerpt from the Home Office Drugs Strategy of 2017 incorporates both the moral and practical obligations of government in tackling addiction. At the core of it is the moral element – the understanding that no one should be left behind. It is an expression of a commitment to equality of access to care and a determination to lend support where it is needed. Those practical obligations relating to funding and commissioning make clear the need to actually deliver. Our current performance as a nation must be measured against this fair minded and responsible promise.

As is explicitly indicated in the wording of the Drugs Strategy,<sup>2</sup> its application relates to alcohol as well as drugs. Indeed, it is submitted in this report that these words must now be read in line with the government's stated obligation to those suffering from gambling, as the Minister for Sport and Civil Society, Mims Davies said in a speech<sup>3</sup> in April 2019:

Prevention is crucial, but we must also make sure those with gambling problems can get the right help. The whole of government is committed to this.

The extension of this moral duty of equality of access that underpins the government's duty to tackling substance addiction now clearly applies to those suffering from gambling addiction. There is then, no room here for any doubt about the nature and the extent to

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1 HM Government, '2017 Drugs Strategy', July 2017. pp28, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/628148/Drug\\_strategy\\_2017.PDF](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF)

2 Ibid. pp7: "While the focus of this Strategy is on drugs, we recognise the importance of joined-up action on alcohol and drugs, and many areas of the Strategy apply to both, particularly our resilience-based approach to preventing misuse and facilitating recovery. Alcohol treatment services should be commissioned to meet the ambitions set out in the Building Recovery chapter that are relevant to them, and in line with the relevant NICE Alcohol Clinical Guidelines 14,15. Commissioning of alcohol and drug treatment services should take place in an integrated way, while ensuring an appropriate focus on alcohol or drug specific interventions, locations, referral pathways and need. In addition, local authority public health teams should take an integrated approach to reducing a range of alcohol related harm, through a combination of universal population level interventions and interventions targeting at risk groups."

3 Mims Davies, 'Gambling Commission's New Strategy'. Speech at the launch of the Gambling Commission's new National Strategy to Reduce Gambling Harms, accessed via: [www.gov.uk/government/speeches/mims-davies-speech-gambling-commissions-new-strategy](http://www.gov.uk/government/speeches/mims-davies-speech-gambling-commissions-new-strategy)



which the government has committed itself. There is no question about the legitimacy of our citizens expectations when they present in need of treatment for an addiction. Only the issue of execution remains contentious. This paper examines the reality and asks whether those unequivocal undertakings already given by government are reflected in the real-world experiences of those seeking to recover from their addictions by asking:

- Are people being left behind?
- Are services effectively funded and commissioned?
- Does the country provide services targeted at helping people fully recover from dependence?

The overwhelmingly powerful body of evidence collated in the CSJ's investigation demands the conclusion that we are manifestly failing in respect of all three questions.

## People are being left behind

Often with tragic consequences to the individual, their families and their communities, even those pro-actively seeking help are far from guaranteed the opportunity to get it.

- More people die of drug misuse every year than all knife crime and road traffic incidents combined. In fact, about 1 in 3 drug deaths by overdose that occur in Europe, happen here, in the UK.<sup>4</sup>
- NHS estimates suggest that there were 338,000 admissions where the primary reason for admission to hospital was attributable to alcohol, an increase of 15 per cent from year ending 2007.<sup>5</sup> There are now 17 per cent fewer people in treatment than just 5 years ago – today only 1 in 5 people with alcohol dependence are in treatment.<sup>6</sup>
- Although there are now grounds to believe things have deteriorated further since 2011, an NSPCC report in that year found that approximately one in eight babies under 1 – the equivalent to almost 94,000 in the UK – live with a parent who is a problematic alcohol user. One in 15 babies under 1 – equivalent to over 50,000 in the UK – live with a parent who uses illicit drugs.<sup>7</sup>
- Just 2 per cent of the nearly 430,000 problem gamblers are in treatment.<sup>8</sup>

4 EMCDDA, 'European Drug Report 2019', 2019. pp79, access via: [www.emcdda.europa.eu/system/files/publications/11364/20191724\\_TDAT19001ENN\\_PDF.pdf](http://www.emcdda.europa.eu/system/files/publications/11364/20191724_TDAT19001ENN_PDF.pdf)

5 NHS Digital, 'Statistics on Alcohol, England 2019', Feb 2019, accessed online via: <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2019>

6 Public Health England, 'Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): April 2017 to March 2018', Nov 2018. pp6

7 Manning, V. NSPCC, 'Estimates of the number of infants (under the age of one year) living with substance misusing parents', 2011. pp4, accessed via: [www.nspcc.org.uk/globalassets/documents/research-reports/estimates-number-infants-living-with-substance-misusing-parents-report.pdf?\\_t\\_id=1B2M2Y8AsgTpgAmY7PhCfg%3d%3d&\\_t\\_q=estimates+of+the+number+of+infants&\\_t\\_tags=language%3aen%2csiteid%3a7f1b9313-bf5e-4415-abf6-aaf87298c667&\\_t\\_ip=80.209.162.34&\\_t\\_hit.id=Nspcc\\_Web\\_Models\\_Media\\_GenericMedia/\\_90e317b1-24e2-41c7-9f2c-3850650ff4f7&\\_t\\_hit.pos=1](http://www.nspcc.org.uk/globalassets/documents/research-reports/estimates-number-infants-living-with-substance-misusing-parents-report.pdf?_t_id=1B2M2Y8AsgTpgAmY7PhCfg%3d%3d&_t_q=estimates+of+the+number+of+infants&_t_tags=language%3aen%2csiteid%3a7f1b9313-bf5e-4415-abf6-aaf87298c667&_t_ip=80.209.162.34&_t_hit.id=Nspcc_Web_Models_Media_GenericMedia/_90e317b1-24e2-41c7-9f2c-3850650ff4f7&_t_hit.pos=1)

8 GambleAware, 'Annual Review 2017/18', Sept 2018. pp1, accessed via: <https://about.gambleaware.org/media/1836/gamble-aware-annual-review-2017-18.pdf>

- We are failing our young people. The number of youths in treatment for drug and alcohol dependency has dropped by 35 per cent since 2009 yet it is accepted that this cannot be explained by differing consumption levels.<sup>9</sup>
- A Citizens Advice Bureau report examining the wider effects of problem gambling found that over a third of families with children affected by gambling-related harm, couldn't afford essential costs such as food, rent and household bills as a result of a family member's gambling.<sup>10</sup>
- Our investigation into hidden addiction in the UK has found that some groups – such as BAME, those suffering mental health illness and vulnerable women – face often seemingly unassailable barriers to care, such as problems with language or cultural attitudes. Vulnerability can often present in mothers whose fear of losing their child obstructs the declaration of an addiction.

It is simply not possible for the reasonable person examining the UK's treatment system to arrive at the conclusion that 'no one is left behind'. Those that are left behind exist in their thousands.

## Services are not effectively funded and commissioned

Services have been choked by successive years of cuts which have already resulted in social harm that will now last for more than a generation. The CSJ has received 99 Freedom of Information (FOI) responses from across the United Kingdom which, together, reveal the extent and the nature of the cuts to the addiction treatment sector.

1. The cuts to addiction services have been utterly inconsistent from one region of the UK to another. Our FOI data reveals funding cuts in some regions of 50% while others made little if any reduction at all.
2. Since 2014 approximately 30 residential rehabilitation centres have been forced to sell assets to survive the cuts, severely reduce their capacity or in many cases simply close their doors.
3. Small local organisations, often with a history of providing hugely valued care, have taken the main brunt of these cuts and many now simply cease to exist.

Although the CSJ relies on its own primary research on this point, it is deeply concerning that despite the Governments explicit indication that services would be 'effectively funded', the cuts have been maintained and continued with the risks well publicised and accepted. Headlines regularly highlight the inadequacy of funding. Although there are a great many

<sup>9</sup> Public Health England, 'Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS): April 2017 to March 2018', Nov 2018, pp5, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/762446/YPStatisticsFromNDTMS2017to2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762446/YPStatisticsFromNDTMS2017to2018.pdf)

<sup>10</sup> Nash, E; MacAndrews, N; Edwards, S. Citizens Advice, 'Out Of Luck', 2018, pp10, accessed via: [www.citizensadvice.org.uk/Global/CitizensAdvice/Consumer%20publications/Out%20of%20Luck.pdf](http://www.citizensadvice.org.uk/Global/CitizensAdvice/Consumer%20publications/Out%20of%20Luck.pdf)

examples,<sup>11</sup> these have included headlines such as ‘UK facing ‘addiction crisis’ as councils cut funding for treatment while alcohol-related deaths soar’ (the Independent) and ‘People are dying and not getting the help they need’ (ITV News).

It is difficult to arrive at the conclusion that these cuts and their effect on our country is not known to government. If this is not active defiance of a stated obligation to leave no one behind then it is demonstrative of a significant disconnect between national strategy and local execution. To many this is accepted as the case. Indeed, even in the national press, one Councillor from Cumbria County Council was frank enough to state:

**I’ve never had a voter come up to me and say we should spend more money on drug treatment services.**

**Cumbria Council Deputy Leader, in interview with BBC, May 2018**

With budgetary pressures felt at the point of commissioning for local authorities, and the decisions made and political consequences felt locally, to a central government seeking to limit the size of the public health budget, this is a convenient dysfunction that leaves the vast majority of regions underfunded.

## The country does not offer services ‘targeted at helping people fully recover from dependence’

What is meant by ‘fully recover’? This is a subject that inspires some debate within the sector. The pursuit of a liberty from dependence on any given substance or behaviour transcends the specificity of those often chemical but also behavioural dependencies – recovery is a process and it involves a re-connection with society. The CSJ asserts that a person in recovery should:

1. be able to live as fully as their physical and mental state allows and be embedded in the wider community;
2. not be dependent on any substance or demonstrate behaviours consistent with dependence;
3. not engage in illicit use of any substance, possess illicit mind-altering substances or return to substances or behaviours to which they were addicted.

11 UK facing ‘addiction crisis’ as councils cut funding for treatment while alcohol-related deaths soar’ – The Independent, 11 February 2019, accessed via: [www.independent.co.uk/news/health/alcohol-deaths-council-funding-cuts-drug-addiction-services-austerity-jonathan-ashworth-a8772301.html](http://www.independent.co.uk/news/health/alcohol-deaths-council-funding-cuts-drug-addiction-services-austerity-jonathan-ashworth-a8772301.html), ‘England hospital admissions for addiction soar as treatment budgets fall’ – The Guardian, 11 February 2019, accessed via: [www.theguardian.com/politics/2019/feb/11/uk-hospital-admissions-for-addiction-soar-as-treatment-budgets-fall](http://www.theguardian.com/politics/2019/feb/11/uk-hospital-admissions-for-addiction-soar-as-treatment-budgets-fall), ‘Drug and alcohol services cut by £162m as deaths increase’ – BBC News, 11 May 2018, accessed via: [www.bbc.co.uk/news/uk-england-44039996](http://www.bbc.co.uk/news/uk-england-44039996), ‘Deaths Rise As Two-Thirds Of Local Authorities Cut Spending On Drug And Alcohol Rehab’ – Huffpost 4 September 2018, accessed via: [www.huffingtonpost.co.uk/entry/cuts-drug-and-alcohol-rehab\\_uk\\_5b7abc30e4b018b93e95e3ac](http://www.huffingtonpost.co.uk/entry/cuts-drug-and-alcohol-rehab_uk_5b7abc30e4b018b93e95e3ac), ‘People are dying and not getting the help they need’: Inside the alcohol and drug addiction clinic battling cuts’ – ITV News, 15 May 2019, accessed via: [www.itv.com/news/2019-05-15/people-are-dying-and-not-getting-the-help-they-need-inside-the-alcohol-and-drug-addiction-clinic-battling-cuts/](http://www.itv.com/news/2019-05-15/people-are-dying-and-not-getting-the-help-they-need-inside-the-alcohol-and-drug-addiction-clinic-battling-cuts/), ‘Residential addiction services in England cut by third amid drug overdose and funding crisis, figures show’ – ‘Considering that there is a crisis of drug related deaths in this country, these figures could not be more shocking’ The Independent, 13 July 2019, accessed via: [www.independent.co.uk/news/health/addiction-drug-alcohol-treatment-austerity-cuts-government-council-a8992696.html](http://www.independent.co.uk/news/health/addiction-drug-alcohol-treatment-austerity-cuts-government-council-a8992696.html)

The core of this definition is that recovery is underpinned by abstinence. Although the meaning of the term 'Recovery' has inspired debate, our position is clear, it is a term that refers to the attainment of a release from physical, psychological and emotional dependence on a substance or behaviour. Recovery involves the cessation of that dependence but also a re-connection with community. That may take the form of family life, for another it may be working, volunteering or simply joining a club.

While health may be at the heart of this issue, particularly in the early stages of recovery, the role of family and the importance of stable housing, securing employment or education and engagement with community are not a 'bolt on' to a recovery journey: they are instrumental in sustaining it. For this reason, no person battling addiction falls squarely and exclusively within the parameters of a single government department. The importance of helping families, encouraging and assisting people back to work, and stabilising housing and life skills is absolutely integral to establishing 'full recovery' and maintaining it. We believe that only by encouraging and supporting a person on their journey to abstinence can we hope to help a person secure a full and independent life.

### **Recovery happens in the community, not in the clinic.**

**Dr David Best, 2012**

The execution of this strategy needs the active contributions of multiple government departments, all taking on the challenge of addiction in our society together and at every layer of government.

### **Beyond the strategy and statistics is a human story**

Recovery is not the rare and unlikely end to an addiction. Examples of recovery are all around us. While the death rates and crime statistics wound our senses and make for dramatic and compelling news stories, the cumulative effect of this narrative serves to betray and conceal the thousands of inspiring and heart-warming stories that would encourage more aspiration in policy making. The CSJ has heard from people fighting their addictions with character and strength of conviction – sometimes a product of love for their child or wider family, sometimes because someone has shown that they believe in them and made them feel valued again.

### **It's not about the poison, it's about the person.**

Recovery is earned through an enormous test of character and emotional determination to rid one's self of often powerful addictions that have taken hold of mind and body. It is a fight to return to people you love and to a future that gives hope. Recovery is as inspirational as it is commonplace. Hard fought for by the individual but often the product of enormous amounts of support, encouragement and understanding. The CSJ has met sportsmen, ex-soldiers and always emotional parents who have emerged from addiction determined and committed citizens.

### Getting people into recovery makes sound economic sense

Estimates in this paper put the combined gross societal cost of alcohol and drug addiction in the UK, using Public Health England (PHE) figures and adjusting with Bank of England rates of inflation, at just under £38bn per year. That is the equivalent of about 2 per cent of the UK GDP – the same amount as the national deficit (net borrowing) recorded in March 2018, or the entire defence budget.

## This paper will call for reform of the treatment sector

### Reverse the damage done

There has been a dismantling of our capacity to treat those in need of treatment for their addiction. For example, it is estimated that there are now at least 60 new addiction psychiatrists required and the sector has seen residential rehabilitation reduce by as much as 1/3. The sector has been significantly de-skilled and the infra-structure has been compromised. Funding on-going research on prevention strategies and improving measurements of outcomes will be a necessary component of building an effective treatment sector. Funding should at least return to and then exceed 2012 spending.

### The creation of a single government agency and strategy to deal with addiction

We propose the creation of the 'Prevention and Recovery Agency' (PRA) and the formulation of the common Addiction Strategy.

- The PRA will enable Localism to succeed by directing appropriate and protected funding to each area and holding each LA to account for their delivery of the Addiction Strategy.
- The PRA will act as a means of sharing information and good practice, as well funding re-training and research into what works.
- The Agency will continue and accelerate the promising work of PHE and other government departments providing support for initiatives and means of working such as FDAC, Social Prescribing, Individual Placement and Support AD, Troubled Families and Housing First.

### Maintain adequate levels of funding

Further, it is simply not good enough to say we cannot afford to do this. The CSJ believes that this is a priority for spending from central taxation. However, to ensure that funds are raised we look to three other potential revenues for funding that may also help to deter addictive behaviours. We would recommend the government:

- impose a tax on alcohol that more proportionally mitigates the harm caused;
- use the gambling levy which is tied to regulation compliance in the preceding year; and
- revisit how we use the proceeds from crime from the Proceeds of Crime Act.

# Louis' story

**I was taken straight off my parents when I was born and taken into care.  
I never found out why.**

From five I was put into a children's home, whilst I was there I was abused, it was sexual abuse. I never told anyone. I was 6 when I left. I always isolated myself. I felt ashamed and I felt abandoned by my parents. No one ever explained why I wasn't with them. I used to rebel against the staff and bunk off. If I did go to school, I would day-dream, I would put a mask on, I was bullied quite a lot.

Addiction really started at 8. I used glue – just for a month. At 10 years old I started drinking Newcastle Brown Ale, it made me confident. I felt different, I felt like a better person. I just carried on drinking from 10. Teachers had no faith in me. I did enjoy a few of the lessons. Most the time I'd spend shoplifting pens and whatever the other kids had ordered and then buy alcohol with the money. I left school with no qualifications at 15. By 16, I was on a Youth Training System put on a placement and on a building site and worked with bricklayers. They were alright, but every Friday they would down tools and head into a workman's club from 12 midday. I'd have a brown paper bag with £25 in it and I didn't have any other obligations.

I joined the Army, the Green Howards, and was sent to Germany and we would go off base for a drink in the German towns. My drinking went up a level to spirits – Vodka and Jack Daniels. In 1987 I was sent to Londonderry. Being a 19–20 year-old I thought it would settle me down a bit. I just wasn't bothered. I was always with this lad. He was my best friend and we were always together on leave. One day, on patrol, he kicked something, and it blew up. He died. I went totally out of control and I was sent back to Cattericks psych ward. After 3 months, I was sent back to finish the tour.

I was asked if I wanted to leave the Army when we got back to England. I got a handshake and train ticket and I went home to Newcastle but there was no one there for me. I slept on a bench and woke up shivering. I have a little joke about it now – I used to talk to the ducks – they were my mates, that's how mad and bad it was on my own. I would sit and cry at night, I'd promise the world to get help.

In 2014 I was offered a rehab for ex-veterans and offered a bed from prison.

I ended up back in the park and I was crying my eyes out. I'd borrowed a gun to kill myself but I made a call first. I called Changing Lives in Virginia House because I knew someone who worked there and she'd want to help me. She stayed on the phone to me for hours in the middle of the night. She said 'please go to the station and we'll help as much as you want'. I was balling. When I got there, she was there. She met me at the station as she got off the train – early in the morning and she took me to Virginia House.

I went through detox and into recovery. It was really hard. Now 29 months later I've never been clean this long and I'm so proud. I started volunteering, Sally trained me up on the tills – how to give the right change and use the machine. I learnt that here by serving the students. I worked as a volunteer for about a year. I got a place to live with some advice and support and we also got my benefits sorted.

Last year, they said there was a job going and asked me to apply. I didn't think I was good enough but they kept asking me so I applied and I got it – I have my 15 hours a week but now I really want more. I've worked here ever since, making coffee. I would never give this up.

I have a little flat that's my own and I do my shopping in the evenings. I meet the guys here every day, one is from the Green Howards and we always have a laugh. I'm happy.

# Introduction

The UK has the resources, knowledge base and experience to deliver the enormous change in our approach to addiction. This paper is an examination of the treatment sector in the UK and the extent to which our country provides equality of access to care. The paper has avoided reference to the association between addiction and crime, this association is well documented and its omission here is not to be read as commentary on its relevance or importance to the wider issue. It must be acknowledged that many will approach treatment through the Criminal Law Courts or through diversion schemes. This well-advised effort by the state to use treatment as a part of many criminal justice disposals mitigates harm to society by addressing the driving forces behind offending. However, the Courts are rarely the first conceivable opportunity the state has had to meaningfully interact with a person who has fallen into addiction. This paper is an examination of the under-performance of current working practices and policy in reaching out to people and helping them into recovery in the community.

This paper will focus on the efforts made by the state to reach out to our communities and help people into recovery before they come into conflict with the state. This paper will refer to examples of good practice and areas of concerns across our union of nations. However, given the extent and scope of devolution and the varying approaches taken by each nation, the policy proposals focus on the English jurisdiction.

## What is recovery

Our definition of recovery focusses on the essential need to not only cease the addictive behavior but to re-connect with community. That term is a broad ranging one;

A person in recovery should:

- be able to live as fully as their physical and mental state allows and be embedded in the wider community;
- not be dependent on any substance or demonstrate behaviours consistent with dependence;
- not engage in illicit use of any substance, possess illicit mind-altering substances or return to substances or behaviours to which they were addicted.

The core of this definition is that recovery is underpinned by abstinence. This word has itself inspired debate, but its meaning is clear. This is the attainment of a release from dependence about helping someone back to a better life in which they are also connected with the wider community. That may take the form of family life, for another it may be working, volunteering or simply joining a club – the reconnection may take many forms.



Beyond this issue of connection with community, is the more contentious issue of continued physical dependency. Medications such as methadone or buprenorphine can sustain a dependency of sorts and yet these drugs are not inherently and necessarily detrimental to a person's well-being when appropriately prescribed. Importantly, they are often nothing short of an essential tool in a person's recovery journey. Moreover, one person's recovery will invariably differ, often very significantly, from another's and this can directly translate into significantly longer periods of dependency on substitute medication.

There must always be at least some exceptions, in extreme cases people who may, perhaps in old age, find themselves depleted of social or health capital are now unable to move past their reliance on medication. Others, that have achieved stability should be appropriately encouraged towards abstinence but must never be pressured. Some may only partially accept the position that it is incumbent upon the state to unashamedly encourage abstinence as the goal. Our position is that this is almost always appropriate. However, whichever view one takes it is almost universally accepted as truth that the pursuit of abstinence has a place in our national effort to support people struggling with addiction and, ultimately, it must be done better.

Where society must draw a line in the sand is at the point where apathy dictates the direction of travel. This is far from uncommon and the CSJ has heard of many cases involving people who felt abandoned and written off to scripts with absolutely no encouragement to meaningfully take on their addiction. This has often been so even in cases where those receiving opioid substitute treatment (OST) are using other substances on top of a script provided solely to underline the perils of addictive and illicit drug use. Without encouragement or support those capable of abstinence, and in the worst cases those who actively desire it, will sometimes not achieve it.

**I walked past this place every day for five years and I didn't even know it was here. I heard someone talking about it when I was picking up my methadone and went in on my way home. That was two years ago, and I've not used in 19 months. When I think about it, it makes me angry.**

**Client of Action on Addiction, Liverpool**

In our research we have been met by scores of men and women who feel frustration and pain at their treatment in a system that continues to see the mere fact that a person is on a script as progress in and of itself. When users of OST are consistently using on top, or are regularly prescribed methadone without sufficient effort being made to challenge, and – much more importantly – encourage a person towards recovery without dependence on medication, the system has failed that person.

However, this age-old debate rages while the face of addiction is changing. Many people feel that abstinence is not really a choice, it is the only realistic option to challenge their gambling or alcoholism. The recent rise in benzodiazepine addiction, cocaine addiction and gambling addiction are all threats that require an infrastructure for care. Worse still, the last 15 years have demonstrated that you cannot predict the next threat. Unless we have a system of care that is professional, stable and with sufficient capacity, we run the risk of exposure to destructive and long-lasting epidemics – as we are currently witnessing in North America.



part one

# The current state of addiction in the UK



# chapter one

# Addiction

The NHS defines addiction as ‘not having control over doing, taking or using something to the point where it could be harmful to you’.<sup>12</sup> There is some debate about whether addiction can be classified as a disorder of the mind in and of itself. Certainly, the World Health Organisation (referencing the ICD-11), the Association of American Psychiatry (DSV-V) and the Royal College of Psychiatry agree that addiction is a mental and behavioural disorder in itself.

This core concept of loss of control is an important one because it speaks to the commonalities in addiction and in some contexts this can make less relevant conversations about the precise substance or behaviour involved. The cocaine addict and the gambler all have in common this fundamental loss of control, indeed when we speak about those addicted to alcohol, drugs or gambling we may need to remind ourselves that they are often the same person. Whether an addiction is the cause or consequence of a person’s suffering, there is invariably a truth that transcends discussion about the substance or behavior to which a person is addicted – there is a person at the heart of this issue and their needs are at least as complex as those of this documents reader.

## The current challenges: substance addiction

The central points that will be established in this chapter are:

- The extent and nature of current drug use is such that there is serious cause for concern for our community’s health and our citizens social well-being.
- Although old threats remain – the nature of the problems we face, the types of drugs consumed and the pathways to drug use, have changed markedly within just the last two decades. They remain changeable and the UK is perpetually exposed to an unquantifiable but serious risk to health if we do not have a robust and adaptable treatment response.
- Emerging and re-emerging threats in the form of addictive drugs or behaviours are evidence of a continued and even enhanced need for a robust, flexible and reactive – as well as universally accessible – recovery sector, able to withstand threats to our community, current and future.

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12 NHS, ‘Addiction: what is it?’, accessed via: [www.nhs.uk/live-well/healthy-body/addiction-what-is-it/](http://www.nhs.uk/live-well/healthy-body/addiction-what-is-it/)

## Alcohol

### Size of the problem

Alcohol misuse is a major health hazard in the UK. Estimates suggest that there are now about 590,000 adults in the UK who are in need of alcohol treatment.<sup>13</sup> NHS statistics<sup>14</sup> have shown that alcohol misuse places a serious burden on the NHS, with an annual cost of £3.5bn.<sup>15</sup>

Drinking levels across the country have stabilised but the impact of alcohol abuse is getting worse, now the heaviest drinkers make up just 4 per cent of the population but this cohort consumes 30 per cent of all alcohol consumed in England.<sup>16</sup> According to ONS data<sup>17</sup> there were just under 7,700 alcohol specific deaths in the UK in 2017. PHE estimate that 200,000 children are growing up with an alcohol dependant parent or guardian.<sup>18</sup>

The All-Parliamentary Group (APPG) for the Children of Alcoholics commissioned a report that revealed that substance misuse was involved in 61 per cent of care applications in England. Despite this, in 2016 over half of councils had no strategy to help children effected by Parental Alcohol Misuse (PAM).<sup>19</sup> A recent report found that 1 in every 10 people admitted to hospital have alcohol dependency and 1 in every 5 use alcohol harmfully.<sup>20</sup>

The scale of the problem is only matched by the inequity of the distribution of harm. It is clear that it is those that suffer the greatest deprivation suffer the greatest harm.

Devolution has seen different approaches and levels of success across our four nations but even within a nation there is significant regional disparity in the severity of the problems faced.

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13 Public Health England, 'Alcohol dependence prevalence in England', Nov 2018, accessed via: [www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england](http://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england)

14 NHS Digital, 'Statistics on Alcohol, England 2019', Feb 2019, accessed via: <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2019> terminology and means of measurement explained by publication: The Statistics on Alcohol England, 2019 [PAS] document explains that there are two measures for alcohol related admissions, it states that: 'Estimates of the number of alcohol-related hospital admissions have been calculated by applying alcohol-attributable fractions (AAFs) to Hospital. An AAF is the proportion of a condition assessed to have been caused by alcohol. Two measures for alcohol-related hospital admissions have been used: Narrow measure – where the main reason for admission to hospital was attributable to alcohol. An alcohol-related disease, injury or condition was the primary reason for a hospital admission, or an alcohol-related external cause was recorded in a secondary diagnosis field. Broad measure – where the primary reason for hospital admission or a secondary diagnosis was linked to alcohol. The narrow measure estimates the number of hospital admissions which are primarily due to alcohol consumption and provides the best indication of trends in alcohol-related hospital admissions. The broad measure gives an indication of the full impact of alcohol on hospital admissions and the burden placed on the NHS. An AAF is the proportion of a condition assessed to have been caused by alcohol'.

15 NHS, accessed via: [www.england.nhs.uk/2019/01/nhs-long-term-plan-will-help-problem-drinkers-and-smokers/](http://www.england.nhs.uk/2019/01/nhs-long-term-plan-will-help-problem-drinkers-and-smokers/)

16 Public Health England, 'The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: an evidence review', 2016. pp25, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/733108/alcohol\\_public\\_health\\_burden\\_evidence\\_review\\_update\\_2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733108/alcohol_public_health_burden_evidence_review_update_2018.pdf)

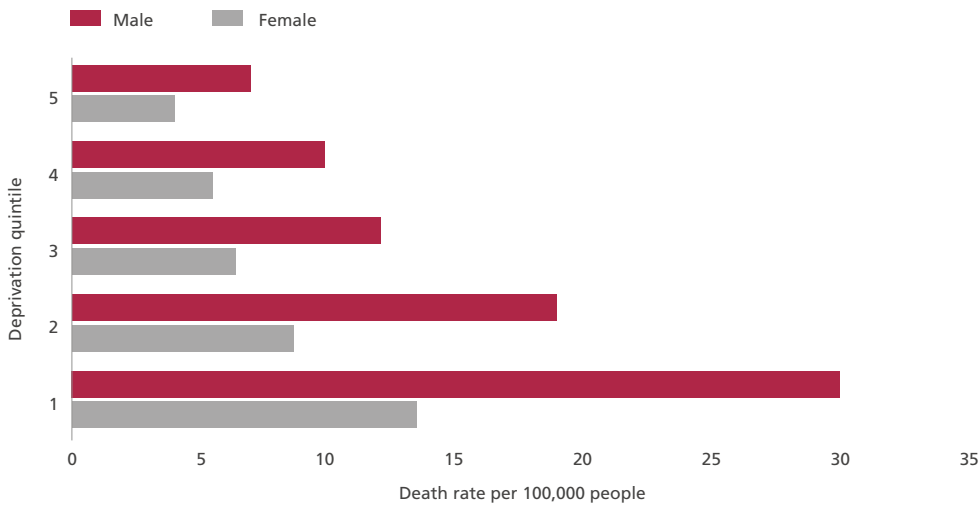
17 ONS, 'Alcohol-specific deaths in the UK: registered in 2017', Dec 2018, accessed via: [www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2017](http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2017)

18 Public Health England estimates, based on 120,000 parents who have alcohol problems, with 200,000 children between them.

19 The original report was commissioned by the all-party parliamentary group (APPG) for children of alcoholics, accessed via: <http://researchbriefings.files.parliament.uk/documents/POST-PN-0570/POST-PN-0570.pdf>

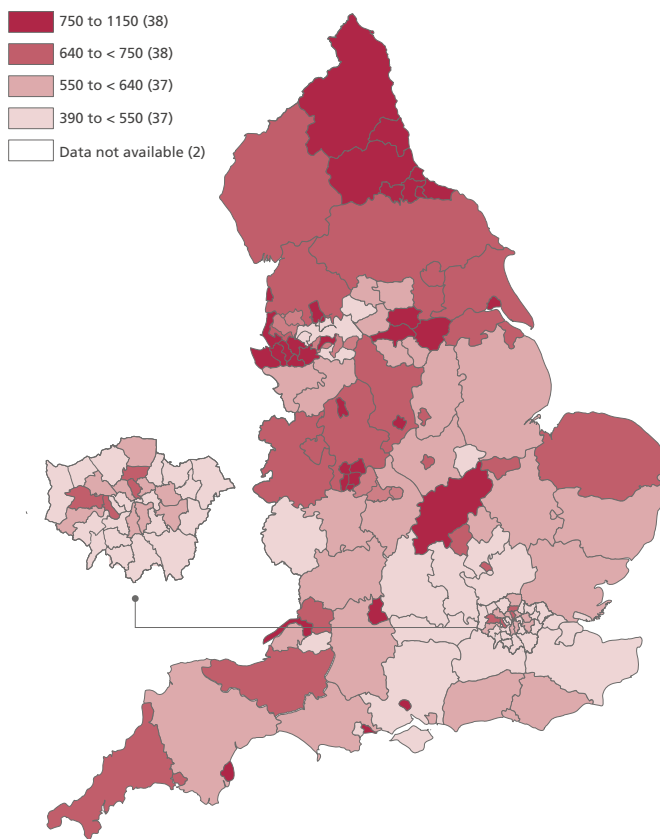
20 The Prevalence of wholly attributable alcohol conditions in the United Kingdom hospital system: a systematic review, meta-analysis and meta regression, Emmert Roberts et al., accessed via: <https://onlinelibrary.wiley.com/doi/10.1111/add.14642>

Figure 1: Alcohol-specific age-standardised rates of death per 100,000 population by deprivation quintile, deaths registered in England 2017



Data taken from ONS<sup>21</sup>

Figure 2: Alcohol related hospital admissions per 100,000 population in England



Map replicated from NHS Digital<sup>22</sup>

21 Index of Multiple Deprivation (IMD) is the official measure of relative deprivation for small areas in England. It is designed to identify those small areas where there are the highest concentrations of several different types of deprivation. IMD Quintile range from 1 to 5, with 1 being the most deprived and 5 being the least deprived. The IMD classification works by grouping together Lower Super Output Areas (LSOAs) based on their level of deprivation. LSOA's based on the 2011 census boundaries, based on postcode boundaries as of August 2018, accessed via: [www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/alcohol-specificdeaths-in-the-united-kingdoms-supplementary-datasets/current/alcohol-specificdeaths-in-the-uk-supplementary-datasets.xls](http://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/alcohol-specificdeaths-in-the-united-kingdoms-supplementary-datasets/current/alcohol-specificdeaths-in-the-uk-supplementary-datasets.xls)

22 <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2019/part-1>

## Treatment

Only 1 in 5 people in England with alcohol dependence are in treatment.<sup>23</sup>

### Has the problem changed over time?

NHS estimates suggest that there were 338,000 admissions where the primary reason for admission to hospital was attributable to alcohol. This is an increase of 15 per cent from year ending 2007.<sup>24</sup> Referring to plans to increase spending on alcohol treatment in hospitals, although expressing that even these efforts were currently inadequate, Professor Drummond explained:

While it's great that the government is to invest more in alcohol care teams in acute hospitals, which is really needed, there is not much point in having a Rolls-Royce hospital-based service when you have a Reliant Robin with a flat tyre waiting in the community to pick you up.<sup>25</sup>

The NHS will always be an absolutely integral part of any sensible treatment of people in addiction but recovery in the community requires continued investment and an understanding that there needs to be more focus on, as Keith Humphreys put it in an interview:<sup>26</sup>

**The need to shift from a focus on treatment intensity to a focus on treatment extensity.**

**Keith Humphreys, Professor, Psychiatry and Behavioral Science, Stanford University**

## Drugs

There is a direct correlation between a person's level of deprivation and the harm caused by alcohol but this is also the case with drug poisonings. The ONS released data to show this correlation using the Index of Multiple Deprivation (IMD) an official measure of relative deprivation for small areas in England and contrasting with rates of death.

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23 Public Health England, 'Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): April 2017 to March 2018', Nov 2018. pp6.

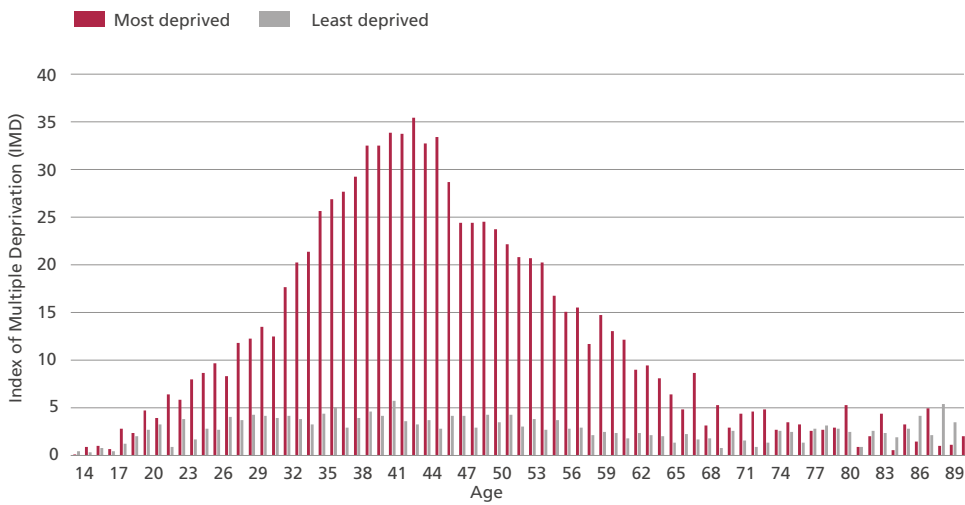
24 NHS Digital, 'Statistics on Alcohol, England 2019', Feb 2019, accessed via: <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2019>

25 Professor Colin Drummond, as reported by BBC News, 'England failing to tackle alcohol 'epidemic', say researchers', 30 July 2019, accessed via: <https://www.bbc.co.uk/news/education-49126495>

26 Circles of Recovery: An interview with Keith Humphries PhD Recovery Research



Figure 3: Drug poisonings by IMD quintile and single year of age, England, registered between 2013 and 2017



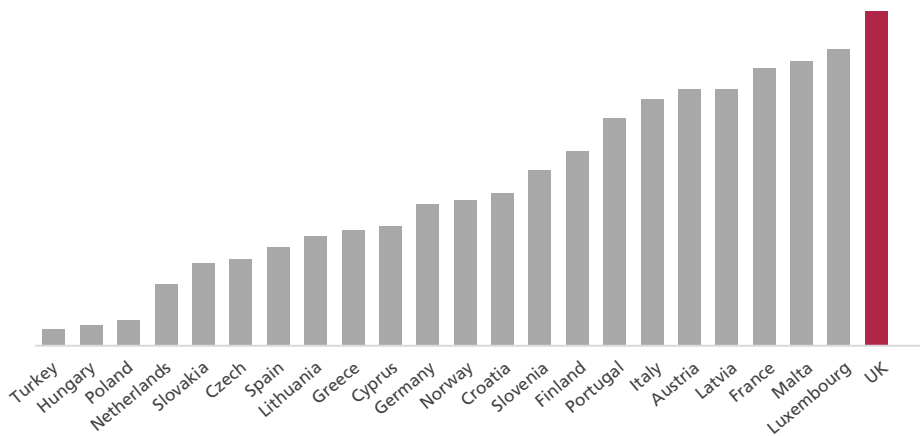
Taken from ONS data<sup>27</sup>

## Heroin

### Size of the problem

According to ONS data over half of all drug poisoning deaths in each year have involved an opiate, 51% in 2018 figures.

Figure 4: Opioids – high risk use estimate



Replicated from EMCDD graph<sup>28</sup>

27 ONS data released August 2019, accessed via: [www.ons.gov.uk/generator?uri=/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/middleagedgenerationmostlikelytodiebysuicideanddrugpoisoning/2019-08-13/b409bf05&format=xls](http://www.ons.gov.uk/generator?uri=/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/middleagedgenerationmostlikelytodiebysuicideanddrugpoisoning/2019-08-13/b409bf05&format=xls)  
 28 Using data from the EMCDDA 'European Drug Report', accessed via: [www.emcdda.europa.eu/system/files/publications/4541/TDAT17001ENN.pdf](http://www.emcdda.europa.eu/system/files/publications/4541/TDAT17001ENN.pdf)

## **In Treatment**

There are currently an estimated 341,000 high risk heroin users with 149,000 recorded as being in treatment.<sup>29</sup> In this context that means engaging with services.

## **Has the problem changed over time?**

Aside from the fact that there are now 17 per cent fewer people in treatment for heroin use than in 2009/10 – there have been further developments. New opioid threats have emerged with the advent of Fentanyl and Carfentanil. Additionally, the rise of prescription drug addiction has notably changed the pathways into addiction. These are examined below separately.

## **Opioids – fentanyl and carfentanil**

The ONS figures released in 2018 stated that that despite the death rates from most opiates stabilising, deaths related to the use of fentanyl have risen by 29 per cent in the single year ending 2017.<sup>30</sup> Carfentanil accounted for 87 per cent of the 31 deaths related to fentanyl analogues in 2017.<sup>31</sup> The new ONS figures reveal that 2018<sup>32</sup> saw similar figures but no marked increase. This developing threat in the UK is already firmly entrenched and posing significant issues to communities in the US. A recent drug bust in a residential flat in the US found 54kg of fentanyl, enough to kill the entire population of London, Berlin and Paris.<sup>33</sup>

## **Opioids – prescription drugs**

1 in 11 patients in England was prescribed a potentially addictive drug last year, many of which were opioids. Dave Baker an 'extended scope' physiotherapist has stated:

People don't always recognise the signs of addiction or realise they are potentially becoming addicted.

Sometimes it's not until they discuss medicine usage, or someone suggests the possibility of reducing their dose, that they show reluctance to do so and start to become aware that they have developed dependency issues.<sup>34</sup>

One recent study<sup>35</sup> which looked at the 703 chronic pain patients found that of these patients, each complaining of musculoskeletal pain, 413 (59 per cent) were prescribed opioids. Of the 3,319 opioid prescriptions issued 1,768 (58 per cent) were found to be strong opioids, including tramadol, buprenorphine, oxycodone, as well as fentanyl and tapentadol. The study concluded that:

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29 EMCDDA, 'United Kingdom Country Drug Report 2019', 2019. pp1, accessed via: [www.emcdda.europa.eu/countries/drug-reports/2019/united-kingdom\\_en](http://www.emcdda.europa.eu/countries/drug-reports/2019/united-kingdom_en)

30 ONS, 'Deaths related to drug poisoning in England and Wales: 2017 registrations', August 2018. pp11

31 Ibid

32 Deaths related to drug poisoning in England and Wales: 2018 registrations, accessed via: [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations)

33 BBC News, 'Record US fentanyl bust 'enough to kill 26 million people'', 25 May 2018, accessed via: [www.bbc.co.uk/news/world-us-canada-44244688](http://www.bbc.co.uk/news/world-us-canada-44244688)

34 Dave Baker quoted by Robert Millett, 'Drug Dependency: a hidden addiction', May 2018, accessed via: [www.csp.org.uk/frontline/article/drug-dependency-hidden-addiction](http://www.csp.org.uk/frontline/article/drug-dependency-hidden-addiction)

35 BMJ Open, 'Opioid prescribing for chronic musculoskeletal pain in UK primary care: results from a cohort analysis of the COPERS trial', June 2018, accessed via: <https://bmjopen.bmj.com/content/8/6/e019491>

Long-term prescribing of opioids for chronic musculoskeletal pain is common in primary care. For over a quarter of patients receiving strong opioids, these drugs may have been overprescribed according to national guidelines.

However, this study may just reveal a small part of what's happening on the national scale. In 2008 there were around 14 million prescriptions for opioids but by 2018 that had risen to 23 million.<sup>36</sup>

The ONS 'deep dive' into drug related deaths reported that:

Over one-quarter of individuals (29 per cent) were recorded as having suffered from a chronic pain condition either recently or in the past. In 26 of these cases, the chronic pain condition was current at the time of death. Many of the individuals had been in receipt of a long-term, repeat prescription of opioid analgesics with abuse potential such as tramadol and oxycodone.<sup>37</sup>

There also appears to be some regional disparity in the prescription of opiates with significantly higher number of defined daily doses (DDD's) in Northern England. A study published in the International Journal of Drug Policy found that:

Of the 7,856 practices included, the median number of defined daily doses (DDDs) per 1,000 registrants per day was 36.9. Opioid dispensing appeared to be higher in the north of England, with the median number of DDDs per 1,000 registrants varying between 53.1 in Manchester, 48.9 in Newcastle, 35.3 in Birmingham and 13.9 in London.<sup>38</sup>

At this stage it is clear that there has, perhaps for the first time in more than a generation, been a significant uptake in opioid consumption and addiction. Even three decades after the 'trainspotting generation' the UK is struggling with the aftermath – there is a lag before the consequences of this harm will be felt by society. Indeed, much of the increase in death rates through drug misuse that we observe today can at least be partially explained by an ageing cohort of heroin users in now severely diminished health. Given this tragic legacy, we would be well advised to be mindful that de-prescribing and amended prescribing practices will not undo this damage but rather mitigate its continued growth.

## Cocaine and crack

### Size of the problem

The UK is the single biggest consumer of cocaine in Europe.<sup>39</sup> The ONS reported in August of 2019 that 'There were 637 deaths related to cocaine in 2018, almost double the number registered a few years earlier in 2015 when there were 320 deaths'.

36 Department of Health and Social Care, reported by BBC News, 'Opioid painkillers 'must carry prominent warnings'', April 2019, accessed via: [www.bbc.co.uk/news/health-48082736](http://www.bbc.co.uk/news/health-48082736)

37 ONS, 'Drug-related deaths "deep dive" into coroners' records', August 2018. pp10, accessed via: [[www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/drugrelateddeathsdeepdiveintocoronersrecords/2018-08-06](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/drugrelateddeathsdeepdiveintocoronersrecords/2018-08-06)]

38 Chen, Teng-Chou; Chen, Li-Chia; Kerry, Miriam; Knaggs, Roger David, 'Prescription opioids: Regional variation and socioeconomic status – evidence from primary care in England' published in International Journal of Drug Policy, Feb 2019. Volume 64, accessed via: [www.sciencedirect.com/science/article/abs/pii/S0955395918302858?via%3Dihub](http://www.sciencedirect.com/science/article/abs/pii/S0955395918302858?via%3Dihub)

39 EMCDDA, 'European Drug Report 2019', June 2019, accessed via: [www.emcdda.europa.eu/publications/edr/trends-developments/2017/html/prevalence-trends/cocaine\\_en](http://www.emcdda.europa.eu/publications/edr/trends-developments/2017/html/prevalence-trends/cocaine_en)

### **In Treatment**

NDTMS data states, however, that the number of new admittances for cocaine treatment among people under 25 in the most recent available year is 19 per cent lower than it was in 2012/13. With rising consumption rates and death rates it is reasonable to identify an increased need.

### **Cocaine: Has the problem changed over time?**

Cocaine use amongst 16–24 year olds has seen a marked increase from 2.1 per cent to 6 per cent. Cocaine deaths increased for the seventh consecutive year and doubled between 2015 and 2018. They are now at record levels.<sup>40</sup>

### **Crack: Has the problem changed over time?**

The number of people being treated for crack cocaine but not opiates increased by 18 per cent last year and 44 per cent since the year before that. In March 2019, PHE published its key findings from the 'Increase in crack cocaine use inquiry',<sup>41</sup> which include:

- the majority of people using crack were observed to be existing heroin users, often with co-occurring mental health problems and at risk of being homeless;
- the rise in crack use is likely to be caused by increased availability (linked to a surge in global production of cocaine), affordability and aggressive 'marketing' by dealers;
- changes in attitudes and stigma associated with crack use, and a reduced focus by police on drug dealing.

### **Benzodiazepines**

The use of Xanax in the UK, a brand name for Alprazolam – itself a benzodiazepine, is growing in popularity amongst young people. Public Health England reported that:

Young people who had problems with benzodiazepines at the start of treatment almost doubled from the previous year. Xanax was the benzodiazepine which saw the biggest increase.<sup>42</sup>

Those reported increases are stark. In fact, the number of young people who reported problems with Xanax increased from just 8 in 2016 to 53 in 2018,<sup>43</sup> although these numbers are small that marks a 560% increase in a year. The wider Benzodiazepine threat is greater than that posed by Alprazolam alone. In fact, since the 1980's there have been concerns about the risk of dependence. Other drugs that fall under the benzodiazepines family, such as etizolam, are regularly used in addition to opiates. According to Scotland's,

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40 Deaths related to drug poisoning in England and Wales: 2018 registrations, accessed via: [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations)

41 Public Health England, 'Increase in crack cocaine use inquiry: summary of findings', March 2019, accessed via: [www.gov.uk/government/publications/crack-cocaine-increase-inquiry-findings/increase-in-crack-cocaine-use-inquiry-summary-of-findings](http://www.gov.uk/government/publications/crack-cocaine-increase-inquiry-findings/increase-in-crack-cocaine-use-inquiry-summary-of-findings)

42 Public Health England, 'Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS): April 2017 to March 2018', Nov 2018. pp6.

43 Public Health England, 'Alcohol and drug treatment for young people: statistics summary 2017 to 2018'. Published 6 December 2018, accessed via: [www.gov.uk/government/publications/substance-misuse-treatment-for-young-people-statistics-2017-to-2018/alcohol-and-drug-treatment-for-young-people-statistics-summary-2017-to-2018#problem-substances](http://www.gov.uk/government/publications/substance-misuse-treatment-for-young-people-statistics-2017-to-2018/alcohol-and-drug-treatment-for-young-people-statistics-summary-2017-to-2018#problem-substances)

National Statistics Publication for Scotland<sup>44</sup> 'benzodiazepines such as diazepam and etizolam were implicated in, or potentially contributed to, 792 deaths in 2018 (67% of the total number of drug related deaths that year).

### Club drugs

Club drugs is a loose term that refers to a variety of substances closely linked with a lifestyle that involves frequently attending nightclubs. Most notably, these substances include: Amphetamines, Ecstasy and Ketamine.

### Amphetamines

Amphetamines have seen a major drop-off in usage across all demographics in the least twenty years or so. In 1996, 3.5 per cent of respondents stated that they had used them in the last year. Young people made up a significant portion of that group – over 11 per cent of them were using amphetamines. In the CSEW 2017/18, that number for young people was just 1.5 per cent, and the number overall less than 0.5 per cent of respondents.<sup>45</sup>

### Ecstasy

Ecstasy saw a steady rise in consumption levels between 2012 and the latest available data (2017/18) among 16–24 year olds, almost doubling from 2.9 per cent so that now<sup>46</sup> 1 in 20 young people have tried ecstasy in the previous 12 months.

### Ketamine

Increasing numbers of young people are using ketamine. Using CSEW data from 2015/16 to 2017/18 increases in consumption are notable from 1 per cent of respondents to 3 per cent just a few years later.<sup>47</sup> The rapid increase in both seizures and crime rates are a strong indication of a growing trend.

### New psychoactive substances

CSEW data indicated that since 2014/15, usage rates had dropped from 2.8 per cent to 2.5 per cent. Among young people specifically, the drop-off had been even steeper – 2.8 per cent of respondents to 1.2 per cent of respondents in 2017/18.<sup>48</sup> However recent data gives cause for concern. Although 2017 saw some reduction in use and a death rate of 61 people, the 2018 ONS figures reveal that last year saw 125 deaths involving NPS.<sup>49</sup>

44 National Statistics publication for Scotland. 1,187 drug-deaths in 2018: up 27% in a year, accessed via: [www.gov.scot/news/1-187-drug-deaths-in-2018-up-27-percent-in-a-year/](http://www.gov.scot/news/1-187-drug-deaths-in-2018-up-27-percent-in-a-year/)

45 Home Office, 'Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales', July 2018. pp10

46 Home Office, 'Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales', July 2018. pp6

47 Ibid. pp7

48 Ibid. pp23

49 Deaths related to drug poisoning in England and Wales: 2018 registrations, accessed via: [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations)

### **Volatile substance abuse**

As with new psychoactive substances, volatile substances are a complicated, evolving subset of illegal drugs that can take various forms. Nitrous Oxide is being misused by a significant portion of people. This is particularly true of young people – 8.8 per cent of whom admitted to using Nitrous in the last year.<sup>50</sup>

### **Regional disparity**

There is a regional disparity in death rates which often correlates with or takes place over same period of time as cuts in funding for addiction treatment services. It should be noted that not all areas that have seen funding cuts have also seen proportionate rises in death rates. Further, some areas have merged their budgets in search of economies and some have achieved these efficiencies. The examination of localities is not an exercise designed to find the worst offenders but rather to highlight, in local areas, what is a national trend. Funding for addiction services has fallen significantly across the UK, this has even occurred in regions which, perhaps for a multitude of sometimes complex reasons, continue to suffer high rates of death through substance abuse. The CSJ would argue that further cuts in real terms to addiction treatment provision in these circumstances simply cannot be justified.

### **Blackpool**

However, between 2013 and 2017, the addiction budget fell by 26 per cent but in real terms, adjusting for inflation the reduction is more akin to a 34.6 per cent reduction in spending and the residential rehabilitation budget reduced by approximately 55 per cent.<sup>51</sup>

Over a similar period of just 4 years,<sup>52</sup> the rate of deaths from drug misuse went up by 17 per cent. In the previous 10 years before, the death rate climbed only 12 per cent.<sup>53</sup> Other areas have seen cuts but those to addiction services have been severe.

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<sup>50</sup> Ibid. pp25

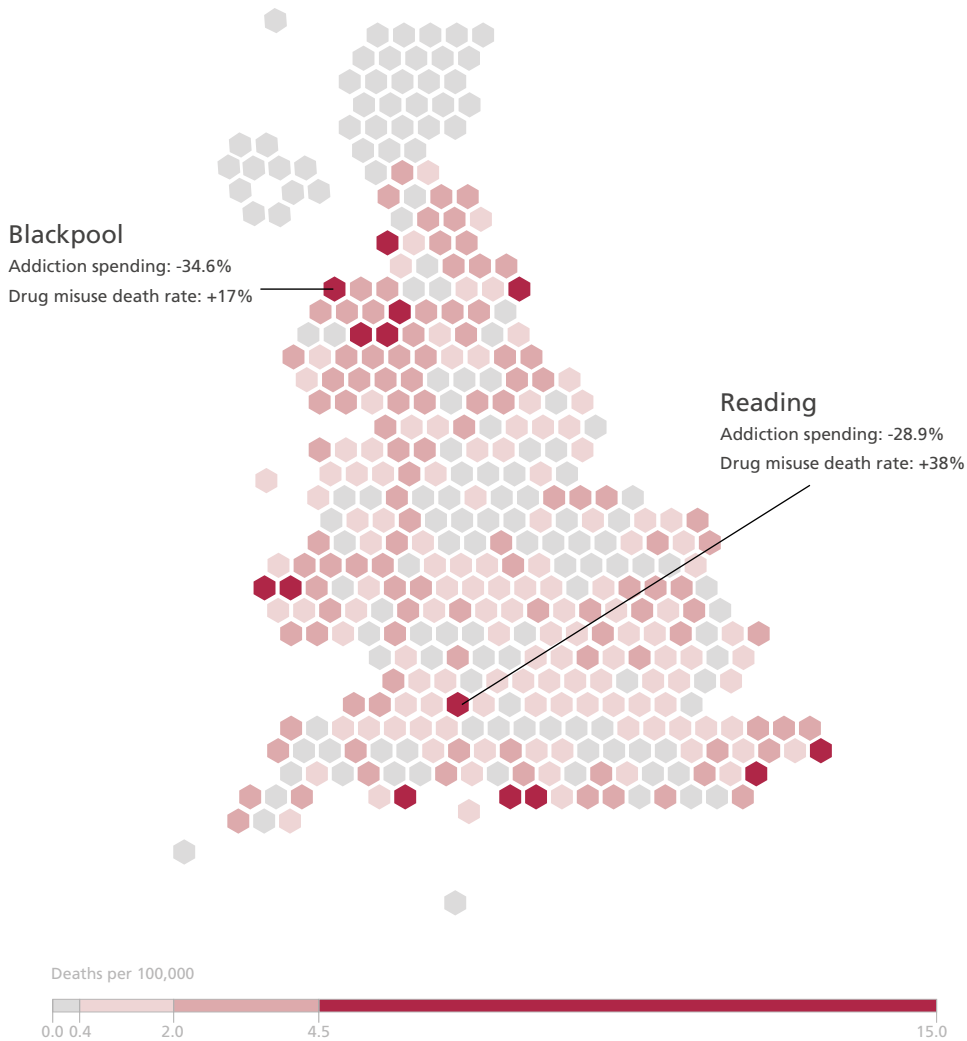
<sup>51</sup> Obtained via CSJ FOI requests to Blackpool Council

<sup>52</sup> As with Reading the change in death rate is calculated using the average drug death rate for 2012–14, and 2015–17.

Whilst these time periods do not map exactly onto the periods over which PHG/addiction spend changes were calculated, by necessity of the data, this provides the closest fit.

<sup>53</sup> Data obtained from the ONS, 'Deaths related to drug poisoning in England and Wales: 2017 registrations', Aug 2018, accessed via: <https://cy.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedto drugpoisoninginenglandandwales/2017registrations/previous/v1>

Figure 5: Regional hotspots of heroin and morphine deaths by misuse, 2014 to 2016, England and Wales



Map replicated from ONS site<sup>54</sup>

### Reading

Between 2013/14 and 2017/18, the addiction budget fell by 21.8 per cent in Reading, from approximately £2.79 million to £2.18 million. If we were to adjust for inflation, although, again, there is a crudeness to this adjustment as no other variables are taken into account, the reduction is more akin to a 28.9 per cent reduction in spending over that period.<sup>55</sup>

54 Access via: [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/halfofheroinmorphinemisusedeathhotspotsinenglandandwalesareseasidelocations/2018-04-04](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/halfofheroinmorphinemisusedeathhotspotsinenglandandwalesareseasidelocations/2018-04-04)

55 Obtained via FOI requests to Reading Council and calculated: 2013–14 total addiction spending by Reading: £2,788,133, adjusted for 2018 inflation from 2014–2018 at 2.4 per cent a year = £3,066,394. The 2017–18 spend is recorded as: £2,181,383. The relevant reduction, using 2018 prices would be from £3,066,394.19 to £2,181,383 = a reduction of 28.9 per cent.

Over a similar period, the death rate from drug misuse in Reading increased by 38.6 per cent – from 5.7 in 2012–2014, to 7.9 in 2015–17.<sup>56</sup>

Different LAs have very different funding pressures, and different competing factors determine spending levels in each area. Some spending levels can be indicative of joint working practices and consequent savings, we must not strictly associate all reduced spending with a reduced service. Further, the position outlined above is not intended to demonise LAs and Reading and Blackpool are referred to as examples but are by no means exceptional in their approach. Rather, the report seeks to re-emphasise the problems associated with central government addressing this threat to our society at arms-length, leaving often inadequate funding to a collective of locally elected public servants who must shoulder the responsibility of these cuts.

Despite the commonalities between regions outlined above, it is important to note that not all areas that have seen decreased spending on addiction services have experienced a rise in drug misuse deaths. That said, those areas in which real people have felt the consequences of cuts to addiction services, have suffered seriously. In the face of indicators of rising harm, it is difficult to see how year on year funding reductions could be justified.

The regional position outlined above is to a large extent reflected in a national trend. Our FOI returns identified that some local authorities have applied severe cuts, reducing expenditure on the treatment of drug and alcohol addiction by over 50 per cent. In fact, this exercise has been repeated by national and regional news with increasing frequency over the last 4 years.

LocalGov reported<sup>57</sup> that FOI data retrieved by Liam Byrne, MP revealed that:

58 per cent of councils report cutting budgets for drug and alcohol treatment services over the last year and 68 per cent reported no budget increase. Around 16 councils implemented a £500,000 cut last year to these services and four reported cuts of over £1.5m.

While the average reduction was £155,000, the largest absolute cut was made by Birmingham City Council (£3,846,000). The largest proportional cut came in Islington – 34 per cent of its budget or £2,431,800.

The death rates since the structural changes in 2012/13 have escalated and it is important to note that while this is a fact, it is not one that can be directly or causally linked solely to the reduction in funding or the new systems of work. That being acknowledged, there is a marked and deeply concerning correlation between this reduction in addiction funding, and wider public health funding, as well as the new systems of commissioning and the increase in drug related deaths. This is an inadequate response to a national crisis.

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<sup>56</sup> Data obtained from the ONS, 'Deaths related to drug poisoning in England and Wales: 2017 registrations', Aug 2018

<sup>57</sup> Local Gov, 'Treatment cut despite 'soaring' alcohol-related A&E admissions', 11 February 2019, accessed via: [www.localgov.co.uk/Treatment-cut-despite-soaring-alcohol-related-AE-admissions/46858](http://www.localgov.co.uk/Treatment-cut-despite-soaring-alcohol-related-AE-admissions/46858)



## The current challenges: process addiction

### Gambling

Gambling is far from novel in the UK. However, we can speak about a recent concerning trend in gambling habits in both adults and children. At the very least, there is now a growing awareness of the harms that this potential cause of addiction can have on individuals' finances and mental health – as well as the effects it has beyond them, on their family and their wider community.

The introduction of the Gambling Act in 2005, the growth of remote gambling, in large part facilitated by changes in technology, and a growing culture of betting in an increasing range of sports have all contributed to an increase in risk of compulsive gambling. This chapter explores the prevalence of gambling and the extent of its harms as well as recent concessions made by the industry and the need for further regulation.

### How prevalent is gambling in the UK?

The Gambling Commission publishes estimates of gambling in the past month. In the year ending December 2018, 46 per cent of adults said they participated in any form of gambling in the past four weeks. Those participating in online gambling has risen from 15 per cent in 2015 to 18 per cent in 2018.<sup>58</sup>

- The Total Gross Gambling Yield (GGY) in the UK stands at £14.5bn (Oct 17–Sep 18), a 4.5 per cent increase on the previous year. The Total GGY for remote casino category slots alone is £2bn.<sup>59</sup>
- There are now 55,000 problem gamblers aged just 11–16 years old and another 70,000 11–16 year-olds are considered to be at risk of developing a problem.<sup>60</sup>

### What is a 'problem gambler'?

This is gambling that 'disrupts or damages personal, family or recreational pursuits', according to the Royal College of Psychiatrists.<sup>61</sup> The Gambling Commission uses the full Problem Gambling Severity Index (PGSI) and the DSM-IV as the main measure of Gambling.<sup>62</sup>

58 Gambling Commission, 'Gambling participation in 2018: behaviour, awareness and attitudes – Annual report', Feb 2019. pp3, accessed via: [www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-participation-in-2018-behaviour-awareness-and-attitudes.pdf](http://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-participation-in-2018-behaviour-awareness-and-attitudes.pdf)

59 'Industry Statistics', updated May2019, accessed via <https://www.gamblingcommission.gov.uk/news-action-and-statistics/Statistics-and-research/Statistics/Industry-statistics.aspx>

60 As reported in The Times, 'Number of children addicted to gambling doubles in a year', 21st Nov 2018 using analysis of Gambling Commission Data, accessed via: [www.thetimes.co.uk/article/number-of-children-addicted-to-gambling-doubles-in-a-year-q3mpzz5sp](http://www.thetimes.co.uk/article/number-of-children-addicted-to-gambling-doubles-in-a-year-q3mpzz5sp)

61 Royal College of Psychiatrists, 'Problem Gambling', accessed via: [www.rcpsych.ac.uk/mental-health/problems-disorders/problem-gambling](http://www.rcpsych.ac.uk/mental-health/problems-disorders/problem-gambling)

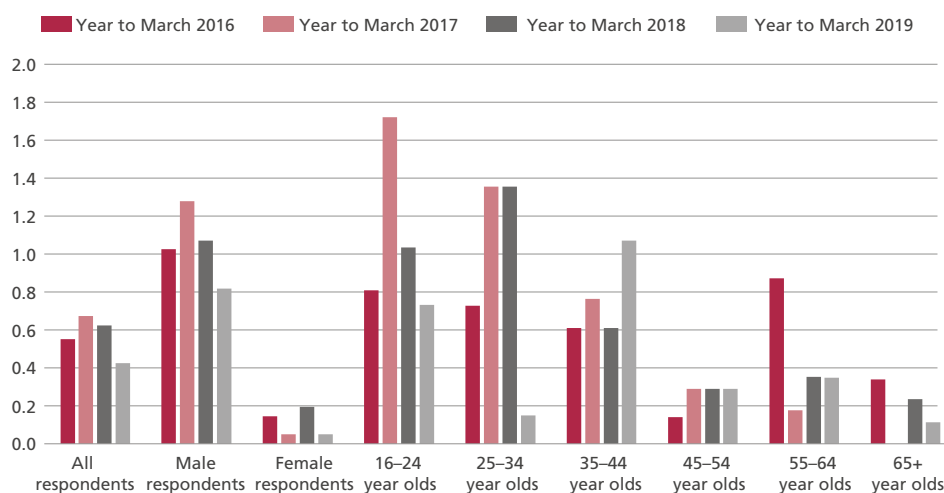
62 The gambling commission explains that: 'Due to the small base sizes presented by the telephone survey, the mini-screen should not be considered the Commission's comprehensive estimate of problem gambling rates in Great Britain. As such the Commission will continue to use the full PGSI screen and the DSM-IV as its main measure of problem gambling using the Health Surveys for England, Scottish Health Survey, and the Welsh Problem Gambling Survey. These health surveys cover approximately 14,000 respondents who are questioned on their gambling behaviour and the results from each survey are then compiled into a Combined Health Survey Great Britain report'

## Gambling related harm

A July 2018 report by the Gambling Commission<sup>63</sup> proposed that the following definition of gambling related harm be adopted and used in British policy and practice:

Gambling-related harms are the adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society. These harms are diverse, affecting resources, relationships and health,<sup>64</sup> and may reflect an interplay between individual, family and community processes. The harmful effects from gambling may be short-lived but can persist, having longer term and enduring consequences that can exacerbate existing inequalities.

Figure 6: Problem Gambling Rates by gender and age



Taken from Gambling commission 2019 Survey.<sup>65</sup>

## Impact

The impact of gambling on the individual and others around them must not be underestimated. The Citizens Advice Bureau's 2018 report, *'Out of Luck – An exploration of the causes and impacts of problem gambling'*<sup>66</sup> found that:

Up to 4.3 million family members, friends and work colleagues of the estimated 430,000 problem gamblers<sup>67</sup> in Great Britain often suffer serious issues such as problem debt and relationship breakdown.<sup>68</sup>

63 Gambling Commission; RGSB; Gamble Aware. 'Measuring gambling-related harms', 2018, accessed via: [www.gamblingcommission.gov.uk/PDF/Measuring-gambling-related-harms.pdf](http://www.gamblingcommission.gov.uk/PDF/Measuring-gambling-related-harms.pdf)

64 Definition of terms: Resources: undermines productivity in workplace, causes accumulation of debt, risks bankruptcy and criminal activity. Relationships: family and friendships risked and increased risk of social isolation and lack of family emotional and financial stability. Health: physical ill health and psychological – anxiety, depression and even suicidal behaviour.

65 Gambling Commission survey data on gambling participation, April 2019, accessed via: [www.gamblingcommission.gov.uk/Docs/Survey-data-on-gambling-participation-March-2019.xlsx](http://www.gamblingcommission.gov.uk/Docs/Survey-data-on-gambling-participation-March-2019.xlsx)

66 The Citizens Advice Bureau, 'Out of Luck – An exploration of the causes and impacts of problem gambling', 2018. Methodology: 'Building on our existing insight we surveyed more than 1,500 people affected by their own gambling, or someone else's, and interviewed 35 people about their experiences of gambling-related harm'

67 This report quoted the figure of 430,000 problem gamblers, which was taken from the Gambling Commission's report published in August 2017.

68 Taken from [www.citizensadvice.org.uk/about-us/how-citizens-advice-works/media/press-releases/citizens-advice-calls-for-mandatory-levy-on-gambling-companies-to-fund-support/](http://www.citizensadvice.org.uk/about-us/how-citizens-advice-works/media/press-releases/citizens-advice-calls-for-mandatory-levy-on-gambling-companies-to-fund-support/) last accessed 25.05.2019. The point is further detailed in the full report on pp3. in which the executive summary states: 'Some estimates suggest that for every problem gambler, between 6 and 10 additional people (such as friends, family or co-workers) are directly affected. This means that between 2.5 to 4.3 million people in Great Britain may be affected by gambling-related harm. Around one in ten of our survey respondents told us that more than 10 additional people were impacted', accessed via: [www.citizensadvice.org.uk/Global/CitizensAdvice/Consumer%20publications/Out%20of%20Luck.pdf](http://www.citizensadvice.org.uk/Global/CitizensAdvice/Consumer%20publications/Out%20of%20Luck.pdf)

That same report found that:

- Two in three gamblers interviewed reported mental distress as an impact of their gambling.
- Three in five reported experiencing relationship problems as a result of gambling.
- More than three-quarters of gamblers and more than two in five 'affected' others had built up debt as a result of gambling.
- Over a third of families with children couldn't afford essential costs such as food, rent and household bills as a result of a family member's gambling.

A recent Swedish study<sup>69</sup> examined the cases of more than 2000 people with purported problems with gambling. This longitudinal study ran from 2005 to 2016 and found a 15-fold increase in suicides amongst those with a gambling disorder compared to the general population. Although Professor Anders Hakansson acknowledges the multiple variables, including co-morbidity, he stated that:

It's not difficult to argue that gambling contributes very strongly to suicidal thinking, especially when debts are so severe that suicide becomes part of the solution a person thinks about in that kind of crisis, with the feeling of what you have caused to your family members.

This is entirely consistent with the more enlightened view about assessing the true impact of gambling in our community recently expressed by William Moyes, Chairman of the Gambling Commission:

We all need to better understand the harms that can be caused by gambling, moving away from simply counting problem gamblers and instead build a greater understanding of the harms experienced.<sup>70</sup>

Gambling need not be 'problem gambling' to be serious. Even modest and occasional loss can have a serious effect on the home. Yet, it must be acknowledged that when we do examine the plight of problem gamblers the prospect of their recovery is deeply concerning. Lord Chadlington, speaking in the Lords made clear the extent of our nations failure to meet our obligations to those effected by gambling, stating

The Gambling Act 2005 has, as one of its three objectives, "protecting children and other vulnerable persons from being harmed ... by gambling". But we are failing to do that—dramatically. Of the 430,000 problem gamblers in this country, nearly 10% are young people aged between 11 and 15. Just 8,000 of those 430,000 are in treatment. This equates to just 2% of all gambling addicts in the country, compared with up to 20% of those addicted to alcohol or drugs.

The Government have to act more decisively, pay less attention to the gambling lobby than they have on FOBTs and put the people, particularly the young people, of Britain first.

69 Karlsson, A.; Hakansson, A. 'Gambling disorder, increased mortality, suicidality, and associated comorbidity: A longitudinal nationwide register study', Nov 2018, accessed via: [www.researchgate.net/publication/328948933\\_Gambling\\_disorder\\_increased\\_mortality\\_suicidality\\_and\\_associated\\_comorbidity\\_A\\_longitudinal\\_nationwide\\_register\\_study](http://www.researchgate.net/publication/328948933_Gambling_disorder_increased_mortality_suicidality_and_associated_comorbidity_A_longitudinal_nationwide_register_study)

70 William Moyes, as reported by BBC News, 'New National Strategy to tackle problem gambling', 25th April 2019, accessed via: [www.bbc.co.uk/news/business-48052226](http://www.bbc.co.uk/news/business-48052226)



## chapter two

# The economic impact of addiction

The cost of alcohol abuse in Scotland alone, according to research from the University of York and cited in the Institute of Alcohol Studies' report *The Economic Impacts of Alcohol*, is £3.6bn a year.<sup>71</sup> The same report also acknowledges an academic analysis by Aberdeen University that puts the figure at £7.2bn.<sup>72</sup> The Scottish government website reports that:

It is estimated that drug misuse costs society £3.5 billion a year whilst the impact of alcohol misuse is estimated to cost £3.6 billion a year – combined, this is around £1,800 for every adult in Scotland.<sup>73</sup>

Northern Ireland's last estimate dates back to 2008/9 in which the government calculated a cost of just under £680 million.<sup>74</sup> When adjusted for inflation, this figure could be as high as £856 million.<sup>75</sup>

For many years the stated figures for the societal cost of alcohol related harm in England and Wales has been £21bn.<sup>76</sup> This figure has attracted some criticism in recent times. Even disregarding the inflationary uplift to these 2011 figures, The Institute of Alcohol Studies has commented that there is a body of evidence that would suggest that this is an underestimation of the true societal cost. The origins of the estimates appear to be a 2003 Cabinet Office Strategy Report. In broad terms, the Home Office has recognised that the figure made up of the following:<sup>77</sup>

71 York Health Economics Consortium, University of York (2010), cited by Institute of Alcohol Studies, 'The economic impacts of alcohol'. pp7, accessed via: [www.ias.org.uk/uploads/pdf/Factsheets/FS%20economic%20impacts%20042016%20webres.pdf](http://www.ias.org.uk/uploads/pdf/Factsheets/FS%20economic%20impacts%20042016%20webres.pdf)

72 Ibid. pp8

73 Scottish Government, 'Reducing the damaging impact of drugs and alcohol', accessed via: [www2.gov.scot/Topics/Justice/policies/drugs-alcohol](http://www2.gov.scot/Topics/Justice/policies/drugs-alcohol)

74 Public Health Information and Research Branch, 'Social costs of alcohol misuse in Northern Ireland for 2008/09', 2010

75 Calculated using the Bank of England's Inflation Calculator, accessed via: [www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator](http://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator)

76 Public Health England, 'Alcohol and drug prevention, treatment and recovery: why invest?', Feb 2018, accessed via: [www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest](http://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest)

77 Home Office, 'Impact Assessment of MUP', accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/157763/ia-minimum-unit-pricing.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/157763/ia-minimum-unit-pricing.pdf)

**Conservatively, the combined gross societal cost of substance addiction to the UK is almost £38bn per year – the equivalent of the UK’s current defence budget.**

1. NHS costs, at about £3.5bn per year (at 2009–10 costs)<sup>78</sup>
2. Alcohol-related crime, at £11bn per year (at 2010–11 costs)<sup>79</sup>
3. Lost productivity due to alcohol, at about £7.3bn per year at 2009–10 costs<sup>80</sup>

Most of the £21bn figure appears only to relate to England, although lost productivity of £7.3bn has been explicitly referred to as a UK estimate and it is based on 2009 to 2010 figures. Assuming the minimum uplift for inflation, by assuming 2011 prices apply to all its components, this would equate to £25.14bn at 2018 prices, when the Bank of England suggested 2.6 per cent inflation average is applied.<sup>81</sup>

The cost of drug use to the UK economy is about £10.7bn, using 2010–2011 figures. This original Home Office estimate was referred to by PHE in their report ‘Health Matters Drug Misuse Harms Society’.<sup>82</sup> Adjusting for inflation only and using the Bank of England’s 2.6 per cent average rate of inflation, that figure would translate into £12.8bn in 2018.

Adjusting for inflation and even accepting that some of the productivity costs apply to the UK and therefore relying only on the figures relating to England, the combined gross societal cost of substance addiction to the UK is almost £38bn per year.<sup>83</sup> That is the equivalent of about 2 per cent of the UK GDP,<sup>84</sup> or approximately the UK’s current defence budget.

Further, these figures were assessed in 2010–2011 when rates of drug use in adults aged 16–59 reporting *last year use* of any drug was 8.9 per cent. By 2017, the last year drug use reported in the same age group was 9 per cent.<sup>85</sup> The consumption rates then are broadly comparable and these estimates remain broadly reliable. The figure takes no account of the societal costs incurred by gambling.

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78 The Department of Health has updated the previous estimate of around £2.7bn at 2006–07 prices

79 The Home Office has recently updated the estimate of the cost of alcohol-related crime: £11 billion in 2010/11 prices. This figure includes the cost of general offences (like violent crime) that are alcohol-related, the cost to the Criminal Justice System of alcohol specific offences (like drink driving) and the cost of issuing Penalty Notices for Disorder. This estimate was arrived at using the same methodology as that which lay behind the widely quoted figure of £8–13 billion in 2006/07 prices. The previous estimate was presented as a range due to a methodological uncertainty, which has now been resolved. Further information is available on request from the Home Office

80 The Department of Health has updated the previous estimate of around £6.4bn at 2006–07 prices, a UK-wide estimate

81 Bank of England Inflation Calculator, accessed via: [www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator](http://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator)

82 Public Health England, ‘Health matters: preventing drug misuse deaths’, Sep 2017, accessed via: [www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths](http://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths)

83 Figure calculated as £37.95bn

84 ONS, ‘UK government debt and deficit: March 2019’, July 2019, accessed via: [www.ons.gov.uk/economy/governmentpublicsectorandtaxes/publicspending/bulletins/ukgovernmentdebtanddeficitorostatmaast/march2019](http://www.ons.gov.uk/economy/governmentpublicsectorandtaxes/publicspending/bulletins/ukgovernmentdebtanddeficitorostatmaast/march2019)

85 Home Office, ‘Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales’, July 2018. pp1

## The potential of an effective approach

For the purposes of this document the savings that could be realised from an effective prevention strategy are not included, as estimates would be speculative. However, it is worth simply acknowledging that the United Nations Office on Drugs and Crime<sup>86</sup> states that:

For every dollar spent on prevention, at least ten can be saved in future health, social and crime costs.

Public Health England have acknowledged the economic benefit in treatment. Their assessment is that for every £1 spent on treating alcoholism there is a £3 societal cost saving or return, rising to £26 over 10 years. A similar benefit is recognised with drug addiction, but the investment to return ratio is recognised as £1 for £4 return, rising to £21 over 10 years.<sup>87</sup>

Of course, it is not suggested in this paper that the cost of addiction in the UK could reach anything approaching zero. Neither is it suggested that all societal costs can be immediately realised as true savings, while, at the same time, acknowledging that many can. The now conservative estimate of £3.5bn that is said to be incurred by the NHS through alcohol abuse alone would be reduced by an effective strategy.

These figures and analogous costs are an attempt to expose the vast cost the taxpayer and the treasury incurs every year by failing to meaningfully address a problem that has demonstrably been shown to be capable of effective mitigation.

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86 United Nations Office on Drugs and Crime, 'UNODC/WHO International Standards on Drug Use Prevention Second updated edition', 2018, accessed via: [www.unodc.org/unodc/en/prevention/prevention-standards.html](http://www.unodc.org/unodc/en/prevention/prevention-standards.html)

87 Public Health England, 'Alcohol and drug prevention, treatment and recovery: why invest?', Feb 2018





## chapter three

# A treatment sector dismantling

In September 2017, the Advisory Council for the Misuse of Drugs (ACMD) warned the Government<sup>88</sup> that reductions in funding for local drug and alcohol treatment services would:

result in the dismantling of a drug misuse treatment system that has brought huge improvement to the lives of people with drug and alcohol problems. If resources are spread too thinly, the report says, the effectiveness of drug treatment will suffer, which could lead to increased levels of blood-borne viruses, drug-related deaths and drug-driven crime in communities.

At the time of writing, two years after the ACMD statement was made, we have seen this trend continue. Nationally, the spending on treatment for alcohol and drug misuse has reduced significantly since 2013, by approximately 20 per cent, as a conservative estimate. Although many in the sector, including Collective Voice, have stated that their analysis shows a reduction of about 25 per cent in spending since 2013.<sup>89</sup> The warnings issued by the ACMD have gone unheeded; the consequences are sadly predictable.

To put the situation into some context there were 285 deaths from knife crime in year ending March 2018<sup>90</sup> and 1,770 road deaths<sup>91</sup> in the year ending June 2018. There were 2,917 deaths<sup>92</sup> in 2018 from drug misuse meaning that deaths from knife crime equated to just under 10 per cent of the deaths through drug poisoning. Drug misuse kills more people than knife crime and road deaths – combined.

Of course, death rates are a crude measure of the impact of drug misuse, often referred to because it is easily quantifiable. It says nothing of the hardship and suffering that lies beneath this figure. Indeed, the CSJ has heard evidence from service providers who believe this figure to be very conservative given the lack of detail in many coroners reports, or

88 As reported on GOV.UK website, 'ACMD warns ministers of falling local funding for drug treatment services', 6 September 2017, accessed via: [www.gov.uk/government/news/acmd-warns-ministers-of-falling-local-funding-for-drug-treatment-services](http://www.gov.uk/government/news/acmd-warns-ministers-of-falling-local-funding-for-drug-treatment-services)

89 Collective Voice, 'Collective Voice responds to the ACMD's report 'Commissioning impact on drug treatment'', July 2019, accessed via: [www.collectivevoice.org.uk/news/collective-voice-responds-acmds-report-commissioning-impact-drug-treatment/](http://www.collectivevoice.org.uk/news/collective-voice-responds-acmds-report-commissioning-impact-drug-treatment/)

90 ONS, 'Homicide in England and Wales: year ending March 2018', Feb 2019. Homicide by use of a knife or other sharp instrument, accessed via: [www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2018](http://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2018)

91 Department for Transport, 'Reported casualties in Great Britain quarterly provisional estimates year ending June 2018', Nov 2018, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/754685/quarterly-estimates-april-to-june-2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/754685/quarterly-estimates-april-to-june-2018.pdf)

92 ONS, 'Deaths related to drug poisoning in England and Wales: 2018 registrations', Aug 2019, accessed via: [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations)

at least there is a need for improved communication with ONS.<sup>93</sup> However, this national picture, although saddening, does not reveal the further inequality that exists within this injustice.

The local picture is diverse. Many areas have seen very significant cuts to spending and at the same time a significant upturn in the death rates attributable to drug consumption. The CSJ received 99 FOI responses from across the UK to examine the spending levels and priorities of each authority.

In Cumbria, the spend on treatment has seen significant cuts between 2013/2014 and 2017/2018. In 2013/2014 the budget for treatment reduced by just over 23 per cent (23.39).<sup>94</sup> This downward adjustment in spending on treatment at a time of increased public health fund spending, also saw the death rate from drug misuse increase by almost 21 per cent (20.8).

A 2016 Article by Colin Drummond, professor of addictions psychiatry, published in the BMJ<sup>95</sup> estimated that the cuts across LA in England were typically in the region of 30% and, again consistent with our findings, some authorities cutting by as much as 50%.

These funding decreases in the addiction sector are happening at a time when public health grants are also falling, but at markedly different rates. Worse still, although the reductions in public health funding inevitably put local authorities in a very difficult position there is often little parity between the public health budget and the spending on addiction when individual localities are examined. At the heart of these cuts is a fundamental system failure. Local authorities have been burdened with increasing responsibilities and with them the treatment of addiction in their community. The direct accountability that local politicians have to their fellow members of the community makes any decision to fund treatment highly unattractive in a case where that money could be spent on a multitude of issues that concern the public. This is to make no criticism or lightly accuse committed servants to their communities of cynically ignoring the plight of the suffering. It is instead an acknowledgment that some necessary decisions must be taken out of the hands of those that bare too greater burden.

### **Residential rehabilitation has been devastated by these cuts**

While it is right to say that not every budget cut will provide the reader with all the information they need about treatment provision in that area or the wider context, many of these cuts have been significant. Between 2013/14 and 2017/18:<sup>96</sup>

- Tower Hamlets went from a spend of £980,000 on residential rehabilitation to £181,000.
- North Somerset reduced its residential rehabilitation budget from £144,000 to £75,000.
- Ealing from £718,000 to just £429,000.<sup>97</sup>

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93 ONS, 'Drug-related deaths "deep dive" into coroners' records', August 2018: pp10, accessed via: [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/drugrelateddeathsdeepdiveintocoronersrecords/2018-08-06](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/drugrelateddeathsdeepdiveintocoronersrecords/2018-08-06)

94 Obtained via CSJ FOI requests

95 Colin Drummond: Cuts to addiction services are a false economy, accessed via: <https://doi.org/10.1136/bmj.j2704>

96 These figures are not adjusted for inflation

97 Obtained via CSJ FOI requests conducted from January to July 2019

**I've never had a voter come up to me and say we should spend more money on drug treatment services.**

Cumbria Council Deputy Leader, in interview with BBC, May 2018

## Gambling

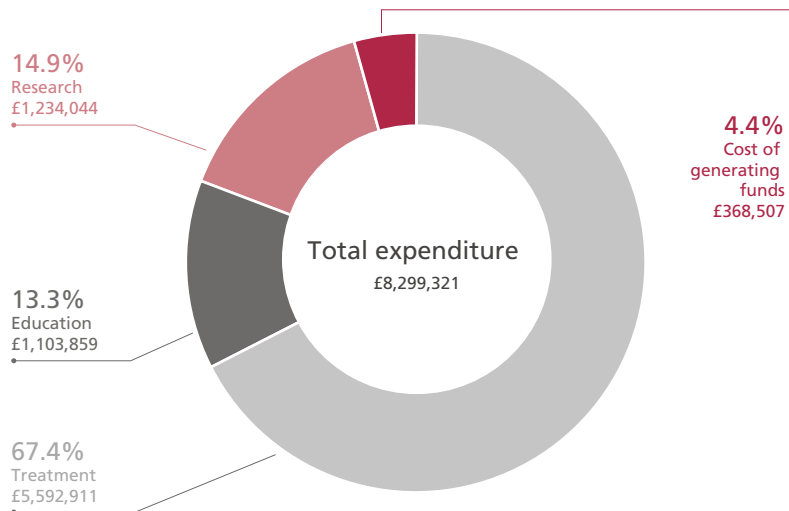
The allocation of funding and treatment for gambling does not follow the same systems as that for substance abuse.

According to GambleAware's Annual Review<sup>98</sup> 2017/18:

The treatment services currently funded by Gamble Aware reach less than 2% of the prevalent problem gambling population across Britain serves to illustrate the potential gap in service provision.

As with all treatment figures, there is a need to be cautious about the expected rates of success in getting people into treatment. There will always be a significant number of people who simply refuse help and will not engage. However, beyond acknowledging this truth, there is little virtue in the points further consideration. The states duty transcends merely having resources available to treat those that present themselves but instead involves a need to encourage engagement and to reach out to all. In many respects GamableAware's approach to delivering the National Responsible Gambling strategy has been transparent and in fact, in comparison to the position with substance abuse, in many ways admirable. Public Health England, for all its well-advised guidance does not enjoy the same extent of control over what eventually makes its way to service delivery, education or research.

Figure 7: Gamble Aware Expenditure



Graphic taken from GambleAware Annual Review<sup>99</sup>

98 GambleAware, 'Annual Review 2017/18', 2018, accessed via: <https://about.gambleaware.org/media/1836/gamble-aware-annual-review-2017-18.pdf>

99 GambleAware, 'Annual Review 2017/18', 2018, pp6, accessed via: <https://about.gambleaware.org/media/1836/gamble-aware-annual-review-2017-18.pdf>

Although the proportion of people with problem gambling that are reached and the clearly inadequate levels of funding are deeply concerning, this clarity of resource allocation provides opportunity to make national and strategic decisions. This position must be contrasted to that revealed from the CSJ freedom of information requests in which many Local Authorities could not advise as to how much was spent on prevention of addiction. GambleAware's expenditure for 2018 was just £8,299,321. However, this charity has seen a doubling in funds from 2012/13.

## The NHS response

As part of its Long-Term Plan, the NHS announced that the gambling clinic would be extended to up to 14 new sites across the country.

**These new specialist services, delivered as part of our NHS Long Term Plan demonstrate the Government's commitment to tackle the danger problem gambling can pose and my determination to ensure society's most vulnerable are protected.**

**Matt Hancock, Health Secretary**

The clinics will also have specialist services to address the growing gambling addiction amongst children with 55,000 problem gamblers in the UK now aged between just 11 and 16 years old. This is another example of how, at times, parts of our nations response can be encouraging and the political will to help clear. But where gaps in care exist there must be concerns about whether we are leaving people behind. Under-funded outreach and variable levels of support dependent upon the type of addiction a person presents with have created these gaps.

## chapter four

# Recovery obstructed

The funding cuts to public health have been compounded by the fact that the treatment budget for addiction has not been ringfenced. The resulting reduction in funding has had a profound effect on the capacity of treatment providers to help those that present with a need. Importantly, it makes any proactive attempt to fund addiction in our communities through effective outreach programs very challenging.

Currently, gaining access to treatment and the on-going support in the community to achieve and then maintain recovery is far from guaranteed in the UK. Many find accessing treatment difficult and do not achieve recovery or have it delayed through inadequate service provision. Service providers from across the country have told the CSJ that all too often small windows of opportunity to engage with those that approach for help close when poor resources and availability delay a treatment response.

This chapter acknowledges that universal challenge but will explore the additional difficulties that many vulnerable people suffer in accessing such care.

### Vulnerability and addiction

Although by no means an exhaustive list, domestic violence, child abuse and neglect as well as modern slavery are all strong examples of social ills that require an investigative, curious and proactive approach by the state. Government has shown a willingness and ability to take on these serious threats to our society. The detection and prosecution of hidden harms such as domestic abuse, FGM and child abuse are the consequence of an increasingly determined and humane state response. These lessons need to transfer into our approach to addiction. There is a growing body of evidence that many who are suffering with addiction are sometimes actively obstructed from treatment by circumstance.

### Women in addiction

There are twice as many men as women that purport to use drugs. However, NDTMS data reveals that males made up approximately 70 per cent of those in treatment for substance abuse.<sup>100</sup> In terms of purported consumption, women are represented at 1:2. However in

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<sup>100</sup> Public Health England, 'Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): April 2017 to March 2018', Nov 2018. pp24

treatment, they are nearer 1:3. Ian Hamilton, Senior lecturer at York University, has stated that there is no doubt that women are underrepresented but the reasons behind this are less clear.<sup>101</sup>

## Addiction in pregnancy

The phenomenon of women in pregnancy demonstrating shame or reluctance to start treatment by first declaring an addiction whilst pregnant is demonstrated by the National Institute for Health and Care Excellence (NICE) guidelines.<sup>102</sup> At paragraph 1.2.1, the guidance acknowledges this identified barrier, stating:

Work with social care professionals to overcome barriers to care for women who misuse substances. Particular attention should be paid to:

- integrating care from different services ensuring that the attitudes of staff do not prevent women from using services;
- addressing women's fears about the involvement of children's services and potential removal of their child, by providing information tailored to their needs;
- addressing women's feelings of guilt about their misuse of substances and the potential effects on their baby.

The 2003 report 'Hidden Harm' indicated that about 90 per cent of women in drug dependence were of 'child bearing age'.<sup>103</sup> The National Institute for Clinical Excellence estimates that around 4.5 per cent of pregnancies (or 30,200 women per year) will involve a substance abusing mother.<sup>104</sup>

## Domestic abuse

Those seeking to recover are met by a system that makes ill-founded assumptions about what a person is willing or able to do. Often it is very practical barriers that obstruct access to treatment. SafeLives report that their research shows that 'four out of five victims [of domestic abuse] do not call the police'.<sup>105</sup> With this level of subjugation and fear, a proactive and prudent approach demands that we expect lower levels of self-reporting to treatment to occur in these circumstances. This is particularly the case for vulnerable women who cannot, or fear that they cannot, leave their home or declare an addiction for fear of what that might mean to either their guardianship of their child or their child's well-being.

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101 Hamilton, I. 'Women also use drugs – not that you can tell from drug policy', in *The Independent*, 2017, accessed via: [www.independent.co.uk/news/health/drug-policy-women-in-uk-accessing-treatment-a8081876.html](http://www.independent.co.uk/news/health/drug-policy-women-in-uk-accessing-treatment-a8081876.html)

102 NICE, 'Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors – Clinical guideline', 22 September 2010, accessed via: [www.nice.org.uk/guidance/cg110/resources/pregnancy-and-complex-social-factors-a-model-for-service-provision-for-pregnant-women-with-complex-social-factors-pdf-35109382718149](http://www.nice.org.uk/guidance/cg110/resources/pregnancy-and-complex-social-factors-a-model-for-service-provision-for-pregnant-women-with-complex-social-factors-pdf-35109382718149). Note, this guidance was last reviewed in August 2018, accessed via: [www.nice.org.uk/guidance/cg110](http://www.nice.org.uk/guidance/cg110) on 01.06.19

103 Advisory Council on the Misuse of Drugs, 'Hidden Harm', 2003, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/120620/hidden-harm-full.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf)

104 National Institute for Clinical Excellence, 'Guidance on Pregnancy and Complex Social Factors', 2010. CG110 pp2

105 SafeLives, 'Key findings: A Cry for Health', 2016, accessed via: [www.safelives.org.uk/node/942](http://www.safelives.org.uk/node/942)

## Sex workers

Sex work is rightly associated with drug use.<sup>106</sup> It is therefore incumbent on us to seek out those we know are being exploited. Once found, that care must go beyond the substance and look at the needs of the person. Person-centric, trauma informed treatment tailored to their needs and background must be given.

A 2017 study by Bristol University entitled 'Identifying possible reasons why female street sex workers have poor drug treatment outcomes: a qualitative study',<sup>107</sup> in part examined the need for tailored approaches to Street Sex Workers (SSWs) battling addiction,

All the participants described group work as a central part of drug treatment. Groups were portrayed as having a potentially positive treatment role but participants said that for SSWs, their usefulness was limited as SSWs felt unable to talk about sex work. Though sex work was a large part of their life, their identity and their drug use, they said they did not want to discuss it because of the negative behaviour of male and female service users towards SSWs.<sup>108</sup>

The same report also makes clear that drug dependency reinforces involvement in sex work and Street Sex Workers report feeling trapped in a 'work-score-use' cycle. One study,<sup>109</sup> published in the *Lancet*, measured substance misuse in trafficked people and stated that:

In a study by Rössler and colleagues investigating mental health of female sex workers, none of the women met the current criteria for alcohol dependency and only 0.5 per cent met the criteria for lifetime alcohol dependency. However, clinical observations suggest that sex workers have high rates of substance use disorders. Reasons for inaccurate self-report regarding substance use disorders could be that sex workers and trafficked patients are afraid of legal consequences and are more hesitant to trust care givers because of traumatic experiences, self-stigma, and difficulty remembering exact amounts and frequency of (poly)-substance use.

'Street Talk' is an example of an organisation that has effectively reached out to people in this position. The founder Pippa Hockton told the CSJ that:

The women in street prostitution who have come to Street Talk since 2005 have without exception experienced childhood abuse, usually multiple abuses and neglect. Over fourteen years of doing this work, I have witnessed the ways in which women who have lived through trauma in childhood are punished over and over again in adulthood for the adverse effects of that early trauma.<sup>110</sup>

The addiction, she explains, is an attempt at 'self-medication to deal with this trauma'. Beyond the significant barriers that co-morbidity cause, Street Talk have recognised behaviours and trends consistent with the study and in their evidence to the CSJ stated that street sex workers:

106 Jeal, N.; Macleod, J.; Salisbury, C. et al. 'Identifying possible reasons why female street sex workers have poor drug treatment outcomes: a qualitative study', 2017, accessed via: <https://bmjopen.bmj.com/content/bmjopen/7/3/e013018.full.pdf>. Original source quoted in report from Cusick, L.; Martin, A.; May, T. 'Vulnerability and involvement in drug use and sex work'

107 Jeal, N.; Macleod, J.; Salisbury, C. et al. 'Identifying possible reasons why female street sex workers have poor drug treatment outcomes: a qualitative study'

108 Ibid. pp3

109 Hulka, L. & Mutschler, J. 'Measuring substance misuse in trafficked people', 2016, accessed via: [www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(15\)00580-5/fulltext](http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(15)00580-5/fulltext)

110 Pippa Hockton, in interview with the CSJ on 28.08.2018

fear authority figures, including health professionals which makes them reluctant to engage. They fear professionals because they are frequently judged, blamed for their vulnerability, frequently disbelieved or it is assumed that they have chosen to be in street prostitution. No woman would ever choose that. Their fear of authority figures means that they are very poor advocates for themselves.

## Ethnic and cultural barriers

Given that the ethnicity of those in treatment has not altered significantly since 2009/10, a study which examined the disparity, published in 2010 and written by JRF,<sup>111</sup> may be regarded as having application today. The report examines only alcohol misuse but its thorough examination of the relevance of cultural factors demands acknowledgement in our understanding of the ethnic disparity in the wider treatment numbers. The report indicated that:

The evidence suggests that minority ethnic groups are under-represented proportionately in seeking treatment and advice for drinking problems, although their rates of alcohol dependence are similar to those in the white population. A lack of awareness of the kinds of support and services available is evident among some minority ethnic groups. In particular, Muslim men, along with those on lower incomes from minority ethnic groups, have reported being unsure about where to go for advice. The literature suggests a high level of reluctance to approach outside agencies across different minority ethnic communities; this can lead to agencies underestimating need among different ethnic groups. Women and young people from South Asian ethnic groups, who are expected to be abstinent, may hide their drinking.

## Leicester

When a comparison is drawn between the recorded ethnicity of Leicester and the treatment populations ethnicity, there is a marked disparity. While just under 51 per cent of the population is white, this contingent represent 85 per cent of the treatment population.<sup>112</sup>

There are regions of the UK that have significantly greater BAME representation than the national average. In these regions it is often the case that, despite a much higher contingent of ethnic groups, the ethnicity of the treatment population remains disproportionately white.

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111 JRF, 'Ethnicity and alcohol: a review of the UK literature', July 2010, accessed via: [www.jrf.org.uk/sites/default/files/jrf/migrated/files/ethnicity-alcohol-literature-review-summary.pdf](http://www.jrf.org.uk/sites/default/files/jrf/migrated/files/ethnicity-alcohol-literature-review-summary.pdf)

112 ONS data fields classifying ethnicity do not marry with NDTMS classifications. For this reason some groups have been included together to allow for like for like comparisons. ONS data relating to White: English/Welsh/Scottish/Northern Irish/British, White: Irish, White: Gypsy or Irish Traveller: Other white has been deemed to be equivalent to White. The classification in ONS data of Multiple ethnic groups White and Black Caribbean/White African/White Asian and Other mixed has been deemed to be equivalent to 'Multi-ethnic groups' in NDTMS data. The ONS field Asian/Asian British: Indian, Pakistani, Bangladeshi, Chinese, Other Asian has been deemed to be equivalent Asian/Asian British. The ONS field Black/African Caribbean/Black British and other Black has been deemed to be equivalent to NDTMS data for classification 'Black/African/Caribbean'. The ONS data fields for 'other ethnic group' and associated sub-classification are deemed to be within what the NDTMS classify as other ethnic groups. These figures use the census from 2011, accessed via: [www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=11&ved=2ahUKewjEKTEm6riAhWtz4UKHTYfBg4QFjAKegQIAxAC&url=https%3A%2F%2Fwww.ons.gov.uk%2Ffile%3Furi%3D%2Fpeoplepopulationandcommunity%2Fpopulationandmigration%2Fpopulationestimates%2Fdatasets%2F2011censuskeystatisticsforlocalauthoritiesinenglandandwales%2Fr21ewrttableks201ewladv1\\_tcm77-290595.xls&usq=AOvVaw3MruC1Etj\\_qlpHHP9DCRC6](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=11&ved=2ahUKewjEKTEm6riAhWtz4UKHTYfBg4QFjAKegQIAxAC&url=https%3A%2F%2Fwww.ons.gov.uk%2Ffile%3Furi%3D%2Fpeoplepopulationandcommunity%2Fpopulationandmigration%2Fpopulationestimates%2Fdatasets%2F2011censuskeystatisticsforlocalauthoritiesinenglandandwales%2Fr21ewrttableks201ewladv1_tcm77-290595.xls&usq=AOvVaw3MruC1Etj_qlpHHP9DCRC6). Although these figures are of some age they are deemed to be a reliable data set. The figures used for those in treatment from the NDTMS data, accessed via: [www.ndtms.net/ViewIt/Adult](http://www.ndtms.net/ViewIt/Adult)] set are unchanged from 2010/11 to 2017/18



## Bradford and Halifax

In Bradford, the white British population is recorded as accounting for just 63.9 per cent of the population, yet non-white groups account for just 5 per cent of the treatment population. In fact, 20.3 per cent of Bradford's population are of Pakistani ethnic origin and 24.7 per cent are Muslim.<sup>113</sup> The CSJ has heard evidence from service providers and lived experience that there is a reported or suspected unmet need in some ethnic communities.

The CSJ conducted a roundtable in a Muslim Community Centre in Halifax and spoke with representatives from the community and those that were still in active recovery. The CSJ has heard that many in the Muslim Community in Bradford and Halifax felt that more needed to be done to challenge social and cultural barriers that made it difficult for some in the community to seek help for their addictions. Others stated that the service provision in the UK is not suited to cultural sensitivities.

**I think people do want to come forward. They need to see that it's possible.**

**Community Leader – Halifax<sup>114</sup>**

There does at least appear to be a real cause for concern about the extent to which ethnic minorities are represented in treatment. The answer to these issues is not always increased funding but it is always about having the resources and a co-ordinated community strategy to take on these sometimes sensitive issues.

## Dual diagnosis as a barrier to treatment

Very often a person seeking treatment for substance misuse will present to either an addiction treatment provider or a mental health practitioner with an existing need for both services. This is often referred to as dual diagnosis.<sup>115</sup> Although there is clear NICE guidance, the CSJ has heard evidence that mental health can, in reality, prove to be a significant barrier to help. A recent PHE report<sup>116</sup> identified that research has revealed that:

mental health problems are experienced by 70 per cent of drug users and 86 per cent of alcohol users in community substance misuse treatment.<sup>117</sup>

The report also reveals that:

a history of alcohol or drug use being recorded in 54 per cent of all suicides in people experiencing mental health problems [...] We also know that in spite of the shared responsibility that NHS and local authority commissioners have to provide treatment, care and support, people with co – occurring conditions are often excluded from services.<sup>118</sup>

113 City of Bradford Metropolitan District Council, 'Population', accessed via: [www.bradford.gov.uk/open-data/our-datasets/population/](http://www.bradford.gov.uk/open-data/our-datasets/population/)

114 An interview in Halifax, 23 July 2019

115 Co-occurring conditions and more generally co-morbidity

116 Public Health England, 'Better care for people with co-occurring mental health and alcohol/drug use conditions', June 2017, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/625809/Co-occurring\\_mental\\_health\\_and\\_alcohol\\_drug\\_use\\_conditions.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf)

117 Ibid. pp8

118 Ibid

In 2016, Professor Alan Maryon-Davis spoke about the need for revised NICE guidelines.<sup>119</sup> These new guidelines specifically addressed the need for the obstacles to treatment that sometimes arise in cases involving a dual diagnosis.

First, there has to be much wider recognition that this group of people, despite their complexities, have as much right to dedicated care and support as anyone else. They should not be turned away or left to flounder. Every effort should be made to help them benefit from the services they so badly need. Crucial to this is a non-judgmental, empathetic approach and the building up of mutual respect and trust.

And secondly, good communication is key! Staff working in mental health, substance misuse, primary care, social care, housing, employment, benefits, criminal justice and the voluntary sector need to have strong leadership to ensure that they are all working together as best they can. We recommend that this can be best achieved by having a dedicated care co-ordinators.

Professor Alan Maryon-Davis' observations will meet with no criticism here, indeed the difficulties surrounding dual diagnosis and the care that must be taken could scarcely be better put. However, it is the administration of the NICE guidelines that many have identified as falling far short of our reasonable expectations. Sufferers of mental health issues and addiction often find that treatment is not forthcoming precisely because of complications arising out of the dual diagnosis.

The CSJ has heard evidence from drug users and treatment providers across the UK that it is still commonplace to find mental health services being denied to those seeking treatment on the basis of their continued substance misuse. This often leads to people being left without help.

Pippa Hockton, of Street Talk, told the CSJ:

The main barrier to addiction treatment for the women who come to Street Talk, is that their PTSD is never diagnosed or treated, with the result that their mental health deteriorates and, in many cases, leads to psychosis, acute depression and anxiety. When women present to mental health services in an acute state, usually at A and E, the symptoms of their illness are wrongly attributed to their substance and alcohol use. They are signposted to addiction services but are far too unwell to engage.<sup>120</sup>

The BMA report, 'Breaking Down Barriers', stated that:<sup>121</sup>

There is often poor integration of mental health services with other services locally, making the patients experience of care more difficult and causing some patients to 'fall through the gaps' in the system.

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119 Professor Alan Maryon-Davis, NICE, 'New NICE guidance on dual diagnosis is desperately needed', 30 November 2016, accessed via: [www.nice.org.uk/news/article/new-nice-guidance-on-dual-diagnosis-is-desperately-needed](http://www.nice.org.uk/news/article/new-nice-guidance-on-dual-diagnosis-is-desperately-needed)

120 Pippa Hockton, in interview with the CSJ on 17.04.2019

121 BMA, 'Breaking down barriers – the challenge of improving mental health outcomes', 2017. pp1, accessed via: [www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=2ahUKewID7dOk9aLkAhX6UBUIHe-sDQEQFjABegQlAxAC&url=https%3A%2F%2Fwww.bma.org.uk%2F-%2Fmedia%2Ffiles%2Fpdfs%2Fcollective%2520voice%2Fpolicy%2520research%2Fpublic%2520and%2520population%2520health%2Fmental%2520health%2Fbreaking-down-barriers-mental-health-briefing-apr2017.pdf%3Fla%3Den&usg=AOvVaw2vDSyHW-Cj2vBAzvS975rX](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=2ahUKewID7dOk9aLkAhX6UBUIHe-sDQEQFjABegQlAxAC&url=https%3A%2F%2Fwww.bma.org.uk%2F-%2Fmedia%2Ffiles%2Fpdfs%2Fcollective%2520voice%2Fpolicy%2520research%2Fpublic%2520and%2520population%2520health%2Fmental%2520health%2Fbreaking-down-barriers-mental-health-briefing-apr2017.pdf%3Fla%3Den&usg=AOvVaw2vDSyHW-Cj2vBAzvS975rX)

## The importance of outreach

- 2018 saw a 5 per cent decrease in the number of young people in specialist misuse services. Since year ending 2009 there has been a 35 per cent decrease in young people receiving treatment.<sup>122</sup>
- Despite stable dependency figures over the same time period, the number of young people receiving treatment for alcohol alone decreased by 17 per cent from year ending 2014.<sup>123</sup>
- Women have been historically under-represented in treatment and the likely reasons are deeply concerning.<sup>124</sup>
- There is evidence to heavily suggest BAME are under-represented in treatment.<sup>125</sup>
- The CSJ has heard evidence from across England that mental health issues have, for many, frustrated access to treatment for their addictions.

There are examples of excellent work across the UK. Groups like Changing Lives in the Northeast can show us real examples of people helped in their moments of extreme desperation, unquestionably saving lives along the way. They are not alone but they are exceptional in that they achieve this in the face of funding challenges, very much despite the conditions forced upon them. We have also heard evidence that the sectors funding cuts have caused it to recede to a more reactive approach.

Current budgets are seeing rehabilitation centres turning people away or raising funds through bursaries to subsidise budgets depleted or stretched by the states dereliction of its duty to citizens seeking recovery.

122 Public Health England, 'Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS): April 2017 to March 2018', Nov 2018. pp5

123 Public Health England, 'Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS): April 2017 to March 2018', Nov 2018. pp6

124 Public Health England, 'Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): April 2017 to March 2018', Nov 2018

125 JRF, 'Ethnicity and alcohol: a review of the UK literature', July 2010, accessed via: [www.jrf.org.uk/sites/default/files/jrf/migrated/files/ethnicity-alcohol-literature-review-summary.pdf](http://www.jrf.org.uk/sites/default/files/jrf/migrated/files/ethnicity-alcohol-literature-review-summary.pdf)



part two

# The opportunity for change

“

When you return to a community your personal integrity and self-respect comes back. There were times when I couldn't even look people in the eye and that's far behind me now.

Dan, Brighton

# The levers for change

- There is an overwhelming body of evidence, at home and abroad, that demonstrates that people can overcome addiction and can enter into lasting recovery free-from dependence.
- Connectedness with society – be that through a loving family, friendship, work or wider participation in a community is integral to a lasting recovery
- People with addiction, as with people without, are complex and their needs reflect that. Often mental health issues, physical health issues and diminished social capital can make a person engaging in recovery yet more vulnerable. Whole person approaches are necessary.

The current systemic failures in the decision-making process and the allocations of funding are important considerations for public policy. Equally, we must recognise the assets at our disposal and the progress made. With system reform there is every opportunity to capitalise on our nations expertise and promising initiatives such as Troubled Families, social prescribing, FDAC, Housing First, Reducing Parental Conflict and the Individual Placement Support pilots.

At a time when so many are left behind it is difficult to recall that there was a time when the UK was considered amongst the worlds leaders in this space. There is an opportunity, that these pages will reveal, to take hold of this threat to our families and our communities and to re-discover an equitable access to recovery – to more successfully prevent harm to our nation's youth.





## chapter five

# Prevention

This is a term used here to refer to those practices that are designed to reduce the prospect of developing substance based or behavioural addictions. The ACMD have defined it in this way:

Drug prevention may include any policy, programme, or activity that is (at least partially) directly or indirectly aimed at preventing, delaying or reducing drug use, and/or its negative consequences such as health and social harm, or the development of problematic drug use.<sup>126</sup>

### Family matters

Before briefly examining any programs or practices that seek to prevent addiction, we should recognise that the breakdown of family is a root cause of poverty. The emotional distress as well as the breakdown in structure in a child's life can itself become a driver to multiple social issues and can be a driver for substance misuse and addiction. The CSJ commissioned ComRes, a leading market research agency, to conduct a logistic regression to demonstrate the impact that experiencing family breakdown in childhood has on the likelihood of experiencing a number of social issues. The model is a robust design in which the influence of demographic attributes as well as experience of the other social issues are controlled for, arriving at a true reflection of the impact that family breakdown has on the lives of individuals. They reveal the significant relationship between family breakdown and some of the most complex and challenging social issues facing Britain today.

Those who experience family breakdown when aged 18 or younger, are almost twice as likely to experience

- alcoholism (multiple of 1.8)
- mental health issues (multiple of 1.7)
- homelessness (multiple of 2.3)

The same polling revealed that well over half (56 per cent) of British adults who report having experienced family breakdown themselves while at preschool (age 0–4) also report having any experience of drug addiction. This figure drops to two in five (41 per cent) British adults who experienced family breakdown themselves while at primary school (age 5–11)

126 ACMD referencing Brotherhood, A. & Sumnall, H.R., EMCDDA, 'European drug prevention quality standards', 2011, accessed via: [www.drugsandalcohol.ie/28054/1/EuropeanResponsesGuide2017\\_BackgroundPaper-Evidence-review-drug-interventions.pdf](http://www.drugsandalcohol.ie/28054/1/EuropeanResponsesGuide2017_BackgroundPaper-Evidence-review-drug-interventions.pdf)

and who report having any experience of drug addiction. One third (35 per cent) of British adults who experienced family breakdown themselves while at secondary school report having any experience of drug addiction.<sup>127</sup>

Initiatives, explored in more detail in this report, such as 'Troubled Families' and DWP's 'Reducing Parental Conflict' are designed to help the family unit and reduce the prospect of a child suffering hardship in the home, they are consequently regarded here as helpful contributors in reducing a young person's prospect of developing addiction.

## What is known about the effectiveness of prevention globally

There is still a substantial degree of uncertainty about what is an effective approach to preventing people from substance abuse or the development of behavioural addictions. The UNODC/WHO International Standard on Drug use Prevention<sup>128</sup> summarises the scientific evidence base behind a number of trials and programmes designed to prevent substance misuse and addiction. The authors of the report indicate that although 'prevention science' has made progress over the decades of research that has occurred globally, there are still significant limitations to this body of work. The authors remarked that:

Often studies are too few to be able to conclusively identify 'active ingredients', i.e. the component or components that are really necessary for the intervention or policy to be efficacious or effective.<sup>129</sup>

The report also states that, globally, there is a strong and urgent need for research funding in this area, particularly in 'rigorous evaluation of their programmes and policies'. However, what is clear is that addiction, or indeed the trauma or poor decision-making processes that later act as a driver for addictive behaviours, can start early.<sup>130</sup> Addaction, a care provider in the UK wrote a report named 'Childhood adversity, substance misuse and young people's mental health'. This report<sup>131</sup> highlights the clear nexus between adverse childhood experiences and a child's propensity to abuse substances, notably informing us that:

Children who experience four or more adversities are twice as likely to binge drink and eleven times more likely to go on to use crack cocaine or heroin.<sup>132</sup>

The CSJ commissioned ComRes poll, which revealed that 16% of those polled had either experienced drug addiction themselves or had experience of an immediate family member or close friend with a drug addiction. That figure rises to 26% when applied to alcoholism.<sup>133</sup>

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127 ComRes polling commissioned by the CSJ, accessed via: [www.centreforsocialjustice.org.uk/core/wp-content/uploads/2019/04/CSJJ6900-Family-Report-190405-WEB.pdf](http://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2019/04/CSJJ6900-Family-Report-190405-WEB.pdf)

128 UNODC/WHO, 'International Standards on Drug Use Prevention, Second Updated Edition', 2018, accessed via: [www.unodc.org/documents/prevention/standards\\_180412.pdf](http://www.unodc.org/documents/prevention/standards_180412.pdf)

129 Ibid. pp5

130 Ibid. pp11

131 Addaction, 'Childhood adversity, substance misuse and young people's mental health', 2017, accessed via: <https://youngminds.org.uk/media/1547/ym-addaction-briefing.pdf>

132 Ibid. pp2

133 ComRes polling commissioned by the CSJ

## Evidence of some effectiveness

For the most part the studies have focussed on substance related addictions and not behaviour addictions such as gambling. However, most approaches that have shown to be at least partially effective have focused not on the actual substance misuse itself but on those risk factors that make drug use more likely. This includes supporting pupils with feelings of hopelessness, impulsivity or sensation seeking. The National Institute for Clinical Excellence Guidelines<sup>134</sup> recommend skills training is offered to young people and their carers, and should include such skills as:

- listening
- conflict resolution
- refusal
- identifying and managing stress
- making decisions
- coping with criticism
- dealing with feelings of exclusion
- making healthy behaviour choices.

In fact, these principles have been at the centre of some of the programmes that have demonstrated that they are ‘likely to be beneficial’. One such programme is called the ‘Good Behaviour Game’ and is delivered in Primary School.<sup>135</sup>

## The Good Behaviour Game

It’s played a number of times in a week and attempts to reinforce good behaviours through a reward during the game but, critically, it is played in teams. The ACMD acknowledged in its 2015 report that:<sup>136</sup>

In one long-term trial conducted in the USA, participation in the game in primary school was associated at age 19–21 with significantly lower rates of drug and alcohol use disorders, regular smoking, antisocial personality disorder, delinquency and imprisonment for violent crimes, suicide ideation, and use of school-based services.

The Department for Education’s guidance, released in 2018,<sup>137</sup> goes at least some way to redressing the paucity in effort made today in tackling a child’s propensity to fall into drug addiction and this should be applied toward the end of summer 2019. It is also

134 NICE, ‘Drug misuse prevention: targeted interventions’, Feb 2017. (NG64) paragraph 1.3.3, accessed via: [www.nice.org.uk/guidance/NG64/chapter/Recommendations#children-and-young-people-assessed-as-vulnerable-to-drug-misuse](http://www.nice.org.uk/guidance/NG64/chapter/Recommendations#children-and-young-people-assessed-as-vulnerable-to-drug-misuse)

135 EMCDDA, ‘Good Behaviour Game (GBG) – group-contingent positive reinforcement of children’s prosocial behaviour’, 2017, accessed via: [www.emcdda.europa.eu/best-practice/xchange/good-behaviour-game\\_en](http://www.emcdda.europa.eu/best-practice/xchange/good-behaviour-game_en)

136 ACMD, ‘Prevention of drug and alcohol dependence’, Feb 2015. pp21, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/406926/ACMD\\_RC\\_Prevention\\_briefing\\_250215.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/406926/ACMD_RC_Prevention_briefing_250215.pdf)

137 Department for Education, ‘Relationships, Education, Relationships and Sex Education (RSE) and Health Education Statutory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers’, 2019, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/805781/Relationships\\_Education\\_Relationships\\_and\\_Sex\\_Education\\_\\_RSE\\_\\_and\\_Health\\_Education.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/805781/Relationships_Education_Relationships_and_Sex_Education__RSE__and_Health_Education.pdf)

encouraging that this is a 'whole-school' approach in which issues surrounding health, sex and behaviour are tackled together. The rise of Chemsex and self-medication amongst younger people means that these issues are sometimes inseparable.

However, underfunding in this area continues today. Teachers need adequate training, arguably beyond that provided by the PSHE Association and Mentor APEPIS-guidance. These issues are not without complexity and this is compounded by the very real potential for well meaning, even essential engagement on these issues to uncover serious trauma. As Addaction advise in their report:

To ensure it is trauma-informed, those delivering the training, or supporting teaching staff to do so, should have a good knowledge of the relationships between childhood adversity, trauma responses, mental ill health and use of substances.<sup>138</sup>

The efforts the UK has made to meaningfully prevent children from falling into addiction have been, historically speaking, underfunded, inadequately researched and, what has been tried, applied inconsistently across the country. Our increasing understanding of the effect of early trauma on a persons mental health, and in fact their physical health, is increasingly advising good practice.

With some direction and funding, further research into prevention strategies would likely be to the benefit of our young people. The UK has a wealth of research resources and expertise to exploit. In addition to our world class Universities, capable organisations such as the Education Endowment Foundation<sup>139</sup> are well placed to facilitate a concerted effort to take strides in this important area of child welfare.

## Trauma informed prevention and Adverse Childhood Experiences (ACE's)

Adverse Childhood Experiences have been defined as:

Intra-familial events or conditions causing chronic stress responses in the child's immediate environment. These include notions of maltreatment and deviation from societal norms.<sup>140</sup>

However, the definition of Adverse Childhood Experiences is inconsistent across literature and the ACMD has stated that:

*"in a recent systematic review<sup>141</sup> 16 broad ranges of ACE were identified and included:*

- childhood physical abuse;
- household substance use;
- childhood sexual abuse;
- emotional neglect;
- parental imprisonment; and
- household mental illness."

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138 Addaction, 'Childhood adversity, substance misuse and young people's mental health', 2017. pp10

139 <https://educationendowmentfoundation.org.uk>

140 Kelly-Irving, M.; Lepage, B.; Dedieu, D., et al. 'Adverse childhood experiences and premature all-cause mortality', 2013

141 ACMD, 'What are the risk factors that make people susceptible to substance use problems and harm?', 2018 referencing Hughes, K. et al. 'The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis', 2017

Hughes et al, also stated that:

The odds of experiencing adult (>18 years of age) problematic substance use (defined as injecting drug use, or heroin or crack cocaine use) was 10 times higher in study participants who reported more than 4 ACEs.<sup>142</sup>

A report published in the *Lancet*, '*The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis*'<sup>143</sup> looked at a range of sources, with a total of 253,719 participants, and it found that:

Individuals with at least four ACEs were at increased risk of all health outcomes compared with individuals with no ACEs. Associations were [...] strong for sexual risk taking, mental ill health, and problematic alcohol use, and strongest for problematic drug use and interpersonal and self-directed violence.

The report went on to interpret the findings by stating that:

To sustain improvements in public health requires a shift in focus to include prevention of ACEs, resilience building, and ACE-informed service provision. The Sustainable Development Goals provide a global platform to reduce ACEs and their life-course effect on health.

An NDTMS report reveals that of the young people entering specialist substance misuse services, 96 per cent of them reported at least one of the 17 vulnerabilities collected via the data gathering system. These include, having mental health problems, being in contact with social services, self-harming experiencing sexual exploitation or domestic violence. More than half stated they suffered from at least three vulnerabilities.<sup>144</sup>

There is a clear need to identify a child's disadvantage at the earliest opportunity. This may be substance-misuse, but it may represent as something other. The effect of an ACE and in particular multiple ACE's is well documented. A BMC study<sup>145</sup> found that after correcting for sociodemographic factors it concluded that:

Modelling suggested that 11.9 per cent of binge drinking, 13.6 per cent of poor diet, 22.7 per cent of smoking, 52.0 per cent of violence perpetration, 58.7 per cent of heroin/crack cocaine use, and 37.6 per cent of unintended teenage pregnancy prevalence nationally could be attributed to ACEs.

## Substance abuse in the home as a driver for ACE

Today only 1 in 5 of those in need of treatment for alcohol abuse are in treatment. It is difficult to conclude that all people in need of help necessarily recognise this or have the motivation to address it. The impact of growing up in a destabilised home gives rise to

142 Hughes, K., et al. 'The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis', 2017, accessed via: [www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667\(17\)30118-4.pdf](http://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30118-4.pdf)

143 Ibid

144 Public Health England, 'Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS): April 2017 to March 2018', Nov 2018, pp6

145 Bellis, M. A., et al. 'National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England', 2014, accessed via: <https://bmcmmedicine.biomedcentral.com/articles/10.1186/1741-7015-12-72>

a risk of multiple Adverse Childhood Experiences (ACE's). Public Health England estimate that 595,000 people in the UK may need treatment for alcohol dependence and of these some 120,000 are living with children.<sup>146</sup>

The NSPCC reported that approximately one in eight babies under 1 – the equivalent of almost 94,000 in the UK – live with a parent who is a problematic alcohol user. One in 15 babies under 1 – equivalent to over 50,000 in the UK – live with a parent who uses illicit drugs.<sup>147</sup>

The National Association for Children of Alcoholics have highlighted that 2.6 million children in the UK are living with an alcohol dependant parent.<sup>148</sup> An analysis of 175 serious case reviews from 2011–14 found that 47% of cases featured parental substance misuse.<sup>149</sup>

Early diagnosis of mental health issues, identifying trauma in the home and training teachers, social workers and the Police in trauma informed approaches is an important step towards mitigating the effects of ACE's on a person's future.

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146 Public Health England, 'Alcohol and drugs prevention, treatment and recovery: why invest?', Feb 2018

147 Manning, V. NSPCC, 'Estimates of the number of infants (under the age of one year) living with substance misusing parents', 2011. pp5

148 NACOA, referencing Manning, V. et al, 'New estimates of the number of children living with substance misusing parents: Results from UK national household surveys', 2009

149 Parental substance misuse How to support children living with parents who misuse alcohol and drugs, accessed via: [www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-substance-alcohol-drug-misuse/](http://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-substance-alcohol-drug-misuse/) and Sidebotham et al, 2016

## chapter six

# Recovery and housing

### The nature and scale of the problem

At the sharpest end, homelessness can mean that someone is forced to sleep rough. Rough sleepers make up a relatively small proportion of the overall number of people who are homeless. For many people who lose their home, they will not end up in this position. Certain groups, including families with dependent children, receive statutory assistance from their local authority to find settled accommodation. A greater proportion of people who seek help from their local authority will receive more informal help. Many single people who do not qualify for an offer of settled accommodation will reside in hostels, which are typically shared and temporary. In addition to those who lose their home, there are a significant number of people living in poor, overcrowded and unstable conditions. This is often referred to as 'hidden homelessness'.

As our 2017 report, 'Housing First',<sup>150</sup> identified, homelessness should be viewed on a continuum. Someone might for example experience several episodes of hidden homelessness or a stay in a hostel before they sleep rough or move between sleeping rough and staying with friends and acquaintances. While the distinction between those enduring rough sleeping and those in inappropriate accommodation will always be a meaningful one worthy of our consideration, any accommodation that is marked by instability and risk to health is to be regarded as not conducive to prospect of recovery.

### What is the housing situation for those in addiction?

According to NDTMS data, 80 per cent of all persons in treatment indicate that they have 'no problem' with housing.<sup>151</sup> In 2017/18, of all those in treatment, regardless of the main substance used, those reporting a 'housing problem' or an 'urgent housing problem' constituted a total of 19 per cent, with an urgent problem cited by only 8 per cent. However, the numbers are significant, the 19 per cent that report at least some problem with housing constitutes just under 24,000 people, almost 10,000 of those people with an urgent housing problem.<sup>152</sup>

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150 The Centre for Social Justice, 'Housing First', 2017, accessed via: [www.centreforsocialjustice.org.uk/core/wp-content/uploads/2017/03/CSJJ5157\\_Homelessness\\_report\\_070317\\_WEB.pdf](http://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2017/03/CSJJ5157_Homelessness_report_070317_WEB.pdf)

151 NDTMS, 'Adult profiles: Housing situation – England – New Presentations', accessed via: [www.ndtms.net/ViewIt/Adult](http://www.ndtms.net/ViewIt/Adult)

152 Ibid

In a 2019 study the Centre for Social Justice found that a third (33 per cent) of British adults who have experienced homelessness also say they have experienced alcoholism.<sup>153</sup> Of the rough sleepers seen in 2018/19 by the London CHAIN database, the most frequently reported support need was mental health, with 50 per cent of those assessed during the period having a need in this area.<sup>154</sup> Alcohol support was the second most prevalent need, at 42 per cent, while 41 per cent of rough sleepers were assessed as having a support need relating to drugs.<sup>155</sup>

Perhaps reflective of the widely accepted position that many in the opioids cohort suffer diminished social capital after many years of drug abuse, those reporting a problem or an urgent problem with housing is significantly higher than the average of all persons in treatment at 31 per cent.<sup>156</sup> The comparison with 'alcohol only' addiction is stark when we see that 89 per cent of this cohort report no problem with housing and only 3 per cent reporting an urgent problem.

ONS figures<sup>157</sup> released in December 2018, showed that in 2017, an estimated 190 homeless people died due to drug poisoning – 32 per cent of the total number 597 deaths of homeless people in England and Wales. Alcohol-specific deaths constituted a further 10 per cent of all homeless people that died that year.

## Gambling and homelessness

There is also a clear association with problem gambling and homelessness. A 2014 study<sup>158</sup> from Cambridge University, examined this issue and found that:

the rate of problem or pathological gambling is significantly higher in the homeless population than the general population.

In fact, that same study found that while 0.7 per cent of the UK population were affected by problem gambling, the level of problem gambling amongst homeless people was 11.6 per cent.<sup>159</sup>

Regardless of whether gambling is a cause or a consequence, recognising and addressing this problem will hopefully give affected individuals a better chance of getting off – and more importantly staying off – the streets.<sup>160</sup>

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153 The Centre for Social Justice, 'Why Family Matters', March 2019, accessed via: [www.centreforsocialjustice.org.uk/core/wp-content/uploads/2019/04/CSJJ6900-Family-Report-190405-WEB.pdf](http://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2019/04/CSJJ6900-Family-Report-190405-WEB.pdf)

154 Combined Homelessness and Information Network (CHAIN), 'CHAIN Annual Bulletin Greater London 2018–2019', 2019, pp31, accessed via: <https://data.london.gov.uk/dataset/chain-reports>

155 Ibid

156 NDTMS, 'Adult profiles: Housing situation – England – New Presentations', accessed via: [www.ndtms.net/Viewwt/Adult](http://www.ndtms.net/Viewwt/Adult)

157 ONS, 'Deaths of homeless people in England and Wales: 2013 to 2017', Dec 2018, accessed via: [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandanddwales/2013to2017](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandanddwales/2013to2017)

158 Sharman, S. et al. 'Rates of Problematic Gambling in a British Homeless Sample: A Preliminary Study', Jan 2014.

159 Ibid. pp528

160 Steve Sharman, as reported on Behavioral and Clinical Neuroscience Institute, 'New study reveals scale of problem gambling among homeless population', May 2014, accessed via: [www.bcni.psychol.cam.ac.uk/news/homeless-people-are-ten-times-more-likely-to-be-problem-gamblers-than-the-uk-population-as-a-whole-researchers-at-cambridge-have-found](http://www.bcni.psychol.cam.ac.uk/news/homeless-people-are-ten-times-more-likely-to-be-problem-gamblers-than-the-uk-population-as-a-whole-researchers-at-cambridge-have-found)



## Rough sleeping and homelessness

For the purposes of this paper we confine ourselves to two considerations, but these are premised on a widely accepted truth that homelessness causes physical and emotional disruption. These considerations are simply:

- **As well as being a human right, stable accommodation is an essential component to any recovery journey.** Recent efforts by government such as the Homelessness Reduction Act 2017, the Rough Sleepers Initiative and Housing First pilots are to be commended but the current level of support offered is, at the time of writing, inadequate.
- **The needs of people in recovery vary greatly and some people will need more support than others.** We must protect the availability of residential rehabilitation as well as structured, medium to long-term housing.

## Treatment and housing

Historically, the state approach has been to address the addiction and then seek to find onward care, including long-term housing, to sustain and further the progress made in treatment. 'Housing First' challenged this approach by recognising the chaotic lifestyles and instability that homelessness creates, and regarding housing as a human right and the foundations for other work. Housing First England report that '70–90 per cent of people sustain their accommodation with Housing First in England'.<sup>161</sup> Housing First have set out ten key principles<sup>162</sup> for designing and delivering housing in England, and they include:

- People have a right to a home
- Flexible support is provided for as long as is needed
- Housing and support are separated
- Individuals have choice and control.<sup>163</sup>

As argued by the Centre for Social Justice, the most effective way to transform the lives of rough sleepers with complex support needs is through a national Housing First programme.<sup>164</sup> The Government since announced £28 million worth of Housing First pilots in three parts of the country, which are underway.<sup>165</sup> However, the scale of ambition does not yet match the extent of the rough sleeping problem – as we know from the case of Finland, when properly funded, Housing First can have a dramatic impact and nearly eradicate rough sleeping altogether.<sup>166</sup>

161 Homeless Link, Housing First England, referencing Pleace, N. & Bretherton, J. in 'Housing First in England: An Evaluation on Nine Services', Feb 2015, accessed via: <https://hfe.homeless.org.uk/about-housing-first>

162 Home Link, 'Housing First in England: The Principles', 2016, accessed via: [www.homeless.org.uk/sites/default/files/site-attachments/Housing%20First%20in%20England%20The%20Principles.pdf](http://www.homeless.org.uk/sites/default/files/site-attachments/Housing%20First%20in%20England%20The%20Principles.pdf)

163 Ibid. Note, the full list of principles read: People have a right to a home; Flexible support is provided for as long as is needed; Housing and support are separated; Individuals have choice and control; An active engagement approach is used; The service is based on people's strengths, goals and aspirations; A harm reduction approach is used

164 The Centre for Social Justice, 'Housing First', 2017

165 As reported by Homeless Link, 'Government launches its three regional Housing First pilots', 9th May 2018, accessed via: [www.homeless.org.uk/connect/news/2018/may/09/government-launches-its-three-regional-housing-first-pilots](http://www.homeless.org.uk/connect/news/2018/may/09/government-launches-its-three-regional-housing-first-pilots)

166 As reported by World Economic Forum, 'Here's how Finland solved its homelessness problem', 13 February 2018, accessed via: [www.weforum.org/agenda/2018/02/how-finland-solved-homelessness/](http://www.weforum.org/agenda/2018/02/how-finland-solved-homelessness/)

## Recommendation

Accelerate the delivery of Housing First across the UK. The forthcoming CSJ Housing Commission Final Report will outline detailed recommendations for the Ministry of Housing, Communities and Local Government.

## Residential rehabilitation

This term is often applied as a description of a method of treatment of itself, but there is a great deal of disparity in terms of approach to treatment, length of stay, and even quality between providers. For the most part, residential rehabilitation involves at least a 28 day stay, and many in the UK can last 12 weeks. Largely, they are modelled around the 12-step programme and a community of those in recovery draw upon each other for mutual support. For many with severe underlying trauma or with such diminished or otherwise compromised ability to live independently, even with some degree of support, treatment in a residential setting is an essential beginning to their recovery journey. The now defunct National Treatment Agency, published a report in 2012 that stated:

Residential rehab is an integral part of any drug treatment system, a vital option for some people requiring treatment for drug dependence. Anyone who needs it should have easy access to rehab, whether close to home or further away.<sup>167</sup>

## Who needs it?

The same 2012 report noted that residential rehabilitation cost around £600 a week, and while it accounted for about 2 per cent of adult drug treatment it also absorbed about 10 per cent of the budget.<sup>168</sup> The question then arises – when should resources be used for residential rehabilitation?

The CSJ has interviewed staff and lived experience at residential rehabilitation services across the country. Hannah Shead, of Trevi House, explains that the women that come to her are in need of a level of support that can help keep mother and child together while the mother starts her recovery journey. The loss of a child to the care system can have a profoundly damaging effect on a woman.

When an adoption is ordered, and the case is closed, what we tend to find is that those women start to disengage, and those women fall by the wayside. The solicitor, the Courts and the social workers drift away and she is left alone, damaged and very vulnerable – it's incredibly traumatic.<sup>169</sup>

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<sup>167</sup> National Treatment Agency for Substance Misuse, 'The Role of Residential Rehab In An Integrated Treatment System', 2012, pp3, accessed via: [www.drugsandalcohol.ie/18195/1/The\\_role\\_of\\_residential\\_rehab\\_in\\_an\\_integrated\\_drug\\_treatment\\_system.pdf](http://www.drugsandalcohol.ie/18195/1/The_role_of_residential_rehab_in_an_integrated_drug_treatment_system.pdf)

<sup>168</sup> Ibid

<sup>169</sup> Hannah Shead, in interview with CSJ



This trauma is a driver for relapse and continued vulnerability. This is not a rare occurrence in the UK, with 90 children taken into care every day<sup>170</sup> – that's one every 16 minutes. In Plymouth alone, one cohort of 18 women had more than 60 children taken into care between them. Trevi House in Plymouth is one of the only publicly accessible treatment providers to offer childcare to women while they are seeking to advance their recovery in a secure environment. Our nation's failure to bring more people into effective treatment undermines our efforts to challenge a broad spectrum of injustice. We know now that domestic abuse cases are often found because of proactive policing or the enquiring and caring efforts of medical staff – these cases do not always present themselves plainly.

Equally, victims of sexual violence often need to be encouraged and supported to come forward. We must take these lessons and apply them to cases in which women with children are suspected of having substance abuse problems. Extending support with real and workable options that allow a person to enter recovery without risking their most important relationship is critical and a stable treatment environment can be an essential component of that treatment.

Yet, there are circumstances in which a person does not obviously present with the sort of vulnerabilities that could easily allow a person to be so deemed. Many people require the removal of themselves from their everyday lives – the pressures and familiar temptations of their routine – to address their addictions. For many, in this position residential rehabilitation provides this often essential detachment to allow a period of change and re-appraisal. It is not a necessary part of everyone's recovery journey but it is nevertheless integral to many and must be made accessible to all, regardless of their means.

<sup>170</sup> Department for Education statistics, 'Children looked after in England (including adoption), year ending 31 March 2018', Nov 2018, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/757922/Children\\_looked\\_after\\_in\\_England\\_2018\\_Text\\_revised.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/757922/Children_looked_after_in_England_2018_Text_revised.pdf)

## Other vulnerabilities

Talking therapy, conducted properly, can be enormously beneficial to a person's mental health. However, uncovering trauma can create vulnerability or volatility perhaps only in the short term. Here, residential rehabilitation offers a degree of round the clock support and safety that significantly reduces relapse and improves safety.

## The effectiveness of residential rehabilitation

It is widely accepted that there is a growing need to apply more rigorous assessment to the efficacy of treatment broadly and this applies to residential rehabilitation equally. The CSJ would endorse recent and longstanding academic calls for more research in this area and would submit that more central ownership of large-scale national research projects alone can help realise this ambition. Nevertheless, in addition to the added security that residential rehabilitation affords those in a vulnerable state and the volumous personal accounts from those that felt the community and structure was integral to their recovery, there is evidence that it can be an effective option. A recent report published in the *Drug and Alcohol Dependence* journal<sup>171</sup> found that:

In line with previous reviews, this review on the most recent studies in the field (2013–2018) provides moderate quality evidence that residential treatment may be effective in reducing substance use and improving mental health. There is also some evidence that treatment may have a positive effect on social and offending outcomes.

### Recommendation

Reverse the damage caused by successive cuts over the last 6 years and re-establish as well as maintain a proportionate and adequate network of residential rehabilitation facilities across the country. This should be done in a way that ensures access to those who in the past have been obstructed from treatment, including mothers in need of support.

171 De Andrade, D. et al. 'The effectiveness of residential treatment services for individuals with substance use disorders: A systematic review', August 2019, accessed via: [www.sciencedirect.com/science/article/abs/pii/S0376871619301875?via%3Dihub](http://www.sciencedirect.com/science/article/abs/pii/S0376871619301875?via%3Dihub)

## chapter seven

# The role of family in recovery

Addiction can be isolating and lonely. Often those gripped by addiction will seek out the company of others who re-affirm their behaviours, and relationships with family and friends can become increasingly strained. An examination of 115 cases of death through drug misuse found that just 10 per cent of individuals were married and 85 per cent had either identified as single, under 16 years old, divorced or widowed.<sup>172</sup> Family can be a powerful stabiliser, capable of preventing addiction or helping a person into lasting recovery. A central part of any effective challenge to addiction in our community must be an acknowledgment that supporting families will provide the state with an ally unrivalled in enthusiasm, hope and tenacity in helping people into lasting recovery. Moreover, the love of family and the need for connection can be a powerful call to arms for a person to seek recovery.

### Rory's journey

I've been dry for 9,339 days, just over 25 years, and it's my proudest life-achievement to date. Ironically, it follows a 10-year period, where I used alcohol to anaesthetise and mask a deep unhappiness. This led to a self-loathing where an ever-increasing alcohol intake took me closer and closer to the point of no-return and a much-shortened predicted life-expectancy being chronically addicted to alcohol.

I didn't become addicted to alcohol overnight. However, my drinking matched my moods – 'Highs' were celebrated. 'Lows' were equally celebrated. And each were just excuse to reach out for the strong lager that became an integral part of my daily life. During that time, I did have short periods where I could abstain, but my relationship at home wasn't right, and drinking was a problem at work too as in the late 80's and early 90's lunchtime drinking was quite prevalent, and the pub became my office as well as an after-work club.

Life took a downward spiral with alcohol helping to paper over the cracks. Rather than facing up to my depression, I simply drank more and more and found myself in a much worse state afterwards feeling more depressed and in need of yet another drink. My second son was born in August 1993 and by Christmas of that year, I realised I'd been drunk every day of his life. This really shocked me, and I hated myself for that. I also hated the person looking back at me in the mirror – and I decided that I needed to change. I'd reached my 'Point-Zero'. The all-time lowest of low points where things couldn't possibly get any worse. I thought during the Christmas Holiday period about picking the right day to start my new life, with its new rules and standards.

172 ONS, 'Drug-related deaths "deep dive" into coroners' records', August 2018. pp8

Who I was going to be, what I'd do with the extra time I'd have and who would be part of my new world became a very exciting prospect.

**My second son was born in August 1993 and by Christmas of that year, I realised I'd been drunk every day of his life.**

When you are addicted it feels like there's no way out, no escape and no future but on 5th of January 1994, my first day back at work after Christmas, I didn't go to the pub as usual – I went home with only one thought, I needed to go for a run. I felt overweight, toxic, unfit and totally ashamed as I set off on my first run of just 100 steps. Still in my work clothes and leather shoes as I had no running gear, I felt totally euphoric as I lay gasping on the pavement a few minutes later as I'd found my way out – the therapy that I'd use to get me through my alcohol recovery and a framework for the rest of my life.



My path out of addiction became a more of personal system upgrade where I felt although I couldn't change the past, but I could shape the future. It started with a blank sheet of paper and I created a new me.

Even though the first runs were very short, running helped. It gave me a 'time out' to consider my future, where things had gone wrong in the past and decide who or what was enabling my addiction. My excess weight dropped off, I had a change of career and found out that I was actually good at running. My times became quicker and the distances grew so-much-so that I ran my first marathon that November and replaced my alcohol addiction with the more positive sense of achievement that running long distance brings.

I feel very lucky to have escaped alcohol addiction all those years ago. I also feel very lucky that I can now help other people who find themselves in the same situation, whether it's alcohol or drugs related. Being an ex-addict myself, I know how they feel and can show them what can be achieved with proper support and understanding. Feeling alone, without help and helpless only fuels the addiction cycle.

**The CSJ has spoken to people in recovery who have trained as football coaches, artists teachers and life coaches. Many return to their professions and more still rediscover their role as a mother or a father. Rory Coleman was motivated by a need to return to his family and be a better father but as he explained to the CSJ running became an important part of that journey. Today, Rory is a life coach in Wales and, at the time of writing, he has completed 1,044 Marathons including 254 Ultra-Marathons and achieved 9 Guinness World Records. Rory has completed the Sahara Desert Ultra, the Marathon des Sables, a 154 mile race said by some to be the hardest land race in the world, a total of 15 times.**

## Policy can help families

'Troubled Families' is a strong example of how government can help people deal with the stresses and strains that can lead to the break-up of a family. The initiative, which began in 2012, targets families with multiple disadvantage – although addiction or substance misuse are not primary indicators. Importantly, the initiative identifies factors that indicate a need for intervention. Local authorities identify those families that present to the state through anti-social behaviour, truancy, unemployment, mental health problems and domestic abuse and assign a key worker to act as a single point of contact.

In March 2019 the Secretary of State for Housing, Communities & Local Government announced the findings of the National Evaluation of the Troubled Families Programme. The report found that the evidence now suggests that:

the programme is having a positive impact on a number of measures. The programme is creating real change for some families. Local managers and practitioners continue to believe the programme is effective at achieving long-term positive change in families' circumstances. Ninety-three per cent of Troubled Families Employment Advisers, 80 per cent of keyworkers and 77 per cent of Troubled Families Coordinators agree with this view.<sup>173</sup>

The benefits of keeping the family together, when it is right to do so, are not always easily measured. However, as a mark only of the Troubled Family initiative's success it is noteworthy that the Ministry of Housing Communities and Local Government (HCLG) have identified economic, social and fiscal benefits of £2.28 for every £1 spent on the programme. In terms of the fiscal benefit, only those budgetary impacts on services, the HCLG identified £1.51 of fiscal benefits for every £1 spent on the programme.<sup>174</sup>

The CSJ applaud this proactive and holistic approach to reaching out to those families most in need of support. However, the criteria for inclusion does not specifically prescribe addiction and this is a shortcoming. It is acknowledged that there is a well-used existing mechanism to allow local authorities to include substance abuse as a criteria through the local discretion afforded to local authorities to include substance abuse within the 'cause for concern' and 'high cost to the public purse' criteria. However, this unnecessary additional factor in the consideration of addiction's relevance to the family underplays the destructive force of addiction.

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<sup>173</sup> Ministry of Housing, Communities & Local Government, 'National evaluation of the Troubled Families Programme 2015-2020: Findings', March 2019, pp8, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/786889/National\\_evaluation\\_of\\_the\\_Troubled\\_Families\\_Programme\\_2015\\_to\\_2020\\_evaluation\\_overview\\_policy\\_report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/786889/National_evaluation_of_the_Troubled_Families_Programme_2015_to_2020_evaluation_overview_policy_report.pdf)

<sup>174</sup> Ibid. pp5

An NSPCC report<sup>175</sup> stated that:

Child maltreatment or neglect might exist when limited finances are prioritised for the procurement of drugs/alcohol over basic needs of the child. It may take the form of poor monitoring leading to accidents in the home due to impaired judgement resulting from acute intoxication, being unresponsive to the child's emotional or material needs and/or failing to provide a stable nurturing environment.

## The Family Drug and Alcohol Courts (FDAC)

FDAC takes a problem solving and therapeutic approach with the objective of securing, as far as is possible, long term improvement to the parents and children alike, as well as the family unit as a whole. This is achieved by Judges working closely with social workers, psychiatrists, substance misuse workers and other to create care designed for the needs of each family unit that presents itself. The system both supports and monitors progress. This is another example of innovation finding its way into traditionally quite rigid processes and using a person-centred approach to find our way forward.

The FDAC system is effective. A study by Brunel University examined 90 families that passed through the system from 2008–10 and compared their progress to 101 families that passed through the standard court procedure between 2010–12. The study examined the efficacy of the FDAC system in reference to, amongst other things, rates of continued substance misuse, relapse and continued family unity.<sup>176</sup>

- 25 per cent of FDAC cases but only 5 per cent of standard proceedings involved a guardian no longer misusing substances at the end of proceedings.
- 75 per cent of FDAC cases but only 56 per cent of standard proceedings involved mothers avoiding relapse in the year after care proceedings.
- 36 per cent of FDAC cases but only 24 per cent of standard proceedings involved Children remaining with parents at the end of proceedings.<sup>177</sup>

In May of 2019, the Department for Education announced that 40 new areas will benefit from £15 million to further expand promising innovations, such as FDAC, to keep families together.<sup>178</sup>

The new programme, 'Supporting Families; Investing in Practice', will help families work on issues together, including those impacted by domestic violence, substance misuse or addiction, in order to help create stability in the home for young people and prevent them being taken into care, where that is in their best interests.

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175 Manning, V. NSPCC, 'Estimates of the number of infants (under the age of one year) living with substance misusing parents', 2011. pp2

176 These findings by Brunel University were drawn on by the Centre for Justice Innovation, 'Better Courts: the financial impact of the London Family Drug and Alcohol Court', 2016, accessed via: <https://justiceinnovation.org/sites/default/files/media/documents/2019-03/better-courts-the-financial-impact-of-the-london-fdac.pdf> and <https://fdac.org.uk/wp-content/uploads/2016/04/Better-Courts-The-Financial-Impact-of-the-London-FDAC.pdf>

177 Ibid. pp4

178 As reported on GOV.UK website, '£15 million investment to help keep families safely together', 22 May 2019, accessed via: [www.gov.uk/government/news/15-million-investment-to-help-keep-families-safely-together](http://www.gov.uk/government/news/15-million-investment-to-help-keep-families-safely-together)



In March of 2018, the NSPCC reported a 30 per cent increase in calls or e-mails from people with concerns about the wellbeing of children who may be affected by parents misusing alcohol or drugs. That equated to almost 200 calls a week.<sup>179</sup> The NSPCC have taken it upon themselves to recognise this safeguarding issue and have created a programme called 'Parents Under Pressure'.<sup>180</sup> This 20-week course has been evaluated<sup>181</sup> and found that the programme:

Significantly reduced the risk of child abuse for almost one-third of the parents who took part in the programme. Those who received treatment as usual showed an increased risk of child abuse over time.

## Helping families stay together

However, merely striving to keep the family unit together is not of itself enough. It must also be acknowledged that where domestic abuse, in any or all of its forms, presents itself, there are safeguarding issues that common principles of justice dictate some families should separate. Any effort to maintain and help protect a family unit is predicated upon this unqualified principle that nothing can undermine the protections that must always be afforded to those that ought to be protected from abuse. However, at least some conflict can be a normal part of any human relationship and emotional conflict is not unknown in even an otherwise healthy and happy family unit. While some conflict can draw short of domestic abuse, it may not draw short of behaviour which can cause sometimes serious harm. Programs like the DWP's 'Reducing Parental Conflict' reflects the government's understanding that the adverse childhood experiences of youth can be the product not merely of family separation but of internal and sometimes intense and sustained conflict.

The Early Intervention Foundation Sector<sup>182</sup> briefing indicated that:

Around 11 per cent of all children in the UK have parents who are in a distressed relationship, with children in workless families almost three times as likely to experience this.

Children in workless families are up to three times more likely to experience damaging parental conflict, according to data from the Department for Work and Pensions.

## The role of family in recovery

The CSJ has interviewed service providers at Adfam – a national charity for families affected by addiction that focuses on providing practical and emotional support to families of people suffering addiction. Not every family can withstand the stress and pressure that addiction brings to the home, those that can, do so under great strain. Worse still not every committed family can succeed in helping their loved one out of addiction. For these families, support is integral.

**The hardest thing was me not being available for my children when I was drinking.**

**Adfam client**

179 As reported on NSPCC website, '30% rise in helpline contacts about parental drug and alcohol misuse', 5 March 2018, accessed via: [www.nspcc.org.uk/what-we-do/news-opinion/30-rise-helpline-contacts-drug-alcohol-misuse/](http://www.nspcc.org.uk/what-we-do/news-opinion/30-rise-helpline-contacts-drug-alcohol-misuse/)

180 NSPCC, 'Parents Under Pressure', accessed via: <https://learning.nspcc.org.uk/services-children-families/parents-under-pressure/#article-top>

181 NSPCC, 'Evaluation of Parents Under Pressure', accessed via: <https://learning.nspcc.org.uk/services-children-families/parents-under-pressure/#article-top>

182 Early Intervention Foundation, 'Why reducing parental conflict matters for the NHS', March 2018, accessed via: [www.eif.org.uk/download.php?file=files/pdf/reducing-parental-conflict-nhs-briefing.pdf](http://www.eif.org.uk/download.php?file=files/pdf/reducing-parental-conflict-nhs-briefing.pdf)

There are in fact some strong examples of programmes in the UK that demonstrably improve the welfare of individuals and strengthen recovery through assisting family units. Action on Addiction's Moving Parents and Children Together Programme (M-PACT) is a 'whole family', structured, brief intervention which aims to improve the well-being of children and families affected by substance misuse. A 12-year evaluation<sup>183</sup> of the programme includes evidence that M-PACT targets some of the individual and familial protective factors which are known to build resilience in families affected by difficulties such as parental substance misuse. Many of the families who have participated in M-PACT have been living with substance use problems for years, and have also experienced other difficulties such as offending, violence, abuse and/or mental health difficulties. The report shows that this relatively brief intervention – which is delivered under licence by facilitators who are trained by experts from Action on Addiction – is able to produce significantly positive changes for many families, even those with multiple and complex needs.

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183 <https://www.actiononaddiction.org.uk/about/about-us/our-reports-and-publications>

## chapter eight

# Connection with community

**A person in recovery should be able to live as fully as their physical and mental state allows and be embedded in the wider community.**

Extract from the Centre for Social Justice definition of Recovery

Dr David Best said in an interview in 2012:

We don't focus enough on what comes after the acute treatments – in short, we study immediate effects of treatment but not the more prolonged course of addiction or the prolonged course of recovery.

We know from the literature around HIV and acquired brain injury that people who choose to disclose their status and who, as a consequence of that disclosure, are able to access supportive groups in their local community report higher self-esteem and better quality of life. It fits entirely with the notion of connectedness to and belonging within social networks and social groups, but extends that idea to incorporate the dynamic influence that a sense of belonging can have on personal wellbeing and perceived identity – key aspects of the recovery journey.<sup>184</sup>

## Dan's journey

In 2011, I returned from working in Japan and, by then, I already had at least some concerns about my drinking. My wife joined me in the UK and we basically started a new life in Brighton – I was looking for a job as a TEFL teacher or anything in education and hoped to secure one within a few months. I struggled to find work and the months turned to years. This new experience of unemployment was one that I found very upsetting and pride destroying. My drinking got progressively worse and even when I did find work, I found that I simply couldn't stop.

I used to drink 2 litres of Vodka a day (if my body would let me). I'd buy 1 litre on the way to work and one on the way back. I'd do my best to drink a bottle while at work mixed into a big Lucozade bottle placed on my desk in full view, in front of about 15–20 students. I've been in hospital 3 times as a direct result of continued heavy alcohol consumption. I was warned by doctors that if I carried on drinking, I would be dead before my 40th birthday. At the time, I saw no reason to live or any real way out of the cycle I was in, so I blocked this unwanted news out

<sup>184</sup> White, W. L., 'Toward an international recovery research agenda: An interview with David Best', 2012

by continuing to drink. In the week leading up to my 3rd hospital admission, all I wanted to do was make this life stop. I wanted to commit suicide. I was so depressed – I felt like only killing myself would bring me peace. Luckily for me my body packed in first.



I knew I couldn't continue functioning anymore and I knew I couldn't change the predicament I was in by myself. My wife was so concerned that I was starting to talk about suicide that she called my parents. They drove for 5 hours and sat by my bedside. I told my dad everything and broke down completely, I cried on his shoulder for 20 minutes. We decided that I would go back to Cornwall with them and seek treatment. I packed some clothes and got into the car, I had to drink on the way for fear of dying if I completely withdrew. I got into a detox and, after two months of waiting, I finally secured residential rehabilitation for three months. This was followed by another 3 months in a move on flat and then I returned back home to my wife in Brighton. I was afraid of inactivity, I had no

friends now and no job – I felt potentially vulnerable to another relapse. That's where New Note comes in. I saw an advert for a group of musicians all in recovery that would meet every Tuesday. I was so apprehensive as I arrived and saw all those new faces but it was seconds before their welcoming spirit made me feel totally comfortable.

There is something unspoken about the support present in New Note. It's not that we are discussing recovery every day, although you could have that conversation with anyone there with ease, it's an understanding that everyone else in that room understands, they've been to where you've been. The music making and creating is a big part of the community, it's about discipline and action, sometimes waiting, listening and allowing silence and at other times doing your part, then finally all coming together as one coherent powerful sound and force.

For me New Note has rekindled my self-esteem, which in turn has developed my confidence. The confidence to play and create music. The confidence to be curious and express ideas. The confidence to simply socialise. The confidence to be in my own skin. Be myself.

Addiction beat me up and left me isolated and alone. From the inside of addiction looking out it feels like I had no choice, no chance and no control. From the outside looking in at someone in addiction it can look like their choice, they've had loads of chances and it is very much in their hands to take control and sort out their lives. The best way to help someone in recovery is to encourage that person to help themselves.

New Note stopped me isolating by giving me the motivation to get out of the house. And in turn it's increased my health by reducing my social anxiety, depression, loneliness, the feeling of being a failure and feeling unwanted on the unspoken edge of societal and family life.

It encourages personal growth by meeting new people, helping each other and in the process making new friends and networks with similar people, in a similar situation with similar goals. The benefit of this is infinite on my self-esteem.

What is really striking to me is the way this community changed me and gave me the confidence to get back into work. I have thought about this and I believe that the effect of this community was more than the support they gave me. I instantly felt comfortable with the others and, in recovery, it is important to be honest with others and yourself. In addiction, your sense of self is really damaged by the dishonesty that comes with hiding that addiction. When you return to a community your personal integrity and self-respect comes back. There were times when I couldn't even look people in the eye and that's far behind me now.

At moments when I was at my lowest and most in need of help, I had to somehow find my desire, nurture my confidence and reconnect with life. New Note Orchestra does all that and so much more.

**The NHS, as part of its universal personalised care model, has already made progress in developing the use of what has been termed 'social prescribing'. This has been described as a way of healthcare professionals referring people to activities in their community rather than using purely medical solutions. Further, the initiative relies of significant interagency working and 3rd sector as well as community involvement. The government is already making real progress in this area, there are currently plans to make social prescribing available right across England with the help of a new Social Prescribing Academy. The ambition is to see over 1,000 trained link workers in post by 2021.**

## Fellowships

Discussions about recovery can quickly become heavily focused on the mechanisms associated with the delivery of care. The strategies of government are necessarily designed to challenge the demand for alcohol and drugs, and curb the extent of gambling across the nation. There is, however, also a need to acknowledge that not every positive contributor to a person's journey to recovery is rooted in a government direction or published guidance. Mutual aid groups in the community can be, and very often are, an inspiration for real change. This inspiration is drawn from people in the group who share a deep understanding of addiction and show abstinence is possible and, at the same time, provide the emotional and social support that sustains that change in recovery. Many speak of the unburdening effect of sharing the emotional distress that self-reflection brings to a person in recovery through mutual understanding. Mutual aid groups are commonly fellowships – which largely use the 12-step model or SMART recovery.

The 12-Step Programme is the most widely used programme and has existed in various, although quite consistent, forms since the 1930's. The CSJ has attended 12-step meetings across the UK and many participants have spoken of the power of the programme in encouraging personal development and a reconnection to a sense of community and moral obligation to others.

The CSJ spoke to Vicky, a lady in recovery in Newcastle, who explained that throughout the 12-step programme she rediscovered an honesty and a moral code that transcended considerations that related to substance misuse and guided her everyday life. She explained that she now felt an enormous sense of pride and a new self-identity which first occurred to her, after many years of self-loathing and depression, as a '*spark of self-love*'. Her recovery has seen her take on work and build what she sees as a resilience that she has never before seen in herself.

The potential benefits of mutual aid is widely recognised and PHE has examined the literature on this issue. The commentary of the ACMD report on mutual aid<sup>185</sup> found that:

- involvement with mutual aid can significantly improve recovery outcomes;
- more active or frequent involvement, such as becoming a sponsor, is associated with greater improvement in outcomes;
- substance misuse treatment providers can improve sustained recovery outcomes (including abstinence) by actively encouraging service users to engage with mutual aid.

Similarly, the NICE Quality Statement QS23 Statement 7<sup>186</sup> does recommend that those in recovery ought to be offered the opportunity of connecting with mutual aid groups.

A recent study<sup>187</sup> in the US by Keith Humphreys and Rudolph H. Moos has further secured the position that self-help groups add value to the overall recovery journey and treatment of those challenging their addictions, as it concluded:

Promoting self-help group involvement appears to improve post treatment outcomes while reducing the costs of continuing care. Even cost offsets that somewhat diminish over the long term can yield substantial savings. Actively promoting self-help group involvement may therefore be a useful clinical practice for helping addicted patients recover in a time of constrained fiscal resources.

## Fellowships in context

The crucial theme in the study above is 'post treatment'. These groups add enormous value and encourage self-development and stability, but they will not forgive a system that fails to deliver the opportunity for change.

Quality Statement 7 of Quality Standard 23:

People in drug treatment are offered support to access services that promote recovery and reintegration including housing, education, employment, personal finance, healthcare and mutual aid.<sup>188</sup>

The stated rationale for this statement is set out in the Statement 7 as follows:

People with drug use disorders have a better chance of recovery and reintegration, and maintaining recovery in the longer term, if they are supported to access services that promote recovery.<sup>189</sup>

There is then clear and well-advised recognition that there are a number of elements that contribute to a successful recovery journey. Mutual aid is important but by no means a replacement for the other support that is so integral to recovery.

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185 ACMD, 'What recovery outcomes does the evidence tell us we can expect. Second report of the Recovery Committee', 2013, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/262629/Second\\_report\\_of\\_the\\_Recovery\\_Committee.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/262629/Second_report_of_the_Recovery_Committee.pdf)

186 NICE, 'Drug use disorders in adults: Quality Standard [QS23], Nov 2012, accessed via: [www.nice.org.uk/guidance/qs23/chapter/Quality-statement-7-Recovery-and-reintegration](http://www.nice.org.uk/guidance/qs23/chapter/Quality-statement-7-Recovery-and-reintegration)

187 Humphreys, K. & Moos, R. H. 'Encouraging Posttreatment Self-Help Group Involvement to Reduce Demand for Continuing Care Services: Two-Year Clinical and Utilization Outcomes', 2007, accessed via: <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.523.2782&rep=rep1&type=pdf>

188 NICE, 'Drug use disorders in adults: Quality Standard [QS23], Nov 2012

189 Ibid

## chapter nine

# Work as part of a recovery journey

### Louise's journey

In May of 2013, Louise had her last drink, she looks back on it with no fondness. Whilst walking her dogs, she explained that she had spent the day at a local school, helping children understand the need to talk about their mental health and to disclose bullying. Three decades ago, Louise was at school. She had been an unusually tall, slight and rather timid teenager. She was bullied relentlessly. Away from school, her family life appeared to be everything one would hope for.

*My dad always worked and the family would take holidays in the summer. There was no abuse at home.*

However, her mother suffered from depression and Louise felt she alone could provide the emotional support her mother desperately needed. For this reason, she also felt unable to talk of what was happening to her at school. The stress built up. She developed alopecia and started to self-harm.

By her twenties, things had the appearance of being easier, she worked in the city and the boozey culture of after work socials went unquestioned in her mind. She was later diagnosed with PTSD and clinical depression, but she explains that at times things were not so clear.

*The work keeps you pre-occupied, I know it's strange, but I didn't notice.*

Her marriage was unhappy, but Louise explained, with great pride, that she had two children. The marriage sank below the by now routinely hostile encounters. Her drinking escalated. Her mental health declined. Eventually, unable to cope and in deep desperation she can now barely relate to, she stabbed herself in her leg, severing an artery. She lost custody of her children. Her will to cope died with the loss of her children and drinking became her terrible refuge.

*I hated what I had done, and I hated the drink. I know it's strange, but I drank to black out the hurt I felt about being drunk all the time.*

Louise's parents wrote to her and encouraged her to seek help. She suspects they understood that she had lost hope and she went to rehabilitation. She left treatment after months of sobriety but, with little in the way of after care, she was drunk within two weeks. High strength cider costing as little as £2.50 and cheap wine blurred out the months that followed. She was ready to give up completely. The council offered to pay for her detox on the condition that she attend 1NE for two weeks, a treatment centre in London. She agreed. It changed her life.

*When I went into 1NE I was dead. I was just a body. I can't believe I was that person now.*

For the first 6 weeks Louise said little, she understood little. Eventually, she began to engage, and the community helped her live life both in and out of the treatment centre.

Today, 5 years after her last drink and first day at 1NE, Louise is sober, she has her kids back and she is ambitious about her future. She remembers how this started for her and her trauma in school. Her old working life was full of stress and excess and she is passionate when she explains that her new work is about helping children. In fact, her voluntary work has been a large part of that recovery and she is training to help children understand mental health needs. She tours schools and helps children understand that they can talk to someone if they're in distress.

## Work in recovery

There is a clear body of evidence that shows that working, be that paid work or volunteering, is an important part of re-connection with community and helps the recovery process. In 2011, Professor Henkel of the Institute of Addiction Research in Frankfurt published a comprehensive review of a body of international research which had been published between 1990 and 2010. These studies included the examination of the relationship between the prevalence of substance abuse amongst the employed and the unemployed.<sup>190</sup> The review involved the investigation of over a hundred and thirty studies which were identified as relevant. It found that 'unemployment increases the risk of relapse after alcohol and drug addiction treatment'. The study also stated that:

It is not yet possible to predict with confidence which individuals will eventually overcome their dependence. Encouraging clinicians to be more ambitious for employment as part of recovery is legitimate, deliverable and overdue. Realising this ambition will involve linking safe, evidence – based recovery-orientated practice with greater work-focused ambition and support, earlier in people's recovery journeys.

Dame Carol Black's UK report of 2016<sup>191</sup> examined the relationship between work and addiction. She found that:

After a searching inquiry we are clear that a fresh approach is needed, one that brings together health, social, and employment agencies in new collaborative ways, personalised to the circumstances of each individual

Addiction treatment does not, in itself, ensure employment, though it brings other social gains. Work has not hitherto been an integral part of treatment, and it needs to be if progress is to be made.<sup>192</sup>

190 Henkel, D., 'Unemployment and Substance Misuse: A Review of the Literature (1990–2010)', 2011, accessed via: [www.ncbi.nlm.nih.gov/pubmed/21466502](http://www.ncbi.nlm.nih.gov/pubmed/21466502)

191 Dame Carol Black, 'An Independent Review into the impact on employment outcomes of drug or alcohol addiction, and obesity', 2016

192 Dame Carol Black's press release on the report, as reported on GOV.UK website, 'Dame Carol Black publishes review on links between work and addiction', 5 December 2016, accessed via: [www.gov.uk/government/news/dame-carol-black-publishes-review-on-links-between-work-and-addiction](http://www.gov.uk/government/news/dame-carol-black-publishes-review-on-links-between-work-and-addiction)



The CSJ has found examples of longstanding recovery through employment across the UK. In Newcastle, an organisation called Forward Assist helps former service men and women re-establish themselves in civilian life. Many have experienced longstanding alcoholism and heroin use, often after severe trauma in combat. Tony Wright the CEO of the organisation explained to the CSJ that:

we tap into our Veterans transferable skills and utilise their leadership skills to help others less fortunate than themselves. They have served their country and now they are serving their community.<sup>193</sup>

This organisation has succeeded in re-connecting people in recovery with work by engaging with their clients and supporting people back to a sense of purpose. These lessons have been learnt slowly by government but, in recent years, notable and commendable progress has been made.

A 2017 DWP report<sup>194</sup> published the results of an evaluation into ‘the wider approaches to supporting clients with a dependency’. This evaluation was conducted by commissioning IFF Research to conduct a qualitative evaluation of two separate working programmes, namely:

- **Recovery works:** This ran for about two years prior to March 2015. The purpose of this programme was to ‘test the impact of awarding Work Programme Providers (WPPs) an additional job outcome payment of £2,500 per participant achieving sustained employment.’
- **Recovery and employment:** This ran for three years prior to March 2016. The purpose of this programme was ‘to test the impact of the DWP encouraging closer working relationships between WPPs and Support Providers (both Treatment Providers and Specialist Treatment Providers).’

These proof of concept initiatives were designed to better understand the potential for more productive interplay between treatment providers and those best placed to help the client integration back into work. In the case of Recovery Works, an incentive-based approach was taken. In the case of Recovery and Employment, an attempt to build communications and human relations between these organisations was relied upon.

While most treatment providers and DWP staff felt that there were barriers to overcome, it was not the financial incentivisation that was most effective but the encouraged collaborative working of the Recovery and Employment initiative.

Some of the key findings outlined below<sup>195</sup> are still relevant today:

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<sup>193</sup> Tony Wright, in interview with the CSJ

<sup>194</sup> DWP, ‘Drug and alcohol proof of concept evaluation, and wider approaches to supporting clients with a dependency’, 2017, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/605013/rr924-summary-drug-and-alcohol-dependency-employment-support.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/605013/rr924-summary-drug-and-alcohol-dependency-employment-support.pdf)

<sup>195</sup> Ibid, text lifted from report. This is not the full list of recommendations and although rationale for recommendations has been edited out in some cases the meanings and conclusions are unaltered

- ‘Encouraging clients to disclose their dependency is a challenge. Clearer guidance over the data protection issues around disclosing that clients have dependencies could prevent the need for clients to repeatedly disclose their situation.’
- ‘Therefore, there may be an argument for more widespread use of ‘expert’ teams within the working programme to assist clients with Drug and Alcohol dependency issues. This would reduce the numbers of staff that need to be equipped with the skills to offer suitable support to these claimants.’

There was a time when the treatment sector was very well funded and many in the sector explain that funding was not always well spent or cautiously allocated. Further, austerity did necessitate more efficient working practices that were hugely beneficial and by this, it is often meant that more co-ordination between organisations took place. This qualitative evaluation can be interpreted as another example of the benefits that can be drawn from creating strong working relationships and breaking down silos of expertise.

## Progress since Dame Carol Blacks report

Currently, PHE is working with community substance misuse treatment providers in 7 areas in England<sup>196</sup> to examine the efficacy of Individual Placement Support (IPS).<sup>197</sup> This initiative is a form of employment support. It involves intensive support into work but, crucially, continued support within work. It has primarily been used in cases where mental health has proved to be a barrier to work.

The current Randomised Controlled Trial (RCT) seeks to evaluate the transferability of IPS to the treatment of those recovering from alcohol and drug dependence (AD). The trial of this system, IPS-AD, will conclude in March of 2020 with results expected to be published in 2021 – but there are initial signs that this initiative is having some success.

The efforts of PHE and DWP to expand the remit of IPS into perhaps its natural territory must be commended. This example of interagency working, although still too rare, has already seen deeper integration of employment support and the treatment sector, and this is rightly expected, given the early signs, to yield real benefits to those seeking to re-connect with the community through work.

This is one of a growing number of other examples, such as ‘See Potential’<sup>198</sup>, that show an increased enthusiasm to integrate government departments roles to achieve a common end. PHE is currently heavily involved in guiding and assisting, amongst others, DWP. It is a principle which must only be extended if we hope to see a meaningful challenge to the UK’s addiction crisis.

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196 Birmingham, Blackpool, Brighton and Hove, Derbyshire, Haringey, Sheffield and Staffordshire

197 Public Health England, ‘Supporting people from substance misuse treatment into employment’, March 2019, accessed via: <https://publichealthmatters.blog.gov.uk/2019/03/27/supporting-people-from-substance-misuse-treatment-into-employment/>

198 The ‘See Potential’ initiative ‘seeks to show how a few simple changes to your recruitment practices could make a difference in recruiting people from all kinds of backgrounds’ and it specifically references targeting, amongst other groups, those in recovery from addiction, accessed via: <https://seepotential.campaign.gov.uk>

## Addiction in work

Legislation that addresses substance misuse in the workplace is rightly focussed on ensuring the safety and welfare of employees and the wider public. The Health and Safety at Work Act 1974 places a duty on the employer to ensure, as far as is reasonably practicable, the health, safety and welfare of employees. The Misuse of Drugs Act 1971 prohibits the production, supply or use of a controlled drug on the work premises. The Management of Health and Safety at Work Regulations 1999 exposes the employer to prosecution if they knowingly allow an employee to continue working while under the influence of a substance when their behaviour places the employee or others at risk.

For a person in addiction, while there is at least some scope to be signed off work by a GP, there is little by way of universally applicable and reliable statutory protection for a person disclosing addiction to an employer.

While employers are mandated to have a policy on substance misuse, the nature of that policy can differ significantly between employers – some offering quite extensive support and others drawing short of this standard.

The CSJ has heard evidence from people in treatment who have only sought help after a dismissal at work, an accident or a court appearance. Early treatment can be hugely beneficial to the individual, their family and the employer. We know that alcohol related harms were deemed to cost the UK economy £7bn in lost productivity,<sup>199</sup> using 2014 figures from PHE. There is a business as well as health and wellbeing case to be made for examining the possibility of extending protections in these cases.

### Recommendation

The CSJ would invite the government to open a consultation with business, and interested parties, to examine how best to enable those that wish to declare an addiction in the workplace to seek treatment. This might include discussions about the virtue of providing assistance with finding and even partially or wholly funding treatment, screening on return to work, as well as assessing the appropriate levels of employment protection following disclosure.

<sup>199</sup> Public Health England, 'Alcohol and drugs prevention, treatment and recovery: why invest?', 2018



## chapter ten

# Recovery lost

The UK is failing to adequately deal with the emerging crisis of addiction. The body of evidence that supports this is now overwhelming. There is nothing about the current approach that allows us to draw any other conclusion than we are moving towards yet further deterioration of the treatment sector. It is worth briefly examining how the current system came into being, and the nature of the current system's failures, to allow us to identify a remedy.

### Background

Prior to 2013, the now defunct National Treatment Agency (NTA) was tasked with expanding treatment for addiction, improving the quality of the provision, and commissioning drug and alcohol misuse treatment services in England. It operated under the Department for Health, and did not address gambling addiction.

### The benefits of the NTA

In many ways the NTA was quite successful. It relied on regional teams known as Drug and Alcohol Action Teams (DAATs) to deliver the drug and alcohol strategy. These teams were charged with delivering the drug strategy. The NTA was located in a mixture of local authority and primary care trusts (PCTs). Each local area had to submit annual commissioning plans to be scrutinised by the NTA to ensure that the plan addressed the objectives of the strategy. It did provide accountability and some consistency, in broad terms, to the execution of the national strategies.

### The NTA had weaknesses

The NTA was overly bureaucratic and costly. It was rightly accused of having the wrong targets, some criticised it for overprescribing methadone. There were also skewed incentives in commissioning, as its financial power sat with Primary Care Trusts, so commissioning decisions were dominated by overinvestment in substitute prescribing services.

## The current system

Following the Health and Social Care Act 2012, changes to the previous system occurred in 2013. This legislation devolved power locally and Health and Wellbeing Boards were established in Local Authorities. Essentially, the Health and Social Care Act 2012 devolved greater power to local decision makers and elected council members:

- Health and Wellbeing Boards (HWBs) were established in county councils, unitary authorities and London boroughs.
- These boards had membership from the local authority, clinical commissioning groups (CCGs) and local branches of Healthwatch.
- DAATs were subsumed or replaced by the new structure.
- HWBs have a narrower membership than the multi-agency DAATs although some HWBs decide to invite a wider range of stakeholders.

In 2013 the NTA was dissolved and its functions were transferred to Public Health England (PHE). These changes mean that drug and alcohol misuse became one of local government's new public health responsibilities. Combined drug and alcohol misuse budgets were calculated and transferred into ring fenced local authority public health grants. Gambling still remains a separate consideration and those with process addictions are dealt with by a separate structure, often even in cases where people addicted to both gambling as well as drugs and or alcohol present for help.

Key differences between the NTA and PHE were explained by the ACMD in this way:

In relation to substance misuse, PHE's relationship with substance misuse commissioners in local government is very different to that of the NTA. PHE's role has been designed to be one of support and advice without any remit for formal performance management or 'delivery assurance'.<sup>200</sup>

## The current system is a regression and fundamentally flawed

Funding levels in each region are a reflection of respective political will and not need.

Many in the sector, some with reluctance, have spoken fondly about a return of some accountability in this space. Public Health England is staffed by experts and consequently has the requisite experience and knowledgebase to guide and assist localities toward the objectives of the relevant strategies. But its supportive role and its complete lack of control over actual front-line budget spends makes effective executive administration of the 'National Drugs Strategy' an ambitious challenge that is often not achievable.

The CSJ has been informed by some local authorities that they could not accurately account for what was spent on childhood addiction.

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200 ACMD, 'Commissioning impact on drug treatment', Sept 2017. pp12, accessed via: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/642811/Final\\_Commissioning\\_report\\_5.15\\_6th\\_Sept.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/642811/Final_Commissioning_report_5.15_6th_Sept.pdf)

Localism should be about communities being enabled to act but instead we are seeing concerning regional disparities in the death rates from drug use. Pluralism could generate societal benefit where local knowledge, innovation, commitment and tailored solutions help deliver the currently separate national strategies for gambling, alcohol and drugs. However, where system dysfunction has led to these concerning regional disparities and fundamentally undermined the principles of equal access to care in the country – this requires nothing less than reform. While each jurisdiction will face its own unique challenges and while wider public spending inevitably has a bearing, these regional disparities speak to a postcode lottery in which the UK Drugs strategy is administered with widely variable degrees of success.

This problem of ever diminishing funding has been compounded by what some regard as misguided commissioning decisions. While the UK has a host of examples of excellent practice, they are tempered by areas in which local people simply have inadequate access to local care. Worse still, while many commissioners enjoy excellent reputations amongst service providers, the CSJ has heard from many in the treatment sector who lack faith that the commissioner is acting under sound advice. Additionally, there is little consistency in working practices – for every area such as Manchester, York and Newcastle that have integrated and established interdepartmental working practices, there are other areas that simply do not.

**The current system of commissioning and provision is about as inefficient as it is possible to be, as most people in addiction treatment have a mental health problem but mental health and addiction services are commissioned and provided in parallel systems. There is no current incentive for those holding senior and influential positions in either system to work towards unifying the services despite the fact that this would be more economically prudent and clinically effective.<sup>201</sup>**

**Ian Hamilton, Senior Lecturer in Addiction and Mental Health, York University**

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201 Written submissions made to the CSJ 30 June 2019





part three

# The way forward

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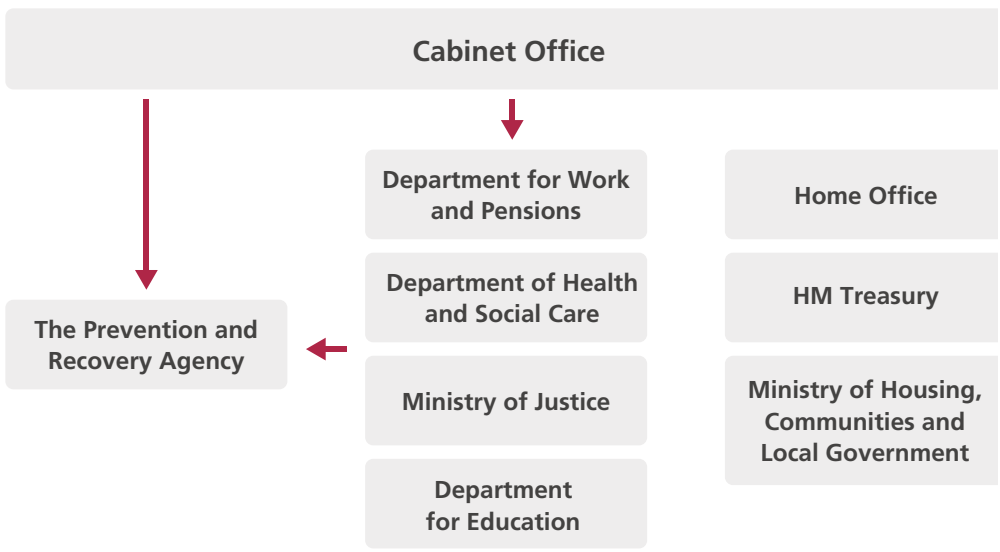
The proposed funding and commissioning model offers the right balance of central oversight and accountability to ensure a consistent approach and equitable access to high quality treatment.

Jon Royle  
Chief Executive, Bridge, Bradford

# chapter eleven

## Realising localism

Localism, as Jane Willis explains in her book 'Locating Localism' is about 'the political establishment making a new civic offer to its colleagues in 'lower tiers' of government as well as to the wider citizenry. It is about the pluralisation of political decision making through greater decentralisation'.<sup>202</sup> In short, it's about 'providing opportunities for people and organisations to act on the ground'. This is not the system in play today – true pluralism in this space would provide a greater clarity of vision, leaving the local authorities armed with the powers but also crucially the means to bring to bare the local expertise and knowledge required to realise the nations objectives. The CSJ would call for this agency to take hold of a national strategy to deal with addiction in all its recognised forms. The Prevention and Recovery Agency would therefore take on Gambling as well as Substance Abuse and would create a single Addictions Strategy.



The Prevention and Recovery Agency will sit within the Cabinet Office.

At the highest levels of government it will draw from and create a mutual strategy with those departments that are crucial to the implementation of the 'Addiction Strategy'.

The PRA will provide a Conditional Grant to each LA Public Health Director – mandating that the allocated funds are spent only in the furtherance of the Addiction Strategy.

202 Willis, J., 'Locating Localism: Statecraft, Citizenship and Democracy', 2016

## The Prevention and Recovery Agency will enable real localism

Each Public Health Director will continue to allocate the now protected fund to the commissioner. The commissioner must take the advice of a Community Advisory Board (CAB). The purpose of this board is to emancipate a broader knowledge and experience base within the community. This CAB should be constituted in such a way as the commissioner thinks will assist them in drafting a treatment plan. However, in addition to those other members the CAB is obliged to invite, the commissioner may add to this group those other parties they deem appropriate.

Mandatory membership of the CAB:

- Lived experience
- DWP
- PCC
- Social Services
- Education

Unless the Board feel that the commissioner has acted in a way that would otherwise give rise to judicial review, the commissioner can return the care plan for approval to the PRA before the grant is then allocated.

I am delighted to support the proposals. Currently we are seeing unprecedented levels of disinvestment, drug related deaths are at record levels and there are falling numbers of people accessing treatment. The proposed funding and commissioning model offers the right balance of central oversight and accountability to ensure a consistent approach and equitable access to high quality treatment. At the same time it will incentivise local stakeholders to develop collaborative, joined up solutions based firmly on the principles of co-production.

**Jon Royle, Chief Executive, Bridge, Bradford**

Since 2014/15 public health budgets to local authorities have been reduced by £700 million which has had an impact on the capacity of local drugs treatment services and their ability to retain an experienced and expert workforce. Local authorities MUST protect and improve the health of their local populations, more effectively including commissioning effective drug treatment services. The proposals put forth here interest us greatly and appear to be an innovative & positive move in the right direction. As people in recovery our only interest is in helping those who are still suffering, we would be keen to support any developments going forward.

**Annemarie Ward, CEO, Faces and Voices of Recovery**

The reports central suggestion of a multi-department approach gets to the core of the problem and offers a sound way of strategically changing the current system. Joining up departments in this way has the potential to make a significant difference to patients lives as it could provide a 'one-stop shop' to meet people's needs, recognising the multi-morbidity that many people have which can't be dealt with by siloed and compartmentalised services.

**Ian Hamilton, Senior Lecturer in Addiction and Mental Health, York University**

I'd be very happy to support the proposed commissioning structure. For me all investment into the drug services is very welcomed, particularly the reinvestment of money from the Proceeds of Crime Act. Taking money away from those who profit from the most vulnerable in our communities.

**T/Detective Chief Inspector, Jason Kew, South East Heroin and Crack, Action Area co-ordinator**

The industry needs to recognise that addiction is not a single-issue problem, we are working with people who are also in recovery from trauma, domestic abuse, poverty, mental health, offending and a range of other issues. Their addiction is merely a symptom of a deeper set of problems. Our approach needs to be less 'silo'.

**Hannah Shead, CEO of Choices Rehabs<sup>203</sup>**

### Recommendation

Establish the Prevention and Recovery Agency and fund it to a level that allows the infrastructure of the addiction treatment sector to recover.

<sup>203</sup> Choices Rehabs is a group representing: ANA Treatment Centres, Bosence Farm, Broadreach House, Broadway Lodge, Gloucester House, Hebron Trust, Kenward Trust, The Ley Community, Mount Carmel, Nelson Trust, Providence Projects, Sefton Park, Trevi House, Western Counselling, Yeldall Manor



## chapter twelve

# The cost of reform and options for revenue

Although necessary system re-design alone will not be sufficient to see progress in our response to the threat of addiction. The inadequacy of funding since the 2012 reforms took hold have had a part to play. Funding should return to and then exceed 2012 spending levels to accommodate the need for undoing the harm of excessive cuts. The additional expenditure required to take on the role of treating gambling addiction adequately must be accepted as an additional budgetary requirement.

### Alcohol taxation

The taxation on alcohol is woefully out of kilter with the damage it causes society. It is incumbent on the government to raise alcohol duty in a sensible and proportionate manner. Even before we consider the clear and substantial benefit that it would bring to the funding of the sector, a meaningful re-alignment will bring a host of health benefits to the nation. The WHO recognises that raising alcohol tax is a proven means of influencing drinking habits.<sup>204</sup>

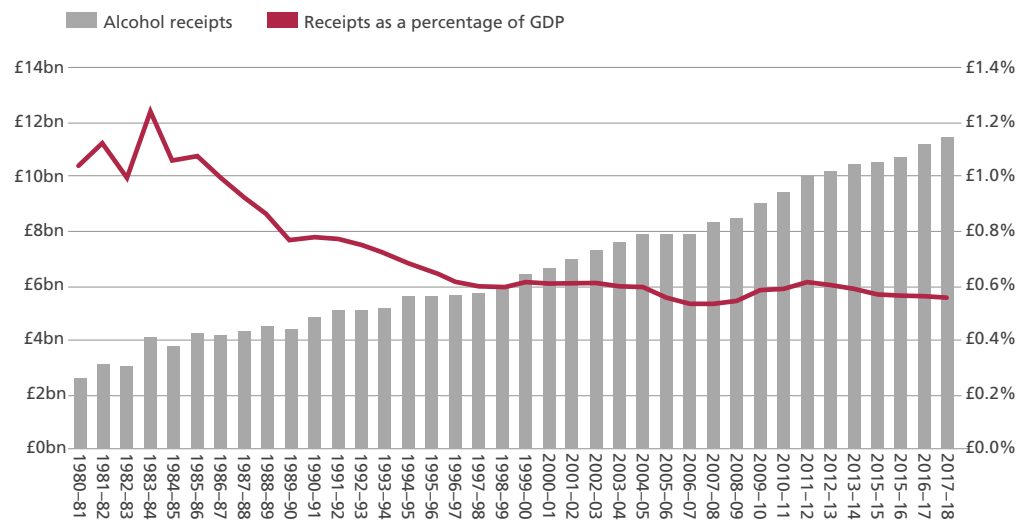
Taxation models relating to duty on alcohol, according to the IAS, have three central functions: to adjust for externalities; raise revenue; or change behaviour. In this paper, two central points are made.

Firstly, the societal cost of alcohol is unacceptable – £25bn by conservative estimates<sup>205</sup> and the rate of taxation increases have left the treasury exposed to the costs of alcohol on society. Our communities remain underserved in their efforts to mitigate the social harms of alcohol. Effectively, over the last 40 years, we have been sleep walking into a national crisis and the current fear of offending the alcohol industry is too prevalent to allow for action.

204 Wagenaar, A.C. et al, 'Effects of alcohol tax and price policies on morbidity and mortality: a systematic review', Nov 2010, accessed via: [www.ncbi.nlm.nih.gov/pubmed/20864710](http://www.ncbi.nlm.nih.gov/pubmed/20864710)

205 Public Health England, 'Alcohol and drug prevention, treatment and recovery: why invest?', Feb 2018. This is the uplifted figure using the stated £21bn figure and uplifting to 2018 values

Figure 8: UK alcohol duty receipts, 1980–2018<sup>206</sup>



Secondly, an effective taxation strategy could achieve sufficient revenue to ensure enormous change to our community by adequately funding a radical new approach to recovery. The case made below is unapologetic in its demands for change. The treatment of addiction is not to be advanced by charitable appeals or excusatory pleas – this paper advocates a morally sound and reasonable re-adjustment to the taxation of alcohol.

Further, the proposed rises have factored in the likelihood of future upward adjustments. Where current rises are under consideration for unrelated purposes, these proposals should be read as an additional uplift. The proposed figures have therefore been created with fiscal caution in mind and have concentrated not on sending shock waves through the industry but simply raising a sufficient revenue to get the recovery sector back to where it needs to be in the fairest way possible.

### The case for taxation in this way should be unapologetic

This is a correction to the massive dealignment between GDP and tax receipts since the 1980's. Alcohol is now 188 per cent more affordable in supermarkets than it was in the 1980s.<sup>207</sup> Looking at the household expenditure on alcohol,<sup>208</sup> the most recent figures suggest that the household expenditure on off-trade alcohol in 2017 was £19,253,000,000 and just 1.5 per cent of the total household expenditure. In 2007, and 1997, the figure was 2 per cent of household expenditure, and in 1987 it stood at 3.2 per cent of household expenditure – despite the spend being about half of that spend today in real terms.

206 Institute of Alcohol Studies, 'How important is the revenue from alcohol duty to the government?', using data from HMRC, accessed via: [www.ias.org.uk/Alcohol-knowledge-centre/Price/Factsheets/How-important-is-the-revenue-from-alcohol-duty-to-the-government.aspx](http://www.ias.org.uk/Alcohol-knowledge-centre/Price/Factsheets/How-important-is-the-revenue-from-alcohol-duty-to-the-government.aspx)

207 Institute for Alcohol Studies, 'The rising affordability of alcohol', 2018, accessed via: [www.ias.org.uk/uploads/pdf/IAS%20reports/sb20022018.pdf](http://www.ias.org.uk/uploads/pdf/IAS%20reports/sb20022018.pdf)

208 NHS Digital, 'Statistics on Alcohol: Table 5 – Household expenditure on off trade alcohol at current prices', Feb 2019, accessed via: <https://files.digital.nhs.uk/A1/9FE2A6/alc-eng-2019-tab.xlsx>



Yet despite this dangerous slide into multiple health risks at the same time as substantial underfunding of the sector the government has proudly publicised the lack of taxation.<sup>209</sup>

A pint of beer will be unchanged and 14p lower than it otherwise would have been since ending the beer duty escalator in 2013.

Pint of cider will be unchanged and 4p lower than it otherwise would have been since ending the cider duty escalator in 2014.

Before confirming that:

The measure is not expected to impact on family formation, stability or breakdown.

The effect on the industry – in particular on British pubs – is relevant, and upward adjustments to prices must work within the confines of this reality. The CSJ does not propose the re-introduction of the duty escalator but it is noteworthy that the abandonment of this policy is arguably in direct conflict with the government’s alcohol strategy.

The Huffington Post reported in August of 2018 that:

the treasury’s own estimates indicate that the government would have raised £4billion extra in revenue if alcohol taxes had risen in line with inflation. Instead the rate of beer is 16 per cent lower in real terms than it was in 2012 and spirits and cider duties have been cut by 8 per cent over the same period. Merely returning alcohol to their 2012 level would raise over £1billion a year.<sup>210</sup>

## The gambling levy

Under section 123 of the 2005 Act, the Secretary of State can make regulations requiring gambling operators to pay an annual levy to the Gambling Commission. The money raised would be used for projects relating to:

- gambling addiction
- other forms of harm or exploitation associated with gambling
- any of the licensing objectives.

The Gambling Act’s objectives includes the aim to:

protect children and other vulnerable persons from being harmed or exploited by gambling.

However, the power set out in s.123 have not yet been used. In fact, in May 2018, the Government responded to the question as to whether HM Government planned to make the 0.1 per cent levy on the gambling industry mandatory rather than voluntary. The government response<sup>211</sup> indicated that it was aware that GambleAware currently ‘asks

209 HMRC, ‘Alcohol Duty Uprating’. Oct 2018, accessed via: [www.gov.uk/government/publications/increase-in-alcohol-duty-rates/alcohol-duty-uprating](http://www.gov.uk/government/publications/increase-in-alcohol-duty-rates/alcohol-duty-uprating)

210 Lord Brooke of Alverthorpe for the Huffington Post, ‘Alcohol Duty Is A Fair Way To Pay For Our NHS’, 13th August 2018, accessed via: [www.huffingtonpost.co.uk/entry/alcohol-duty-is-a-fair-way-to-pay-for-our-nhs-we-cant\\_uk\\_5b6daa8be4b027b231c4fdd6](http://www.huffingtonpost.co.uk/entry/alcohol-duty-is-a-fair-way-to-pay-for-our-nhs-we-cant_uk_5b6daa8be4b027b231c4fdd6)

211 Lord Ashton of Hyde responding to ‘Gambling: Taxation: Written question – HL7791’, asked on 11 May 2018

operators to donate 0.1 per cent of their GGY and that most do. GambleAware received just less than the £10 million it rightly expected in voluntary donations in 2017/18. The government stated that:

We want to see an effective and sustainable voluntary system, with improved coordination and better understanding of what measures are most effective to ensure future funding increases will be spent in the most effective way.

Further stating that:

The Government does not consider that introducing a statutory levy is necessary or appropriate at this stage.<sup>212</sup>

At the time of writing, it has been reported that:

William Hill, Ladbrokes Coral owner GVC Holdings, Flutter Entertainment (formerly Paddy Power Betfair), The Stars Group-owned Sky Betting & Gaming and bet365 have agreed to increase their voluntary contribution from 0.1 per cent to 1 per cent of gross gaming yield in no more than five years.<sup>213</sup>

Simon Stevens, NHS England chief executive was quoted on the NHS website as saying:

This is an industry that splashes £1.5 billion on marketing and advertising campaigns, much of it now pumped out online and through social media, but it has been spending just a fraction of that helping customers and their families deal with the direct consequences of addiction.

The sums just don't add up and that is why as well as voluntary action it makes sense to hold open the possibility of a mandatory levy if experience shows that's what's needed. A levy to fund evidence-based NHS treatment, research and education can substantially increase the money available, so that taxpayers and the NHS are not left to pick up a huge tab.

The statutory mechanism is in place. There is no reason to limit the country to a delay of up to five years and settle for the top five companies. It's incumbent upon our government to re-assert its authority over licensed industry and mitigate its harm to our society. There are people lost to gambling that can be saved with help. As to who should take on this financial burden, we may conclude that the taxpayer ought to, alternatively or perhaps at least additionally, the gambling industry that yielded £14.5bn in GGY last year, might do considerably more.

The CSJ does regard the employment of s.123 as necessary and appropriate. The government should use this existing legal mechanism to enable it to make good the damage this industry causes.

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<sup>212</sup> Ibid

<sup>213</sup> As reported by iGaming Business, 'UK operators confirm plans to increase voluntary RG levy', 19th June 2019, accessed via: [www.igamingbusiness.com/news/uk-operators-confirm-plans-increase-voluntary-rg-levy](http://www.igamingbusiness.com/news/uk-operators-confirm-plans-increase-voluntary-rg-levy)

## Proceeds of crime

The Proceeds of Crime Act empowers the Courts to seize assets and capital from those convicted. With about 60% of all societal costs through drug misuse incurred through drug related offending, there is a powerful case to suggest that a significant proportion of the monies sized in these circumstances ought to go some way to resolve the damage caused.

Currently, the CSJ is working with senior law enforcement and joining their efforts to appeal to the Home Office for a revision of the way POCA money is re-distributed.

# Conclusion

- People are being left behind
- Services are not effectively funded and commissioned
- The country does not offer services 'targeted at helping people fully recover from dependence'.

Experts in the field have long advocated the position that it is unhelpful to look at addiction as a criminal justice issue and they are right. Many have instead contested that this is a public health issue and that a patient-centric approach must be taken. This position reflects the necessary understanding and compassion needed but it fails to adequately recognise the yet wider scope of recovery and the challenges and stigma of the environment in which it takes place.

Recovery should involve a person being given a genuine opportunity to live as fully as their physical and mental state allows and be embedded in the wider community. This can mean fostering and supporting relationship development with family, entering work, or other purposeful engagement with society. Not all people in recovery will require the full spectrum of social support but our systems of work must be capable of delivering that whole person support where it is needed.

Successive and pending budget cuts to addiction services have had a significant effect on our communities. We know that drug related deaths have greatly increased in number since the reforms and subsequent budget cuts. In 2012, drug-related deaths accounted for 2,597 deaths,<sup>214</sup> broadly similar to the figure recorded ten years prior in 2001 of 2,830 people. However, following the 2012/13 reforms, the drug related death rate has risen substantially and was last recorded, in 2018, at 4359 people – an increase of 16% in a single year and therefore not only the highest number since records began in 1993 but the highest ever single year increase.<sup>215</sup> Hospital admissions for alcohol misuse have increased by 15 per cent since 2007.<sup>216</sup> We have never seen a time in which gambling harm has been adequately addressed but arguably the threat has changed and escalated. GambleAware estimated that it has helped about 2% of the nations problem gamblers.

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214 ONS, 'Deaths Related to Drug Poisoning in England and Wales: 2012', Aug 2013, accessed via: [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2013-08-28](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2013-08-28)

215 ONS, 'Deaths related to drug poisoning in England and Wales: 2018 registrations', Aug 2019, accessed via: [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations)

216 NHS Digital, 'Statistics on Alcohol, England 2019', February 2019

Addiction entrenches and accelerates disadvantage. There is a direct correlation between socio-economic deprivation and the harms that alcohol cause. A person is 10 times more likely to be a problem gambler if they have experienced homelessness and ONS data shows that a person who dies from drug misuse is more likely than not to be outside employment or education.

Worse still, your prospect of the finding help in these circumstances largely depends upon where you live, with some local authorities making cuts to services that exceed 50 per cent and others making no cuts at all. Fewer young people and adults are finding their way into treatment and the UK maintains its inglorious position as one of Europe's poorest performers in tackling addiction.

This paper calls for a fundamental re-approach to our approach to addiction.

Our aim should be to take the position as world leader in this challenge and that is attainable. Recent initiatives such as Troubled Families, the Individual Placement Support pilots (IPS-AD), Reducing Parental conflict and Social Prescribing are all clear examples that extol the benefits of a proactive effort to reach out and support those that need help back to themselves and their families. The government has around it the knowledgebase, skill sets, experience and within sector at least – the determination, compassion and innovative outlook necessary to achieve real change. The sector needs:

- Guidance and accountability to ensure the best of service delivery alone makes it to our most vulnerable.
- Resources to deliver help to both those that seek it and those that need encouragement and support into recovery.
- Room for local discretion and innovation.

A successful system of care must achieve the objectives of deliverable and acceptable national standards, equality of access to treatment, and stable long-term funding streams will achieve this. A central body such as the PRA will secure funding for the essential tools required for research, upskilling the work force, and capacity-building by regaining lost residential rehabilitation capacity.

This body will provide resource and training from its budget and pool of expertise to assist schools in researching and developing an evidence-based prevention strategy.

There is a cost of reform. Funding should at least return to and then exceed 2012 levels. It is not the person seeking recovery or their family that ought to shoulder the burden of showing that they should be entitled to the help that was promised by the Home Office in 2017. The burden lies with the government to show that this expense is not justified – it may choose to argue that the funding and processes in place are adequate. That would be a conclusion that defies the body of evidence in this paper.

It may seek to argue that the funding is not available or cannot be found. That argument could not withstand the plethora of options – including, but not restricted to, a more proportionate taxation or levy of the alcohol and gambling industries. The cost of getting things this badly wrong is enormous and threatens to grow significantly with the next threat that makes its way to our shores. Further, a government that refuses

any increase taken from general taxation would then have to contend that it would also be unacceptable to raise these badly needed funds in other ways that are objectively attractive in their own right.

### **Recommendation**

In the event that the government sought to off-set the costs of the PRA and its functions, it should consider raising revenue through these options:

1. Imposing a treatment tax on the alcohol industry that accounts for £25bn a year in societal costs or simply raise duty levels.
2. Using the provision in Gambling Act, Section 123 raise a Levy on the Gambling industry that, last year, recorded a £14.5bn annual Gross Gambling Yield.
3. Diverting a larger amount of money attained by the state from the Proceeds of Crime seized from drug dealing and direct those funds to treatment and recovery.

Only a government that takes charge of this crisis and delivers hope to the millions of families desperate for support back to health and social connection will have delivered on its word and its moral duty.

# Appendix

## Statutory regulation of talking therapy

Before we examine the shortcomings in the current system, it is important to recognise that the CSJ has heard evidence from people who have expressed their belief that they have benefitted enormously from the efforts of service providers from counselors to case workers. Good practice, or at the very least, effective practice, is far from the exception to the rule in this space.

However, we have also heard shocking examples of mistreatment and negligence that have given rise to serious concerns about the regulatory approach to this industry.

**In fact, psychotherapists and addiction counselors providing talking therapy are not subject to statutory regulation at all.**

While it is possible for non-statutory regulators such as British Association for Counselling and Psychotherapy (BACP) and UK Council Psychotherapy (UKCP) to discipline and even 'strike off' an individual – there is nothing that can effectively stop them from practicing.

## Unsafe spaces

A report by Unsafe Spaces,<sup>217</sup> published in May of 2016, highlighted the extent and nature of this threat and thoroughly examined the arguments put forward by opponents to regulation. Perhaps one of the most striking features of this report related to the number of people that continue to practice after being struck-off – the report examined 74 such cases involving practitioners or organisations.

Of the 68 individuals or organisations overseen by BACP and subsequently struck off, over 20 per cent continued to advertise after being struck off. In the case of UKCP, although the numbers were very small,<sup>218</sup> 75 per cent continued to advertise after being struck off. In total nearly a 1/4<sup>219</sup> of those struck off continued to advertise after being struck off.

217 Unsafe Spaces, 'Why the lack of regulation in counselling and psychotherapy is endangering vulnerable people', May 2016, accessed via: <https://notsobigsociety.files.wordpress.com/2016/05/unsafe-spaces-report-may-2016.pdf>

218 UKCP number of individuals as baseline n=4 and those continuing to practice n=3

219 17 of 72 continued to advertise which equates to 23.6 per cent

Nor is it the case that the public enter into this peril with an understanding of the risks they face. The Unsafe Spaces report referenced a 2010 survey<sup>220</sup> of mental health services. When the question was put to the respondents as to whether they felt counselling and psychotherapy should be regulated, 85 per cent either 'agreed' or 'strongly agreed'. Further, 41 per cent were not aware of the lack of statutory regulation in this field.

The CSJ has explored this issue with service providers and has heard direct evidence from people with lived experience who have detailed their experiences. Venessa, from the Northeast, explained that she had been exploited by a therapist during her battle with alcoholism:

My mother found out I was drinking again and I found myself back in treatment this time. I turned up drunk and I was honest with them about that. I couldn't engage and I left. In August 2013 went to treatment again, I was reluctant and I only agreed to go for three months. I didn't want to leave my boyfriend. By this time, I was totally detached, I felt like an alien not connected to society almost feral and definitely not connected to family. I used to go through bins on the street to look for cigarette ends in front of people – I didn't care.

I agreed to go for three months but I really developed there. I started to laugh again, even taking a shower and having breakfast felt new. I wanted to stay for longer and in the end, I left after 5 months. But one of the therapists started a relationship with me while I was under his care. He started drinking and took me into a Pub when I left treatment. I relapsed and just 2 months after leaving I was drinking in my dressing gown – the trust I had in others had totally broken down. Eventually my serious drinking returned and I would wake up in the night and drink vodka, it was a full time job getting alcohol and drinking.

I've complained but he just works anyway – you can work without being registered as a counsellor.

**Venessa**

## The potential scale of this issue

This is not a small problem reflected by occasional case studies. There are 44,000 registered counsellors and psychotherapists registered with BACP.<sup>221</sup> According to the NHS, there were over 1.4 million referrals to talking therapies in 2017–18,<sup>222</sup> although this is reflective of the wider space and not specifically treatment for addiction or any one talking therapy profession. Further, although addiction undoubtedly needs specialist therapy, the exploration of the issues that gave rise to or surround a patient's addiction will often uncover other psychological issues including the most severe life traumas. The discoverer ought to be armed with the skills to deal help, if not they risk making the patients plight yet worse. Our understanding of the data reveals that these co-occurring mental health issues are commonplace amongst those seeking help for their addictions. According to a NDTMS report,<sup>223</sup> 'of those starting treatment where a mental health status was recorded, 52,397 individuals (41 per cent) said they had a mental health treatment need'.

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220 Mind, 'The Protection We Deserve: Findings from a service user on the regulation of counselors and psychotherapists', 2010, accessed via: [www.cpcab.co.uk/Content/Publicdocs/The%20Protection%20We%20Deserve%20-%20survey%20report.pdf](http://www.cpcab.co.uk/Content/Publicdocs/The%20Protection%20We%20Deserve%20-%20survey%20report.pdf)

221 As reported on BACP website, 'BACP Membership', accessed via: [www.bacp.co.uk/membership/home/](http://www.bacp.co.uk/membership/home/)

222 As reported on NHS England website, '1.4 million people referred to NHS mental health therapy in the past year', 2 December 2017, accessed via: [www.england.nhs.uk/2017/12/1-4-million-people-referred-to-nhs-mental-health-therapy-in-the-past-year/](http://www.england.nhs.uk/2017/12/1-4-million-people-referred-to-nhs-mental-health-therapy-in-the-past-year/)

223 NDTMS, Adult substance misuse statistics from the national Drug Treatment Monitoring System: April 2017 to March 2018. pp9



## Client blaming

Looking at all treatment entrants over the last ten years we see some noteworthy fluctuation in the success/drop-out rates, with an observable increase in successful completion from 2009 until its height in 2014–15, and a steady decline thereafter. The current drop-out rate for all substances is 35 per cent. The situation is yet more pronounced in the case of opiate users. Of the 36,438 seeking help with opiate addiction, over 14,000<sup>224</sup> dropped out or left, or 40 per cent.<sup>225</sup>

The drop-out rate has been accompanied by what has been termed by some as a ‘client blaming culture’. These drop-out rates are often attributed to ‘the client not being ready’ and this is undoubtedly true in many cases, if not the majority, but there are serious questions to be asked about whether we are doing enough, given the poor-quality control measures in place. Moreover, the treatment sector is characterised by dedicated people, often with personal experience of addiction who want to see a well-regulated and widely respected professional body which adds value to people’s lives.

### Recommendation

We would advise that the government introduce adequate statutory regulation and support current efforts in this area to afford patients confidence in treatment and recourse in the event of malpractice.

224 Exact number 14,639

225 NDTMS, Adult substance misuse statistics from the national Drug Treatment Monitoring System: April 2017 to March 2018. pp43



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