



Public Health
England

Protecting and improving the nation's health

Drug prevention, treatment and recovery for adults: JSNA support pack

Good practice prompts for planning comprehensive interventions in 2015-16

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Published September 2014

PHE publications gateway number: 2014372



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Introduction

An estimated 300,000 people in England are dependent on heroin and/or crack. There are also reports of more people having problems with other drugs, including new psychoactive substances (so-called 'legal highs'), image and performance-enhancing drugs, and growing concern about dependence on prescribed and over-the-counter medicines. Added to this, an individual's drug use or dependency can significantly impact the people around them, including their families, friends, communities and society.

Investing in effective prevention, treatment and recovery interventions is essential for tackling the harm that drugs can cause, helping users overcome their addiction, reducing involvement in crime, sustaining their recovery, and enabling them to make a positive contribution to their family and community.

Planning is key. Successful plans will be based on the local needs and community assets assessment, and will reflect evidence of what is known to work in addressing the root causes and wider determinants of drug dependence, and delivering the greatest gains.

Effective local systems will be those that raise their recovery-orientated ambitions and improve the progress of service users while continuing to protect them from the risks of drug misuse (and are seen to do by providers and users). They will encourage more service users to complete their treatment but will not put at risk any who are benefiting from their existing treatment.

This document outlines key principles that local areas might consider when developing plans for an integrated alcohol and drugs prevention, treatment and recovery system. There are six principles, followed by a series of prompts to help put them into practice.

1. Commissioning principles for adult alcohol and drugs prevention, treatment and recovery

[Note: the principles in this section cover the commissioning of alcohol and drug services, and are repeated in the JSNA support pack for alcohol prevention, treatment and recovery interventions for adults.]

Local authority public health commissioners work closely with all relevant partners to commission high-quality, evidence-led alcohol and drug services based on outcomes.

What will you see locally if you are meeting the principle?

Effective health and public-health commissioning of services that achieve positive outcomes for individuals, families and communities by:

- effective partnership working between local authority-led public health, the NHS (clinical commissioning groups and NHS England local area teams), mental health services, Jobcentre Plus, Work Programme providers, adult social care, children's services and criminal justice agencies
- operating transparently according to assessed need
- bringing providers and mutual aid together into cost-efficient delivery systems
- fully involving service users and local communities, including through Healthwatch

Alcohol and drug users have the best possible access to warm, safe and affordable homes, suitable for their needs in the community, that local conditions will allow.

More alcohol and drug users in treatment are supported into work by an effective partnership between the treatment and employability sectors.

An integrated support offer involving greater support around training, education, voluntary work and general improvement of skills and work experience.

What questions should you ask to check you are following the evidence and best practice that supports the principle?

1.1. Embedding in local systems

- 1.1.1. Do alcohol and drugs needs assessments, the local commissioning strategy, clinical commissioning group strategy, and joint health and wellbeing strategy demonstrate an explicit link between evidence of need and service planning?

- 1.1.2. Does the local public health structure have mechanisms in place for reporting on alcohol and drugs to the health and wellbeing board and police and crime commissioner?
- 1.1.3. Has the local authority public health team responsible for commissioning alcohol and drug services, established partnership arrangements with clinical commissioning groups, local clinical networks, NHS England local area teams and criminal justice agencies?
- 1.1.4. Is a joint commissioning approach adopted where there is a shared responsibility for commissioning and planning (eg, local authorities/clinical commissioning groups) around hospital-based services pathways?
- 1.1.5. Is there a formal strategic partnership in place for alcohol and drugs involving key stakeholders and agencies (health, public health, housing, employment, social care, families and safeguarding, and criminal justice), the aim of which is to develop a fully integrated system of health improvement, treatment and recovery for alcohol and drug misusers?
- 1.1.6. Do the general public, service users and staff in other mainstream services have ready access to information that enables them to understand the alcohol and drug services available, the pathways between them and points of entry?
- 1.1.7. Are there clinical governance mechanisms for assuring the quality and safety of alcohol and drug treatment services? Are these clearly embedded in public health systems?

1.2. Needs assessment

- 1.2.1. Does the local needs assessment, conducted as part of the JSNA, include a comprehensive section on alcohol and drug-related harm that reflects need across the whole spectrum of harm and readily acknowledges the impact of alcohol and drug work across the public health outcomes framework and the NHS outcomes framework, resulting in partnership collaboration and support?
- 1.2.2. Is there a shared understanding of the local level of demand and need, based on a range of local and national data across a range of public services?
- 1.2.3. Are health and public health commissioners using a range of hard and soft intelligence to understand local need in relation to misuse of or dependence on prescription and over-the-counter medicines, including dependence arising inadvertently from the prescribed use of a medicine?
- 1.2.4. Do you use existing local networks for finding and sharing information with partners about new psychoactive substances?

- 1.2.5. Is local data on alcohol and drug interventions provided in hospitals, primary health care and other settings collected to inform needs assessment?
- 1.2.6. Do commissioners analyse the local levels of alcohol and drug-related admissions to hospital in order to target interventions?
- 1.2.7. Do commissioners analyse and monitor local specialist alcohol and drugs treatment data, including specific breakdown by gender, age, postcode, condition, route of admission, repeat admission, etc, in order to compare current treatment provision with need?
- 1.2.8. Has a mutual aid self-assessment tool¹ been completed as part of the local needs assessment?
- 1.2.9. Does the needs assessment take into account the availability and potential development of existing community support networks and other local assets, using a methodology such as asset-based community development?
- 1.2.10. Are the following identified:
 - gaps in delivery of primary, secondary and tertiary prevention for alcohol and drugs
 - the extent of drug treatment penetration and access to alcohol treatment by the estimated dependent population
 - the impact of services on health and wellbeing, public health and offending?
- 1.2.11. Does the local needs assessment take account of the needs of women and young girls vulnerable to alcohol and drug misuse (for example, those subject to domestic violence or sexual assault, or involved in prostitution, or with poor mental health)?
- 1.2.12. Does the local needs assessment take account of other groups who may have specific needs in relation to their alcohol and drug use, eg, lesbian, gay, bisexual and transgender (LGBT) including men who have sex with men (MSM), black and minority ethnic groups (BAME)?

1.3. Finance

- 1.3.1. Is investment sufficient for a range of prevention, harm reduction and treatment services commensurate with the level of identified need?
- 1.3.2. Can commissioners identify the total level of local investment by all partners who contribute to delivery?

1.4. Effective commissioning

- 1.4.1. Is commissioning based on the evidence base, such as NICE guidance, for effective interventions in tackling alcohol and drug-related harm?^{2,3,4,5}
- 1.4.2. Is there an alcohol and drugs planning document that describes how best to meet local need, which clearly identifies:
 - the level of local demand
 - existing strengths and ways in which services can be commissioned
 - finance and resources made available?
- 1.4.3. Is investment in alcohol and drug prevention, treatment and recovery based on an understanding of expenditure, performance and cost-effectiveness?
- 1.4.4. Are there contracts in place for commissioned services that specify the outcomes to be achieved and that are regularly monitored and reviewed?
- 1.4.5. Are care pathways and services geographically and socio-culturally appropriate to those for whom they are designed?
- 1.4.6. Are pathways for both alcohol dependent and increasing/higher risk drinkers jointly agreed and regularly monitored and reviewed by all relevant local partners?
- 1.4.7. Are service users, carers and people in recovery involved at the heart of planning and commissioning? Is this evident throughout needs assessment and key priority-setting processes both for community and prison based services?
- 1.4.8. Are commissioning functions fit for purpose? Is there sufficient alcohol and drug misuse commissioning capacity and expertise, including information management?
- 1.4.9. Is there a workforce strategy and improvement plan that covers the commissioning partnership itself? Does this ensure that all staff are competent to commission safe and effective services?
- 1.4.10. Do service specifications clearly indicate the level of professional competence required to deliver safe and effective services?
- 1.4.11. Do commissioners include formal evaluation of the range of alcohol and drug interventions within the commissioning strategy?
- 1.4.12. Do all agencies have agreed policies for monitoring the delivery of services in full compliance with the Human Rights Act and the protected characteristics within the Equality Act 2010?

1.5. Commissioning services for individuals in contact with the criminal justice system

- 1.5.1. Are there clear pathways for alcohol and drug misusing offenders to access alcohol and drug treatment at every point in the criminal justice process (ie, police custody suites, courts, youth offending teams, community rehabilitation companies/National Probation Service, prisons, and the children and young peoples' estate)? Are these pathways part of the local integrated offender management model?
- 1.5.2. Have discussions with police and crime commissioners taken place on investment in police custody-based alcohol and drug misuse interventions or other appropriate criminal justice pathways?
- 1.5.3. Has the local authority engaged with the NHS England local area team responsible for health and justice to agree a jointly owned and collaborative approach to commissioning fully integrated services that effectively support and engage individuals as they transition between custodial and community settings?
- 1.5.4. Have commissioners engaged with their local National Probation Service and community rehabilitation company to agree capacity and treatment interventions required for offenders subject to statutory supervision in the community and on release from prison.

1.6. Involvement with mutual aid significantly improves recovery from alcohol and drug dependency

- 1.6.1. Is there a shared, locally developed vision of recovery where mutual aid is appropriately integrated with alcohol and drug services (including in-patient and residential treatment)?
- 1.6.2. Do people in treatment have access to a range of peer-based recovery support options, including 12-step, SMART Recovery and other community recovery organisations?
- 1.6.3. Are local services encouraged to support service users to engage with mutual aid groups by including specific requirements in their service specifications?

1.7. The home environment enables people to sustain their recovery

- 1.7.1. Have the housing needs of alcohol and drug users in the community, prison and residential treatment been identified and used to inform local commissioning plans for housing, homelessness and housing related services?
- 1.7.2. Are the housing needs of alcohol and drug users and their families (where appropriate) assessed in a timely manner to prevent homelessness and/or to enable move-on to a suitable home? (This includes those in prison, in

residential services and those living in their own home but at risk of homelessness)

- 1.7.3. Is good quality housing information and advice readily available?
- 1.7.4. Is there a range of suitable housing options to meet different needs including: emergency bed spaces; direct access accommodation; refuges for those fleeing domestic abuse; supported housing; floating support available to those in their own home; accommodation specifically for women or young people, housing for people with complex needs (eg, Housing First⁶)?
- 1.7.5. Are alcohol and drug users who are rough sleeping able to access emergency accommodation and appropriate support?
- 1.7.6. Do housing services support homeless alcohol and drug users to access primary care?
- 1.7.7. Have commissioners, service users and providers agreed a definition for a 'suitable' home? Is the definition based on the description of 'suitable' found in the Homelessness (Suitability of Accommodation) (England) Order 2012,⁷ as a minimum? Is the local definition consistently applied in practice by staff working with alcohol and drug users when supporting them along the pathway? Are frontline housing staff (working in local authority services, for social landlords and housing support providers) trained in working with alcohol and drug users to meet their housing and related needs?
- 1.7.8. Is there a hospital discharge policy and procedure in place for homeless alcohol and drug users (and others) to enable access to a pathway to suitable housing?

1.8. Getting a job enables people to sustain their recovery

- 1.8.1. Are treatment commissioners and providers jointly planning with local Jobcentre Plus (JCP) and Work Programme (WP) leads how to meet the employment, training and education (ETE) needs of the alcohol and drug misusing population?
- 1.8.2. Are the ETE needs of alcohol and drug misusers reflected in local worklessness and employability strategies?
- 1.8.3. Are commissioners incorporating ETE in performance monitoring arrangements with treatment providers and providers as part of supervision for key workers?
- 1.8.4. Have JCP, WP and treatment providers agreed a process of joint working between agencies, including arrangements for three way meetings?
- 1.8.5. Are there jointly delivered training sessions between JCP, WP and treatment providers in each area focusing on structures, service offers and

the mutually beneficial relationship between treatment and employment outcomes?

- 1.8.6. Are key ETE service directories shared across JCP, WP and treatment providers, including the sharing of promotional materials?
 - 1.8.7. Are there local single points of contact in JCP, WP and all treatment teams and have their details been circulated?
 - 1.8.8. Has the partnership considered establishing employment champions in treatment teams, whose role it is to liaise with JCP and WP, and to champion ETE?
 - 1.8.9. Is data sharing taking place effectively, using the TPR referral forms (TPR1 and TPR2)?
 - 1.8.10. Has some form of co-location been considered, even if this is part time (eg, treatment workers spending two days a week in WP or JCP premises and/or vice versa)? Employability sessions could also be jointly delivered.
 - 1.8.11. Are treatment providers, JCP and WP engaging with local employers to make the case and address negative preconceptions and stigma about employing people with a history of alcohol and drug misuse?
 - 1.8.12. Are there case studies of successful employment outcomes shared across treatment provider, JCP and WP staff?
 - 1.8.13. Are discussions about employability introduced early on in treatment journeys, and are commissioners and treatment providers assessing the prioritisation of the ETE agenda in local recovery provision?
 - 1.8.14. Are treatment staff encouraging clients to consider appropriate disclosure of their alcohol and drug misuse within JCP and WP?
 - 1.8.15. Are providers actively working with JCP and WP to address low levels of skills, training, education and work experience?
- 1.9. **Commissioning hospital-based alcohol and drug services**
- 1.9.1. Are there services in place to meet the needs of alcohol and drug misusing hospital patients?
 - 1.9.2. Is there a strategic understanding at health and wellbeing board level of how alcohol and drug services for people in hospital integrate into the overall local system of alcohol and drug interventions and treatment?
 - 1.9.3. Are linkages to community alcohol and drug services offered to support patients requiring further treatment and recovery support?

1.10. Young people, children and families

- 1.10.1. Are effective referral pathways and joint working arrangements in place with children and family services where there are safeguarding issues and with local Troubled Families provision where alcohol or drug misuse is a factor?
- 1.10.2. Have local protocols between alcohol and drug systems, and children and family services been developed in line with 'Supporting information for the development of joint local protocols between alcohol and drug partnerships, children and family service'?⁸

2. Drug misuse and dependence are prevented by early identification and interventions

What will you see locally if you are meeting the principle?

Factors underpinning health inequalities and associated with later dependence on drugs (and alcohol) are addressed in a broad range of policies and strategies.

A range of evidence-based prevention programmes is supported.

Drug misuse is identified early, and people who use drugs are offered prompt access to a range of early interventions, treatment and recovery support appropriate to their needs, at all stages of their recovery journey.

What questions should you ask to check you are following the evidence and best practice that supports the principle?

- 2.1. Are you working in partnership with the police to support the disruption of drug markets?
- 2.2. Is there support for workplace programmes of early identification and intervention?
- 2.3. Are employers supported in policies that identify and support employees at risk of developing drug dependence?
- 2.4. Is every contact with a drug user made to count? Are validated identification tools being used and brief interventions provided at early contacts with all health (including sexual health), criminal justice and social care services?
- 2.5. In acute and hospital-based settings are NHS professionals aware of groups that may be at an increased risk of harm from drugs, and those with a drug-related condition? Do they have the skills to screen individuals for drug use and deliver brief advice or refer to specialist treatment as required?
- 2.6. Can agencies work collaboratively to identify the needs of vulnerable young people and troubled families, build resilience via whole family interventions, and minimise harm via effective safeguarding protocols?
- 2.7. Are health and public health commissioners working together to prevent dependence on prescription and over-the-counter medicines, including dependence arising inadvertently from the prescribed use of a medicine?
- 2.8. Has the need for additional community interventions and treatment access in relation to khat use been assessed and any identified need met?
- 2.9. Are you working collaboratively with local statutory and third-sector organisations to improve pathways to interventions for specific hard-to-engage groups, eg, working with sexual health services, mental health services, LGBT charities?

2.10. Do prevention activities for drug misuse (including new psychoactive substances) include building resilience and social capital, as well as information and campaigns?

3. There is prompt access to effective treatment

What will you see locally if you are meeting the principle?

All people who use drugs have prompt access to a system that provides for continuity of care between prison, residential and community environments.

What questions should you ask to check you are following the evidence and best practice that supports the principle?

- 3.1. Is there access to community-based interventions within three weeks of referral for all groups, including those who might find it difficult to attend (for example, parents, those in employment, people who use prescription/over-the-counter medicines and new psychoactive substances (NPS)?
- 3.2. Are screening, assessment and referral available and effective in all open access services, primary care, children and family services (including maternity, health visitors and family intervention projects), Jobcentre Plus and Work Programme, housing services, victim support and domestic violence services, sex worker support services?
- 3.3. Are assessment and referral arrangements based on an individual service user's strengths? Can these arrangements identify treatment and recovery support needs, and can they tailor packages of care to individual need?
- 3.4. Are services designed to be safe, attractive and accessible to all users, eg, women, LGBT, MSM, parents of young children?
- 3.5. Do services take a whole family approach when assessing and responding to the recovery needs of people who use drugs? Are there good joint working arrangements with children and family services?
- 3.6. Are services set up to ensure they continue to be accessible to those whose circumstances change (eg, people entering employment, education or training)?
- 3.7. Are there adequate arrangements to cover custody suites, courts and other points in the criminal justice system to ensure that individuals with drug needs are identified and screened? Are required assessments and restriction on bail assessments completed promptly where necessary, and are individuals referred or case managed into treatment services effectively?
- 3.8. Are plans in place to develop effective continuity of care arrangements with the prison alcohol and drug misuse and 'through the gate' offender management services in the appropriate designated resettlement prisons?

- 3.9. Is access to residential treatment and inpatient detoxification supported by clear assessment processes and funding arrangements? Is access available at any point of the recovery journey and is it based on need?
- 3.10. Is there effective continuity of care between community-based and residential drug treatment services? Does this include a) preparation prior to entry to residential services, and b) continued post-residential support to ensure recovery outcomes are sustained?
- 3.11. Are there relevant information-exchange arrangements, using appropriate protocols, to ensure effective inter-agency working and to support continuity of care (eg, between community and custody-based services, and for specific groups such as those identified under local integrated offender management and multi-agency risk assessment conference arrangements)?

4. There are interventions to address the health harms of drug use

What will you see locally if you are meeting the principle?

All people who use drugs have prompt access to interventions to address the health harms of drug use, including interventions to prevent drug-related deaths and blood-borne viruses.

What questions should you ask to check you are following the evidence and best practice that supports the principle?

- 4.1 Is there ready access for all people who inject drugs (including NPS and image and performance-enhancing drugs) to sufficient injecting equipment to ensure coverage,⁹ and to advice and information on blood-borne viruses and bacterial infections, and alternatives to the most harmful ways of taking drugs?
- 4.2 Are hepatitis B vaccinations for people who use drugs promoted in line with national guidance and quality standards?^{10,11,12}
- 4.3 Are confidential tests for HIV and hepatitis B and C, and screening for tuberculosis, promoted in accordance with national guidance and quality standards?^{10,11,12}
- 4.4 Are pathways to treatment and support for hepatitis, tuberculosis and other respiratory diseases agreed between drug and health commissioners to ensure ready access, and is specific support in place for people who use or have used drugs?^{13,14}
- 4.5 Are commissioning and services coordinated or integrated to improve access to support for mental health problems (crisis, severe and common), wound care, sexual health and dental health? Are service users offered general healthcare assessments that cover these issues and, where appropriate, are they referred to specialist services?
- 4.6 There is a substantial body of evidence demonstrating that LGBT people experience significant health inequalities, which impact both their health outcomes and their experiences of the healthcare system. Has substance misuse been considered as part of a wider investigation into the health inequalities affecting LGBT people?^{15,16}
- 4.7 Is there a good understanding of and effective responses to the health impacts of emerging drug-use trends, such as 'chem sex' among some men who have sex with men?¹⁷

- 4.8 Are there any specific interventions to raise awareness of the harms of drug use, including new psychoactive substances, for specific at-risk groups, such as pregnant women, older people and those with existing long-term conditions?
- 4.9 Are drug services addressing the very high rates of tobacco smoking among their service users and staff, using integrated, whole-service strategies and offering (or working with stop smoking services to offer) interventions that include stop smoking support (NRT and psychosocial)¹⁸ and harm reduction for people unable or unwilling to stop smoking?¹⁹
- 4.10 Are all relevant services (especially primary care and emergency departments) able to identify and refer to specialist care for the acute health harms caused by some NPS, such as ketamine and GHB?
- 4.11 Do local agencies have a good understanding of new psychoactive substance use in their area, and use this knowledge to develop local responses to these substances?
- 4.12 Do treatment services have links with A&E and primary care services to pick up people with acute NPS problems who may need to receive treatment or harm reduction interventions?
- 4.13 Are effective overdose-awareness training and information, and naloxone provided for service users and their family/carers?
- 4.14 Is there ready access to an appropriate range of opioid substitution medications and to supervised consumption for all those starting opioid substitution treatment or needing continued (or a return to) supervision to ensure medication-compliance and to reduce overdose risk?
- 4.15 Is excessive or increasing alcohol use among drug users in treatment addressed?
- 4.16 Are there appropriate local reviews of drug-related deaths and action in response to their findings?²⁰

5. Treatment is recovery-orientated, effective, high-quality and protective

What will you see locally if you are meeting the principle?

Treatment services are high-quality, evidence-based and deliver a broad range of effective interventions.

People in treatment and their families are protected and provided with appropriate, quality interventions.

What questions should you ask to check you are following the evidence and best practice that supports the principle?

- 5.1 Are there clinical governance mechanisms for assuring the quality and safety of drug treatment services? Are these clearly embedded in public health systems?
- 5.2 Does the local system have access to a full range of psychosocial, prescribing and recovery-support interventions? Are commissioners testing whether the principles and features of recovery-orientated drug treatment^{21, 22} are being achieved?
- 5.3 Are prescribing practices in line with clinical guidance?^{12, 23}
- 5.4 Are packages of care tailored to individual service users? Do these take into account the treatment and wider recovery support needs of individuals and their families?
- 5.5 Is the treatment system able to respond rapidly and effectively to changing patterns of alcohol and drug misuse and drug problems, including new and emerging drugs, poly-substance use, volatile substance abuse, chem-sex, prescription and over-the-counter medicines, and khat?
- 5.6 Are responses in place or being developed, in primary and specialist care, to identify and meet the specific treatment needs of people misusing or dependent on prescription and over-the-counter medicines?
- 5.7 Are there mechanisms (and appropriately trained staff) for involving families, partners and carers in treatment, where appropriate?
- 5.8 Are all interventions for people who misuse drugs delivered by appropriately trained, competent and supervised staff?^{24,25,26} Are psychological interventions based on a relevant evidence-based treatment manual, which guides the structure and duration of the intervention?
- 5.9 Is a range of services available that supports individuals' different treatment goals, in line with NICE guidance? Do local services offer interventions supporting abstinence, maintenance, and relapse prevention?

- 5.10 Is a full range of addiction specialist and non-specialist medical competencies available among the workforce? Does the range of medical competencies allow the system to provide clinical leadership and support?²⁵
- 5.11 Are services tailored towards women with, for example, women service users offered the option of a female keyworker and women only groupwork provision where practicable? Do services provide women-only sessions? Are there links with women's services which can provide treatment and recovery support?
- 5.12 Are there specialist referral pathways in place for pregnant women?
- 5.13 Are the links between domestic violence and drug misuse considered in care planning and reviews? Is there joint working with and effective pathways to services for victims and perpetrators of domestic violence?²⁷
- 5.14 Are there protocols and pathways to support service users who have both alcohol and drug misuse and mental health problems, including those in crisis?
- 5.15 Is treatment and care, and the information people are given about it, culturally appropriate? Is it accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English?
- 5.16 Are service users who care for or have contact with children assessed and given information about the risks to children from drugs and medications, and about the need for safe storage? Are home environments visited and assessed for risks and for suitable storage?
- 5.17 Is care planning sufficiently recovery-orientated (ie, coordinated across services, covering all domains, including recovery support and reintegration)
- 5.18 Do recovery care plans empower service users to take responsibility for their own health and recovery?
- 5.19 Is a service user's treatment regularly reviewed using appropriate measures of recovery?²¹ Is treatment then optimised or adapted to ensure continued benefit and the best chance of recovery?
- 5.20 Are service users encouraged to take opportunities to recover, and given the option to come off medication with appropriate support when appropriate?
- 5.21 Do commissioners and providers use the recovery diagnostic tool to understand local system blocks to recovery and to help service users move through treatment and overcome dependence?
- 5.22 Is recovery visible within the local system via recovery champions, mutual aid and peer support, and contact between people in treatment and others further in their recovery journeys?
- 5.23 Do local services facilitate access to mutual aid and peer support groups by advocating for it, accompanying service users, providing meeting space, attending

open meetings, providing or arranging transport, using peer supporters, supporting single-sex groups, etc?

5.24 Are partnerships using NDTMS/TOP data to measure the achievement of drug strategy outcomes and progress against public health outcomes framework measures? Are they using this information to improve local services and pathways?

6. Treatment supports people to sustain their recovery

What will you see locally if you are meeting the principle?

The number of people successfully completing treatment is increasing, and recovery from dependence is sustained.

What questions should you ask to check you are following the evidence and best practice that supports the principle?

- 6.1 Does the partnership have a written strategic plan to increase service users' access to education, training and employment?
- 6.2 Do people who have successfully completed treatment receive regular recovery check-ups? Are they given additional support or rapid re-entry to treatment if needed?
- 6.3 Is ongoing support available to help people sustain their recovery? Does this include relapse prevention? Is there other support from mainstream and specialist services, and/or peer support and mutual aid?
- 6.4 Are there opportunities for those in recovery to support their own and others' recovery as peer supporters or recovery champions?
- 6.5 Does the partnership regularly monitor and review levels of successful treatment completion and sustained recovery using NDTMS, TOP, and other specific measures (where appropriate)?
- 6.6 Do the resettlement plans, prepared by community rehabilitation companies' staff in the resettlement prisons, identify the treatment and recovery interventions that will be required on the prisoner's release into the community and are there clear lines of responsibility for who delivers these?

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