DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Secretary of State for Social Services

Prime Minister

Mr Fowler intends to give the attached response to the report of the Advisory Council on the Misuse of Drugs. He will announce that £2m is making available from in grants to authorities as pump priming. A note on the sort of initiatives he wants to encourage is attached.

29 November 1982

Willie Rickett Esq
Private Secretary to the
Prime Minister
10 Downing Street
LONDON
SW1

Dear Willie

We spoke this afternoon about my Secretary of State's proposed announcement of the publication of the Advisory Council on the Misuse of Drugs' Report on Treatment and Rehabilitation, scheduled for 1 December 1982.

I am attaching for the Prime Minister's information:

(i) Summary and recommendations of the Council's Report.

(ii) Correspondence between my Secretary of State, the Home Secretary and the Secretaries of State for Scotland, Northern Ireland and Wales.

(iii) Draft PQ Answer.

Attached to the draft PQ Answer are the Notes of Guidance on the type of scheme which we wish to encourage via the additional £2 million which we are making available for grants to authorities and voluntary bodies.

If there is any further information which you feel would be useful to the Prime Minister, I would of course be only too happy to help.

Yours ever

Mrs C L Souter
Private Secretary

29 NOV 1982

E.R.

N.B. The Secretary of State wishes to amend this himself.

DRAFT PQ AND REPLY

PQ: To ask the Secretary of State for Social Services, when the report of the Advisory Council on the Misuse of Drugs on treatment and rehabilitation is to be published; and what action the Government proposes to take.

SUGGESTED REPLY

The Advisory Council's report is published today. The report spells out the changing nature and growing problem of drug misuse. It shows the effect on individuals, their relatives and friends, and on the work of health and social services agencies, the police, the courts and the probation service. It gives an overall view of treatment and rehabilitation services currently provided for drug misusers and makes recommendations for their strengthening and development.

The Council challenges the "traditional" tendency to treat specific forms of addiction. It advocates instead a broader approach aimed at responding towards the whole range of problems encountered by drug misusers. As the council says, what is needed is "a long-term response which can bring about enduring change in the drug misuer's behaviour".

We welcome this report and are grateful to the Council for its work. My rt hon Friends and I recognise the challenge posed by the growth of drug misuse to which the Council has drawn attention and are determined to respond positively. Drug misuse is a major social problem with grave consequences that we cannot ignore. This field has not had adequate attention in the past and it is clear that new initiatives must now be taken.

We accept the Council's view that prime responsibility for the provision and development of services should remain at local level. This is consistent with our general policy for the health and personal social services.

It is important that each regional health authority should in consultation with local authorities, assess the extent of drug problems in its region - as the report recommends - and monitor the effectiveness of services in dealing with them. Each region must develop a policy for meeting local needs in this field, and we shall be following up developments under the arrangements introduced

this year for improving the accountability of the health service.

Recommendations are made in the report for the establishment of regional drug problem teams and of drug advisory committees in each district. Arrangements are being made for the report to be widely distributed to health and local authorities and to voluntary and professional bodies for their comments on these and other specific recommendations, including the Council's suggestions for the development of hospital based treatment services, advisory and counselling services, and residential facilities and for improvements in training. As recommended by the Council, such statistical data as is maintained centrally will be made available at regional and district level.

The report deals with prescribing safeguards. We believe it important to look in detail at the role of doctors in the treatment of drug misuse and at prescribing patterns, including the criticisms made of the prescribing practice of certain doctors. I am arranging for a special conference of the medical profession to be held in the New Year. As a matter of urgency my right hon Friend, the Secretary of State for Home Affairs, has already invited comments from the profession and other interested bodies on the Council's recommendation that current licensing arrangements for the prescription of heroin and cocaine should be extended to include dipipanone. He is also considering ways in which the tribunal procedure established under the ~~MDA~~ Misuse of Drugs Act 1971 to deal with irresponsible prescribing might be made more effective and less time consuming; at the same time investigation will continue into the prescribing practices of a number of doctors.

My right hon Friends and I are concerned about the deficiencies in services which the report highlights and are anxious that the need to engage in consultations should not delay authorities in preparing the ground for new initiatives.

We are therefore making available £2 million for grants to authorities and voluntary bodies in England to enable them to bring forward schemes in the coming financial year. Grants will be made on a pump-priming basis - as recommended in the report and we shall be inviting proposals. Notes have been prepared on the sorts of schemes we wish to encourage. We shall be inviting comments on these with a view to issuing guidelines early in the New Year. I look forward to an imaginative response from authorities and voluntary organisations.

X (attached)

[In Scotland, ...]

[In Wales, ...]

[In Northern Ireland, ...]

C

DRAFT

(Guidelines for local initiatives)

TREATMENT AND REHABILITATION OF DRUG MISUSERS

INTRODUCTION

1. The DHSS is making £2 million available to support initiatives taken in 1983/84 by health authorities, separately or jointly with local authorities, or by voluntary organisations, to improve the help provided for people with health or social problems related to their misuse of drugs. These notes explain the Department's objectives in providing the funds and the procedures by which bids for them may be made. In the Annex suggestions are made as to sorts of projects and forms of spending for which support could be provided.

OBJECTIVES

2. Copies of the report on Treatment and Rehabilitation of the Advisory Council on the Misuse of Drugs (ACMD) have been distributed widely to health and local authorities in England, and to professional and voluntary organisations. Comments have been invited on the Council'sproposals for strengthening and improving the range of service provision available for people with problems related to their misuse of drugs.

3. £2 million is being made available in 1983/84 - in advance of final decisions on the report - to help voluntary bodies and authorities who, in the light of their own assessment of priorities, wish to bring forward initiatives in this field to improve the range of services provided locally. For planning purposes it can be assumed that a similar sum will be available in 1984/85 and 1985/86. The broad objectives of the central initiatives, initially, are:

(i) to encourage local assessment of the nature and spread of drug misuse problems;

(ii) to improve levels of professional awareness and expertise in providing help for people with drug related problems;

(iii) to improve links between hospital-based treatment services and the communities they serve;

(iv) to help improve the effectiveness of services provided and secure greater value for money.

4. The objective is not to supplant authorities' responsibilities for providing services and training, but to enable them to introduce improved arrangements in the short term for considering the needs of people with drug related problems and to carry out their responsibilities towards this group.

USE OF FUNDS

5. Special provision for the funding of a range of initiatives is being made in 1983/84. The funds will be made available to health authorities, or directly to voluntary organisations. Health authorities may use the funds to make grants to local voluntary bodies (under powers given in Section 64 of the Health Services and Public Health Act 1968) or to cover local authority expenditure on jointly planned schemes. Powers are not available for the Department to pay grants directly to local authorities.

6. Details of schemes and bids for funding may be submitted by statutory authorities or by voluntary bodies subject to the following conditions:

(i) only service or training initiatives to be undertaken in England will be considered;

(ii) schemes should have regard for securing value for money - details of efficiency gains to be made should be given, where appropriate;

(iii) local voluntary sector projects should have been the subject of consultation with the relevant Health and Social Services Authorities and have their support; written confirmation from authorities should be provided;

(iv) capital investment schemes should have been the subject of consultation and agreement with the relevant agencies who would have to meet expected revenue consequences; written confirmation from authorities should be provided;

(v) provision should be made available for the evaluation of all schemes designed to improve the effectiveness of existing services or to test alternative methods of providing services; bids should indicate firm proposals for and estimated costs of evaluation;

(vi) schemes for testing new approaches to training should have been the subject of consultation with the relevant professional training bodies.

7. Funding is available for both capital and revenue projects for up to 2 years. Allocations will be made for eligible schemes and projects initially on a first come, first served, basis. Ministers will be considering, in the light of comments on the ACMD report, the need to consider more favourable subsequently bids for projects in selected areas. District Health Authorities should notify their Regional authorities of the bids they make. Regional Health Authorities are free to make bids in their own right. The clsoing date for bids will be 30 June 1983. No local voluntary or statutory project will be supported indefinitely from Departmental funds and, unless so stated, a grant in the financial year 1983/84 will not imply a commitment by the Department to provide funding in following years.

DEFINITION OF DRUG MISUSE

8. The terms "drug misuse" and "drug related problems" have the meaning given to them in the ACMD report on Treatment and Rehabilitation, and in turn from the Misuse of Drugs Act 1971. Consideration will be given primarily to projects designed to help drug misusers, but schemes that also are concerned with the prevention of solvents abuse will be considered.

EVALUATION REPORTS AND AUDITING OF ACCOUNTS

9. Where innovatory or experimental projects are funded under this scheme, the Department will ask for a written report to be made within 6 months after the ending of the project or of the Department's financial support. The Department will give details of the conditions under which grants are made in the letters approving particular projects for funding.

APPLICATION PROCEDURES

10. Details of schemes thought to be eligible for funding should be sent to ..... DHSS, Alexander Fleming House, Elephant & Castle, London SE1 6BY. Applications do not need to be set out in a particular form, but details should include all relevant financial costings and estimates, and, where necessary, background information should be provided on existing services or training provision which projects are designed either to complement or to supplement.* The Department would aim to reply within one month of receipt of applications. Applicants should not assume that funds are to be allocated until they have received a letter giving confirmation.

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* Applications for funds for accommodation schemes should indicate whether the housing costs of the project can be met from other sources. DHSS grant aid for housing costs (that is in addition to the costs for care and support provided) will be available only exceptionally.

CHAPTER 11 - SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

11.1 In chapter 2 of this report, we have described the historical background to the present services for drug misusers and have concluded that in many instances recommendations made for improving them have never been fully implemented, due in part to the lack of any effective machinery to achieve this. The services themselves have been described in chapter 3 and our analysis of them in chapter 4 has demonstrated that they are now less able than ever to cope with the problems of drug misuse.

11.2 All the indicators point to a substantial increase in the numbers of people misusing drugs. That misuse extends from the opioids through amphetamines and barbiturates to the minor tranquilisers. The increase in multiple drug misuse has been a matter of particular concern to us. In parallel with this growth in drug misuse, there has been increasing questioning of the practice of prescribing controlled drugs to addicts especially on a long-term maintenance basis.

11.3 We have also noted the growing difficulties in finding adequate funds to maintain existing services, particularly by non-statutory agencies, but also by statutory agencies.

11.4 This analysis of the current situation has led us in chapter 5 to propose a move away from the present approach which is largely substance or diagnosis centred towards a problem oriented approach similar to that in the field of alcohol where the term problem drinker has now been adopted. Thus when we use the term problem drug taker we mean any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco).

11.5 It follows from this that we consider that services should be developed in a way which will enable them to respond to the needs of the problem drug taker. The aim must be to provide a range of treatment modules within a long-term perspective. It is this element of matching the individual's needs with service responses which we consider is most lacking in United Kingdom services at present. The main objective must be to utilise not only the full range of specialist services, but also the existing statutory services concerned with social support, including social work and youth services, housing and employment agencies. We must aim to use and build upon the resources we have with imagination and care and to bring co-ordination and consistency to services for problem drug takers.

11.6 We have therefore recommended in chapter 6 the establishment, using existing resources as far as possible, of regional and district drug problem teams and of district drug advisory committees which together can

ensure the co-ordinated development of services suited to local needs and can make available specialist advice and support for those working with problem drug takers. Within this framework we make recommendations on the future role of agencies providing services for problem drug takers.

11.7 In chapter 7 we have paid particular attention to the concern at the increasing involvement of doctors working away from hospital-based services in general practice (both NHS and private) and in other forms of private practice and to the risks inherent in this unplanned development. We have concluded that while there may be a role for some of these doctors in the treatment of problem drug takers, there is also a need to ensure that this role is consistent with good medical practice, and that adequate support is available to enable a multi-disciplinary response to be made to the needs of their patients.

11.8 The development of services will require improved training for those likely to come into contact with drug misusers. In chapter 8 we have drawn attention to the lack of training related to drug misuse in professional courses, and to the dearth of specialist training programmes on this subject. We make recommendations which we hope will improve this worrying situation.

11.9 While we consider that it should not be given priority over the provision of services there is a clear need for more research into the treatment and rehabilitation services provided for problem drug takers, along the lines proposed in chapter 9.

11.10 One of our major concerns has been the funding of services. The present arrangements, particularly in the non-statutory sector, are complex and uncertain. If there is to be an adequate response to the undoubted increase in problem drug taking then additional funding must be made available both at local level.

11.11 Against this background we make the following specific recommendations:

Central/Local Responsibilities

i. There should be no changes at national level in the current allocation of responsibility for policy on services but the arrangements for central government to give advice and support to local agencies should be expanded (6.46-6.51).

ii. The new arrangements to improve the accountability of the National Health Service should be used as one means of achieving implementation of our recommendations (6.52).

iii. Prime responsibility for the provision and development of services should remain at local level (6.2 and 10.14).

Development of Services

iv. In developing services full use should be made of existing resources (6.4).

v. Each regional health authority should ensure that the extent of problem drug taking in its region is monitored, assess the extent of the services provided and develop a policy for meeting local needs (6.6).

vi. Each regional health authority should establish a multi-disciplinary regional drug problem team (6.6).

vii. Regional drug problem teams should have a permanent identifiable base, usually a designated treatment clinic, or another existing specialist service where one exists (6.8).

viii. Apart from providing a specialist service, the regional drug problem teams should have a peripatetic role within the region, giving support and advice to, and liaising with specialist and non-specialist agencies and encouraging the development of new services (6.9).

ix. Within three years, drug advisory committees should be established in the majority of health districts to monitor the extent of problem drug taking, assess the effectiveness of existing services and to foster their improvement (6.11 and 6.12).

x. Membership of the drug advisory committees should include representatives of health and local authorities and other statutory and non-statutory agencies (6.14).

xi. In the longer term each health district should establish a team similar to but broader in composition than the regional drug problem teams (6.15 and appendix G).

xii. As the advisory committees and district teams become established the regional teams should concern themselves more with long-term strategy for the development of services (6.16).

xiii. Relevant statistical data held by central government should be made available to drug advisory committees and regional drug problem teams while preserving confidentiality (6.20).

The Role of Individual Agencies

xiv. Hospital-based treatment services should encompass the treatment of all forms of problem drug taking (6.23).

xv. The minimum nucleus of such a service should comprise a consultant psychiatrist, with either a senior registrar, registrar or clinical assistant, as well as a social

worker, nurse and secretary, who should have had special training and experience. The consultant should either have charge of or access to beds in an inpatient unit and laboratory facilities should be available (6.24).

xvi. The minimum functions of a clinic should include the acceptance of problem drug takers as patients from a variety of referral sources preferably from their general practitioner for assessment; with options of help from different disciplines, in liaison with other services (6.25).

xvii. Advisory/counselling services should be developed and might be combined with day care centres (6.31 and 6.33).

xviii. A wider range of residential facilities is needed and their development should include a greater degree of flexibility in the programmes offered and in the length of stay (6.34 and 6.35).

xix. The expertise and methods of working introduced by the non-statutory agencies should be borne in mind when services are developed (6.36).

xx. Local authority social services should consider ways of promoting their involvement in developing services (6.40).

xxi. Structured hostel provision should be made available to organisations working with problem drug takers by means of management agreements with housing associations (6.44).

Prescribing Safeguards

xxii. A network of support based on the regional drug problem teams should be available to doctors not working in hospital-based services who are treating problem drug takers; where necessary such doctors should liaise with hospital-based services and should utilise the services of other disciplines; and opportunities should be created for them to develop their knowledge and understanding of drug problems (7.18 and 7.19).

xxiii. Guidelines should be prepared on good medical practice in the treatment of problem drug takers (7.24).

xxiv. As a matter of urgency, the ability to prescribe dipipanone, and therefore Diconal, to addicts should be restricted to doctors licensed by the Secretary of State (7.27).

xxv. This licensing restriction should also be extended at the earliest possible date to all other opioids, such extension being considered urgently in conjunction with the preparation of guidelines for good practice (7.32).

xxvi. The Government should consider as a matter of urgency ways of fulfilling the original intention that the Misuse of Drugs Act should be able to deal with all forms of irresponsible prescribing, ranging from serious professional misconduct at one extreme to poorly judged but bona fide intention at the other (7.38).

Training

xxvii. Consideration should be given to developing training about drugs, alcohol, solvents and tobacco in an integrated way, particularly for those working with the young (8.10).

xxviii. The appropriate professional bodies should review the provision of education regarding drug problems in pre-qualification courses (8.12), and explore ways in which education and training about problem drug taking might be included in post-basic qualification courses (8.13).

xxix. Employers of residential staff should consider ways of providing in-service training (8.14).

xxx. The appropriate professional bodies and national training agencies should examine the pre- and post-qualification courses for residential staff and should ensure the inclusion of education about drug problems in their curricula (8.14).

xxxi. More in-service training should be provided at local level both for particular professional groups and for multi-disciplinary groups (8.15 and 8.16).

xxxii. Training and education in drug problems should be designed and provided specifically for senior and middle managers (8.8 and 8.17).

xxxiii. The Health Departments should establish one or more intensive multi-disciplinary courses for trainers involving supervision over at least six months (8.18).

xxxiv. The Health Departments should consider ways in which the need for multi-disciplinary expertise and training might be met including the possible establishment of a national training facility (8.20 and 8.21).

xxxv. Local training courses should be considered for pump priming funding by central government (8.22).

xxxvi. The need for financial provision to be allocated for the training of staff in non-statutory agencies should not be overlooked (8.23).

xxxvii. Training provision should be reviewed from time to time jointly by the appropriate government departments and the national professional bodies (8.24).

Research

xxxviii. Further research is needed into service policy, techniques and processes of treatment and rehabilitation, and the factors which influence problem drug takers to seek help (9.4-9.7).

xxxix. New mechanisms are needed to ensure that such research is initiated (9.3).

xxxx. The need for research should not delay help for the problem drug taker, but the monitoring and evaluation of new and existing services is important (9.10).

Funding

xxxxi. There may be a need to redirect current resources towards services for problem drug takers, and priorities should be reviewed (10.4).

xxxxii. Funds should be provided primarily from local sources, most probably from joint funding arrangements (10.14).

xxxxiii. There should be increased funding direct from central government possibly by way of pump priming grants normally for a minimum period of 5 years (10.16).

xxxxiv. Consideration should be given to the issuing by central government of guidelines to health and local authorities on the provision of funds (10.17).

xxxxv. Ways of funding services should be reviewed urgently, taking into account the special factors which affect provision for problem drug takers (10.18).

R. DUCKWORTH,
Chairman, Treatment and Rehabilitation Working Group.

W. E. C. ROBINS,
Chairman, pro tempore, Advisory Council on the Misuse of Drugs.

D. J. HARDWICK,
Secretary.
14th July, 1982.

C2

PREVENTION AND TREATMENT OF DRUG MISUSE

SUGGESTIONS FOR LOCAL INITIATIVES

This Annex suggests a range of schemes for improving services for drug misusers which health and local authorities and voluntary bodies might wish to consider. The suggestions take account of the deficiencies in services and training provision identified by the report on Treatment and Rehabilitation of the Advisory Council on the Misuse of Drugs - in particular , deficiencies in staffing in existing drug treatment centres, lack of specialist health service provision in parts of the country where drug misuse problems are growing, and both under-subscribed and insufficient rehabilitation facilities.

Applicants should be aware that accommodation schemes may be eligible for capital and annual revenue grants from the Housing Corporation or local housing authorities if they are planned in consultation with a registered housing association as well as a voluntary organisation.

APPOINTMENTS .

1. Appointment of suitably qualified staff to work with designated drug teams at Regional level in setting up and carrying out studies of the extent of drug misuse problems within the Region, the nature of the problem, and the possible use of indicators to monitor Regional trends.

2. Appointment of community psychiatric nurses to work within the community in liaison with staff of existing drug treatment facilities. This could enable patients to be seen without their needing to attend routinely as out-patients - so saving on psychiatric out-patient time, and enabling centres to see more patients for initial assessment (avoiding delays in appointments during which motivation for seeking treatment may be lost).

3. Creation of clinical assistant/hospital practitioner posts in existing drug treatment centres. Additional posts, if filled by GPs with an interest in the addictions, could provide the close association between GPs and specialist centres suggested by the ACMD. The posts would enable centres to see more patients for initial assessment.

4. Appointment of ex addicts as counsellors (in nursing assistant posts.) Some use of ex addicts as counsellors has been tried to provide a bridge between hospital facilities and therapeutic communities.

EQUIPMENT

5. Provision of additional equipment for toxicological screening to support existing drug treatment facilities. Many general psychiatric units do not at present have access to the latest technology to assist in diagnosis and treatment.

ACCOMMODATION

6. Provision for half-way houses/hostels. Some former in-patients require support before assuming a stable position in the community, for whom a place in therapeutic communities would be inappropriate. Half-way houses operated jointly by health and local authorities or by health authorities and a

and a voluntary organisation could fill that need. Joint operation could enable admissions policy to be co-ordinated with that of associated hospital in-patient facilities. (DHSS grants would be available for care and support provided ~~,~~ Grant aid for housing costs would be available only exceptionally.)

7. Grants to voluntary organisations to assist in setting up and running hostels/rehabilitation houses. The majority of existing facilities are in the South East. New hostels or rehabilitation houses are needed elsewhere so that residents can keep in touch with the communities in which they had cultural roots. Funding could include provision for the training of supervisory staff. (Repeat not a. and d para 6).

DAY CENTRES AND ADVISORY SERVICES

8. The establishment of experimental day centres for drug misusers. Such centres could provide greater opportunities than are available in out-patient clinics for involving young drug misusers in structured activities - so helping prevent resumption of drug misuse through boredom - and helping improve their social skills. Separate centres would be desirable for older patients. Centres could be staffed by community psychiatric nurses, social workers and voluntary workers.

9. The establishment of experimental day hospitals for drug misusers. One or two experimental projects could be funded to explore alternatives to detoxification through in-patient admission or on an out-patient basis. A day hospital setting may, for example, be more appropriate to certain drug misusers (eg single mothers with children) for whom in-patient treatment might not be suitable and out-patient attendances provide insufficient motivation.

10. Grants to street agencies/walk-in centres. These can provide a means of bringing into treatment young people, many of them without GPs, who would not otherwise come into contact with treatment services.

11. Grants for establishment on an experimental basis of telephone information and advisory services. These could be assessed for their success in helping bring people into treatment.

TRAINING AND EXPERIENCE

12. Creation of posts in existing drug treatment centres to enable development of specific training programmes for different professional groups. While generally, the level of training available to those working with drug misusers needs to be improved, there are few people suitably qualified and with the time to provide training (additional to that required for their professional qualifications). Additional funds could help staff in existing centres to develop a programme aimed to help limited numbers of staff from other centres to improve their training skills in this field.

13. Provision for training allowances for GPs wishing to follow postgraduate training in the drugs field.

14. Grants in the form of bursaries to voluntary bodies to enable training of hostel staff.

15. Provision for proleptic appointments. In some Regions, it may not be possible to create new consultant posts specifically for drug treatment centres. Proleptic appointments would enable existing general psychiatric staff wishing to work in this field to acquire necessary additional expertise.

DES, Scotland and Northern Ireland content:

no comments.