

Section D: Drug treatment, social care and support for drug users in re-establishing their lives

Even from a cursory glance at the figures or a brief chat with a drug user it is clear there have been major improvements in both the capacity and accessibility of drug treatment in England over the life of the current strategy. Awareness of treatment and its potential has increased – not just among those with experience of drug use, but also among the wider community.

Confusion still exists however as to what ‘treatment’ actually means. For some the term refers simply to the range of medical interventions that deal directly with the individual’s physical addiction to a substance. For others treatment embraces psychosocial interventions such as counselling. For many drug users however, and by that we mean of course those at whom treatment is targeted – problematic opiate users – the primary aim of going into treatment is to get a script – and this is undoubtedly easier to achieve for the majority of users across the country. However, should accessing a methadone prescription really be the height of our expectations of a treatment system? **DrugScope** believes by now we should be aiming much higher.

Many of the practitioners and commissioners **DrugScope** has spoken to this year are adamant that for treatment gains (such as better health and cessation of offending) to be sustained, provision must include not just the clinical and the psycho-social but also focus as a primary objective on access to mainstream services such as housing, employment and training. This viewpoint is supported by research from the USA and Europe that demonstrates that sustained positive treatment outcomes are dependent on the individual’s ability to stabilise and improve aspects of their life in addition to their drug use.

For many people this is achieved through securing a home, rebuilding family relationships and gaining satisfying employment.¹

Currently we describe these interventions as “wraparound services”. However there is a question as to how sustainable and beneficial an approach is that places the drugs agency at the centre of a system of interventions when we know that the key objective for sustained recovery is reintegration into the mainstream community. Given the priority currently being placed on successful discharge, **DrugScope** is hopeful that incentivising mainstream access for people who have experienced problems with drugs to “wraparound services” can become a key outcome in Local Area Agreements thus contributing to tackling social exclusion.

The performance management systems that have been put in place by the Home Office and the NTA are acknowledged as now outdated and limited. Largely based on proxy indicators of effectiveness, they fail to identify exactly what outcomes are being achieved for the substantial investment in treatment services. One example of this is retention. The target for client retention for treatment to be considered successful is currently 12 weeks. The evidence base for this is weak and the target is held by many to be irrelevant to client success and rather more symbolic of system success. Indeed the target was set at a time when evidence about effectiveness was limited. With the development of the TOP system **DrugScope** believes it is now time to review current targets and using the new data that will become available, identify more client-focussed ways of managing the performance of our treatment services. **DrugScope** is disappointed to learn that the current retention target is in the recently published PSA for Drugs and Alcohol and hopes that the continued use of this proxy indicator does not mean there is a lack of confidence in the ability of TOP to

¹ For example, Padgett, D K et al (2006); Housing First services for people who are homeless with co-occurring serious mental illness and substance abuse. Research on Social Work Practice 16, p 74 - 83

accurately reflect treatment effectiveness. **DrugScope** hopes that if TOP is unable to deliver, other indicators for measuring the effectiveness of drug treatment may yet be identified.

Providers, practitioners and commissioners were highly critical of the current performance management system throughout our recent consultation. Key among the criticisms was the potential for providers and commissioners to supply misleading data about what was happening in their services. One example of this was the provider of criminal justice services who claimed that if they reported a less than optimum rate of conversion from initial assessment to engagement in treatment they were encouraged by the commissioner to “lose” the initial assessment form. Another incident was raised by a commissioner who said that he recently found team leaders in their main service were instructed to class every treatment “drop out” prior to the 12 week retention target date as a completed intervention in order to avoid dropping below the NTA target. **DrugScope** has since learned these are far from isolated incidents.

While it is tempting to believe that the solution to this is an ever more rigorous performance management system, **DrugScope** believes that of equal if not greater importance to the mechanism used to collect and analyse data, is the environment and culture within which performance management takes place.

The consequences of not meeting targets currently can be severe. From a call from the NTA to the Local Authority Chief Executive for a commissioner to be hauled over the coals, to the loss of a major contract for a provider, being scored as “RED” (i.e. not achieving the quarterly target) is to be avoided at all costs. What were once called liaison meetings between local partnerships and the Government Office or NTA are now dubbed “Challenge and Confirm” meetings. As one commissioner told us:

“No one wants to be ‘challenged’, everyone wants to ‘confirm’. So people lie. We don’t get a chance to sit down and see why we might not have reached the target, we don’t get a chance to work out if it was the right target for [our area]. We just get told if we don’t do it we’ll be in trouble. So we just say yes.”

This approach actually undermines partnerships rather than encourages improvement as even those who are improving can be ‘slated’ for not having reached targets that may not even be relevant to their area.

DrugScope believes that good performance management is critical to having an effective drug treatment system. However performance management is about more than measurement. Alongside robust systems for collecting outputs, we must have effective outcome monitoring stretching across the drug treatment and mainstream services. To be meaningful, this must take place within a climate where providers and commissioners – and government agencies for that matter – are enabled to analyse performance, own and understand their mistakes and receive support to improve performance.

Despite revised clinical standards and considerable good practice advice for clinicians **DrugScope** learned through its consultations that inadequate dosing, disciplinary discharge, lack of mental health interventions, poor physical health interventions all seem still to be a feature of a number of treatment systems across the country.

DrugScope fully supports the work undertaken by the NTA with the Healthcare Commission to challenge these practices but hopes that a more rigorous regime – involving unannounced visits and with less reliance on self-assessment either by the provider or the commissioner - can be established to raise standards further where problems are identified.

There is concern that the substantial expansion of the treatment workforce has not been matched by a sufficient commitment by government or the NTA to encouraging and supporting staff training and professional development. With cuts in DIP, young people and some local treatment budgets investment in training, practice skills and development is less not more likely. Improving access to and the quality of treatment services has a direct link to the competence, confidence and effectiveness of the workforce (in specialist and generic settings). Greater integration of service delivery (e.g., for young people and families and with 'wraparound' support) will require more multi-disciplinary training and development, with a workforce capable of working across a range of activities and relating to each other with confidence and in collaboration. As has been mentioned, the STRADA project in Scotland provides an effective model for delivering high quality training to meet national and local policy initiatives.

13. Where is drug treatment succeeding and where are the gaps?

Treatment system capacity has significantly improved nationwide. Clinical care is better and efforts being made to better understand treatment outcomes are welcome. **DrugScope** acknowledges the recent focus on the service user's 'journey' and the need for treatment to be person-centred, positive and directed through a care plan developed and owned by service users themselves.

The greater recognition of the role of the service user in developing and planning treatment services as a whole is something **DrugScope** welcomes. However we are unconvinced that beyond recognising that service users should have a role, many local partnerships and providers do very much about it at all. So while we welcome the increased commitment to user involvement we believe that there is much for the drug sector to learn from the independent advocacy movement in mental health and the learning disability sector. We

believe that choice, independence and challenge are the right of every service user.

The number of women accessing drugs treatment is still a lower proportion than one would expect. Similarly according to our consultation people from black and ethnic minorities appear to be under represented in the voluntary treatment system but over represented in terms of treatment referrals through the criminal justice system.

The best exploited entry route into treatment in terms of new referrals is currently the criminal justice system – and here our stakeholders expressed concerns. Despite the best efforts of staff to provide a positive treatment experience for the most prolific offenders, evidence points to the fact that not only does the treatment system fail to “grip” these individuals, it also fails to stop their offending behaviour. DIP workers across the country reported the famous “revolving door” of treatment to still be in full swing with the same individuals coming through the DIP/Treatment system repeatedly. **DrugScope** believes there is a critical need to assess the effectiveness of the DIP programme for the most prolific offenders – as this may indicate that we are reaching the limits of what can be achieved through compulsory treatment.

The emphasis within treatment services on solutions to tackle problematic opiate use (such as methadone prescribing and buprenorphine) has given an impression to many that drug services are just for heroin users and unless your problem involves heroin it is not worth going along. The NTA evaluation of crack cocaine services was inconclusive about their value.² However, clearly some of the interventions already available within drug services can have an impact on stimulant use. Rapid/open access harm reduction focussed services

² Weaver, T et al (2007) National evaluation of crack cocaine treatment and outcome study (NECTOS), National Treatment Agency

seem to attract more stimulant users than traditional community drugs teams. **DrugScope** would be pleased to see more investment in tier two services for all drug users – but would welcome a more thoroughgoing evaluation of their impact on harms related to stimulant use and poly drug use where stimulants are the primary drug.

Models of Care and its update have been useful for many in the field in orientating and better understanding the components that make up an effective treatment system. However, questions need to be asked about the role of clinical drug treatment services as the fulcrum of that system. Many people who experience problems with drug use do not use, access, and in many cases do not need a specialist clinical drugs service. This is not to suggest they do not benefit from some form of intervention. Many people who successfully tackle their drugs problems do so through different types of interventions (such as abstinence focussed groups like NA or small local counselling agencies). Many people will tackle their own substance use through making significant changes in their family or personal circumstances (such as moving away from a partner who uses drugs). Others will find the impetus to stop using comes from a new life opportunity such as a new job, or a new house – or even a new relationship. If Models of Care is to continue to act as a proxy National Service Framework for substance use **DrugScope** recommends that more work is undertaken to map and understand the care pathways that do not focus on clinical drugs services.

The UK has a strong tradition of harm reduction services – and was successful in the 1990s at maintaining a relatively low rate of HIV infection among its drug injecting population. However, during our consultation we were told in all regions that investment in harm reduction services had reached a plateau or reduced during the life of this strategy, that enhanced provision through specialist needle exchanges and open access drug services was rare and that a reliance on pharmacy based needle exchange had restricted the variety and suitability of injecting equipment available. Recent data from the Health

Protection Agency has shown that blood born virus prevalence among drug users is rising substantially.³ The UK still has one of the highest drug-related death rates in Europe. Given the expansion in drug treatment it is a concern that there has not been greater progress in reducing drug-related deaths.

While **DrugScope** welcomes the recent publication of an Action Plan for Harm Reduction by the Department of Health and the allocation of an additional small investment in the infrastructure that supports harm reduction, we feel that more needs to be done. **DrugScope** believes that harm reduction needs to be given a higher priority by Government – and this should be reflected in increased funding for these services. Clear targets relating to harm reduction need to be embedded in the mandatory outcomes for all local agencies. If a separate Action Plan for Harm Reduction is needed at a national level it needs to include clear targets, a planned programme of national activity and a framework for evaluation of that activity. The current Action Plan is brief and while indicating some direction for travel is not clear about what will be done. To be meaningful it will need thorough revision.⁴

The ability to access and engage in treatment in primary care was a priority for many of the users and carers we spoke to during our consultation. This was backed up by specialist workers who felt their services were jammed with people who could receive a better and more convenient package of care from their GP. **DrugScope** is unaware of any nationwide research exploring the impact of the GP contract on uptake of drug treatment in primary care but this may be a useful starting point to reassess the situation. Opportunities to incentivise GP provision of drug treatment as well as options for penalising non-participation need to be explored.

³ Health Protection Agency (2006), Shooting up: infections among injecting drug users in the United Kingdom 2005. An update 2006. HPA

⁴ The public health deficit in the drug strategy is amply demonstrated by the Drug Harm Index that has been criticised for focusing too much on crime and the impact on community to the detriment of individual harms requiring public health interventions. See for example, Newcombe, R (2006) The science of harm. *Druglink*, 21 (6), p 20-21

DrugScope welcomes efforts by the NTA and the Home Office to resolve problems relating to the commissioning of tier four services. It is clear that not only are many individuals who may benefit from residential treatment unable to access it, but also that while there is a lot of good quality residential treatment, the quality controls that effective commissioning should bring to a healthcare market are missing. As well as exploring other options for commissioning residential services, **DrugScope** welcomes the efforts of a number of local partnerships to explore solutions for tier four services in-borough. Sometimes this means local residential units – but also the growth of abstinence focussed day programmes is beginning to offer people coming out of treatment more flexible community based options for rehabilitation.

The ability of treatment services to appropriately respond to individual need (including that for access to interventions enabling individuals to deal with problems related to alcohol use and those problems related to over the counter and prescribed substances) using a range of interventions including extended prescribing where appropriate is critical. **DrugScope** acknowledges NICE's work in the area of clinical interventions and in particular its objective of standardising prescribing practice across the devolved administrations and Northern Ireland.

14. How can drug treatment be made more cost-effective so that existing resources can go further?

At the moment the costs of drug treatment are relatively high. It is **DrugScope's** understanding that there are a number of structural and practical reasons for this.

In most areas the bulk of drug treatment is provided through high cost specialist services, even when need may be more appropriately met through lower level interventions. Efforts should be made to effectively "titrate" the intensity of treatment to the needs of the client as early as

possible in the treatment journey. This would have the added advantage of opening treatment markets up to a wider range of non-statutory and primary care providers.

There is little support for small voluntary sector providers to compete on a level playing field with large charities and NHS trusts. This means that monopoly providers who effectively are able to set their own “local tariff” for services can dominate treatment markets. Disinvestment in these monopoly providers is very difficult for local partnerships. At one of our consultation groups we were told that a commissioner had pulled back from going to competitive tender after being told by a specialist provider that disinvestment would result in cessation of service provision immediately. In another the Mental Health Trust used the leverage of the PCT overspend on mental health services to prevent decommissioning. In another area we were told that the local statutory provider had informed the DAT that it would need

“...6 months notice and 6 months to tender and then 6 months to wind the service down so you might as well not bother.”

In another area the commissioner, having let the contract to an independent provider, was told that as clinical governance arrangements were deemed to be inadequate by the Mental Health Trust no case notes would be transferred – effectively halting the process of reprovision. **DrugScope** believes that both commissioners and providers would benefit from clear guidance from the Department of Health as to how disinvestment and reprovision can be appropriately handled.

Commissioning of treatment is resource intensive partly due to the demands of central performance management and partly to the lack of incentives to establish multi agency commissioning partnerships across borough or area boundaries.

In some cases criminal justice interventions are dealing with the same client group as regular open access services, utilising the same clinical services with broadly similar outcomes but at a higher cost. This maintenance of two separate referral systems for the same client group is expensive.

DrugScope understands that block contracts are expensive. There is no national tariff for drugs treatment. Setting one would enable commissioners to begin to look at alternate regulatory systems for spend. The extension of existing healthcare reforms to drug treatment services would enable commissioners to reduce costs and provide a greater choice for service users through multi-area commissioning.

As is stated elsewhere in this document, many treatment gains are lost through the lack of support and opportunities available to drug users within mainstream services such as housing, training and employment. While this often appears as an inefficiency of the treatment system, the solution lies not in specialist services, but in addressing the problems of access to mainstream services.

15. There are many competing priorities within local areas. How should the provision of drug treatment be prioritised locally?

The provision of drug treatment should be prioritised according to local need taking into account national outcomes for public health, criminal justice and children's services within the Local Area Agreement.

Reinvigorating DATs and enabling them to make the local case for investment in drug interventions should be a priority. Within the Sustainable Communities Strategy of every local area is a series of outcomes set by the LSP as long- term objectives for joined up service delivery. It is critical that DATs are able to identify what the impact of substance use is on those aspirations and use that information to drive

through investment. Sufficient levers at a regional government office level can be pulled to ensure that investment is maintained without the heavy-handed performance management framework and central control that stifles local decision making currently.

16a. What can be done to help local partnerships meet the needs of drug users?

First of all, local partnerships need the **freedom** to be able to identify what the needs of their local drug using population are. Then they need the **flexibility** to be able to effectively strategically plan their investment to meet those needs. Partnerships should be encouraged to look at the needs of their population across a range of substances including alcohol. This should not be without some central guidance and support. However, local partnerships have been clear with us that without some local freedoms and flexibilities protecting the gains made over the past five years against a background of possibly reduced or plateau funding will be extremely difficult. Increasingly resources from other parts of the pooled local mainstream budgets will be required to meet the needs of people coming out of and still within treatment. It's unlikely that the Pooled Treatment Budget will increase sufficiently to enable the level of investment required to ensure appropriate 'wraparound services' are available to assure treatment gains. These 'wraparound services' will need to be sourced within the local mainstream. Put simply, drug users need to be included in the global planning of local strategic partnerships to meet the need of their most disadvantaged groups. DATs need to become adept at first of all identifying the need for investment from elsewhere in local budgets and then they need the support from regional government through the LAA negotiation process to enable them to ensure that this mainstream investment is made. This will be most critical during any transitional phase should the Pooled Treatment Budget be included in the mainstream local pooled allocation.

In order to support this, a genuine cross departmental commitment to meeting the needs of drug users needs to be clearly established at a national level. Many partnerships have commented to us that fragmentation at a national level has led to fragmentation at a local level. Leadership needs to come from central government to all departments and interest groups in the local partnership. **DrugScope** would welcome a renewal of the government's commitment to a joined up approach to drug strategy, including a better balance between public health and crime. There have been many suggestions as to which department should lead on drug strategy over the past year. **DrugScope** believes the administrative centre of the drug strategy is less important than the recognition that every government department has responsibilities with regards to substance use (see below - section on extending substance use measures to other areas of the PSA framework at the end of this document).

More needs to be done to incentivise partnership working – both within and outside borough boundaries so that diverse needs can be met cost effectively. For example, the maintenance of 32 separate treatment and commissioning systems across London does not use available resources effectively to meet the different needs of London's diverse population. It is understandable that there has been a clear need to ensure minimum provision is available in every area. **DrugScope** recommends that given that this principle of minimum provision is now accepted, the establishment of region-wide challenge funds to encourage partnership commissioning to meet specific multi-area needs should be explored.

16b. How could local accountability and performance management systems support this?

As every government department has a role to play in tackling substance use, every local agency does too. Accordingly, local performance management systems need to incorporate substance use

as a key issue. One example of this is the proposal that one of the key indicators used to judge NHS performance over the next three years will be a combined measure of numbers in treatment and retention (though **DrugScope** retains its reservations about the appropriateness of the current retention target). Issues related to substance use need to be grafted onto the existing and new performance management frameworks for local authorities and local partnerships. We have already discussed the place of substance use indicators and evidence within the JAR and the APA of children's service. Work needs to get underway now to ensure that drugs issues are reflected in the Comprehensive Area Assessment. Headline indicators may include the existence and effective operation of a multi agency partnership to tackle drug use, the level of contribution of mainstream funding to drug interventions and the numbers of people who have experienced problems with substances who received – for example – housing support or training. The mandatory outcomes within the LAA that related to drugs form a reasonable starting point at the moment however additional measures should be explored. Wherever possible the effort should be made to ensure that outcomes rather than processes are used to evaluate progress. This means that the exhaustive process monitoring and proxy outcome indicators currently in place should be phased out – initially for the most effective local partnerships but, over time, completely. There should still be a facility for additional scrutiny and 'special measures' for areas where substance use is perceived as a major problem but where efforts to tackle it are weak, or in areas where partnerships themselves identify the need for additional support, but this should be the exception rather than the rule.

17a. How can the needs of under-18s with drug problems be met?

Please see section on young people.

17b. What is the role of specialist drug services for young people and what should children's services do?

Please see section on young people.

18. What can be done to ensure that effective drug treatment is provided both to offenders in prison and in the community, ensuring continuity of care between the two?

The Government recognised the need for more investment to improve drug treatment in prisons when in 2005 it announced additional funding for a new approach – the Integrated Drug Treatment System (IDTS).

Responsibility for commissioning drug treatment in prisons has been passed to Primary Care Trusts – this is a welcome development. However, the 60% reduction in planned spending on the IDTS in 2006/2007, which accompanied this move, was not welcome.

The IDTS was announced in recognition that prison drug treatment services were under-resourced and “have delivered inadequate or inappropriate clinical treatment practices, particularly with regard to substitute prescribing...”. In many prisons there have often been poor links between prison Counselling, Assessment, Referral, Advice and Throughcare Services (CARATs), clinical services and community treatment.⁵

DrugScope is greatly concerned that services will deteriorate if the IDTS as originally described is not delivered – as looks likely – as a result of this reduction in funding. In particular we are concerned that no assessment on the quality and availability of treatment in prisons given the impact of the cut has been announced. No arrangements appear to be in place to monitor and evaluate the appropriateness and effectiveness of drug treatment and aftercare for prisoners in the absence of an adequately funded IDTS.

⁵ Letter dated July 2006 from the Director of Health and Offender Partnerships, Department of Health

According to the British Medical Association, “incoherent Government policy and inadequate funding is creating a crisis that threatens to overwhelm the prison health care system”.⁶ This view has been borne out universally across our consultation this year, with many of our stakeholders deeply concerned that any progress made by individuals prior to sentencing would almost certainly be negated by the imposition of a custodial sentence. However it was the view of many that as this was recognised by the judiciary, courts were less inclined that they might otherwise have been to “send people down”.

If IDTS does not go ahead as planned we will have missed a huge opportunity to have an impact on drug harms. **DrugScope** urges the Government to reinstate its full original funding commitment to the IDTS and commence delivery of it immediately.

In the absence of adequate funding for the IDTS, efforts must be made to ensure minimum standards of care are met and rational policies are utilised to end, in particular, problems of associated with release – for example, people being released on a Friday afternoon when there may not be access to services and support.

19a. What more should be done to facilitate better access for drug users to the mainstream services they need to help re-establish their lives (e.g. supported housing, employment, education, training and healthcare)?

Many of the recommendations we have already made in this document are specifically aimed at improving drug users’ access to mainstream services. **DrugScope** firmly believes that without prioritising this issue many of the gains we have made over the past ten years will be lost.

⁶ Press release, British Medical Association, 8 February 2007

It is therefore critical that the needs of drug users and of communities where problematic drug use is widespread are accepted as part of the mainstream need of every local area. As outlined above, through a mixture of effective training, performance management and, in the short term, financial incentives, mainstream services will need pressure both from their local partnership and on occasions from central government departments to ensure they are taking account of this in their planning and service delivery. In addition to this however specialist agencies need to stop expecting mainstream services to “wraparound” drug treatment. Drug treatment needs to become more of a mainstream intervention and less of a silo. Government should consider the possibility as a short-term measure of using quotas particularly in pressured areas of spending such as housing. Disincentives to work with drug users – such as the automatic eviction of individuals with a history of drug use from social housing – should be avoided at all costs.

In addition to this however is the need to begin to tackle the stigma attached to drug users. It is hard to imagine another group in society – with the exception of child sex offenders – more reviled and feared by the general public than people who have experienced problems with drugs. It can be a real barrier to reinclusion in society . The stigma is reinforced by the way that some sections of the media, and some politicians, report and comment on drugs. There are few areas of policy where issues are so often sensationalised, oversimplified, misunderstood or, indeed, deliberately misrepresented – for example (but by no means the most extreme) the modest proposal by NICE (out for consultation) to provide vouchers to incentivise participation in treatment was reported in one national newspaper as “iPods for junkies”.

The criminal justice emphasis of the current drug strategy is seen by many as reinforcing the public perception that people with drug problems are first and foremost criminals.

DrugScope recognises that stigma may have a role to play in prevention of drug use, however if this is a desirable impact, the opprobrium needs to be attached to the behaviour rather than the individual. **DrugScope** recommends that consideration be given to adopting the approach used by the Department of Health campaign to end discrimination against people with a diagnosis of mental health problems “Action on Stigma”. By promoting positive images of people who have stabilised or recovered from problematic substance use we can begin to tackle their exclusion – and reinforce the many gains people make in treatment and afterwards.

19b. Where are the main gaps?

Access to mainstream services was an issue that came up repeatedly during our consultation. The biggest issues unsurprisingly were about housing and access to employment and training. **DrugScope** welcomes the national roll out of Pathways to Work – however we believe that personal advisers need to demonstrate a thorough understanding of problematic substance misuse, the needs of problematic drug and alcohol users and those in treatment. The Department for Work and Pensions must demonstrate a clear commitment at both a national and a local partnership level to supporting the training and employment needs of this client group.

We know that poverty and social exclusion are not just risk factors for developing substance use problems, but also play a major role in amplifying the impact of those problems on individuals and in reducing the ability of those individuals and communities that experience the worst effects of substance use to move towards inclusion. One ex-user in the Midlands told us:

“It’s a kind of triple whammy. Your life’s sh*t so you use drugs. You use drugs so your life’s sh*t. You get help, but

cos you're an ex-drug user you can't get a job so you can't get a house so your life's sh*t. So you use drugs."

If the above is a "triple whammy", then you can multiply the effect again by adding in mental health problems. Across the country we heard a very familiar tale of people being excluded from mental health services because their primary problem was held to be a substance use issue or excluded from drug services because their primary problem was a mental health issue. Someone, somewhere, has to take responsibility for helping this group of people. Unfortunately in many cases that responsibility seems to fall on the criminal justice system and eventually the secure estate. **DrugScope** believes this is an unreasonable expectation of an already overburdened part of the criminal justice system and urges the government to consider providing more appropriate non-custodial residential support for these individuals.

Once again the issue of harm reduction is raised when we look at gaps in mainstream services. The reduction in the number of specialist needle exchange services means that many drug users with chronic and acute presenting conditions relating to injecting end up as acute admissions to mainstream health services. Estimating the health benefits of early intervention for this group may not be straightforward, but **DrugScope** recommends that work be undertaken to identify opportunities for work with people experiencing health problems within extended primary care services to avoid an undue burden falling on secondary services.

