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▶ The commissioning and provision of advocacy for problem drug users in English DATS: a cross-sectional survey.

Cargill T., Weaver T.D., Patterson S.

Drugs: Education, Prevention, and Policy: 2012, 19(2) , p. 163–170.

Request reprint using your default e-mail program or write to Dr Patterson at s.e.patterson@qmul.ac.uk

The first investigation of the commissioning and provision of advocacy services for problem drug users in England comes to the disappointing conclusion that far from being seen (as per national guidance) as "essential", in practice it is usually an optional extra which gives way to competing priorities.

Summary Advocacy is generally understood as supporting someone who is 'disempowered' to express themselves and negotiate with a more powerful agency. For England's National Treatment Agency for Substance Misuse (NTA) which monitors and seeks to improve treatment for drug users, advocacy is an "essential" element of effective drug treatment systems. However, the drug action teams responsible for local implementation of the drug treatment strategy are not required to provide advocacy or report centrally on its development. The onus rests with each team to assess the local need for advocacy and to commission or provide services as appropriate.

To assess the degree which this happens in practice, a survey was conducted in 2010 of a randomly selected one third of the 149 drug action teams in England. The selected 50 were representative of all such teams on a range of characteristics. Team coordinators were asked to identify the best informant from their staff team who was then phoned and (if they agreed) interviewed. Of the 50 teams, staff from 43 completed interviews. Three quarters were commissioners while about 1 in 7 led on user involvement for the team.

Main findings

Preliminary interviews with key informants led to a definition of advocacy as: "The provision of support to problem drug users experiencing treatment-related issues by a professional organisation or individual, independent of the treatment provider". All

interviewees endorsed this definition, but in theory, and even more so in practice, advocacy was conceived variously as both constituting and encompassing user involvement and peer support, sometimes simultaneously. Commonly it was taken to include general support from current or past drug users to help patients access or continue with treatment (for example, helping them get to appointments), or gathering user views to inform service development. Advocacy was also understood as a mechanism for user involvement and a way of promoting collective user views.

Though 29 interviewees saw advocacy as needed in their areas, only six based this view on a formal assessment of need. No drug action team had a strategic plan for advocacy, but a third included it in more general strategic planning frameworks, most often user involvement. Neither did any team have a post dedicated to developing advocacy though 11 could identify a responsible officer.

Of the 43 interviewees, 15 said advocacy was not available in their areas, while just four said their areas had commissioned formal advocacy services consistent with the definition used by the study. Three of the four had procured these services through a tendering process while the fourth had formalised the service provided by an organisation formed by drug service users.

Informal arrangements were described in 13 areas where, though not specifically commissioned, advocacy fell within the remit of services or posts funded for other purposes. Commonly it was understood as inherent in service delivery and the teams provided no specific direction regarding nature or access. In 8 of the 13 areas, peer-based advocacy was provided by individuals affiliated with the local user group or peer support services, some of whom worked in treatment services. In another three areas the advocacy brief was held by drug action team or treatment service staff responsible for user involvement, and in two it was devolved to specialist support services such as those offering legal advice or housing support.

More ad hoc arrangements characterised 11 areas, where advocacy was provided as and when necessary by people in a range of roles who were or had been in contact with treatment services. Some informants said frontline treatment staff had an advocacy role.

Asked about their plans, a further 12 areas aimed to commission formal advocacy services, seven of which currently had only ad hoc arrangements and three none at all.

The most common barrier to providing advocacy (cited by half the interviewees) was the lack of a specific budget. The view that problem drug users should be able to or can speak for themselves was mentioned by 13, negative outcomes from advocacy by 9, and lack of national direction by seven. Among influences promoting provision, most often mentioned was the need expressed by service users, sometimes within a formal needs assessment process.

The authors' conclusions

These findings represent the first investigation of the commissioning and provision of advocacy services for problem drug users in England. The overall impression is that as long as advocacy services are seen as an optional extra, drug action teams will give precedence to competing priorities. Greater priority is likely to be fostered by conceptual clarity, and by evidence that advocacy affects the indicators of treatment effectiveness through which the performance of drug action teams is monitored.

The findings highlight the lack of strategic planning for advocacy and (perhaps as a result) the diversity in approaches; less than one in 10 areas provided professional, independent advocacy services, that provided in many areas is anything but independent, and over a third of areas report no advocacy services, even when this is understood to encompass informal or ad hoc approaches. Even with full implementation of the planned service developments, formal advocacy would be available in little more than a third of English drug action team areas.

Lacking a clear national policy direction, and because links between advocacy and the indicators of effectiveness on which they are judged have yet to be demonstrated, commissioners allocate resources elsewhere and muddle through with a variety of informal and ad hoc modes of provision being cited as meeting the NTA's expectation that advocacy be seen as "essential" to effective treatment systems. Our findings suggest that in many areas advocacy has yet to be recognised as such and is anything but integrated in to the complicated drug treatment milieu.

Achieving integration will be no simple task. Given the interviewees' comments, on the face of it dedicated funding would be required along with clear national guidance and models and a requirement on areas to report on the delivery of advocacy services. However, the authors argue that implementing effective advocacy depends first and foremost on clarity about its rationale. Attempts to design and implement services will be undermined while advocacy as an end in itself (a right adhering to citizenship) is conflated with advocacy as a means to an end (supporting achievement of performance targets). Only when advocacy is clearly conceptualised will it be possible to address the array of negative views, scepticisms and misconceptions described by informants as barriers to advocacy.

FINDINGS The featured study comments that the situation found in England is mirrored in Scotland. A more recent edition (2009–2010) of the Scottish report cited in support of this contention says that problem drug/alcohol users are among the groups for whom there is limited or no advocacy provision. In England current guidance on what and how local areas should report in respect of their drug treatment plans says that drug action teams may find it useful to bear in mind that "... the development of advocacy services is an essential element of developing effective drug treatment systems". Under their plans for maintaining and improving access to treatment, it invites them to check whether they have "A network of advocacy and support services ... which includes access to drug related support and mutual aid groups". While recognising the importance of advocacy and seeking to provoke areas to consider whether they have done enough to promote it, this formula does little to clarify the muddle about its role which the authors of the featured study saw as the prime obstacle to effective implementation.

Thanks for their comments on this entry to Jason Gough of Patient Opinion, a national UK service based in Sheffield and Stirling. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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