Drugs: Our Community, Your Say.

A Response to the Government Consultation on the National Drug Strategy

DrugScope
October 2007

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This response was produced by DrugScope with the support and input of many organisations and individuals who have worked with us throughout our 2007 policy review - members of our expert groups, our trustees and contributors, the people who came to our conference and the many workers, managers, commissioners, service users and family members who came along to our consultation events. We would like to thank everyone for their contribution.

Definitions

ACMD	Advisory Council on the Misuse of Drugs
APA	Annual Performance Assessment
APACS	Assessment of Policing and Community Safety
ARP	Arrest Referral Pilots
BCS	British Crime Survey
BMA	British Medical Association
CSCI	Commission for Social Care Inspection
CDRP	Crime and Disorder Reduction Partnership
CJIP	Criminal Justice Intervention Programme
CSIP	Care Services Improvement Partnership
DAAT	Drug and Alcohol Action Team
DAT	Drug Action Team
DCLG	Department for Communities and Local Government
DCSF	Department for Children, Schools and Families
DfES	Department for Education and Skills (now the Department for Children, Schools and Families)
DH	Department of Health
DIP	Drug Intervention Programme
DTTO	Drug Treatment and Testing Order
ECM	Every Child Matters
FE	Further Education
HCC	Healthcare Commission
HE	Higher Education
IDTS	Integrated Drug Treatment System
ISDD	Institute for the Study of Drug Dependence
JAR	Joint Area Review
LAA	Local Area Agreement

LSP	Local Strategic Partnership
NICE	National Institute for Clinical Excellence
NIMHE	National Institute for Mental Health in England
NTA	National Treatment Agency
PCT	Primary Care Trust
PSA	Public Service Agreement
PSHE	Personal, Social and Health Education
RSA	Royal Society for the encouragement of Arts, Manufactures & Commerce
RSA Commission	RSA Commission on Illegal Drugs, Communities and Public Policy
STRADA	Scottish Training on Drugs and Alcohol
TOP	Treatment Outcomes Profile
YJB	Youth Justice Board
YOT	Youth Offending Team

Key Messages for the New Strategy

1. While advances have been made in tackling drugs and alcohol, there is still a great deal to be achieved.

2. Engaging the community and all local agencies in an integrated approach to substance use depends on an integrated and joined up approach at a governmental level. We welcome the new package of Public Service Agreements (PSAs) announced in the Comprehensive Spending Review in October – but we think the Government can go further in embedding responses to drug and alcohol use in all our public services so no one can pretend that this isn't something they can help with, that there isn't something they can do.

3. The current criminal justice and specialist treatment focus of the strategy needs to be balanced with a tangible and explicit commitment to tackling poverty and social exclusion through a package of interventions including healthcare, employment, housing and education. The most disadvantaged suffer the most as a result of substance misuse and we need to help people make the most of opportunities that can help them build resilience. Stabilising a person's drug use with a methadone script is a start but is not enough - as has been stated before, "Poverty is not soluble in methadone hydrochloride.[1]"

4. We should avoid creating an imbalance in young people's services by establishing a dependence on *specialist* treatment. Specialist drug services have a small role to play in young people's interventions – and most of the investment to keep children and young people safe from drug harms needs to go where most of the work takes place: in front line children's services, supporting families and strengthening communities.

5. DrugScope has spent the best part of the last six months on the road talking to people about drugs and alcohol and we learned a lot. Everyone – from the most hardened drugs worker to the parents of service users - believed that we need to educate our young people about drugs – and we need to do so in a way that's responsible, sensitive and honest.

[1] Carnworth, T and Smith, I (2002), Heroin century, Routledge

6. DrugScope is aware of the temptation to use shock tactics to demonstrate political commitment to tackling drugs. We would however advise the Government strongly not to go down this route. Evidence suggests that it is counter productive and that it does not help young people avoid coming to harm.

7. Treatment has been a major feature of the past few years. There has been a significant expansion, a fall in waiting times and the quality has improved in many areas. But it is services and support such as housing, training and employment that make a vital difference. These are so fundamental they should not be called *wraparound* services, but *core* services. People should not be excluded from housing, education or employment because they have had problems with drugs. This means that we need to start dealing with the stigma and discrimination people who managed or are trying to sort out their substance use face. Which is why DrugScope is asking the Government to learn lessons from the Mental Health and Learning Disability fields about reintegration.

8. In terms of structures, Drug Action Teams (DATs) have been surprisingly resilient. Effectively abolished some five years ago, most areas still have one and though performance is variable they demonstrate that there is a local commitment to and interest in tackling substance use problems. Over the past few years, 'local' has taken second place to 'national' in terms of treatment and other priorities. However the Comprehensive Spending Review has signalled clearly that local flexibility will once again be a feature of drug strategy. We welcome this.

9. Tackling drug related crime is heralded as one of the big successes of the past few years. DrugScope is looking forward to seeing some more detail of the evaluations that have allowed this assertion to be made. We welcome the alignment of the Drug Interventions Programme with the Priority and Prolific Offenders Scheme as we believe this will allow a better fit of interventions for those whose offending may predate their drug use and be less of a causative factor than may have been assumed. We also welcome the announcement of regional demonstration projects that will evaluate alternatives to custody for those whose offending is related to their alcohol use. Treatment in prisons for substance users is lagging behind that in the community by some considerable way.

DrugScope is with the British Medical Association (BMA) who in a press release in February this year said:

> **"Incoherent Government policy and inadequate funding is creating a crisis that threatens to overwhelm the prison health care system."**

10. DrugScope has always worked closely with law enforcement agencies and organisations working within the criminal justice system. This work has made two things clear to us over the past year. The first is that no matter how good supply side interventions are, they have little if any impact on the overall supply of illegal drugs in and to the UK. The second is that substance use still brings unacceptable levels of crime and disorder to some of our most disadvantaged and socially excluded communities. The best police forces understand that tackling the impact of this on people makes sense. We need to learn from them and begin to measure the effectiveness of policing less in terms of who got arrested and how much they were carrying, but on how an operation or initiative has made people's lives better – what the tangible improvements are in terms of health, environment, perceptions of safety and fear of crime.

11. Finally DrugScope would like to see an end to 'playing politics' with this most important area of public policy. We will achieve most through an honest coalition of all those concerned, where opinions are shared openly, and where we can learn from our mistakes – and celebrate our successes. DrugScope is keen to see a reinvigoration of the cross cutting partnership approach to substance use. By this we do not simply mean partnerships at the level of local government – though these are probably the most critical in terms of strategic implementation. Nor are we referring simply to cross-departmental partnership – where all in central government recognise and take responsibility for their own contribution to tackling substance use. We mean partnerships at every level. From the partnership between a drug user and their key worker, the partnership between a family and a local agency and the partnership inherent in a supportive community. There is no way anyone from the drug user to the minister can tackle the problems associated with substance use on their own.

DrugScope and Our Constituency

DrugScope is the UK's leading independent centre of information and expertise on drugs. Our aim is to inform policy development and reduce drug-related harms – to individuals, families and communities.

We provide quality drug information, promote effective responses to drug use, undertake research, advise on policy-making and good practice, encourage informed debate and speak for our members working in drug treatment, education and prevention and other areas.

DrugScope occupies the "demilitarised zone" in the so-called "war" on drugs. We do not believe that the continuing polarisation of discourse between health and criminal justice, between legalisation and prohibition, between maintenance and abstinence, does much to benefit either individuals whose lives are affected by substance use or the communities in which we live.

Over the past 12 months, **DrugScope** has reviewed and reformed its policy work, changing both the way in which we represent the views of our stakeholders and how we use those views to build new policy and engage with current and future debates in drug strategy. **DrugScope**'s new policy framework is focussed on fluid, broad and consensual policy formation and response.

DrugScope does not work for the drugs field or the government. **DrugScope** works **with** the drugs field and **with** the government because we all want to achieve the same thing. That is to improve the quality of life and opportunity of those individuals and communities experiencing harm because of substance use. This is a hugely emotive area of public policy – it is **DrugScope**'s role to promote an informed, calm, rational debate – where responses to the issues of substance use are proportionate and pragmatic.

The **DrugScope** constituency is made up of a broad group of individuals and organisations. These include member and non-members, organisations and individuals:

⇒ **People working in the substance use field;**

⇒ **People who work in other fields but whose work brings them into contact with substance use;**

⇒ **Substance use service providers in the voluntary, public and private sectors;**

⇒ **Public bodies (like local authorities, police organisations and PCTs);**

⇒ **Politicians and civil servants;**

⇒ **People who have direct experience of substance use.**

DrugScope's membership and stakeholder group is **not** defined by a particular philosophy but by an interest in or experience of substance use.

The breadth of **DrugScope**'s constituency is singular in the UK substance use field and alongside its perceived independence is the greatest strength of the organisation.

DrugScope Policy Framework

DrugScope's policy work is informed by our commitment to reduce the health, social and economic harms to individuals, communities, and society that are associated with the use of drugs.

DrugScope is rigorous in examining and acknowledging the underpinning assumptions of policy and the evidence base for its implementation

DrugScope celebrates diversity and is proactive in rejecting discriminatory practice.

DrugScope seeks to build consensus where possible and to work collaboratively and creatively with others in the arena of un-coerced collective action around shared interests, purposes and values.

DrugScope is committed to working to promote the right to health, education, housing, employment, and freedom of expression and movement of every individual.

DrugScope policy positions are built upon three platforms:

Stakeholder consultation - Throughout 2007 we have spoken directly with over 600 individuals affected by or impacting on drug strategy in the UK. Between March and May we held nine regional consultation events in London, Exeter, Birmingham, Sheffield, Newcastle, Manchester, Liverpool, Norwich and Cardiff. Participants included drug users, their families, treatment workers, police officers, teachers, community representatives, scientists and academics, youth workers, senior managers, young people, probation officers, custody staff from police stations and the secure estate, customs officials, doctors, nurses and local government officers. Over 150 people attended our conference in Cambridge in July. We held a further three stakeholder meetings in London and Birmingham in September 2007.

Expert Scrutiny – Over the past 12 months we have hosted a number of expert groups – both individually and in partnership with other organisations - in order to scrutinise

specific areas of drug policy. These have included - the long-term future and purpose of drug strategy, young people's policy, localism and national structures and partnerships.

Evidence Base - DrugScope has the largest library of drug information in the world. This comprehensive English language collection includes monographs, journals, and reports from the UK, Europe and around the world, spanning more than four decades. Uniquely in the UK, the library also holds a wealth of 'Grey literature' and many hard to find items, such as local reports, educational materials and policy documents. **DrugScope** both in its current form and in its previous incarnation as the ISDD (Institute for the Study of Drug Dependence) works closely with the research community to distil and disseminate the most impactful and relevant findings from academics, service providers and government bodies.

Through our work with our stakeholders, our many publications, our magazine *Druglink* and our website, we have created opportunities for debate and discussion about strategy with many – both inside and outside the traditional drugs field. It is this debate and discussion, the sifting of the evidence and the regular ongoing and extensive nature of our contact with our stakeholders that reinforces our unique overview of UK drugs strategy. It is from this perspective and in collaboration with our unique constituency that we offer the following response to this consultation.

Trends In Drug Use

Since 2004 through our magazine *Druglink*[2], we have been conducting a street drug price and trend survey. The findings of these surveys line up alongside official sources such as the British Crime Survey and Home Office data on drug enforcement activity, and policy reviews such as that published by the Royal Society of Arts, in coming to the following headline conclusions:

- the population of chronic heroin and crack users appears to be ageing with fewer younger people entering this problem drug using population than previously;
- instead, among vulnerable young people, the drug use profile is increasingly 'polydrug' in complexion involving alcohol, cannabis, ecstasy and cocaine[3];
- the general prevalence of drug use appears relatively stable after the increases of the 1980s and 1990s;
- but the availability of cocaine powder has increased, signaled by a decline in both price and purity. Generally the price of illicit drugs has fallen markedly during the life of the current drug strategy;
- there has been a substantial increase in the prevalence of 'home grown' cannabis produced in commercial quantities;
- fears about an 'epidemic' of crystal methamphetamine in the UK have proved as yet unfounded;
- young people's use of alcohol has increased, although overall may now have stabilised.

The recently published Office for National Statistics document "Statistics on Drug Misuse, England 2007" identifies that lifetime use of a class A drug dropped slightly from 12.1% in 1998 to 10.5% in 2006. The same publication however indicates that people saying that they had used any Class A drug in the last year had increased, from 2.7% in 1998 to 3.4% in 2006.

[2] Our 2007 survey compiled feedback from 80 drug services, drug action teams and police forces in 20 towns and cities across the UK and represents a snapshot of current UK street drug trends.
[3] Parker, H., Painting by numbers. Druglink: 22 (4) September/October 2007, pp24-25

How Was It For You? - A Decade in View

This section of our response provides a snapshot of our stakeholders' views of the past ten years of drug strategy.

There was a universal welcome for the additional investment that had taken place over the past five years. Although there were concerns in some areas that the drug treatment sector had expanded too quickly - resulting in a dilution of skills and a reduction in specialism - by and large the rapid increases in workforce, budget, client load, are seen as an overwhelmingly positive development. However in spring 2007, every area we visited (with the exception of Cardiff) had recently experienced cutbacks across their treatment, DIP or young people budgets. Notwithstanding the difficulties inherent in any reduction of funding, stakeholders told us that the way the funding was cut was as problematic for them as the fact of the cutbacks. Commissioning plans need to be completed and finalised at the very latest by the beginning of the financial year – this means drafts need to be available for local and NTA approval in January and February. Yet most cuts to local budgets in 2007 were announced "in year" – after the cut off dates for treatment planning and local budgeting. This meant that commitments made by commissioners had to be changed and service configurations altered at little or no notice. This has a real impact on the ability of local partnerships to deliver best value – and to plan collaboratively. **DrugScope** hopes that in future, funding commitments and funding expectations made by government will be honoured and that if reductions are made sufficient notice will be given to local areas to enable them to achieve efficiencies sensitively and with minimum impact on service users.

The major result of the increase in investment has been a substantial increase in treatment capacity - identified by many in the field as the single most important achievement of the current strategy. The focus of the treatment effectiveness strategy on the individual and the move towards the recording of individual treatment outcomes through TOP (the Treatment Outcomes Profile) is positive. However, this very recent attempt to measure effectiveness is being undermined by concerns expressed by many engaged in face to face work with drug users that the treatment experience is becoming ever more mechanised and that there is a risk of "losing the individual" in the treatment

system.[4] Others have expressed concern that the emphasis of TOP on measures of offending behaviour lends an inappropriate focus to what is essentially a healthcare intervention.

The increased ability of the drug treatment sector to account for its performance was seen as a welcome development, though some people representing smaller agencies felt that they were overburdened with data collection. There is a concern currently that performance management has become detached from real "value for money" indicators of success – and that systems overestimate the crime costs of drug use and underestimate the health and other social costs. In most groups we talked to there was concern about the "TESCOisation" of drug treatment services – where

> **"…as long as the right boxes get ticked and the right forms get faxed it doesn't actually matter what happens to the client." [5]**

People working in the criminal justice system (particularly in the metropolitan centres) strongly expressed the view that the highly structured treatment systems that now existed presented a number of barriers to effective multi agency working. Examples of this identified in our consultation included multiple assessment and duplication of and confusion between case and care management.

The increase in funding in the current strategy and the emphasis on performance management has meant that the role of the commissioner has become ever more important. There was a highly variable level of confidence about commissioning across the country. Many providers particularly talked about inconsistency of commissioning practice across regions, "obsessive-compulsive" tendering of services, contractual instability and poor guidance for commissioners particularly around procurement. Concerns were expressed about a lack of transparency and a perception that 'political' factors influenced decision-making. The recent NTA commissioning training was welcomed as a step towards dealing with the skills shortage.

Commissioners themselves were critical of the systems within which they were commissioning. Key issues for them included the application of European procurement

[4] Ashton M.(2004) Burgered: quality of life and addiction treatment. Unpublished. This makes the challenging point that the goals of a national treatment strategy might not necessarily be the goals of the client.

5 See Kemmesies, U.E.(2002), What do hamburgers and drug care have in common: some unorthodox remarks on the McDonaldization and rationality of drug care, *Journal of Drug issues*, 689-708.

regulations to small contracts; lack of notice of reductions in funding; poor levers to engage partner agencies (e.g. housing, primary care), over- prescriptive guidance restricting local flexibility and 'data blight' - too much information to analyse locally and too few central reports being generated for local use.

Commissioning at tier four is highly problematic with a number of practitioners highlighting the difficulty of getting funding for tier four placements and tier four providers talking about the difficulty of financial survival when, for example, spot purchases were being reviewed on a fortnightly basis in some cases.

Across England there was a strong recognition of the NTA's role in achieving these improvements. In particular they were credited with driving reductions in waiting times and standardising access to treatment across the country. There was also a welcome for Models of Care and its update with participants commenting that it established a reasonable framework for service provision even if sometimes it was used inflexibly. However there was a sense in all workshops that in achieving these gains the NTA and the Home Office had adopted a "strong-arm" approach that had stifled debate and discussion in the field. Alongside what was described as "rigid performance management" a number of participants in workshops said they felt frightened to speak out and that locally criticising the drug strategy was "not allowed". This was particularly described as an issue in three regions.

Other participants felt that the strong leadership shown by the Home Office and the NTA had effectively let the Department of Health and the-then Department of Education and Skills "off the hook". Participants referred to the impact of this locally stating that if there wasn't a lead for education and health from the Whitehall departments then there wasn't a lot of leverage locally to "get people round the table".

As might be expected, criticism of the criminal justice focus of the drug strategy particularly since the establishment of the Criminal Justice Intervention Programme (CJIP) and the Drug Intervention Programme (DIP) was widespread. The chief criticisms were that this had led to a lack of emphasis on healthcare and social issues meaning critical gains that could be made through the increased investment were either being under-reported or simply not achieved. The shelving of the roll out of the Integrated Drug Treatment System for prisons (IDTS) is a major concern for those working in DIP and regular treatment systems – as well as for drug users themselves.

Evidence provided to **DrugScope** indicated that in some areas the current system for DIP is complex and inflexible – the opposite of what the intentions were at its inception in 2003. According to our reports and as detailed later in this report this meant people's needs "got lost" within the system, or they were "assessed to death" through repetitious overly bureaucratic processes. In three of our nine areas, participants described individuals having four or five required assessments and follow-ups within short periods of time.

The need for better co-ordination of aftercare and better access to mainstream services and opportunities such as education, primary care, and employment for service users was probably the most common theme across the country. In particular the lack of adequate housing services was identified in seven out of our nine groups as the biggest blockage in the treatment system. One troubling phenomenon was the lack of incentive to those involved in housing management to provide support to drug users. In every area we received reports of people being evicted from their housing because of their history of drug use with no other housing or social support being offered. Universally this led to deterioration in their ability to manage their drug use and offending.

Young people's issues were high on the agenda in all our discussions over the summer. The reduction in the Young People's Substance Misuse Grant and the possible removal of the ring fence raised huge concerns about the future of young people's services. However, the integration of young people's drug interventions into the local Every Child Matters (ECM) agenda was viewed as a positive move – and there was a high level of confidence that this would yield positive results across the country. This commitment to holistic, child-centred services by the Government was applauded. However concerns about the fragmentation of the agenda came to the surface with the awareness that young people's drug treatment was becoming a political issue and was about to be overseen by the NTA. Young people's specialists, practitioners and managers greeted this with general dismay as they believed this meant that young people's treatment would be delivered from within a system developed to run adult treatment. This was felt to be inappropriate and unhelpful in terms of local fit with Children's Trust arrangements.

The potential successes of integration and mainstreaming in the young people's agenda were seen by many as further evidence of the need to embed drugs needs assessment, commissioning and intervention in the Local Area Agreements. Utilising the locally agreed outcomes of the Sustainable Communities Strategy was suggested as a way of safeguarding investment in and commitment to drug interventions in the long term. There

are concerns about the possible removal of the “ring fence” on the pooled treatment budget. While DAT partnerships we spoke to believed this was still desirable, there would need to be specific outcomes within the LAA that could provide some transitional protection.

Section A: Building A New Drug Strategy

1a. Are these the right aims for the new drugs strategy?
1b. Which are the most important and why?

DrugScope believes that while these statements may cover the appropriate areas of concern, they are not the right aims for the strategy. The second statement should not be an aim of the strategy but if expressed in less emotive language may be an appropriate operational objective.

Additionally our stakeholders have told us that they believe that framing the strategy in "negative" terms (e.g., 'reducing the harms caused…') is not constructive – and makes it much harder to get people on board locally.

DrugScope suggests the following overall aim for any new national strategy:

> **"To increase the well being of people directly and indirectly experiencing problems with substance use, ensuring the broadest range of opportunities and assistance is available for those communities experiencing the highest levels of problematic substance use."**

The use of this positive aim would mean measuring real outcomes for individuals and communities using a range of indicators including health, crime, educational attainment, employment, economic wellbeing. This aim also enables the targeting of resources at those areas experiencing the greatest problems. The focus of this aim is on substance use not just illicit drug use. **DrugScope** believes that the objectives of the national alcohol strategy sit easily under this aim and given the overwhelming evidence that alcohol use causes at least as much damage to our communities and to individuals as illicit drugs we have no hesitation in calling for a UK Substance Use Strategy to tackle both alcohol and drugs. **DrugScope** welcomes the emphasis by government to tackle both drug and alcohol related harms implicit within the new PSA. However the disparity in delivery systems and resources for drugs and alcohol may negate the impact of this.

In terms of young people's substance use, **DrugScope** believes the natural home for a substance use strategy lies within the Every Child Matters agenda. Accordingly we would expect substance use (including alcohol, tobacco and solvents) to be an explicit cross cutting aim of overall strategy for young people as delivered by Children's Trusts. Drug and alcohol use has a clear impact on the opportunity for every child to reach the five outcomes[6] and all partnerships need to be challenged to develop integrated responses.

DrugScope does not believe any one of the statements is any more important than any of the others. However, amongst those concerned with implementing this strategy in England and Wales there is a concern that drug users and their families are often isolated from the wider community and are unable in many cases to take advantage of the mainstream opportunities to better their own lives – such as housing, employment, education and training – that we know make a real difference to both recovery and prevention. **DrugScope** hopes therefore that the Government will reprioritise work within communities – such as that achieved through many Communities Against Drug Projects in the early years of the current strategy – to provide additional resources to increase resilience and opportunity for families and individuals affected by drug use. Additionally **DrugScope** hopes that the absence of a specific health focussed aim does not imply a continued over emphasis on crime prevention, which we believe has led to a strategic imbalance in the current strategy.

[6] The outcomes are: Be healthy; Stay safe; Enjoy and achieve; Make a positive contribution; Achieve economic well-being

Section B: Young People, Education And Families

Most children and young people do not and will not use illegal drugs. More young people say they are offered illegal drugs than use them. Most young people who do use drugs will not become problematic drug users and will not require specialist drugs services but will stop using with the help and support of their family or a trusted adult such as a teacher or a youth worker.

But despite indications that illegal drug use among young people may have stabilised and indeed be falling, there is no room for complacency – especially in the light of concerns about levels of alcohol use - and **DrugScope** has worked hard this year to ensure that young people's substance use issues have never been far from the top of the political and media agenda. We have been critical in the past of a governmental perspective that at times has seemed to ignore this issue. A lack of activity and leadership within central departments – particularly the former Department for Education and Skills – has been frustrating and disappointing. We have been told by stakeholders that reductions in funding (particularly the 10 per cent cut in the Young People's Substance Misuse Grant in 2007/08), the extension of adult methodologies to young people's services (such as the young people's Drug Treatment and Testing Requirements and Arrest Referral Pilots) and delays to essential guidance have all been real worries for services working with vulnerable young people.

However, throughout our consultation this year we have been encouraged by examples of excellent working and real partnerships across the country. The extent to which young people's drug issues have been incorporated into the work of Children's Trusts is positive. **DrugScope** welcomes the work of the new Department for Children Schools and Families (DCSF) in driving forward this holistic model of services for young people – and promoting the Every Child Matters (ECM) vision. This approach to young people's services – hopefully soon to be extended to the Youth Justice Board (ECM includes Youth Offending Teams, or YOTs, and they are fully part of Children's Trust arrangements) - will ensure that services remain child focussed, that the five key outcomes of ECM can be achieved for all young people, and that drug use will not become an excuse for not supporting or helping any young person to reach their full potential.

DrugScope welcomes the recommendations of the National Institute for Clinical Excellence (NICE) on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people.

However **DrugScope** does have some concerns about the detail of some of the work with young people – and in particular the inappropriate focussing of drug education, funding for young people's substance misuse interventions and the potential dominance of the young people's agenda by a young people's treatment sector promoted by the NTA.

DrugScope has been increasingly concerned about the extent of confusion around the purpose of drug education programmes, particularly in schools. The hold up in the publication of the evaluation of Blueprint has served to underline these concerns. However, **DrugScope** would like to see a continued resource for effective universal drug education, which can delay the first use of illicit drugs and reduce alcohol use by young people, while continuing to develop holistic services for vulnerable young people.

DrugScope acknowledges that maintaining a ring fence around young people's substance misuse budgets though desirable may be difficult within the context of child focussed local commissioning. However, in light of the substantial shifts in local commissioning systems and the very real gains that are being made in acknowledging the role of drug interventions in enabling Children's Trusts to undertake effectively their safeguarding role, we cannot help but feel that not only were the funding cuts this year ill judged - they were potentially extremely damaging to the interests of young people. Concerns have been voiced that the funding cut sent out a negative and unhelpful message about the value and importance of drug education and prevention work with young people.

In the light of this **DrugScope** is committed to work in close partnership with the young people's substance use community to ensure the assertive monitoring of the impact of substance use on the ECM outcomes in those areas where funding has been most affected. We understand there may be a need to explore how services may best be provided in an integrated agenda, but strongly believe that this should focus on enhancing effectiveness rather than saving money. **DrugScope** expect that DCSF will implement a system for the monitoring of drug spend in Children's Trusts during this transitional period particularly if a ringfence is not in place.

Specialist treatment is only required by a small number of young people who experience problems with substance use. While it is critical that specialist treatment is available to all who need it, its provision must not come to dominate the young people's substance misuse agenda in the way specialist treatment has come to dominate the adult agenda. In many ways, the need for specialist treatment should be reducing year on year as 'up stream' initiatives like Sure Start and integrated children's services become better established. We know that stresses in the family, mental health problems, school exclusion and truancy, poverty and social exclusion and living in a community where there is easy availability of drugs and alcohol are significant risk factors for young people's problematic substance misuse. **DrugScope** believes that the best results in preventing problematic use in young people will be achieved by tackling these root causes. The Government's commitment to eradicating child poverty by 2020 with the goal of halving the number in poverty by 2010, thereby tackling (directly and indirectly) many of the risk factors contributing to problematic substance use, is to be applauded.

Arrangements for the strategic development of drug interventions for young people – including universal and targeted drug education, low-level interventions, targeted interventions and specialist treatment – must be established within all Children's Trusts. While **DrugScope** welcomes the support that the NTA is offering DCSF in managing this important area of work we believe it is critical that their role is clearly identified as providing specialist support in relation to clinical treatment, and that this must not come to dominate the agenda on a local, regional or national level. **DrugScope** recommends that performance management of this strand of the strategy is clearly located within the existing arrangements for Children's Trusts. The Joint Area Review (JAR) of young people's services should examine evidence relating to critical aspects of provision such as drug education, low level interventions and specialist foster care. There are currently only three indicators in the Annual Performance Assessment (APA) of Children's Trusts that relate to substance use. These are:

- **Substance misuse related admissions to hospital, ages under 20;**

- **The proportion of young people within the YOT with identified substance misuse needs who receive specialist assessment within five working days and, following the assessment, access the early intervention and treatment services they require within 10 working days;**

- **Proportion of those in substance misuse treatment who are aged less than 18.**

These indicators singularly fail to represent the range of interventions that should be available for young people experiencing problems relating to substance use. **DrugScope** recommends that additional indicators relating to the quality and coverage of drug education, the accessibility of low level interventions, and the extent of effective screening for substance misuse within mainstream young people's services be identified as a priority. DrugScope acknowledges the role of Healthy Schools in providing some of this assurance, however concerns about the 'watering down' and 'downgrading' of the Healthy Schools initiative are widespread and it may now be appropriate to look for a more robust measure.

2. What is the most effective way to keep children off and away from drugs?

The evidence shows that most children and young people do not use illegal drugs. **DrugScope** believes that this can be reinforced through the development of locally focussed systems that provide accurate effective information and guidance to young people. Children's Trusts must ensure that substance use is addressed at all levels of intervention with young people across all mainstream services. Only by integrating young people's substance misuse interventions in this way can children and young people be effectively safeguarded from the harms relating to substance use, both their own and parental/familial use.

The provision of good quality drug education whose purpose is clearly understood and where quality is measured locally and nationally through independent inspection is critical.

The provision of good quality interventions aimed at increasing engagement and resilience in the most at risk young people and providing specialist treatment for the minority who require it, is a clear requirement if the five outcomes of ECM are to be met.

All professionals working with children and young people should be trained to tackle substance misuse confidently, focussing on reducing harm and promoting well-being. Improving the training and competency of professionals and carers working with the most vulnerable young people – for example residential social workers, staff in the young people's secure estate and YOT workers – should be a priority.

3. How should parents, guardians and carers be supported to protect children from using drugs?

Parents, carers and guardians need good quality information and interventions. These should be universally available but additional resources need to be targeted at the most vulnerable families.

Family support has a role in prevention and in helping to tackle upfront many of the risk factors which mean a child or young person is more likely to become involved in drugs. A 'whole family' approach, which provides families with holistic support to identify what they see are the main problems, what needs to happen to tackle them and support through the process of change, is often successful. However, at present too many families are denied support of this nature until they reach crisis point - by which time it can be very difficult to tackle ingrained and intractable issues.

Eligibility thresholds are too high and insufficiently flexible to recognise the accumulation of risk within a family situation. Similarly, the tension between adult services, which are almost exclusively concerned with the individual adult service user, and children's services, which focus on child protection issues, means that families fall into the 'service gap'. Practical steps, like joint training sessions for professionals and the use of secondments by children's and adult service directorates, could help to address this problem. The voluntary sector, which does not encounter the same stigma as statutory services, is often well placed to delivery this type of intervention.

The need to support effective parenting has been a priority for some time but **DrugScope** believes there is a need to incorporate information about substance use in all interventions with parents. However from our work in this area we understand that parents are often resistant to taking part in drugs programmes as they feel they are being stigmatised and judged. One of our stakeholders recently told us:

> **"They sit there all stony faced and then when you ask them what's up they say 'my kids don't take drugs and they never would'. They just switch off or they get angry. It's always some other kid who's the one who might. Never theirs."**

In light of these experiences it is particularly important that parents are consulted on the formulation of drug education programmes.

In order to ensure parents and guardians can benefit from drugs education there is a need to ensure that information about drug use is just one of the issues parents are helped to deal with in sessions like this – alongside, for example, sex and relationships, health and well being, choices in education. Drug education for parents is better received when it takes place as part of a parcel of other information.[7]

Schools can be a focal point for reaching parents, but it should be recognised that this may not be the most appropriate location for all parents and that parents with children potentially 'at risk' may be those particularly difficult to reach through schools. The youth service has a key role in reaching especially vulnerable young people and their families. **DrugScope** welcomes the increased recognition of the importance of the youth service (for example, in the Youth Matters green paper) and increased funding.

Significant adults need support to foster aspiration in young people – and can be effective as role models. In our discussions around young people's services our stakeholders told us unequivocally that it is not about celebrities giving out badges and autographs, it is about the adults who matter to young people helping them towards independence, showing them that they have choices, and that adult life is something to look forward to.

DrugScope recognises the work that has been undertaken by many organisations around parenting particularly YOTs. The recent evaluation of this work by the Youth Justice Board established that:

- in the year before parents were referred to a YOT parenting programme, 89% of their children had been convicted of a recordable offence. This compares to 62% in the year after they left the programme;
- the number of recorded offences committed by the same child fell from 4.4 per child to 2.1 per child;
- more than 90% of participants felt that they had benefited and a similar percentage said that they would recommend it to other parents.

[7] DrugScope, Drug Education for Hard to Reach Parents, 2004

DrugScope would hope to see a thoroughgoing evaluation of the medium- and long-term impact of these programmes on substance use commissioned in the near future.

The voluntary sector currently provides invaluable support to parents around drugs but often it is focussed on the parents of adult children. Where there are significant problems around substance use in a family **DrugScope** suggests that learning from organisations such as Homestart who provide intensive parent support and befriending could have an impact. This could be particularly useful in tackling issues relating to parental substance use. Enhancing the role of the health visitor to provide support around drugs and alcohol could be a critical help to struggling families – **DrugScope** welcomes the health-led parenting project pilots and we look forward to seeing the findings.

The ACMD update report on Hidden Harm was critical of the lack of progress in England in tackling parental substance use.[8] **DrugScope** suggests this reflects a lack of leadership and available funding from central government. The Social Exclusion Task Force's recent work on multiple/deep social exclusion and the Families at Risk Review identified substance misuse as a significant factor in reinforcing that exclusion.

4. What needs to happen to achieve more effective joint work between children's services and drug services in support of young people?

In March 2007, NICE published guidance on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. This guidance recommended that a co-ordinated response to the development of integrated approaches to the prevention of problematic substance use among those under the age of 25 should be the responsibility of the Local Strategic Partnership and the Children's Trust. **DrugScope** concurs with this. Effective local strategy and service delivery needs joined up strategy and but also a cross cutting strategic lead from central government. **DrugScope** would welcome joint work between the Department for Communities and Local Government (DCLG) and the DCSF to help local areas deliver against this agenda.

Clarifying responsibilities for joint working to tackle substance use among young people will first and foremost be the role of the Children's Trust and **DrugScope** expects that the Common Assessment Framework, better training and support for mainstream young

[8] Advisory Council on the Misuse of Drugs (2007), Hidden Harm Three Years On: Realities, Challenges and Opportunities.

people's staff and a rebalancing of the role of specialist treatment and holistic services for young people according to individual need will improve joint working.

5. What might an effective local system look like that identifies problems early, provides integrated prevention services and ensures that other specialist services are available when required?

An appropriate system is child centred, looks holistically at the needs of young people and children and provides support to parents and carers. It is delivered through all agencies with safeguarding responsibilities. In particular the renewed focus on youth work is crucial to achieve positive outcomes for all young people and those at risk of experiencing problems with substance use.

The system is effectively performance managed locally through the same arrangements as other services commissioned and co-ordinated by the Children's Trust.

DrugScope's consultations throughout 2007 identified high levels of concern about the appropriate resourcing of young people's services but a high level of confidence in local commissioning systems to be able *in time* to deliver effective local systems of care. This was obviously dependent on the different local timescales for development of Children's Trusts.

6. What needs to happen to ensure that children's and adult services work together effectively to safeguard and improve the well-being of children and young people affected by substance misuse?

The ACMD's Hidden Harm report was clear that:

> **"… substance misuse services must see the child behind the client and recognise their responsibility for ensuring the child's well-being, in partnership with others. The children must be seen and listened to, their needs assessed and responded to. Substance misuse services must therefore become family focused and child friendly…"**

Drug services on the whole remain unfriendly to families. They are overwhelmingly located in environments inappropriate for children, have little if anything in the way of crèche facilities, and are open at hours which restrict access for parents caring full time for their children unless they are able to find alternative daytime childcare. In addition to making drug services more family friendly, **DrugScope** recommends that more drug services should be provided by agencies that are already family-friendly – such as GP surgeries and health centres.

There is also a need for better information sharing and co-ordination when a child is understood to be at risk – but this must be achieved sensitively if the parent is not to disengage completely from services. Adoption of local protocols needs to be supported by multi-agency and multi-professional training.

In order to facilitate this there is a need for better and more regular training for specialist drugs workers around parenting and family support as well as child protection so they are able to intervene supportively with all parents with whom they work.

The Government should adopt the recommendation of the ACMD in its Hidden Harm report that social care workers receive training that addresses parental substance use and that such training is a requirement for registration by the Social Care Councils.

DrugScope is a partner with the University of Glasgow for STRADA (Scottish Training on Drugs and Alcohol). The project has been core funded by the Scottish Executive since 2001 to provide training, education and development for staff working in social care services, health care, housing, education, police, prisons, employment services and voluntary sector services working with drug and alcohol misusers. The Executive has also funded specialist training to assist with the implementation of the recommendations of the 'Hidden Harm' report and Action Plan. The project has developed the competence, confidence and effectiveness of staff and organisations working in the drug and alcohol field and is a model for training and workforce development that should be considered for adoption in England and Wales.

7a. What role should education in schools and other settings play in reducing the harms caused by drugs?
7b. What should drug education aim to achieve, when should it start and how might it be improved?

DrugScope believes that the purpose of education around substance use is to contribute to improving the health and well being of children and young people by:

- reinforcing the choice of the majority of young people never to use drugs;
- providing realistic and effective information to reduce the harm of substance use by young people.

Drug education should provide the opportunity for children and young people to develop their knowledge, understanding, skills and attitudes about drugs and appreciate the benefits of a healthy lifestyle. This should be delivered in formal and non-formal education settings.

There is no conclusive evidence that universal drug education in and of itself is equivalent to 'prevention' if this means reducing the number of young people who will experiment with drugs. As one stakeholder told us:

> **"We cannot inoculate young people against drug use with just a few hours of drugs education."**

However, **DrugScope** is keen to see the forthcoming (but apparently delayed) results of the Blueprint programme to see if this is able to shed more light on this issue.

What evidence there is about drug education indicates that it can help to delay the onset of drug use. There is an established link between trying drugs at a later age and a reduced risk of drug-related harm. Drug education can help to inform young people about risk and steer them away from the most harmful drugs, the most dangerous patterns of substance misuse and the riskiest forms of drug administration.

A number of research projects from around the world have established clear evidence about the characteristics of effective drugs education. These include:

- that the programme should have clear aims and objectives;
- that it addresses knowledge, skills **and** attitudes;
- that it meets the needs of the young people, including developmental and cultural needs;
- that it challenges misconceptions which young people may hold about their peers' behaviour and their friends' reactions to drug use (young people frequently overestimate the prevalence of drug use amongst their peers);
- that it uses interactive approaches;
- that education should form part of a wider community approach to substance use.

Drug education should take account of the views of children and young people, so that it is both appropriate to their age and ability, and relevant to their particular circumstances.

There is a growing consensus that drug education requires an open, safe and secure learning environment if it is to be of value to young people. **DrugScope**'s members and stakeholders were firmly of the view that random drug testing and use of sniffer dogs in schools damages the environment of trust crucial to effective drug education and is harmful and counterproductive. Random drug testing in schools has not been shown to have a positive impact on subsequent behaviour.

As we have already stated, **DrugScope** believes that all drug interventions for young people should be inspected and performance managed within the same framework as other young people's services – that is the Annual Performance Assessment (APA) and the Joint Area Review (JAR).

Drug education in schools should be delivered in the context of Personal Social Health Education (PSHE). **DrugScope** also believes that in order for this to be meaningful the provision of PSHE should be made a statutory requirement on all schools and that within this there should be clear national standards for substance use education. **DrugScope** would like to see a further commitment to building drug education into mainstream teacher training both through initial teacher training and continuing professional development.

In terms of when drug education should start there is a broad consensus that substance use education (including substances like alcohol, tobacco and medicines) should take place for all school age children. There are many good examples of age appropriate approaches to drug education for primary school upwards. It is also worth acknowledging that drugs education should not end at school leaving age but should continue throughout full time education and training. **DrugScope** would welcome a commitment from the Government that support would be given to all training providers, HE and FE colleges, and universities to enable them to provide effective universal interventions and information.

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

[Note this question comes later in the consultation paper]

As described above, **DrugScope** believes the role of *specialist* treatment for young people is limited. Every effort should be made to provide drug interventions for young people within mainstream children's services - with integrated services, clear frameworks for screening and assessment, adequate and stable funding, a robust inspection framework and a skilled workforce. Where specialist treatment is necessary, case management should remain with non-specialist services. The case for residential rehab for young people has not been made convincingly – but specialist foster care has been demonstrated to deliver good outcomes for a small number of young people.

Young people in custody have significantly higher levels of substance misuse and mental health problems and are at particular risk of suicide and self-harming. The Youth Justice Board is currently piloting new guidance aimed at improving the care and management of substance misuse in secure estates. It is crucial that for young people in secure accommodation, drug and alcohol treatment is integrated with all other services, particularly mental health, so that often complex needs are properly assessed, effectively managed and continuity of care provided on release.

Section C: Public Information Campaigns

As the UK's leading independent drug charity **DrugScope** is committed to the provision of accurate, impartial information to the public and specialist interests. **DrugScope** believes that good information services build the foundations of good policy and community resilience.

8. What role should drug information campaigns play, what should they aim to achieve and how could this be measured?

Drug information campaigns meet three imperatives:

- To inform the public about the facts relating to drug use
- To demonstrate political commitment to tackling drugs issues
- To provide individual advice and information including signposting

Drug information campaigns should aim to achieve a reduction in the harms related to drug use.

There is an inherent difficulty in measuring this type of work because essentially you are trying to demonstrate something has *not* happened. However, in line with standard health marketing techniques **DrugScope** would suggest the use of proxy measures which explore the penetration of key messages to certain groups, number of referrals made to specialist services, number of referrals received by specialist services, number of repeat calls to an information service.

Even so, government faces some entrenched and paradoxical problems in delivering credible drug information campaigns. This was acknowledged in the recent review of the FRANK campaign published by the Home Office. In 2004, 51 per cent of young people agreed with the statement, ‘The people who work there [staffing the FRANK helpline] really know what they are talking about.’ By 2006, this had fallen to 40 per cent. The review suggested that one reason for this decline ‘may be due in part to the more explicitly negative messages about drugs that FRANK is now carrying which at the same

time has produced an increase in parental support'. This outcome was mirrored in a review of the US government's anti-cannabis media campaign.[9]

From a political perspective, a campaign that has the support of parents may be deemed a success. However, the essential test should be whether the key target audience, young people, views a campaign as a credible source of information. **DrugScope** believes there may be a case for government to commission but not be the lead agency in delivering information campaigns – political considerations can be kept at arms length and a campaign may have more room to be 'controversial' (if potentially more effective) in its message or format.

9a. Should there be different approaches to information campaigns, such as harder messages on drugs (e.g. shock tactics or legal consequences)?

Shock tactics that are perceived by the target audience to exaggerate risk or represent it in a way that is alien to their experience have been demonstrated to be counter productive – reducing the credibility of information sources and encouraging risk behaviour. Research in both the USA and the UK confirms this view.[10] Shock tactics can have an impact on behaviour where there is already a clear acceptance among the target audience of the risk and where the 'shocking' consequences are immediate – for example drink driving, not wearing seatbelts.

Shock tactics may serve to confirm decisions that have already been made, however **DrugScope** believes there is little place for them in public information campaigns about substance use. While shock tactics may also emphasise a political commitment to tackling substance use this is not a legitimate purpose for such campaigns.

9b. Who is being missed out?

Drug subcultures can be very localised and there may be a case for piloting localised campaigns where a specific problem has been identified or where a particular group may be excluded from understanding more general campaigns, for example because of language barriers or on grounds of culture or religion. These would be best conducted by local agencies, but funded centrally.

[9] Ashton, M. (2005) Boomerang ads. Drug and Alcohol Findings: 14, pp 22-24
[10] For example, Dorn, N. and Murji, K. (1992) Drug Prevention: a review of the English language literature. ISDD.

Charities such as Rethink have highlighted a need to target information on the health risks of cannabis to people with mental health problems.

10a. Should drugs and/or substance abuse campaigns be targeted at the under-11 age group?

There is no evidence to suggest that large-scale substance use media based information campaigns would be effective in improving the health and well being of younger children. The members of **DrugScope** specialist young people's policy forum felt strongly that substance use education for younger groups needed to be delivered and evaluated in a one to one situation (by parents) or in small groups (in a school setting).

10b If so, at how young a group?

See above.

11. How can information campaigns best help our children to keep away from drugs?

This is not an achievable aim for public information campaigns unless part of a wider community approach with schools and families, including local media and retailers (e.g., sale of alcohol and solvents).

12. Is there a place for role models, including those drawn from peer groups, in drug Information campaigns?

The **DrugScope** expert group strongly felt that the most effective role models were those from the local community or family and that the use of celebrity role models was not particularly useful. This is supported by research undertaken for the Scouting Association earlier this year that suggested that young people found family and community role models believable and effective but were underwhelmed by celebrities.

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.[11]

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

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

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 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 buprenophine) 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.[12] 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 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.

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

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.[13] 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.[14]

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.

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

[14] 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 commissioners 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 lead 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.[15]

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.

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".[16] 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.

[15] Letter dated July 2006 from the Director of Health and Offender Partnerships, Department of Health
[16] Press release, British Medical Association, 8 February 2007

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.

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.

Section E: Protecting The Community From Drug-Related Crime And Re-Offending

There are a variety of estimates of the real extent of drug-related crime and offending – and of the relationship between drug use and offending behaviour. While there is a strong correlation between drug use and certain crime types, the profile of substance use and criminal behaviour in the UK is changing. Accordingly while there is still a population of individuals who are undoubtedly committing crime solely in order to fund their drug habit, there also appear to be large numbers of offenders where the relationship between their criminal behaviour and their drug use is less clear. We need to develop a better understanding of this in order to effectively tackle crime.

How we define drug-related crime is important too. Some crimes – mainly the acquisitive ones, usually without violence, are strongly related to the need to acquire funds to buy drugs. Other crimes – often violent crimes like assault, the range of hate crimes like domestic violence and racially motivated assault and property crimes like criminal damage and disorder offences are often related to intoxication and disinhibition.

A recent presentation at the British and European Societies of Criminology given by Alex Stevens and Peter Reuter identified problems with the assumption at the heart of current strategy - that of causality in the drug-crime link. Current strategy proposes that a large proportion of crime is directly caused by drugs and that the majority of harm caused by drugs is related to crime. This, they said, ignores the complexity of crime causation and the other influences on drugs and crime. In particular they were concerned about the reliance on support for this assumption on the behaviour and reporting of the small cohort of offenders who are arrested. In addition, they questioned the effectiveness of treatment in preventing criminal activity. We know that the peak age of offending is many years before average age of treatment initiation and that only a small proportion of offenders enter treatment. This would seem to indicate that even the expected impact of the expansion of treatment on crime of 4% based on NTORS may be ambitious. In conclusion they suggested that the reliance on this data from uncontrolled studies could at best utilise "short term reductions to make long term predictions".

DrugScope believes that if this is the case, while it may be an interesting research area or basis for a series of pilots, it by no means represents the kind of convincing evidence on which we would want to rest the whole of our national strategy. Many of the

anecdotal reports we received during our consultation bore this out. In particular services described to us a revolving door of treatment, where the same offenders came back again and again. Workers told us that many of the people with whom they were working would probably be "bang at it [offending] anyway". This was said to be a particular feature of people using stimulants and alcohol who were reported to be an increasing presence at the front end of treatment services since the introduction of test on arrest and mandatory assessment.

20. What are the most effective ways of reducing drug-related crime and re-offending?

Clearly the provision of effective interventions through the criminal justice system with power to work coercively if necessary is critical in order to reduce the likelihood of reoffending. However, the imposition of traditional drug treatment programmes on prolific offenders, where the relationship between their criminal activity and their drug use is correlative rather than causative, may not be effective in getting them to stop offending.

Current efforts through the DIP programme seem largely aimed at the range of acquisitive crimes. Here there have been a number of successes over the past three years for a large group of individuals who would not otherwise have accessed drug treatment. They have been able to get into treatment, their drug use has become more stable or it has stopped and they have stopped offending.

However many drug services lack the resources, expertise and specialist input required to deal adequately with offending behaviour that does not fit into this traditional pattern. **DrugScope** recommends that we adopt a more sophisticated approach to diversion on arrest and utilise more mainstream probation style programmes which focus on the offending behaviour rather than the substance use, or which focus on managing intoxication – particularly from stimulant or alcohol use - as opposed to managing the economic impact of opiate use. It may not be appropriate to locate all or indeed any of these interventions within drug services.

Accordingly, **DrugScope** welcomes the intention of government to align the Prolific and Priority Offenders Programme with the Drug Interventions Programme and hopes this will enable greater flexibility in the deployment of interventions that will tackle offending behaviour as well as drug use.

In line with concerns about alcohol related offending, **DrugScope** welcomes proposals from the Home Office to explore interventions through a programme of regional demonstration projects identifying alternatives to custody.

21. What is the best way of ensuring that all partners are engaged in dealing with drug-related crime?
22. What is the best way to determine and agree local priorities and strategies?

For partners to engage there must be something for them to engage with. Local understanding of and determination of priorities in terms of drug-related crime is a critical issue. Using the new Crime and Disorder Reduction Partnership (CDRP) national standards framework, local priorities can be identified and a plan of action decided upon. Local partnerships can then identify how they might best tackle the different kinds of substance use related crime and what interventions are appropriate to their needs.

23. How can local communities better work together to tackle drug-related crime?

Both CDRPs and LAAs should have in place formal and informal consultation structures to enable local communities to influence and contribute to the full range of local strategies and to contribute to them to tackling drug related crime.

There are also opportunities through structures like Police Community Forums and Police Authorities to have an impact on local crime prevention.

24. Are existing funding and delivery structures effective or do changes need to be introduced (in order to truly embed programmes like DIP into 'business as usual')?

Currently DIP is commissioned and funded through a distinct budget line. If DIP is to be fully embedded in "business as usual' then the funding strand will need to either be brought into the Safer and Stronger component of the LAA or included in the Pooled Treatment Budget. Given the inequity in DIP funding across the country however, which is a serious issue of contention – particularly for non intensive DIP boroughs which border

intensive DIP boroughs - the Government may wish to encourage boroughs to bid in partnership for enhancements to existing treatment systems to improve performance.

As discussed above, bringing DIP interventions into the range of options for local partnerships to explore may also create a more flexible and equitable system to extend and mainstream this area of work.

25. How can commissioning and co-commissioning arrangements best be applied to the whole drug strategy, and what role should regional offender managers and other stakeholders (e.g. primary care trusts, local authorities and the Department for Work and Pensions) have in commissioning and co-commissioning drug treatment for offenders?

Please see question 24.

26. Proposals to provide statutory provision on release for offenders with prison sentences of less than 12 months have been deferred. In their absence, are there arrangements – other than DIP – that could help to provide continuity of care on release for this group of drug-misusing offenders?

DrugScope believes that the government should reinstate plans to provide statutory provision on release for all offenders with no delay.

Section F: Enforcement And Supply Activity

Enforcement and supply activity has in many ways been the poor relation of treatment and tackling drug related crime throughout the life of the current strategy. At some levels in the police the understanding of the national strategy and the commitment to delivery in partnership (particularly around issues of public health and the Drug Interventions Programme) has been outstanding, however overall delivery at a local level has often been disappointing.

Among the reasons for this are lack of national direction, lack of coherent local or national targets, and poor partnership working.

In terms of national direction, there is a distinct misfit between what the police are expected to do and what they are able to do. While the top-level drive of the strategy is to reduce the availability of drugs across the UK, the police's actual ability to do so is limited. Police operations do disrupt street and middle markets on a regular basis – large quantities of drugs are seized and drug gangs are broken up. However, owing to the ready availability of drugs and the profits to be earned from the trade, the gains from local enforcement activity are generally short-lived. At a local level if activity is disrupted, it can easily be displaced to another location. And where drug dealers are taken off the streets or middle market/wholesale traffickers are imprisoned, they seem to be quickly replaced with little sustained impact on supply, price or purity.[17]

Although the political imperative is for such activity to continue, there are questions to be asked about cost effectiveness and 'value for money'.

DrugScope believes that the purpose of availability and enforcement must be first and foremost to reduce harms to the community. This means that we need to develop a better understanding of how these interventions impact on drug markets and even more importantly what impact they have on the quality of life of the community.

[17] Best, D et al (2001) Assessment of a concentrated, high profile police operation: no discernible impact on drug availability, price or purity. British Journal of Criminology: 41 (4), p.738-745; also, Parker, H and Eggington, R (undated) Managing local heroin-crack problems: hard lessons about policing drug markets and treating problem users. Manchester University
See also: Cabinet Strategy Unit (2003) SU Drugs Project – Phase 1 report: understanding the issues

In addition to this, **DrugScope** would welcome a clear national lead around this to be evident in the new strategy and would also hope that through the National Standards Framework for Community Safety and using the Assessment of Policing and Community Safety (APACS) Framework that targets for policing to reduce drugs harm to communities can be in place in all areas to support the overall work of local partnerships.

27a. How can police forces best build confidence that drug supply is being effectively tackled locally?

During our consultation we were told of an estate where a number of large scale policing operations took place to disrupt supply over a 12-month period. After the first operation where a large quantity of drugs were seized the number of dealers and the quantity of heroin that was seized was widely publicised and the community were very pleased. After six weeks however the dealers were back and after the next operation and similar publicity about quantities seized, the community expressed great dissatisfaction and said that they felt the operation was a waste of money and time. However after a third operation, the publicity was much more low key and focussed on what had been achieved for the community rather than simple statistics about seizures. In this case, an open drug market that had centred around a small parade of shops was disrupted and people who hadn't been able to use the shops were able to do so again. Both the traders and the community were pleased with the results and the operation was demonstrated to have a real impact on quality of life.

It is these types of approaches to communicating success that **DrugScope** feels build public confidence in availability and enforcement operations. As we were told at the time,

> **"…no one really cares if it's a hundred or a thousand grams of cocaine that are lifted in [a local area], but people do care if 20 old ladies can buy their Pickles a tin of Whiskers without fear."**

27b. Do the police and local communities have all the powers they need to tackle anti-social behaviour related to drug dealing and use?

DrugScope understands from its consultation and through discussions with those working in community safety and the criminal justice system that no further legislation is required to enable police and local communities to tackle the problems relating to

substance misuse, however we have picked up on concerns that the uneven implementation of some existing powers is causing problems in some areas. For example zero tolerance of alcohol related disorder in one borough can lead to increased alcohol related disorder in another borough as troublemakers “relocate for a scrap”.

28. What role should communities play in tackling drug dealers and drug supply?

There are well-defined roles for communities to play in tackling drug dealers and drug supply. These include using the Crimestoppers numbers, being active in local neighbourhood crime prevention groups such as Neighbourhood Watch and through involvement in police community forums. Communities also have a vital role to play in stifling the illegal activity that often sits alongside drug markets – such as the onward sale of stolen goods.

29. Which organisations might be able to assist in assessing the impact of supply-side activities in communities?

As we have already said, it is critical to assess the impact of supply side operations in terms of the quality of life of communities and the effect on the drug market. In terms of the first impact – that on quality of life – key organisations to involve are the local strategic partnership and the agencies that contribute to it. The community themselves should be involved in this assessment – setting baselines about the impact of the market and assessing the benefits associated with its disruption in the short, medium and long term. In terms of market disruption itself as an end, critical people to engage will include local drug users and drugs agencies.

30. To what extent and how should the UK tackle potential emerging threats (such as methamphetamine) as opposed to established drugs (such as heroin)? Methamphetamine is commonly referred to in the media as ‘crystal meth’; it has many street names including ‘ice’.

Responses to tackle potential emerging threats should be determined by the available evidence as to the likelihood and/or seriousness of the threat and not, for example, by media reporting. Potential threats can include the emergence of new drugs but can also

come from existing drugs – e.g., increases in prevalence, changes in use and new evidence as to harms.

Experiences in other countries can inform pre-emptive and preventative responses, as can intelligence on high level and international criminal activity. However, as a general rule it should not be assumed that every potential threat to the UK will be realised. There are examples of drugs that were problematic in the USA such as phencyclidine ('angel dust') that failed to appear in the UK in any significant quantity.

The Advisory Council on the Misuse of Drugs (ACMD) has a key role in conducting early warning assessments of drugs which might become problematic and their harms, although any moves to control should be accompanied by a robust evidence base across physical, mental and social harms. Enforcement activity should be focussed on those substances likely to cause the most harm to society as whole – from the user to the wider community.

So far, it would seem that the presence of crystal methamphetamine in the UK is limited – and could remain so given the relative cheapness and availability of other stimulant drugs such as cocaine and crack. Another factor that could inhibit widespread availability is that, from experience in other countries, crystal meth is produced 'in situ' rather than imported. This increases the chances of detection, not least because of suspicions that might be reported within the local community. The same scenario seems to apply to commercial cannabis farms in the UK that are regularly detected and disrupted by police.

Enforcement activity should be focussed on those substances likely to cause the most harm to society as whole – from the user to the wider community. **DrugScope** supported the reclassification of methamphetamine to Class A in January 2007 (following the advice of the ACMD) as a sensible precautionary move. There is no evidence available to establish whether it has been a deterrence to use, but reclassification has enabled police forces (nationally and locally) to allocate resources to identification and preventative measures.

31a. Do you think that there are ways in which the UK's broad approach to working with governments in priority drug producing, transit and consumer countries to tackle the causes and effects of drug problems and the harms caused to the UK can be developed and improved?
31b. How might this be achieved?

The actual countries involved in the main, primary plant drug production are just Colombia for cocaine (with Bolivia and Peru) and Afghanistan (with some production in Mexico and the Far East) for heroin. Yet despite so few countries being involved - none of who carry any diplomatic or economic 'clout' - nevertheless, the combined weight of the international community seems powerless to stifle production. This is a significant indicator of how complex the situation is, both within the producer countries and geopolitically within and between the main players on the international stage. And also why simplistic and environmentally hazardous solutions such as crop spraying etc are non-starters. The answers have to be sought within producer countries in terms of economic, political and social stability, which may seem a distant hope for the main countries involved.

Similar situations apply in transit countries where the necessary enforcement infrastructures are not in place and where often corruption is rampant. Again under those circumstances it is hard to see what significant impact can be made on international drug trafficking unless the cornerstones for effective enforcement are in place.

Nor does there seem to be much scope for international cooperation on demand reduction. The recent USA/UN – backed campaign by the Colombian government to 'shame' European governments into doing more to tackle demand for cocaine was widely regarded as ill-conceived.

In general, the nature of a drug culture is very much determined on a national basis and national links to particular sources of drugs. So for example, during the 1980s, although both the UK and the USA experienced significant economic downturns with consequential rises in problematic drug use – for the USA the main problem was crack cocaine while for the UK it was heroin.

However, when it comes to limiting the damage caused by drugs, then much can be done. The risk factors contributing to problem drug use in the UK apply and are mitigated

by good health care, employment and housing. The are tremendous global health gains to be made through public health-oriented harm reduction measures especially in reducing the spread of blood-borne viruses among injecting drug users. However progress in this and other harm reduction actions are severely hampered by the implacable opposition of the USA and the UN Office of Drugs and Crime. **DrugScope** calls upon the UK government representatives to the Commission on Narcotic Drugs to exert pressure on those opposed to such measures that could save so many lives and significantly reduce harm to the wider community. There are a number of organisations that can offer assistance, in particular the International Harm Reduction Association and the International Drug Policy Consortium, of which **DrugScope** is a founder member.

32. How might we better measure the impact of supply and enforcement activity?

The key measures should be around:

Quality of life of communities – including levels of crime, anti social behaviour, mental ill health;
Impact on Drug Markets – purity, price, availability, time for which market was disrupted;
Economic – Impact on regeneration, void properties, local business 'footfall';
Environmental – Impact on physical environment, level of drug litter, public drug taking;
Health – Impact on health of drug users, impact on health of wider community.

Changes in these measures should be evidenced by the relevant local agencies and the work could be undertaken through the Crime and Disorder Reduction Partnership. Evaluations of this kind should not be restricted to supply side interventions – but could also extend to other community level activities aimed at tackling the problems related to substance use.[18]

[18] An Australian review of the international evidence suggests that partnership working at a community level can reduce harms associated with drug markets. See Mazerolle, L et al (2005) Drug law enforcement: the evidence. Victoria: Turning Point Alcohol and Drug Centre

Section G: Broad Strategic Questions

33a. What are the most effective ways of preventing and reducing the harms caused to young people and families by drugs?

Please see section on young people.

33b. Do young people's and adult services need to work more closely together?

Please see section on young people.

34. How can we improve the effectiveness of specialist drug treatment services and help drug users to re-establish themselves in the community?

Please see section on treatment.

35. What more could be done to reduce the impact of drugs and associated crime on local communities?

Please see section on protecting the community.

36. How can we further reduce the supply of drugs and improve detection and the prevention of importation?

Please see section on availability.

37a. What could we do more efficiently?
37b. Where is value for money not being delivered?

As we have detailed elsewhere in this document **DrugScope** believes there are a number of areas where strategy could be implemented with greater efficiency.

Firstly the strengthening of local partnerships will enable better tailored interventions to be delivered to more individuals and communities across the UK. Strengthened central

partnerships will reduce the silo mentality that is once again allowing performance management systems to proliferate. Currently the performance management system for DIP operates separately to the performance management system for mainstream treatment and interventions, though both are overseen by the NTA. Most DATs have at least a full time data analyst to satisfy central demands for information. In addition to this, drugs partnerships are also required to report through the CDRP framework and in some cases through the PCT framework. These multiple systems are wasteful and inefficient. The production of a single annual DAT plan and report aligned to the local area agreement containing the range of information required centrally should be sufficient to ensure adequate performance.

The multiplicity of performance management systems at a partnership level seems to be being replicated for individuals within the treatment system. In 2002, the NTA with NIMHE (now the Modernisation Agency) launched a programme called Opening Doors. This programme sought to bring process modernisation techniques to local treatment systems. This programme encouraged partnerships, providers and service users to identify the client experience of treatment – mapping excessive assessments, duplicated interventions, and inappropriate referrals. The purpose was to ensure that local treatment systems were efficient and person centred. This initiative was not continued far beyond the inception of DIP when it began to identify that the new criminal justice interventions teams were effectively establishing new carved-out treatment systems that created duplication and caused blockages and log jams in the mainstream treatment services. Given the levels of duplication and repeated assessment we have observed, **DrugScope** believes that now may prove a good opportunity for the Opening Doors programme to be repeated – enabling local partnerships to get a better grip on cost savings and creating a more streamlined service user experience.

As detailed in our section on treatment, we understand that there are efficiencies that could be achieved within the commissioning system. Setting a tariff for treatment and supporting smaller non-statutory providers to compete with the NHS and large independents on a level playing field will produce more competitive markets and also drive efficiencies. This would require sign up to the voluntary sector compact and a better recognition that small charities can often provide better more locally appropriate services than large national bodies or the NHS. Incentivising multi area partnership commissioning in key areas will reduce waste. **DrugScope** welcomes the inclusion of substance use in the new Health and Social Care Outcomes and Accountability Framework.

We also believe that observed in the round, better overall value for money would be observed if the strategy was less focussed on purchasing treatment in order to reduce the economic and social costs of crime and more focussed on deploying resources to meet local need across a range of indicators including crime, health, social inclusion, safeguarding children and regeneration. Value for money for direct investment in drugs services will also be enhanced by a central and local challenge to mainstream services to play their part in supporting people who have experienced problems due to substance use to access their services.

38a. Have we got the right national, regional and local structures to ensure effective delivery of the drug strategy?
38b. How could these be improved?

DrugScope believes that the most effective mechanism for delivery of the national drug strategy at a local level is the multi agency partnership reporting into the Local Area Agreement and being performance managed through the same systems as other areas of local policy. There is currently a debate about whether the Pooled Treatment Budget should be ring fenced, ringfenced transitionally or just included in the Local Area Agreement from 2008/9. Our position on this is that it will depend on the local partnership. Just as local area agreements were phased in over three stages, so the pooled treatment budget can be combined with the LAA at different points in different areas. If a local partnership is confident that it can safeguard outcomes and meet local needs through the LAA then unless there are any huge objections in terms of performance they should be able to use the same freedoms and flexibilities around their pooled treatment budget as they would around other parts of LAA spend. Where there are concerns locally – or regionally at a Government Office level - integration with the LAA can be a staged process.

In terms of national structures, **DrugScope** believes that there will always be a need for a health-focussed body to look at the growing evidence base around drug treatment and disseminate it to those responsible for delivery. This may be an appropriate role for the NTA or alternately could be delivered by NICE whose work on the new clinical guidelines has been so successful. In terms of standards and inspection **DrugScope** believes the new merged regulatory authority should be able to take forward the work of the Healthcare Commission (HCC) and Commission for Social Care Inspection (CSCI) in inspecting residential and clinical services. Local regulation and standards should be in

place for all other services. There is a need for a single national body whose role should be to support local partnerships through a transitional period between now and mainstreaming. This body could be a statutory agency – however given that this work should take place outside the current performance management regime it may be more appropriate to have a non governmental body deliver this support and foster a strong, open and confident environment for the local and regional implementation of the National Drug Strategy.

In terms of the leadership from central government and the departmental home of the strategy, we are, as we have said before, less concerned with this than we are that there is a genuine commitment to real partnership working at a national level. Obviously however there is a need to have "the buck stop somewhere". **DrugScope** believes that strategy should either remain where it is currently at the Home Office – in order to reduce disruption at what is in all going to be a period of great challenge – or move to a department with a cross cutting remit such as DCLG or even back to the Cabinet Office. It is critical that wherever the strategy is located there are individuals with skills of diplomacy, knowledge of local systems, a good reputation for honest brokerage with local authorities and PCTs, that they can work in a cross cutting role, and have a real community focus. The ability to know which levers to pull will now, more than ever, be more important that the ability to yank them really hard. **DrugScope** does not believe it would be useful to transfer responsibility to either the Department of Health or the Department of Justice but both departments clearly have an important role to play. However **DrugScope** does believe that young people's drug strategy must be managed and monitored through the ECM structures and that of necessity means it should be located at a central government level in the new department for Children Schools and Families.

DrugScope understands that in the shift from a centrally driven strategic system to a locally driven one, some areas of duplication are unavoidable, however we believe it will be critical for government to rationalise the continuing role of the NTA as described within the PSA on Drugs and Alcohol in order to ensure that the commitment to local evolving strategy is not undermined by continued central process driven performance management and inappropriate ringfencing.

39a. The Prime Minister announced on 18 July that he will ask the Advisory Council on the Misuse of Drugs to look at whether cannabis should be reclassified from a Class C drug to the more serious Class B. This is because of concern about stronger strains of the drug, particularly skunk and the potential mental health effects they can have. Do you think that cannabis should be reclassified and, if so, why?

We note that the question does not ask why cannabis should *not* be reclassified.

The classification of cannabis was last reviewed in 2005. In a statement to Parliament in January 2006 the then Home Secretary, Charles Clarke, accepted the advice of the ACMD to keep cannabis at Class C. The ACMD carefully considered all the available evidence on, for example, the effects on physical and mental health, cannabis potency and trends in use. The ACMD noted an increase in the potency of skunk (sinsemilla)[19] and, although it has long been established that cannabis use can worsen existing mental health problems, it considered more recent research data on the relationship between cannabis use and the triggering of the onset of psychotic symptoms. The ACMD concluded that, at worst, the risk of an individual developing schizophrenia as a result of using cannabis was very small. Recently published studies, including a review of the evidence on cannabis use and psychotic outcomes published in the Lancet in July 2007, echo and do not contradict the ACMD's findings.[20] It is unclear what new evidence has emerged since 2005 to merit a further review or a reclassification from class C to B. The downward trend in cannabis use, including among young people, has continued since reclassification.

The ACMD included among its recommendations that there should be 'a substantial research programme' into the relationship between cannabis use and mental health, to better determine the link between cannabis use and mental health problems and the development of preventative measures. DrugScope continues to support the recommendation – nearly two years on we are not aware that such a programme is underway.

[19] Forensic Science Service data showed that the mean THC content of sinsemilla increased from 5.5 per cent to 14.2 per cent between 1995 and 2005. There was no evidence that the potency of cannabis resin had changed in any significant way.
[20] Cannabis use and the risk of psychotic or affective mental health outcomes: a review, The Lancet Vol 370 July 28 2007

In his statement to Parliament in January 2006 Charles Clarke announced a review of the drug classification system, saying "The more that I have considered these matters, the more concerned I have become about the limitations of our current system…For these reasons, I will in the next few weeks publish a consultation paper with suggestions for a review of the drug classification system, on the basis of which I will make proposals in due course."[21]

The review was welcomed by **DrugScope** and, among others, the ACMD and the Science and Technology Select Committee (which was conducting an inquiry into the way government uses evidence to inform drug policy). It was a surprise and disappointment when the Government reversed this decision.

There has never been a review by government of the Misuse of Drugs Act or the appropriateness of the drug classification system. Numerous inquiries and reports (most recently by the Science and Technology Select Committee and the RSA Commission on Illegal Drugs) have questioned the evidence base for the classification of some drugs and the mechanisms for keeping them under review - the Misuse of Drugs Act was described as 'not fit for purpose'. Although the legal framework for classifying drugs is not addressed in the consultation document, DrugScope believes that the Misuse of Drugs Act should – as the government announced in 2006 – be reviewed. The review should include consideration as to whether – as recommended by both the RSA Commission and the Science and Technology Select Committee – there should be a new scale of harms including alcohol and tobacco.

39b. Are there any other changes that you would wish to see and, if so, why?

DrugScope notes the intention to create a cross cutting framework of PSA's that will support the drug strategy. However, while some linkages are implicit some key areas of crossover are missing. **DrugScope** recommends that the range of PSA Delivery

[21] Hansard, 19 January 2006, column 983.

Agreements that could contain measures that would support the intentions of the drug strategy could include:

PSA 10. Raise the educational achievement of all children and young people

- Measures might include the number of young people assessed as vulnerable to or at risk of developing problems related to substance use thriving in education.

PSA 16. Increase the proportion of socially excluded adults in settled accommodation and employment, education or training

- Measures might include the number of people leaving or being stable within drug treatment accessing, for example, secure employment and housing.

PSA 19. Ensure better care for all

- Measures might include the numbers of drug users able to access the whole of their drug treatment through primary care or the numbers of people experiencing chronic or acute health problems as a result of substance use accessing health interventions through primary care.

PSA 21. Build more cohesive, empowered and active communities

- Measures might include the percentage of people who have experienced problems with substance use who feel they belong in their communities or the percentage of people who have experienced problems with substance use who feel they have been involved with the design of local services. In addition, measures could be included which assess an expanded role for the third sector in relation to substance use.

The inclusion of measures relating to substance use in these and other of the new PSA Agreements would make a huge contribution to driving mainstream efforts to improve treatment, community resilience and integrated young people's service. **DrugScope** asserts that the inability of government to drive and monitor activity across these areas in pursuit of its aim of reducing the harm and impact of substance use would represent a missed opportunity in any new strategy.

DrugScope is extremely grateful to Sara McGrail who not only prepared this document (September – October 2007) but played such a crucial role in devising and facilitating the consultations with our members and stakeholders.