

Criminal justice

National report

November 2004

Drug misuse 2004

Reducing the local impact



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The photographs used throughout this report are posed by models and the Audit Commission does not intend to imply that the people depicted in the photographs are drug users.

Summary

The effects of drug misuse are felt by everyone as drug problems fuel crime and anti-social behaviour. Some significant progress in tackling the problem has been made. Clinically effective programmes are now in place to help get problem drug users off illegal drugs for good. Even so, drug abuse remains deep-rooted and continues to blight the lives of individuals and disrupt communities. The principal reason is that those users causing the severest difficulties have a set of complex and usually interrelated social and psychological problems. These need to be treated as a whole if they are to get the best chance of starting, completing and sustaining recovery successfully. In practice, the focus at the moment is on treating the addiction rather than on providing the wider range of support needed to bring some order to drug users' often chaotic lives.

The facts speak for themselves. One in three problem drug users are homeless or in need of housing support. Their long term drugs issues often start at a young age. They struggle to get benefits and access to the range of services needed to support a more stable lifestyle. Many have mental health problems and over half of newly committed prisoners are classified as problem drug users. Some users who have embarked on treatment can rely on others for support. But many face this challenge alone. Too often they simply drop off the recovery path. Thirty-four per cent of drug users leaving treatment drop out within the first twelve weeks, losing contact with support organisations and often slipping back into old behaviours.

The result is that the taxpayer foots the bill for treatments which are often started repeatedly by a drug user before being successfully completed. Housing, social care and other services must provide users with follow-on services which maintain progress made during treatment and ultimately help the individual to become employed, housed and more self-sufficient. Local leaders responsible for these crucial services have more to do to deliver coherent and tailored services to individual users if intervention is to deliver results. But at the same time it is important to maintain a focus on early prevention work through education and young people's services to prevent drug misuse in the first place.

There has been impressive progress since 2002 when the Audit Commission report *Changing Habits* recommended wider and more flexible community-based drug treatment services for adults. Local commitment backed by national strategies, programmes and funding is having an impact. The capacity of local drug treatment services has grown. Local agencies are working more effectively in partnership and services are more integrated. As a consequence, waiting times are down and twenty per cent more users are now starting treatment. There is also a national programme specifically aimed at getting offenders into treatment.

Despite this, the thirty-four per cent drop-out rate remains a significant problem. For users to complete the recovery path successfully and sustain a stable lifestyle the report urges:

- Better support and follow on services to back up treatment then sustain recovery: From the outset, a supportive infrastructure of key services should be in place to sustain users on the tough road back to recovery. Follow-on services must be kept in place as users' rebuild their lives once their clinical treatment has concluded. Local authorities, the health service, police, prison and probation all have core responsibilities to deliver parts of an integrated package of tailored support such as housing, help with transport and child care. Existing partnerships already provide the vehicle to pull services together but the effectiveness of the response varies greatly across the country.
- Services to meet needs of users and carers: Illegal drug users with unstructured lifestyles can be easily put off participating in a recovery programme. Policy makers and local practitioners should use the insight of users and carers to shape the services to meet individual needs. Inconvenient appointment times, transport and dilapidated premises are unnecessary barriers. Front-line staff who display an encouraging attitude towards drug users from the outset substantially increase the users' prospects of staying the course. Focusing on the individual and not just their 'drug problem' will lead to more effective use of resources and better value for money.

Two separate problems for local services are short-term funding and the fragmented regulatory framework. Government and the relevant national bodies must act to enable local partners to take long-term funding decisions. They should encourage a more strategic approach to user and carer involvement in shaping services.

Local authorities, health services, police and probation partners are currently preparing the drug misuse component of local crime and disorder strategies for 2005 to 2008. These offer an excellent opportunity for local agencies to sign up to strategies which will provide drug users with an effective pathway to recovery together with good prospects for a sustained and stable lifestyle. This in turn will help make communities safer for everyone.

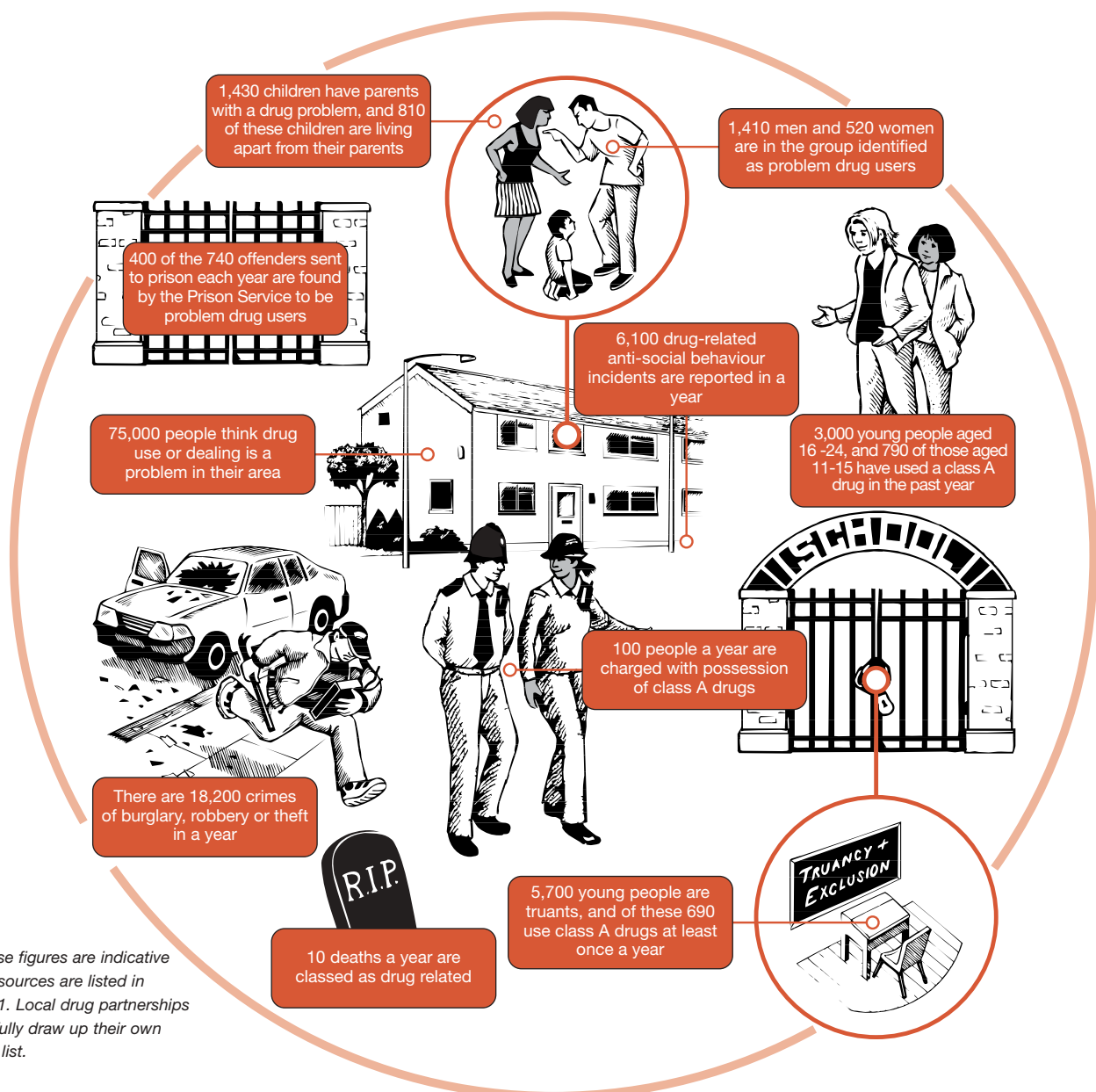
Introduction

The impact of drug misuse

- 1 Combating drug misuse is a principal concern of both national and local government in England and Wales. In response, the government published a national strategy in 1998, updated in 2002, which is backed by earmarked funding and public service agreement targets (**Ref. 1**). Funding for local drug partnerships in 2004/05 has grown to £537 million in England and (within a wider strategy for tackling all forms of substance misuse), £15 million in Wales. The national strategy concentrates attention on an estimated 280,000 problematic drug users, a small proportion of all those taking illegal drugs, but a distinct group that causes and suffers the most damage, including:
 - harming their physical and mental health, their ability to support themselves and their acceptance by the community;
 - undermining family life – compromising the health and development of children (**Ref. 23**), and burdening parents and partners (**Ref. 2**);
 - committing offences, particularly acquisitive crime and so victimising individuals and businesses;
 - acting anti-socially and stimulating fear of crime, including prostitution and neighbour nuisance; and
 - damaging neighbourhoods – including intimidation by drug dealers and discarded needles.
- 2 The extent of these effects vary by at least a factor of three across the country. The effects are dependant upon the prevalence of problem drug use and are often greatest in more deprived areas (**Refs. 3 and 4**). To illustrate the scale of the problem for a medium-sized city, large London borough or small county, **Figure 1, overleaf** contains recent national statistics, which are scaled down to a population of 300,000 people.

Figure 1
Describing the scale of the problem

An illustration of the impact of problem drug use in an area with a typical population of around 300,000 people.



Changing habits

- 3 The Audit Commission reported in 2002 on community treatment for drug misuse in *Changing Habits* (Ref. 5). The way forward at that time was highlighted as being achievable if:
 - partnership working and commissioning was strengthened;
 - the quality and range of treatment services was reviewed;
 - better care co-ordination and joint working was promoted;
 - resource use was more flexible; and
 - support to primary care was improved.
- 4 Since 2002, local and national arrangements have improved considerably:
 - national guidance, support and performance management of local partnerships are all better;
 - leadership of the original drug action teams (DATs) has improved as partnership working evolved;
 - arrangements for commissioning drug treatment are more structured, to take account of change in both the NHS and social care provision;
 - treatment services have expanded; and
 - more drug users are entering treatment, particularly by the new route through the criminal justice system (CJS).
- 5 Since 2002, good progress has been made against many of the Commission's recommendations, in particular the framework for funding drug treatment services, reduced waiting times and meeting the ongoing needs of ex-prisoners. But there is more to be done in:
 - effective financial planning and joint commissioning;
 - engaging the participation of drug users and carers;
 - improving the match between the needs of drug users and services, including aftercare;
 - consistency in the quality of care planning and treatment; and
 - rationalising the regulatory framework.

The aim of this report

- 6 This report is aimed at decision makers in local authorities, education services, English primary care trusts (PCTs)/Welsh local health boards (LHBs), police, probation and prison services. The report looks beyond community treatment to determine how well the national drug strategy is being delivered locally. To improve local performance, some recommendations are aimed at government and national agencies. While alcohol misuse falls outside the scope of this report, many of the recommendations are relevant to those who seek to reduce it. The findings reported here will interest service providers and groups representing drug user, carer and community interests. While the report is primarily concerned with England, fieldwork was carried out in Wales to learn from the different arrangements that apply there. The change in the law covering drug possession was examined by the Home Affairs Select Committee in 2002 and as such is not an issue covered here.

Improvement journeys

- 7 The report traces two improvement journeys, which are illustrated using fictional stories. The first, for individuals, follows a path from problematic drug use towards a stable life that is safe for them, and for people near by. The second, for local agencies working in partnership, brings together people from different organisations and varying perspectives to reach a shared goal. Both of the paths include three key stages (**Figure 2, overleaf**):
- recognising the problem;
 - finding the right route; and
 - maintaining progress.
- 8 Communities are adversely affected by problematic drug use and people are key to tackling it successfully. Together, drug users, their carers, service providers, local drug partnerships¹ and government can make a difference. But a successful journey depends upon how well individuals appreciate each other's perspectives, ambitions and goals.
- 9 This report recognises the progress that has been made since 2002; and makes recommendations for local agencies and government to:
- improve the focus on the drug user and carer;
 - provide 'follow-on' services, enabling drug users to complete the recovery journey;
 - reduce reliance on short-term funding streams, encouraging mainstream solutions; and
 - develop Strategic Regulation.

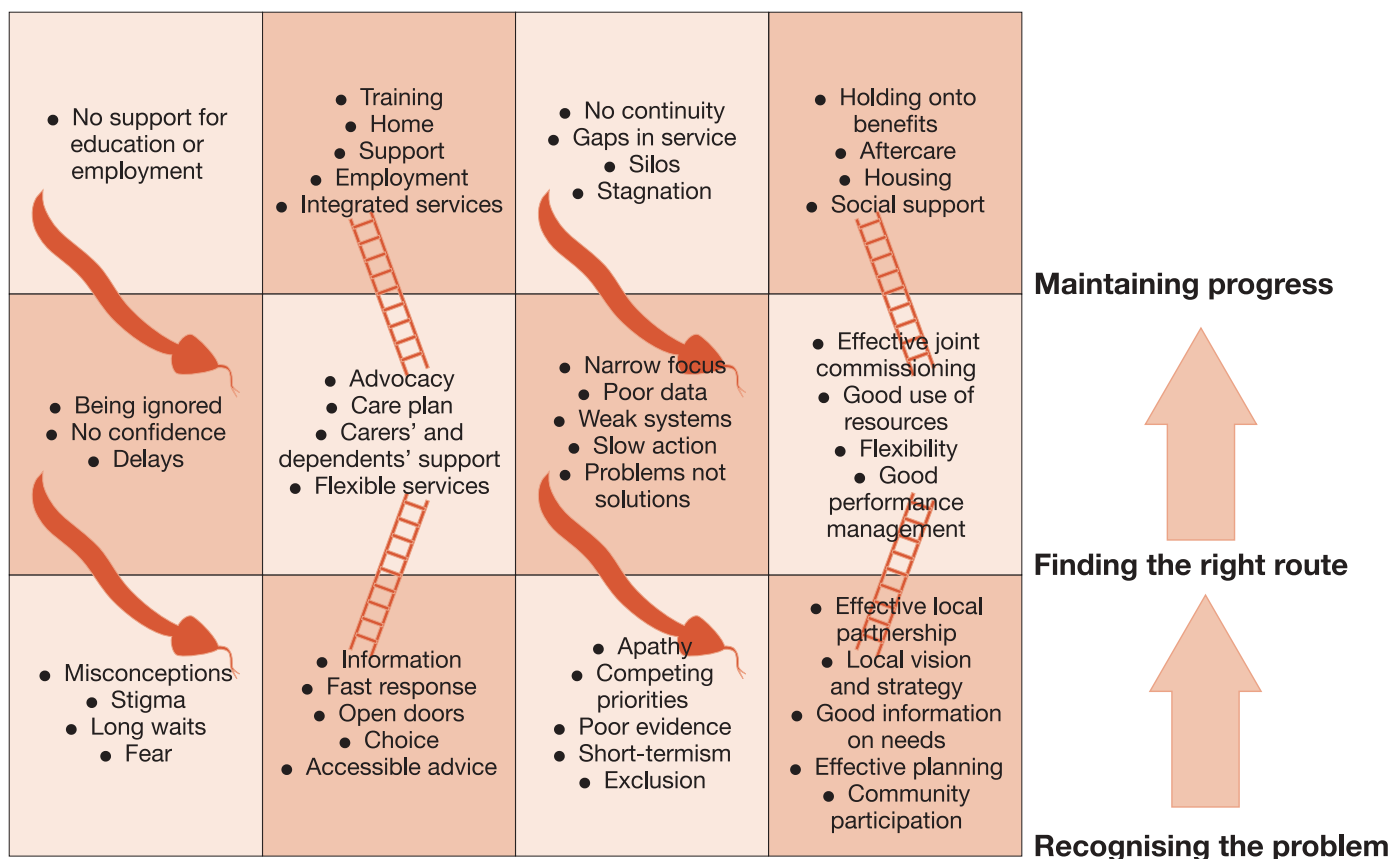
¹ Since 2001, local partnerships delivering the national strategy have evolved considerably, so structures and titles vary considerably across England and Wales. The phrase 'local drug partnership' is used throughout this report as an inclusive term for all such arrangements.

10 The following items accompany this report:

- a separate wall chart, which illustrates how national policy translates into action by local drug partnerships;
- findings from the surveys of service users and senior managers are available on the Audit Commission’s website, www.audit-commission.gov.uk; and
- information of help to users and carers and professionals working with them is available on the website of the National Treatment Agency for Substance Misuse (NTA) www.nta.nhs.uk

Figure 2
The journey

On the journeys described in this report, progress is not smooth. It can move in fits and starts, accelerate forwards and even reverse.



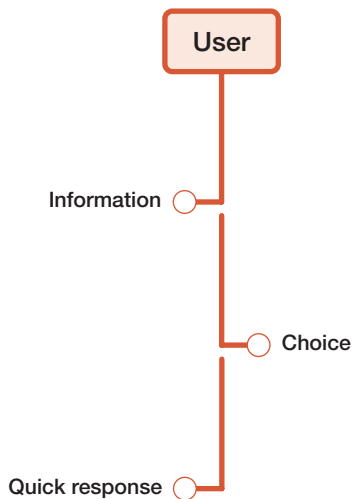
Source: Audit Commission

1



A tale of two journeys

More can be done to help drug users start the journey to recovery by giving them and their carers timely information. There is now quicker access to a better range of treatment services, but the wider personal and complex needs of individuals are not yet being addressed soon enough. The most vulnerable drug users need a package of support services.



Recognising the problem – the user perspective

Greg, 20, has been arrested for stealing a wallet containing £300. It is his fourth arrest this year and the money would have bought heroin and crack cocaine for a week. At the police station, Greg is talking to a drugs worker about what treatment would involve. This did not happen last time Greg was arrested – it's a new scheme. Greg's solicitor has warned him that the Magistrates will be tougher on him if he fails to accept help.

Greg knows his girlfriend Tracey will say the same as the Magistrates – Tracey has been trying to cut down her own use of drugs and alcohol since finding out that she is pregnant. Tracey has heard through a friend about a special scheme where trained midwives help women who take drugs through pregnancy and support them in keeping their babies. Tracey asked her GP if she could join this scheme, but the GP hasn't heard of it and so can't help.

Pat, a lone pensioner and Tracey's mother, has custody of Tracey's other two children and is struggling to bring them up. Pat does not know that she can claim benefits or ask social services for help in caring for the children.

How will Greg, Tracey and Pat get the help they need to begin their journeys?

- 11 The introduction summarised the position as reported in 2002 and that progress has been made in responding to the recommendations of *Changing Habits* (Ref. 5). This chapter describes the journey to recovery from the perspective of the user and carer.
- 12 Each recovery path follows a different route (Appendix 2). Drug users need to take a big step as they seek help. Most only do so as a result of desperation, after all else has failed. The trigger may be:
 - a personal crisis, such as medical emergency, job loss, homelessness or relationship breakdown;
 - the active encouragement of someone valued by the user, such as a carer, a recovering drug user, an outreach worker; or
 - an opportunity presented through the CJS following arrest for a drug-related crime.

You have to be ready in yourself, if you don't feel ready then it's a waste of time.

One of my friends was badly treated, you are not a person.

- 13 Drug users gave a variety of reasons for not contacting local services, ranging from 'not being ready' to past negative experiences (**Ref. 6**). Barriers to taking the first step include denial, stigma, fear of exposure, low self-esteem and peer pressure to continue. Women, in particular, reported fear of initiating child protection proceedings as a reason for not contacting services.

Seeking and accessing information

- 14 Only when a drug user comes to the notice of a service provider can treatment interventions begin. At this stage easy access to accurate and understandable information should be available for users and carers to help overcome fear and misconception. The information should explain the available options in alternative languages and formats. *Changing Habits* (**Ref. 5**) recommended better engagement by local services with people in hard-to-reach communities and improved access to services where problems are apparent. Since 2002 detailed guidance, for example, covering issues of diversity, homelessness and sex work, has been produced and actively promoted by the government and NTA.
- 15 Currently, a wide range of information and publicity is available about drug use and its impact upon people. National campaigns include 'Talk to Frank', while local initiatives range from posters and websites to innovative approaches that target information at grandparents. Under the recently re-named drugs intervention programme, formerly known as the criminal justice interventions programme (CJIP), local 24-hour helplines are being set up throughout England to provide drug using offenders with service and self-help information, including appointments to meet their local criminal justice interventions team (CJIT).
- 16 Information that delivers consistent and coherent messages should be provided to all young people at an early stage to help prevent drug misuse. Research is continuing into the most effective method of achieving this (**Ref. 7**). Education about all drugs forms part of the national curriculum, but evidence about how well this is delivered in schools is mixed. Greater flexibility is needed by schools, for example, if drug activity near the school increases, teaching plans should be amended to increase the emphasis on sources of help or give a timely warning. Community projects, such as Positive Futures, divert some young people away from drug use but short-term approaches to funding and operation hamper longer-term effectiveness (**Ref. 7a**).
- 17 Drug users knock on many doors when seeking help, for example, GP surgeries, schools, drop-in centres, religious organisations and specialist drug agencies. Alternatively, during a crisis their needs may be identified by police or hospital staff. All frontline public service staff should possess timely and accurate information about local drug treatment services, together with easy access to effective systems for referring drug users to local sources of help. The introduction of national occupational standards for drugs and alcohol (DANOS) has helped to improve the training of frontline staff in successfully identifying and reacting to problem drug use (**Ref. 8**). Directories of local services are common, but they do not always contain up-to-date information. Contact details alone are not enough – users are likely to drop out of treatment if they do not understand what to expect.

I have kids and I was scared of having them taken away, I did not know my rights when I went last time, you need a solicitor there to help you.

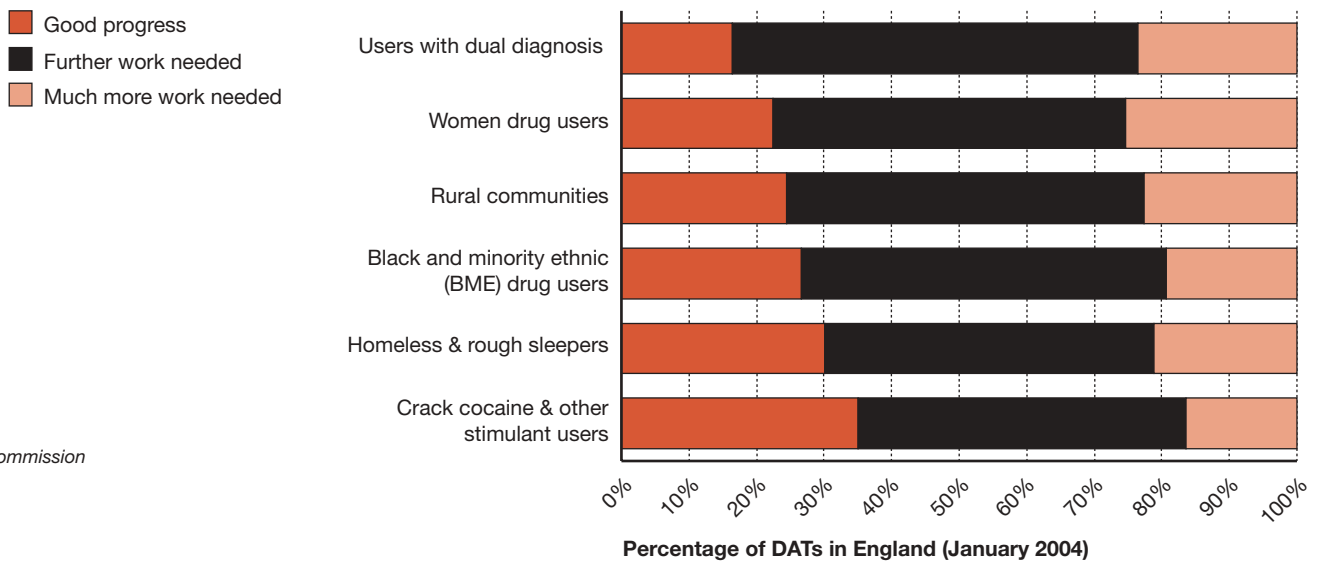
All they had to give me was counselling, I needed more, I needed to get away.

- 18 Set against this improving position, the reality, as expressed by drug users, is that information about help sources, service details and eligibility is unavailable when it is most needed. Even greater difficulty is found by drug users with mental health problems, those who live in rural areas or are from minority ethnic groups (**Ref. 9**).
- 19 Local services need to ensure that information is in the places where users and carers in crisis might easily find it – this is especially true for those without access to the internet. Users say that their principal information source is their peer group, usually fellow drug users. Recognising this, some drug partnerships are harnessing the knowledge of users and carers by asking them to review publicity material.

Availability of choice

- 20 Not all drug users and their carers have the same aspirations. While regarding drug taking as a lifestyle choice some users seek to reduce the risk to themselves and others but are not seeking long-term rehabilitation. To harness the potential to change behaviour, service providers must appreciate a user's own view of the future and allow informed choice and opportunity. Advocacy services are important for drug users in complicated situations, and users say that frontline staff need to be more aware of this, as well as being proactive in promoting them. However, as is recognised by the NTA, there are few advocacy services currently available, particularly for minority ethnic communities. Local action is needed to increase access to advocacy for which Guidance from Scotland is helpful (**Ref. 36**).
- 21 *Changing Habits* (**Ref. 5**) recommended making sure that services match users' needs in order to minimise the risk of 'revolving doors' – users being passed around from service to service, dropping out and only reluctantly returning. Drug users report that the range of treatment services has improved since 2002, but choice remains limited in both treatment type and service operation. The government's *Models of Care* framework, published in 2002, established the range of appropriate adult treatments in England (**Ref. 10**), while the first part of parallel guidance in Wales is to be issued in November 2004. Analysis of local drug treatment plans shows that the range of local services still varies widely between localities (**Ref. 11**). In most areas the needs of minority ethnic groups are still not being met, for example, little is known about the drug problems of refugees and asylum seekers (**Figure 3, Ref. 12**). There has been little progress in meeting the needs of drug users who also have mental health problems ('dual diagnosis').

We are all different so why can't services be like that?

Figure 3**DATs' self assessment of progress in meeting the needs of vulnerable groups**

Source: Audit Commission

- 22 Limited choice is a significant barrier to drug users who are seeking help, especially drug users with chaotic lives and those in employment. Drug users reported inflexible appointment systems and restricted opening hours as frequent limitations. Local partnerships should engage with drug users in their area to identify and then remove barriers or limitations to choice.

Quick responses to users' requests

- 23 When starting on the pathway, having found a source of help and asked for support, users and carers need a quick response to establish a commitment before their self confidence and motivation evaporates. *Changing Habits (Ref. 5)* reported in 2002 that long waiting times prevented users from making such a commitment. Progress has been made since then; users value the quick response available from drop-in services. A concerted effort has reduced the waiting time for more structured drug treatment.

It's not that you don't want to see them, but you're all over the place.

It was difficult to make appointments in the school holidays.

Mornings are a waste of time because you are up all night.

24 Average waiting times in England have reduced by over 70 per cent since 2001 for the main forms of treatment. They are now close to the two and three week national targets (**Ref. 13**). However, in June 2004, only one in five English drug partnerships reported an average wait of three weeks or less for all forms of treatment. Overall, waiting times are lower for the 25 English partnerships that received the first tranche of funding under drug interventions programme. The NTA ascribes this success to the provision of rapid prescribing services, which see referred users within a week. Waiting times for other users in these partnership areas have also improved. Local performance can be significantly improved where system efficiency is reviewed, as found by the Youth Justice Board following introduction of the persistent young offender scheme.

Conclusion

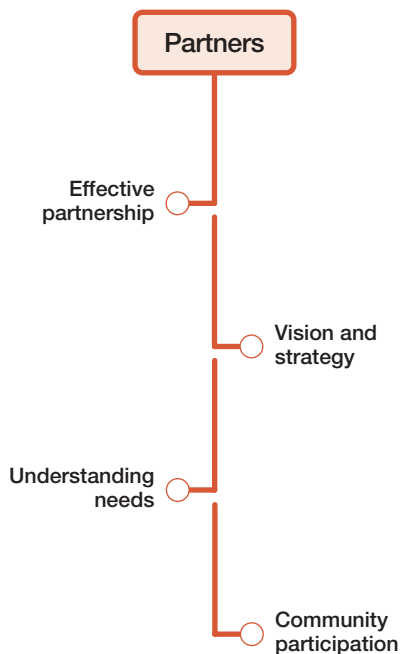
- 25 Drug users starting out upon the recovery journey are vulnerable, they need information and encouragement to enable them to commit themselves to begin and continue treatment. Although public information about local drug services has significantly improved, it needs to be targeted at the services and places to which users and carers turn in a crisis. Users who rely upon their peers for information risk being fed misconceptions about what services are available.
- 26 While the range of treatment services has improved since 2002, more choice, greater flexibility and responsiveness to drug user needs is still required, especially for people with complex problems. Further development of advocacy would help this. Waiting times are much shorter than in 2001, but they remain too long in most areas for one or more treatment types.
- 27 This chapter described three key aspects that influence how effectively users and carers needs are identified; seeking and accessing information, availability of choice and quick responses to requests. Chapter 2 examines how well local drug partnerships identify what they need to do about drug misuse.

2



Recognising the problem, the local partnership perspective

Tensions between member agencies and poor involvement of drug users and carers hamper progress in some areas. Partnerships are not a substitute for ensuring that mainstream services are integrated and effective in offering a package of support to people with multiple or complex needs.



Janet, deputy Chief Executive of the Council, is taking over the role of Chair to the local drug partnership from the Police Commander, who is moving to another area. The Commander outlines police concerns about drugs:

- *the new initiative to target prolific and persistent offenders has found that the majority are drug dependent;*
- *a recent police authority consultation identified drug dealing as the public's top concern; and*
- *although the community safety strategy includes an aim to reduce drug-related crime, it is not something that the police can do alone because people need help to stop committing crime and to begin treatment.*

The Commander is doubtful about the commitment of other agencies to tackle drug misuse:

- *education and social services are preoccupied with setting up a children's trust and do not know whether young people are receiving help when they need it;*
- *members of the Council recently refused planning permission for a much-needed open access drugs service;*
- *arguments between health and probation service representatives about reconciling performance targets stymie progress;*
- *research into local patterns of drug use and need is under way, but the analyst carrying out the work is struggling; and*
- *a user forum was set up last year but only met twice.*

How will Janet lead partners whose current commitment to the goal is unclear?

How can Janet quickly secure real improvements for drug users and victims of their actions?

28 Chapter 1 highlighted the perspectives of users and carers. This chapter reviews how effectively local agencies respond by:

- working together effectively;
- setting a vision and strategy for the local area;
- understanding local needs; and
- building community participation.

- 29 Local agencies on their journey to reduce problem drug use follow the direction set by the national strategy that aims to:
- reduce the availability of illegal drugs;
 - influence young people and strengthen communities; and
 - treat drug users and help their families, with close case management of users identified as offenders.

Working together effectively

- 30 To ensure a coherent approach to drug-related problems, *Changing Habits* (Ref. 5) recommended effective links between services. Since 2001, local drug partnerships have evolved considerably (Box 1).

Box 1

A brief history of local drug partnerships

Multi-agency teams (DATs in England, drug and alcohol action teams in Wales) were established in 1995 and reorganised in 2001 from health to local authority boundaries. Following the Police Reform Act 2002 in many parts of England the DAT has largely merged with the local crime and disorder reduction partnership (CDRP) (Ref. 14). Where there are both county and district councils, the DAT operates at county level and the CDRP at district level. DATs and CDRPs are trying to link up their work but often find this difficult to do. In Wales, community safety partnerships, through a substance misuse action team, became responsible for tackling drugs in April 2003.

Responsible authorities are local (and fire) authorities, PCTs (LHBs in Wales) and the police. Youth offending teams, probation and prison services are often involved.

The partnerships vary considerably in structure. Most have at least one member of staff focused on drug misuse (often called the DAT co-ordinator). Figure 5 in Chapter 6 highlights other people with key roles. The accompanying wall chart illustrates how local drug partnerships link national aims to local outcomes.

Source: Audit Commission

- 31 Senior managers of local drug partnership agencies are committed to delivering the national strategy. A survey of senior managers found that three out of five managers who sit on the steering group of the local drug partnership are also on that of the local strategic partnership (LSP), the group responsible for forming a vision for the local area (Ref. 15). Some senior managers say the merger of DATs with CDRPs has marginalised drug reduction work, while others see the mergers as providing greater influence in shaping both the vision for the local area and mainstream services.

We are providing more opportunities for drug users. For example, developing a local treatment centre where previously they had to go in to the city. All the agencies pulled together to make that happen.

- 32 The extent to which member agencies of local drug partnerships own the responsibility to reduce drug misuse and commit to effective joint working is more important than organisational structures. Senior managers said that tackling drug misuse is a high priority both for their organisations and for local people, because of the link to reducing crime and disorder. Of those managers surveyed, 83 per cent spoke highly of their local drug partnership, seeing their own and other agencies as actively involved, particularly the police. However, 50 per cent of managers see the different attitudes of various agencies as a barrier to success, with 21 per cent concerned about whether co-operation will happen in practice. Some local drug partnerships are holding their vision steady and harnessing the expertise of partner agencies (**Case study 1**).

Case study 1

Leadership success factors identified by Manchester Drug and Alcohol Action Team

Manchester's drug and alcohol action team (DAAT) is an example of a drug partnership contributing to achievement of a long-term social vision for the city. They identify the success factors as:

- a general agreement on a comprehensive long-term vision for the city which stops the DAAT from being diverted by short-term crises;
- fully involved partnership leaders who use away-days to create time to agree the plan to reduce drug misuse, and to give clear, consistent feedback to the public about what the DAAT is doing and why;
- maintaining an enthusiastic attitude despite setbacks, demanding active commitment to the DAAT by all agencies, for example, by following up non-attendance at meetings;
- promoting a blame-free culture that actively supports partner agencies; and
- making sure that effective people fill managerial roles.

Source: Audit Commission

Setting a vision and strategy

- 33 The commitment of each agency to work together in the local drug partnership needs to be directed by a common strategy to reduce drug misuse. Most areas already have an overall vision produced by the LSP. This should set the aims for community safety and, within that, drug misuse reduction. An effective local drug partnership will:
- be clear about how its activity contributes to achieving the aim of the LSP;
 - have secured agreements with all agency partners on information sharing;
 - materially influence the content of mainstream services, especially housing, social care and education;

We have started to get people around the table to look at how we can work together... We have got housing and social services to work together to deliver solutions with no additional resources.

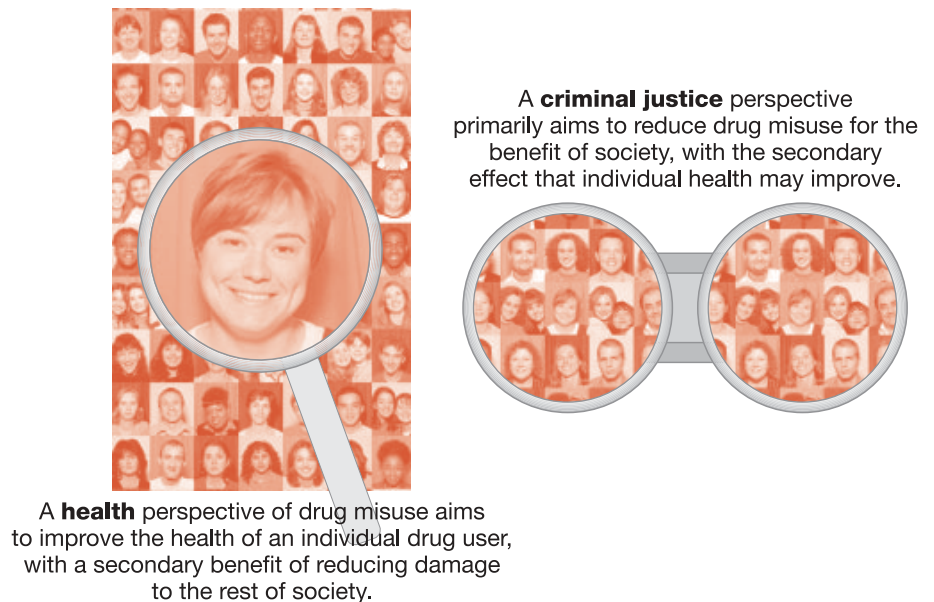
They don't get the right people into treatment. The DAT is very woolly-headed. I don't know where the LSP makes a contribution. The police are willing to do their bit, but other agencies are less willing.

- use a mix of available resources economically and efficiently to meet local priorities;
 - shape prevention, treatment and follow-on services effectively; and
 - practice a mutual accountability for performance that involves relevant senior managers and elected/appointed members.
- 34 Partner agencies that cannot agree upon common priorities will hinder effective outcomes. Where local drug partnerships lack a shared vision or suffer from competition driven by individual personalities or ownership of funding, service delivery is inconsistent and incoherent for drug users and carers. Some partnerships have yet to resolve the tension between criminal justice and health perspectives towards drug misuse, something they should do quickly (**Figure 4**).

Figure 4

Unresolved differences of perspective cause tension

Local agencies need to agree a common vision.



- 35 Drug misuse often has its roots in unresolved problems during adolescence (**Ref 27a**). The way that the drugs strategy is delivered for young people is changing. In England the government's reforms to provide integrated children's services will be implemented through enactment of the Children's Bill (**Ref. 16**). Children and young people's partnerships (CYPPs¹), which oversee these services should include with mainstream services both prevention and responses to drug misuse, plus support for children of adult drug users. Many of those commissioning drugs services report that the CYPP does not see tackling substance misuse as essential to achieving broader objectives. These drug partnerships are unwilling to transfer responsibility for young people's programmes to the CYPPs, which could marginalise the issue with future children and young people's services. The diagram in Appendix 3 suggests one way to avoid this, although a variety of arrangements can work. **Case study 2** describes how Waltham Forest LSP recognised and linked these issues together.

Case study 2

Action for young people in Waltham Forest

In the London Borough of Waltham Forest, the LSP's overall aim for young people reflects national priorities:

- to maximise health;
- to minimise criminal activity; and
- to maximise the contribution to the local economy.

However, provision of young people's services had received a lower priority than other pressing local issues, for example, reducing high infant mortality and improving mental health services. Expenditure on young people's substance misuse services by mainstream services was also low historically.

Under new government funding arrangements, a substantially increased grant became available for 2004/05. The LSP now sharpened its aim from a broad 'all youths' vision to target those aged 14 years with a poor academic prediction score at key stage 2. The LSP's revised aim is to improve outcomes, including reduced substance misuse for this vulnerable group, at age 19. Performance in achieving the new aim is being undertaken through improved high-level co-ordination, which is monitored by an LSP subgroup comprising health, local authority, police, further education and business representatives. The DAT reports to this subgroup on the substance misuse elements of the initiative.

Source: Audit Commission

¹ The abbreviation CYPP in this report covers all forms of such partnerships in both England and Wales. In Wales, Young People's Partnerships cover ages 11-25. There are also separate children's partnerships.

Understanding local needs

- 36** *Changing Habits* (Ref. 5) recommended that local drug partnerships identify the needs and profile of all local problem drug users, taking into account existing users' satisfaction with the content and impact of the treatment they receive. In the period up to March 2004, English local drug partnerships were required to submit numerous detailed plans to regional government office drugs teams (GODT) and the NTA. Frequently, the combined plans failed to present a coherent local strategy. From April 2004 only the adult treatment plan is submitted, but all local drug partnerships are required to assess the level and pattern of drug misuse alongside that for crime and disorder, and to formulate and implement a three-year strategy covering 2005-08¹.
- 37** The change to surveying patterns of drug misuse together with crime and disorder to inform an overall local strategy is welcome. Agencies need the combined evidence to plan and build the capacity to respond effectively. The extent to which partnerships have gathered sufficient information varies. Some are collaborating with neighbours to derive the benefit of access to a larger information 'pool' (Case study 3).

Case study 3

Sharing information in Tees Valley and in Merseyside

Five DATS in Tees Valley pooled their resources to develop a multi-agency database that will help them to create a local picture of substance misuse. The database matches police, social services, Connexions, treatment provider and ward-level socio-economic information. Initial funding for this project was provided from the invest-to-save budget. The scope of the original project is now widening to include new information needs, for example, that of the NTA, and to link with information about crime and disorder.

Similar work over several years in the Merseyside area by the Centre for Public Health has also built up a rich store of information.

Source: Tees Valley Joint Strategy Unit, www.teesvalley-jsu.gov.uk, Liverpool John Moores University, www.cph.org.uk.

- 38** *Changing Habits* (Ref. 5) suggested that forecasts and trends for each local partnership could be provided by the national drug treatment monitoring system (NDTMS), which collates anonymised data on each person in treatment. Such is the problem with the NDTMS computer system, that until this year it has proved difficult to confirm even the total number of people in treatment (Ref. 18). While action by the government to tackle the problem with NDTMS is underway, local drug partnerships should make their own forecasts to inform their three-year strategies.
- 39** The Home Office has provided a tool for estimating the impact of the DIP on demand for treatment, and more recently the level of housing need among drug users. In addition, research exists that is helpful to local partnerships (Box 2, Ref. 9), but knowledge of its existence is poor. Work underway by the government to publish and maintain a catalogue of completed and ongoing research is welcome.

¹ Under the Crime and Disorder Act 1998 as amended by the Police Reform Act 2002 (Refs. 17 and 14).

Box 2

Needs assessment of black and minority ethnic communities

The Department of Health's (DH's) black and minority ethnic drug needs assessment project consulted over 12,000 people (including approximately 2,000 drug users) within a six-month period. The exercise gathered the views, perceptions and detailed needs of 30 ethnic and national groups in 47 geographical locations across England on drug prevention, education and treatment.

Phase one of the project aimed to identify visible barriers and produced 51 local reports that were disseminated within the communities from where research was done. These reports have now been analysed by DH to enrich a previously scant evidence base. Phase two is due to report in October 2004 and aims to dismantle visible barriers and identify invisible barriers.

Source: University of Central Lancashire

- 40 Few local partnerships systematically measure user satisfaction with local services and use the information to plan improvements. Most local drug partnerships aim to develop user and carer involvement but are unaware of the substantial guidance now available on how to do this for public services generally, and on the learning gained by related services such as mental health. This is a missed opportunity to achieve a key outcome. Where user and carer feedback informs the improvement process, more people are attracted into treatment and stay there (**Case study 4**).

Case study 4

User involvement leading to better services in Calderdale

Calderdale's drug user group sought feedback from their peers about the local needle exchange service because poor service standards, building condition and staff attitudes were causing concern.

Pollsters interviewed 187 drug users to gather their opinions. From these opinions recommendations for improvements were made to the local drug partnership. The changes were implemented in 2003 and since then there has been:

- an increase in people using the service from 180 to 500;
- a reduction in waiting times;
- more flexible opening hours; and
- increasing numbers of users moving on to treatment programmes.

Source: Audit Commission

It's difficult to make all parts of the system work together, but where this happens it's most rewarding.

We are re-designing the substance misuse service to be client-centered, and based in the community.

There's this prolific offender... my aim is to invite him onto the platform beside me, to tell people how lives can be changed through drug treatment.

Building community participation

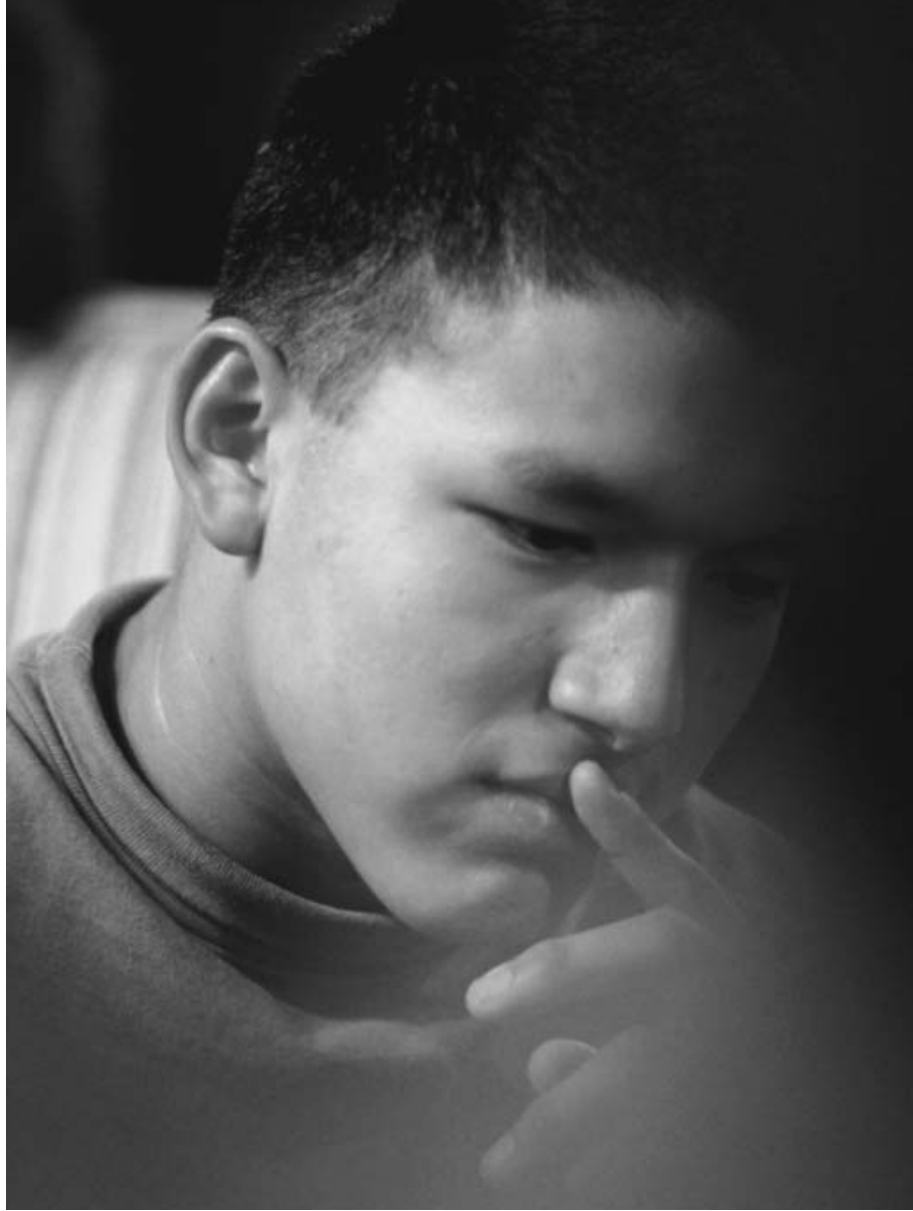
- 41 Consultation by local drug partnerships with local communities is essential in order to harness the support of local people and the expertise of drug users and their carers. Influencing, as well as listening to public opinion, is important to reintegrate users with local communities and reduce stigma. Although there are growing national and local efforts to seek user and carer feedback, doubt still exists about what value these exercises produce, because:
- the information and any good practice is not collated nationally, and is therefore not having an impact on policy or practice;
 - the initiatives do not link nationally or locally to other public involvement in health, local government or policing;
 - there are no success criteria for user and carer involvement, nor is there any national guidance covering set up or operation; and
 - carers' fora are under-developed in comparison to user fora, and neither experience consistent funding and support.
- 42 Some national agencies such as the NTA are acting to improve their connection with users and carers. The NTA now has both a user and a carer sitting on its board, a regional user and carer representation framework and a dedicated national project officer. Locally, user and carer involvement activities by drug partnerships varies widely. In addition, co-operation is rare across service boundaries (**Ref. 19**). Particular gaps exist around the challenging task of reaching out to the most vulnerable groups, and user advocacy to help people to express their needs effectively.
- 43 Further capacity building is needed, including the training of leaders or facilitators. Professionals, users and carers describe the main success factor in establishing and building capacity for public involvement as personal peer support, and consistency in funding. Regional and national action can help support local drug partnerships by pooling and sharing information and good practice.

Conclusion

- 44 Clear partnership arrangements exist for the local delivery of drugs strategies throughout England and Wales. However, delivery effectiveness varies according to the commitment of local agencies and the quality of leadership. Where both of these pre-requisites are good, progress is being made, but differences of attitude between individuals and agencies remains a significant barrier in many areas. Resolving such differences is a key challenge.

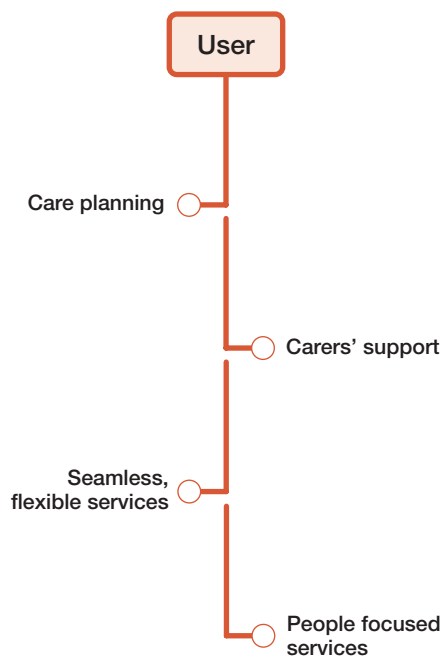
- 45 Strategies for preventing and reducing drug misuse by children and young people, plus support for children of adult drug users, should be led by the emerging CYPPs. A challenge to future performance is that many CYPPs are slow in taking on board their responsibility for tackling all forms of substance misuse. The CYPPs should work with the local drug partnership to establish clearly areas of responsibility, allocation of resources and performance targets for the delivery of the national drugs strategy in their area.
- 46 The requirement to prepare composite community safety and drugs strategies covering 2005-08 enables local drug partnerships to restate their vision and to develop plans that are based upon a sound understanding of need. Better use of information sources is needed, including published research, feedback from users and carers and insights from community participation.
- 47 This chapter reviewed the effectiveness of local agencies in working together to identify problem drug users and their impact on the community. Chapter 3 reviews how well local drug partnerships assist problem drug users in making the recovery journey.

3



Finding the right path, the user perspective

Drug users are more likely to stay on the recovery journey when care is well planned by empathetic staff and offers a package of support to help solve the range of problems faced by the drug user. Despite a welcome expansion of treatment, services are not integrated and the carer's needs are neglected.



Greg phoned the service that the arrest referral worker had suggested to him in the police station, but the service could not see him for a month and in the meantime he forgot about the appointment. The court sentenced Greg to a drug treatment and testing order (DTTO), so each week he is required to pass a drug test to check that he remains 'clean' and spend 20 hours on a treatment and rehabilitation programme.

Although several other offenders on the 'rehab programme' have dropped out, Greg finds the mix of medication, group work and adult literacy support helpful. He has reduced his drug use and has not reoffended. Greg is now worrying about what will happen when this help ceases, as the court order ends in six months time – programme staff are promising new 'aftercare arrangements', but they too seem unsure about what will happen.

Meanwhile, through a friend who is also a drug user, Tracey is now being supported by a specialist midwife whom she trusts. She is also being prescribed methadone by her local GP and chemist rather than going to the depressing clinic away on the other side of town. Tracey wants to find somewhere decent to live once the baby is born. Tempers often fray in Greg and Tracey's damp bed-sit and drug dealers regularly accost them in the stairwells of the block.

Pat, still caring for her two grandchildren and coping with Tracey's unpredictable moods, found a leaflet in the library about carers, and wondered if she was one? Pat thinks she is, but isn't sure. Her neighbour said Pat wouldn't get help because she is managing, just...

How do Greg and Tracey find a safe and affordable home, with their record?

Will the local carers' helpline have good news for Pat, or must she just cope on her own?

- 48 Chapter 2 reviewed the effectiveness of local agencies in working together. This chapter examines how they help problem drug users benefit from treatment through:
- better care planning;
 - better support for carers and dependants;
 - seamlessness and flexibility in service provision; and
 - quality of service.

They never really look at why you're using, like the other stuff...it's all about drugs.

I was given a copy of my care plan, I am shown my notes at the end of every one-to-one...this really helps me because I can see how well I'm doing.

Better care planning

- 49 Choosing the right path on the recovery journey is vital because failure damages self confidence, motivation and capacity to maintain progress. User and carer needs vary across a broad spectrum. There is a complex and important overlap with mental health issues (Ref. 19a). *Changing Habits* (Ref. 5) recommended more effective multi-disciplinary assessment, care planning and co-ordination to ensure that the services provided closely match a client's needs. This approach was incorporated into *Models of Care* in England, which describes how services link together to create an integrated care pathway (Ref. 10). Little information is held nationally, or often locally, on how many drug users actually have a current care plan, whether it is being delivered, or what the user thinks of it. The impetus caused by the government's target to increase overall numbers in treatment does not focus attention on the quality of the treatment provided. Consideration by the DH to use a measure based on care plans is welcome as a more effective indicator of outcomes.
- 50 Where local surveys have been undertaken, these often confirm the experience of drug users who report care planning as mainly done 'to them' not 'with them'. Duplication is common, with different professionals asking the same questions. Professional assessment tends to concentrate on drug use and omit other key factors, for example, accommodation, employment and relationships, which affect the journey to recovery. For non-residential treatment provision, the 'wrap-around' services to support drug users may also include help with transport, child care and managing personal finance. Good practice approaches to care planning include:
- a common, clear process shared between client and worker;
 - understanding of confidentiality and consent that aids information sharing; and
 - single assessment and multi-disciplinary review, where possible.
- 51 Drug users say that at the moment they generally do not receive the integrated care envisaged in *Models of Care*. National reviews, such as those of safeguarding children (Ref. 20) and persistent and prolific offenders (Ref. 21), and local inspections of prisons or social services confirm this. To improve local performance in terms of the number of drug users successfully achieving their treatment goals, more attention by local services to care planning is essential.
- 52 All English local drug partnerships received specific funds for 2004/05, to extend an idea piloted in the high-crime, 'intensive DIP' areas. The aim is to create CJITs that use a case-managed approach to offer support and access to treatment from a drug-using offender's first contact with the CJS, through custody, court and sentence. The CJIT assessment form covers social needs, but it is only used for drug users whose journey started in the CJS.

53 While it is too early to assess the benefit of CJITs, the approach has wide support among practitioners. Early experience shows that operational challenges need to be faced. For example, only 28 per cent of those seen by arrest referral workers in 2003/04 went on to engage with treatment (**Ref. 11**). Completion of DTTOs has been below expectation (32 per cent by June 2004). The National Audit Office has recommended that more attention is paid to assessing each offender's suitability for a court order and that time before sentencing is used to build the offender's motivation to complete it (**Ref. 22**). The 'whole person' approach to assessing risks and needs is core to the approach adopted by both probation services and youth offending teams. Local drug partnerships should seek to learn from and adopt similar approaches. Under the prolific and persistent offender scheme launched in September 2004, each CDRP identifies those local offenders who cause the most crime and disorder. Initial indications are that most such offenders are also drug users, and so part of the response by the CDRP will involve drug treatment. It is important that as the government develops this initiative, the new arrangements help rather than complicate care planning.

Supporting carers

I had drug counselling with my girlfriend...until you do it you don't really know what you are doing to others, once you know it kicks you to change.

- 54 Research shows that support by carers helps users to succeed on their journey through treatment. Carers themselves need support, because caring is difficult where drug users have chaotic lives. It makes erratic, emotional, rather than physical demands on the carer. The tendency to hide the problem because of shame and social stigma means that large numbers of carers are unknown to local services. *Hidden Harm* (**Ref. 23**) drew attention to the number of children of adult drug users. Local agencies through the new CYPPs still have much work to do to address its recommendations.
- 55 Some users reported faster recovery once partner, children or parents, had received help for themselves and consequently learned how to manage the user's needs. Help should be available – the Carers (Recognition and Services) Act 1995 (**Ref. 24**) gives people who provide 'substantial care on a regular basis' (estimated at a minimum of 20 hours per week) the right to an assessment from social services. Implementation is patchy. Assessments are not always carried out. Social services statistics do not currently record how many of the assessed carers are those of drug users. Evidence from carers' organisations shows that there is little awareness among carers of their entitlement to an assessment. In practice few carers receive services in their own right, but as a minimum, they should expect an annual discussion of their needs and details of the help that is available. Current national initiatives to reduce stigma and develop guidance for carers' support are therefore welcome.

I nearly killed my Mam, she was worried to death about me...she needed some help too.

It's quick to get in to rehab but you have to wait ages for detox.

When I finished my detox I had to wait three weeks for rehab...still in the same area, surrounded by the same people...all using, there should be somewhere to go in between.

- 56 These issues are parallel to those raised in the Audit Commission's report on those caring for older people (**Ref. 25**), but exacerbated by the stigma of drug use. As with older people, a clear and co-ordinated approach is needed if this is to change:
- identifying carers, or helping them to identify themselves, as early as possible;
 - involving carers who provide substantial and regular care in plans for those they care for; and
 - providing tailored carer assessments that skilfully identify needs and explore the options for providing support.

Seamless and flexible services

- 57 Treatment is now more widely available across England than in 2001. The total number of people having at least an initial assessment for structured treatment was 126,000 in 2003/04 as measured by a more robust process introduced in 2004 that identified some double-counting in earlier years. Allowing for this change, it is likely that 20 per cent more people started treatment in 2003/04 compared to 2001/02. The growth in capacity has been mainly in community services, for example, the number of:
- open access drugs services, providing advice and help about avoiding health risks;
 - pharmacies participating in local needle exchange schemes (although this is still less than one in five);
 - GPs offering treatment through shared-care schemes (increased from 20 to 31 per cent since 2001 in England (**Refs. 26 and 26a**)); and
 - structured daycare and structured counselling.
- 58 The capacity for treatment in prisons has also increased significantly and the Prison Service recognises the need to further improve the range, quality and continuity of integration with community treatment services. Outside prison, variable access exists to hospitalised detoxification and the variety of residential rehabilitation centres. In addition, capacity data about such services is not robust. The evidence supports the initial findings of recent reviews that:
- access to residential rehabilitation is frequently determined by delays in community care assessments or funding (**Ref. 27**);
 - there appears to be a national shortage of in-patient detoxification facilities, particularly outside large urban areas (**Refs. 27 and 27a**); and
 - where in-patient detoxification is provided in mental health units, drug users often wait longer because emergency admissions fill limited bed space (**Ref. 27**).

- 59 The most vulnerable young people, including those looked after by local authorities are at risk of turning to drugs when faced with a combination of other problems (**Ref. 29**). Support services that tackle a range of problems are the best setting in which to provide young people with help relating to drug misuse. The Health Advisory Service set out standards (**Ref. 28**), but in many areas local agencies do not know whether they are meeting them. Agencies are expected by the government to target the most vulnerable young people, to strengthen environmental factors that protect them against substance misuse, and to identify what interventions or treatment are needed. No recent figures for progress are yet available.
- 60 While relatively few young people need specialist treatment for drug misuse, when they do it should be through adolescent facilities, with flexible arrangements for transition to adult services (**Ref. 28**). Comparative information on the availability of these facilities is not currently available, but youth offending teams (YOTs) reported difficulties finding specialist help to which to refer young offenders (**Ref. 30**). Some progress is being made in realigning resources to address this. As noted by the NTA 'young people's treatment has traditionally been under-resourced and marginalised' (**Ref. 31**), so much work needs to be done by both government and local agencies.

People-focused services

You feel judged by staff.

- 61 Too many drug users start treatment, but fail to continue. It is crucial for treatment services to address the causes. Only 52 per cent of clients who were discharged in 2003/04 had remained in treatment for 12 weeks or more following triage assessment and 34 per cent of users leaving had dropped out of treatment after less than twelve weeks (**Ref. 32**). While some types of treatment are designed to last for less than 12 weeks, the figure for community-based treatments is only 54 per cent (**Ref. 32a**). There is a great variation between providers and localities, and research into reasons for this is being given priority by the government. While young people and offenders appear more likely to drop out of treatment, the type of drug used or the ethnicity of the drug user had little effect on retention (**Ref. 33**). Relapses are costly because drug users may re-present themselves for treatment several times before being successful. Improving fairly basic administration and customer care would be welcomed by users who cite a range of practical factors as barriers, including delayed letters, staff who miss appointments, distant or dilapidated premises, restricted opening hours and long waits at clinics.
- 62 Although many drug users value treatment services and find them welcoming and non-judgemental, drug users highlight the attitudes of staff as a main reason for not continuing with treatment (**Refs. 9 and 34**). It is crucial that the frontline staff who have first contact with a drug user, (including receptionists), are fully aware of and have the skill to respond effectively to their fear, uncertainty and low self esteem. Staff attitudes are known to impact on the actual quality of care delivered. The Scottish Executive highlighted staff attitudes as 'the cornerstone of therapeutic activity' (**Ref. 35**). The expansion of treatment has led to staff shortages and high turnover in some areas.

Drug users lack confidence in staff if they appear to be inexperienced or unable to meet complex needs (for example, of those using multiple drugs, or pregnant). It is also important that staff know how to give culturally sensitive care to black and minority ethnic drug users. Action to ensure that staff training is provided and put into practice should be a priority for those commissioning and managing treatment. It is also important that the NTA regularly updates the national workforce strategy to take account of more flexible forms of working, such as nurse prescribing.

- 63 While many local drug partnerships have had little contact with their workforce directorate of their strategic health authority and are therefore missing out on useful sources of expertise and funding, promising initiatives exist. For example:
- drug users are being trained alongside primary care staff on a Royal College of General Practitioners course, so that they can become peer mentors;
 - a voluntary organisation is training drug users to mentor frontline staff. Mentor and mentee then work jointly to change staff attitudes about drug users and to improve service quality in housing, job centres and citizen's advice bureaux (Ref. 19); and
 - a national carers' organisation is training carers to become peer educators in drugs awareness. The aim is to offer national volunteer accreditation and to build up a bank of trained carers for use by local services (Ref. 19).

Conclusion

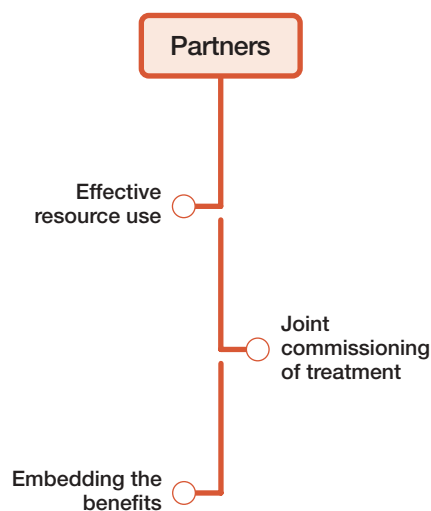
- 64 Drug users, their families and carers need ongoing support to sustain a commitment to their journey. Care planning is frequently ad hoc and should be a routine activity monitored by local drug partnerships in order to deliver the vision of integrated care envisaged in current national guidance.
- 65 Adult treatment capacity in England has grown significantly since 2001, but there are gaps in help for carers and for young people. Too many drug users drop out of treatment for avoidable reasons and the importance of staff attitudes to the success of treatment has yet to be fully recognised by local services. More training is needed to ensure that staff in the expanded services can gain users' confidence.
- 66 This chapter reviewed how drug users find the path for their recovery journeys. Chapter 4 examines how well local partnerships use their resources to build this path.

4



Finding the right path, the local partnership perspective

Local drug partnerships face the challenge of planning for long-term change with a complex pattern of often short-term funding. Most partnerships could make more effective use of the resources. There are some encouraging examples of treatment services that have been re-designed with the help of drug users and carers, but in many areas joint commissioning of drug treatment services has had little impact.



Janet has a headache as she leaves a meeting of the local drug partnership where its budget was discussed. Finance staff assure her that the budget is much simpler than last year's, but there are still pages of different funding streams with varying restrictions and priorities, and no overall picture of future commitments. Janet is doubtful that the total resources will match the strategic priorities that were finally agreed at last month's partnership away-day. What is also worrying are the weak connections with mainstream services, like social services and education.

Clearly, Janet and the partnership steering group face an urgent need to set yet more time aside to map the total provision and predicted expenditure against needs, if they are to get their heads round exactly how they will achieve their priorities. Janet knows that finding such time in everyone's diaries will be very hard, and so it's quite likely that they will run with things as they are.

Janet was shocked by the stories of disjointed services that she heard from users and carers at a workshop on drug-related deaths – underlined by the coroner tracing the reasons why a girl of 16 died alone in a squat after taking an overdose of drugs.

How can Janet harness the expertise of partners to tackle some of these issues?

- 67 Chapter 3 reviewed how problem drug users experience their recovery journeys. This chapter examines the effectiveness of local partnerships in ensuring that suitable recovery paths exist for drug users to follow by:
- effective use of resources;
 - effective commissioning of local drug treatment services; and
 - embedding the benefits of treatment in the long term.

Effective resource use

- 68 Local drug partnerships have access in 2004/05 to ring fenced government funds totalling £537 million in England and £15 million in Wales. Expenditure on treatment alone through mainstream funds of partner agencies is estimated at a further £200 million in England (Ref. 31) and £8 million in Wales. Funding will increase further – recent announcements include an increase of 18 per cent in the Substance Misuse Action Fund in Wales and of 52 per cent in the Pooled Treatment Budget in England. Many partnerships also draw down further funds from external sources, such as neighbourhood renewal, national lottery and the children's fund. The government, in response to recommendations in *Changing Habits* (Ref. 5) to put a stronger emphasis on long-term funding, has simplified matters by:
- rationalising drugs strategy funding streams, reducing the number of streams from 18 to 8 in England for 2004/05; and
 - committing over two-thirds of the funding in England and Wales for a three-year period through the adult pooled treatment budget and drug interventions programme.

Give us secure funding so we could plan over a longer timescale and be flexible with our budgets.

69 While this simplification is welcome, local drug partnerships are still uncertain about their funding position from year to year. The number of English local drug partnerships classed as 'intensive drug intervention programme' grows annually, changing plans and priorities. At best, local drug partnerships only know their full allocation of earmarked funding at the start of each financial year. Moreover, the government continues to give short notice of in-year funding. In contrast, other centrally set budget planning starts in the middle of the previous year, for example, the NHS local delivery plan or annual policing plan. Action by the government and the Welsh Assembly Government to further consolidate budget planning cycles across departments and between funding streams is essential to improve the local delivery of the national drugs strategy.

70 Concerted action to improve the efficiency of resource planning and use is equally needed by both local drug partnerships and mainstream services. Many local drug partnerships operate in isolation from mainstream services and in so doing rely too heavily on government funding. Consequently many local services are characterised by approaches that are narrow, separate from each other and short term, for example:

- the connection between reducing drug misuse to agencies' overall goals is unclear;
- work is seen as affordable only with additional government funding; and
- financial monitoring does not test how the increased total resource is used to leverage better outcomes and is not incorporated into mainstream services.

The biggest difficulty? The ability of agencies to sign up to targets, but fail to offer any resources.

71 Many local partnerships have yet to demonstrate, however, that they can manage their resource base effectively:

- in some areas, over 40 per cent of the 2003/04 adult pooled treatment budget remained unspent at the financial year end, with average under-spending for all partnerships being 11 per cent;
- few local drug partnerships and CYPPs have planned how to achieve local goals by using the flexibility provided by the merged young people's funding streams for 2004/05 onwards; and
- an ongoing review carried out by the Audit Commission in Wales is examining the difficulties that some LHBs have in identifying current spending on tackling substance misuse, which may hinder the transfer of responsibility and budgets to local CSPs.

72 Local agencies working should agree on:

- how reducing problem drug use supports the agreed vision for the area;
- service levels and associated performance targets, taking account of the cost of meeting them;
- the mainstream resources each partner agency has committed;

- how short-term government funding is used to:
 - achieve a more demanding level of performance than is usually set;
 - test options for improvement and to learn from experimentation; or
 - cover the costs of setting up or closing down projects and services.

- 73 The variation in local drug partnership spending raises doubt about value for money, which current performance measures do not address. Demographically similar areas vary considerably in the proportion of their budget spent on the main tiers of drug treatment; open access services such as needle exchange, community treatment by GPs or specialist services, and inpatient/residential treatment. Spending also varies within each treatment tier, for example, in the ratio between prescribing places and structured counselling places, or between the number of places for residential rehabilitation and inpatient detoxification respectively. Analysis of local treatment plans does not explain the investment imbalance.
- 74 For some partnerships further inefficient expenditure control is evident. An underlying cause is often short-term planning which is encouraged by short-term funding, for example:
- short-term or short-notice projects, which incur significant costs in setting up/closing down, and have design flaws arising from lack of time to consult local people;
 - community projects in the same area, drawing from the same funding stream, that are not in touch with each other (**Ref. 37**);
 - residential care placement decisions determined by a weekly cost limit, not the cost and value of a complete course; and
 - late payment of voluntary provider invoices, driving up administrative/banking costs and thus increasing prices or restricting services.

- 75 When local drug partnerships demonstrate more efficient resource use, a further consolidation of funding streams may be appropriate by governments, in order to maximise mainstream funding that contains strong incentives for achieving agreed outcomes. In the meantime, considerable improvement is required in the way that all local partnerships plan, spend and monitor their resources.

I am usually a 'can-do' person, but I feel overwhelmed by [both] the agenda and juggling complex relationships.

Effective commissioning of drug treatment

- 76 *Changing Habits* (**Ref. 5**) recommended clear arrangements for joint commissioning of drug treatment services. English drug partnerships now have joint commissioning groups. By NTA assessment (**Ref. 11**):
- only 25 per cent are making 'excellent progress' in joint commissioning;
 - 15 per cent are failing to make adequate progress; and

- 60 per cent are making progress – but only on some issues.

Joint commissioning in Wales is at an earlier development stage, for which similar data is unavailable.

- 77 The key factors that determine progress are the extent to which local agencies are:
- concentrating their efforts on making joint treatment commissioning a reality; and
 - engaging providers, users and carers in service design and performance monitoring.

Making joint commissioning a reality

- 78 While improvement to adult drug treatment commissioning in England has increased both access to treatment, less attention has been paid to:
- deciding how well the package of local services meets the needs of drug users and delivers long-term benefit;
 - deciding how best to use limited local resources to concentrate, in particular, on the drug users with the most chaotic lives; and
 - planning for success, making sure that for the growing number of drug users beginning treatment, sufficient capacity exists to maintain the journey.
- 79 Poor evidence frequently underpins many commissioning decisions taken by local drug partnerships:
- English local treatment plan data is inconsistent and ill-defined and does not enable benchmarking between partnerships;
 - Welsh substance misuse action plans do not contain any comparative data; and
 - a number of English and Welsh NHS trusts cannot identify the cost of drug treatment provision due to the wider problems of poor information systems and weak financial management (**Refs. 38 and 39**).
- 80 In addition, few joint commissioning groups have made time to:
- map the entire range of local services already commissioned;
 - challenge the effectiveness of current provision in the light of evidence; and
 - eliminate inefficiencies and ineffectiveness, for example, access restrictions, gaps and overlap between existing services.

The biggest achievement has been getting people into treatment quickly, and extending the range of treatment.

- 81 Nationally, the government and the NTA have published substantial research and guidance for commissioners of adult services. However the quality of all local treatment plan data needs swift improvement to enable comparison between similar areas. A current pan-government programme will produce much-needed guidance about commissioning young people's treatment services by March 2005. Responsibility for commissioning young people's services should be led by the local CYPP.

Relationships with providers, drug users and carers

- 82 Drug user and carer involvement in joint commissioning of services is poor among most local drug partnerships. Barriers to greater inclusion include resistance by some staff and inaccessibility, particularly in rural areas. Some partnerships have overcome such barriers and work co-operatively in commissioning treatment services with providers, users and carers (**Case study 5**).

Case study 5

Working together for improvement in Shropshire

Despite efforts by the DAT, in 2002 Shropshire had few GPs who were willing to treat drug users. Although the mental health trust's substance misuse service was generally good, waiting times for both community and in-patient treatment were long. Impetus for improvement came from:

- appointment by the DAT of an effective joint commissioning manager which increased the DAT's capacity to tackle problems;
- a challenge by the NTA, which compared local performance with that elsewhere; and
- pressure from users, carers and an MP in one part of Shropshire, who wanted drug treatment to be available locally.

A collaborative approach to finding a solution involved:

- listening to users, carers and clinicians;
- funding a carer group to provide local support and to reduce stigma;
- intervention by the PCT and mental health trust to:
 - increase the number of GPs taking part in shared care;
 - engage the help of GPs from other towns to help plug gaps in clinics; and
- assistance from the National Institute for Mental Health Excellence under the English Opening Doors programme to hold a meeting between GPs, staff and service users to agree improvements.

As a result of the action taken, waiting times improved and are now the best in the region. Moreover, the DAT learned from its success by subsequently bringing GPs, users and in-patient unit staff together to devise the plan to relocate the unit.

Source: Audit Commission

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- 83 Many relationships with providers are unsatisfactory, with about one in five local drug partnerships reporting a fraught relationship with the main NHS provider; usually a mental health trust in England (**Case study 6**). Senior health managers would benefit from better engagement with the joint commissioning groups of their local drug partnerships. Many psychiatrists specialising in addiction are frustrated with the way that their services are commissioned. The proposal for payment by results under the NHS improvement plan should spur NHS providers to agree expectations with commissioners (**Ref. 40**).

Case study 6

Problems with commissioning treatment services

Poorly drafted or non-existent service level agreements between DATs and NHS providers form an unsound foundation for treatment service provision. When ambiguity exists expectations are infrequently met, and disputes and problems swiftly follow, for example:

- pooling of drug treatment funding within a general NHS service pool leaving no audit trail to demonstrate on what the money was spent;
- using specific funding from three partnerships to provide an NHS psychiatric service across an area covering eight partnerships; and
- operating a different treatment philosophy to that specified by the drug partnership.

NTA intervention in such cases has improved services, though not without significant impact, for instance prompting re-definition and/or re-tendering of services in order to reduce waiting times.

Source: Audit Commission

-
- 84 Non-NHS providers have an equally vital role to play in providing local drug treatment and wider support services. However:
- few local drug partnerships have a framework to harness expertise and build trust with non-NHS providers, while ensuring probity in resourcing decisions;
 - some contracts for treatment services are let on timescales or terms that providers say do not allow for investment in staff development or quality assurance; and
 - some commissioning decisions are insufficiently substantiated, which can lead to acrimony in competitive tendering.

We have significant difficulty in recruiting competent and knowledgeable staff especially to the DAT.

We need to allow time to recruit the right staff and time to train them. There is always pressure to deliver immediate results.

- 85 The expansion of treatment services since 2002 is partly responsible for these circumstances. Commissioners and providers all draw on a limited pool of people with relevant knowledge and change management skill. The number of people working in the drug treatment sector has grown by 36 per cent since March 2002, exceeding by the end of 2003 the 2008 target of 9,000. Senior managers report that the lack of trained staff remains a key barrier to tackling drug misuse (Ref. 15). Training supported by the NTA is improving the situation, but senior managers responsible for local drug partnerships and treatment provision need to ensure that staff involved in commissioning are both skilled and supported.

Embedding the benefits of treatment

- 86 Lasting community benefit depends on lasting outcomes for individual users; if more people pass successfully through treatment, more support will be required in terms of housing, money management, working skills and employment. Creating such follow-on capacity is challenging for local drug partnerships. Housing is an acute example of this. One in ten drug users starting treatment has no fixed address (Ref. 32a). Accommodation is a significant factor in helping people to stop offending. In many areas access to housing is difficult due to market pressures and drug users gain little public sympathy, for example, the majority of rough sleepers are problem drug users (Ref. 41). Action to improve access to housing can be successfully taken (Case study 7).

Case study 7

Improving joint work on housing in Liverpool and in Reading

Liverpool drug and alcohol team (DAAT) commissioned research to identify gaps in the current provision of accommodation and support for substance misusers in the city. The research recommendations are being used to develop a joint strategy between the DAAT and the supporting people commissioning body. This collaborative approach to commissioning services is expected to have a significant impact on the future provision of accommodation and support services for substance misusers in Liverpool and to help address problems identified in a recent inspection.

Drug dealers selling crack cocaine in Reading exploited local drug users to take control of their homes. Reading Borough Council's housing department and Thames Valley Police established a protocol for a rapid reaction to such abuse of tenants' homes. The aim of the protocol is that tenants may report drug-related activity without fear of reprisal and that drug dealers are arrested more quickly. The protocol, modelled on that in use by other councils, recognises that drug using tenants may be vulnerable and not the main source of illegal activity, in which case they are offered drug or alcohol treatment and alternative housing.

Source: Audit Commission

87 Only one in five local drug partnerships reported that they had made good progress in making supported housing available (**Ref. 11**). Many areas are only now starting to quantify the level of need. Recent government guidance suggests that one in three drug users presenting for treatment is in housing need, and some local research has found even higher rates of need (**Ref. 39a**). Partnership senior managers reported that local authority housing departments are less engaged and effective in tackling drug misuse than education or social services. Local authority housing policies frequently exclude drug users from priority housing unless the drug user can prove that they are vulnerable under the terms of the policy. The government's supporting people fund covers such instances, and while the fund will not cover accommodation costs, it can help vulnerable people to locate and sustain a tenancy. Inspection of supporting people partnerships by the Audit Commission paints a mixed picture, with some areas providing effective services that benefit drug users, and little provision in others. Planning through the local partnerships that are responsible for reducing drug misuse, supporting people and local authority housing services should ensure that accommodation is available to drug users, during and at the end of their recovery journey.

Conclusion

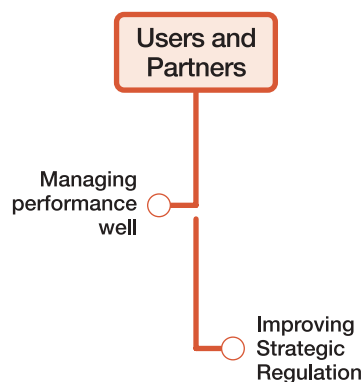
- 88 Many partnerships have yet to demonstrate effective use and management of resources. There are examples of inefficient financial planning, especially in relation to the use of short-term funding. All local partnerships need to do more to make sure that effective use is being made of resources, that local stakeholders are involved and that planning includes improved follow on services.
- 89 Although national research exists into 'what works', there is little evidence locally of commissioning decisions being based on proven effectiveness and value for money. While some local drug partnerships are making excellent progress in working with providers, users and carers to redesign and improve treatment services, many are struggling. Senior managers responsible for local drug partnerships need to take stock of existing treatment provision and judge its fitness for purpose against current and projected demand, using nationally available research to inform their assessments.
- 90 Local drug partnerships have substantial ground to cover to improve the provision of follow-on services so that the needs of drug users and their care plans are met. Too often the approach to treating drug misuse is to 'see the drugs' and 'ignore the person'.
- 91 This chapter reviewed how well local drug partnerships ensure that suitable paths exist for drug users to follow. Chapter 5 examines how drug users arrive at a point where they are no longer a risk to themselves or others and how agencies are held accountable for making this possible.

5



Maintaining progress

Drug users need a safe destination at the end of their recovery journey, including help to find a home and a job. Local leaders responsible for housing, social care and other support services must provide drug users with follow-on services to help them become self-sufficient. Local drug partnerships need to check their progress through local and national lines of accountability. Strategic Regulation would help to improve accountability and to reduce bureaucracy.



Greg and Tracey are feeling optimistic. Greg's key worker helped with the forms and telephone calls so that Greg and Tracey could move into a council flat a few weeks before the baby is born. With the help of her midwife, Tracey is confident that she can keep this baby because attitudes have changed since the birth of her younger children. Greg has enrolled on a building course at the further education college and is being paid an allowance. Greg thinks he and Tracey will have enough to live on.

Pat too feels that she has turned a corner. She rang the helpline and was given information about support that she didn't know existed. Pat may be eligible to receive benefits to help with the cost of caring for the two children. Pat is also going to see a social worker about respite care for her during the school holidays. When Tracey brings the baby over to Pat's, they all feel safer when the children play in the local park, the new council waste bins mean less discarded needles and other rubbish.

Will Tracey, Pat and Greg's expectations be met in the long term?

Janet is feeling better about the partnership. After spending a very satisfying day at a conference with service providers, users and carers, which was facilitated by regional GODT and NTA staff, Janet thinks that she has, at last, formed an agreement on a way forward to meet everyone's priorities. She was surprised at some of the users' suggestions, as they will cost little to implement and could be achieved very quickly.

It was also encouraging to see managers, doctors, police and users at the same table, sleeves rolled up, willing to listen – and more importantly fired up to go back and do something!

Janet is also looking forward to next week's launch of the children and young people's strategy for the area, confident that it now includes action to prevent young people from becoming drug users.

Who will hold Janet accountable for delivering what has been agreed?

Can the local agencies learn from this experience?

Sometimes you need some respite further down the line, it's really difficult to get this, lots of people relapse then.

- 92 Chapter 4 reviewed the extent to which local drug partnerships ensure that suitable local pathways exist for problem drug users to follow on their recovery journeys. This chapter examines how both users and partners maintain the progress achieved through their recovery journeys.
- 93 Continuing the journey with drug users and their carers beyond treatment programmes is a challenge for public services. All the necessary follow-on support for the drug user to maintain a stable life needs to be available from the moment treatment ends or reduces in intensity. *Changing Habits (Ref. 5)* recommended improvement in this area especially for ex-prisoners and those with complex, continuing problems. Recovering drug users have to overcome social exclusion

It is easy to be strong when you are in the clinic, but after you leave...it is really tough...

Aftercare is left until the last minute and sometimes it just can't be sorted out in time...Key workers need to be more involved.

Recovery does not end when you finish treatment...It's only the beginning.

I attend a skills training programme, I love it because it really helps me build my confidence.

barriers similar to those faced by people with mental health problems (**Ref. 41a**). The English *Models of Care* guidance recognises that aftercare is crucial, but this emphasis was lost in the drive to increase treatment capacity. At the start of 2004, only 24 per cent of English local drug partnerships said that they had made good progress in developing aftercare services (**Ref. 11**).

- 94 The drug interventions programme places an emphasis on end-to-end care as a success criterion. CJITs, once fully operational, may provide drug users with better care management, but only if:
- they start their journey from within the CJS; and
 - the support is actually available after they complete their sentence.

It is currently unclear whether CJIT activity will improve aftercare services for all drug users or just for those in the CJS.

- 95 Failure to encourage drug users to continue their journey may result in relapse, drug misuse and re-offending. Drug users place a high value on such follow-on help, particularly with housing, employment, education and training (**Case study 8**), with good practice that includes:
- key workers who plan aftercare from the beginning and who follow up drug users after they have left treatment;
 - access to employment and skills training programmes;
 - access to local drug user support groups; and
 - access to specialist housing advice and post-treatment supported housing.

Case study 8

Staying on the pathway

A recovering, long-term heroin user in a rural area where housing and jobs are scarce had a short-lived lapse into drug misuse after a domestic crisis. A local faith group, a progress2work caseworker (run by JobCentre Plus) and access to supported accommodation helped him to recover from the relapse. He now recommends the progress2work scheme to other users, while being in full-time work, a stable relationship and his own home.

A heroin addict was 'clean' on his release from prison and helped to run a group tackling drug misuse by local young offenders. He lived 'where he could' after losing his tenancy as a result of substantial rent arrears accrued while he was in prison. He declined supported accommodation by a local homeless hostel because he did not wish to jeopardise his recovery by exposure to drug dealing. After changes were then made to the local council's housing allocations policy, he was offered a fresh tenancy.

Source: Audit Commission

The biggest difficulty is responding to the ever-changing and growing expectations of the government.

Managing performance well

- 96** *Changing Habits (Ref. 5)* recommended better government co-ordination on drug treatment policy and development of a national performance management framework. Considerable pan-government working is now happening led by the Home Office, but performance management of local drug partnerships is still in its infancy. The benefit that local communities have gained from the £600 million additional investment in drug treatment since 2002 cannot yet be quantified nationally or compared between areas. No satisfactory outcome measures usable at local level have yet been agreed. A recently announced Drugs Harm Index is initially only at a national level (**Ref. 42**).
- 97** The requirement for monitoring information from English local drug partnerships is now less onerous and will be mainly gathered from standard returns by mainstream services. The reduced set of 16 performance indicators comprises activity/output measures that are only indirect measures of outcomes. The English drugs performance management framework (PMF) is welcome. It aims to shift performance monitoring activity to local drug partnerships through locally agreed targets with GODTs (**Ref. 43**). An equivalent framework for Wales is being developed during 2004 (**Ref. 45**). It is too early to judge how the PMF will work in practice, but success will require:
- consistent and workable performance indicator definitions;
 - individual agency targets that match those set nationally;
 - a small set of performance indicators, with an outcome focus;
 - accurate collection and sharing of information;
 - consistent and transparent assessment of partnership performance;
 - support from GODT staff with skills and knowledge for their new role;
 - involvement from partnerships and other local stakeholders in adapting the framework in future;
 - accountability for performance that sits with the governing bodies of local partnership agencies; and
 - a strategic regulatory framework that has the PMF at its core.
- 98** While 74 per cent of senior partnership managers said that they report to their own organisations at least quarterly on the work of the local drug partnership, 7 per cent do not. Senior managers in a minority of local drug partnerships reported poor performance or lack of engagement by a key partner. Locally elected/appointed members and senior managers responsible for local drug partnerships need to ensure that local arrangements are effective in identifying problems, and that scrutiny of unresolved issues is escalated to a point where sufficient authority exists for a decision or solution to occur (**Case study 9**). From the hard won progress to date, those involved in local drug partnerships have gained significant experience, which should be reused to further improve services.

*Partners have to realise that the DAT is **them**, and not some other external body!*

NTA regional staff are excellent. They give us a hard time, but we appreciate them because they make you perform well.

Case study 9

Action to improve poor performance

Two poorly performing local drug partnerships were helped to improve when a chief executive took the chair (a local authority in one case and a PCT in the other). In each instance, the chief executive recognised that current arrangements were not working well and acted to improve the situation by:

- using personal influence and authority to engage the leaders of other agencies and to challenge unsatisfactory providers;
- cutting through the complexity and professional jargon to apply basic performance management principles to the partnership; and
- acting to improve the capacity and competence of joint commissioning staff.

Source: Audit Commission

- 99 Elected and appointed members of partner agencies have an important role to play in ensuring that local drug partnerships are held to account. Firstly, in seeking the views of people directly affected by problem drug use and assessing whether outcomes are improving. Secondly, in responding to the results of internal and external progress assessment, by seeking assurance that improvement opportunities are pursued and to scrutinise unresolved problems.

Improving strategic regulation

- 100 English local drug partnership performance is monitored jointly by regional NTA and GODT staff. While 64 per cent of senior managers across England and Wales said that 'disproportionate scrutiny of plans and performance' is a barrier, they voiced a positive opinion of national and regional monitoring overall, especially by the Welsh Assembly Government. Drugs partnerships in England have found the oversight arrangements confusing. A recent government review (**Ref. 44**) gives the opportunity to realign regional roles. Any change in arrangements will need to take account of:
- strategic health authority oversight of PCTs and mental health trusts;
 - local criminal justice board oversight of delivery of targets to narrow the justice gap and to increase public confidence;
 - shared responsibility between local authorities, police and the national offender management service for young offenders; and
 - the need to cross the boundary between health and criminal justice perspectives on tackling drug misuse – a key strength of the NTA.

We deal with the bureaucracy but have limited time for the issues, the process is too micro-managed.

There is a clash over joint accountability. This is because of the differing philosophy of individual agencies and how they are evaluated or inspected.

We seem to be treating targets, not people.

We have a programme of projects, which includes housing, to meet drug-related offenders as they come out of prison. We get them into a house and a job, and hopefully they will stay out of trouble.

- 101 A range of inspectorates assess the work of individual partnership agencies. While these inspectorates review action to reduce drug misuse, it is frequently only a single aspect (**Ref. 22**), or as a minor part of a broader review (**Ref. 20**). The joint work between the NTA and the Healthcare Commission to pilot an inspection of treatment services by area is promising. It offers an opportunity to test the effectiveness of both commissioning and service quality. An aim of the PMF, also relevant if widened to cover CDRPs, is to act where partnership performance is poor. In such cases, the performance of one or more of the partner agencies is often of concern to other inspectorates. To deliver the benefit of better, more strategic regulation, a joint area-based approach based on the PMF should be the basis on which all regulators operate in future.

Conclusion

- 102 Access to follow-on services is a vital part of the journey for drug users and carers, with current provision being of highly variable extent and quality. The developing CJITs should help, but are directed to drug users within the CJS only. Locally elected/appointed members need to ensure that public services make the same provision for drug users as for other vulnerable people.
- 103 Performance management arrangements are now more streamlined and form the basis for a more constructive relationship between governments and local drug partnerships. Work to improve the outcome focus of performance indicators remains necessary. This should be carried out with a view to using the PMF as a basis for Strategic Regulation.
- 104 All regulators should systematically share information and learning from their oversight of the partner agencies. Agreement on a shared view of the risks relating to local effectiveness in tackling drug misuse is required. Much learning has taken place since *Changing Habits* (**Ref. 5**) reported in 2002 and opportunities now exist to share and use this learning locally, regionally and nationally.
- 105 This chapter reviewed how local agencies ensure an outcome from helping drug users and how better, more strategic regulation would further improve performance. Chapter 6 describes the way forward and makes recommendations to local agencies, as well as government and regulators.

6



The way forward

People, working together, make a difference – to individual users on their recovery journey, and to local drug partnerships in bringing improvement to communities. People providing services must make sure that they focus on the needs of the whole person and not just the drug problem. We suggest a way forward that would improve both performance and outcomes.

106 Chapter 5 drew to a close the two journeys – that of the problem drug user and that of the local authority, health and criminal justice services. This chapter describes the way forward for local drug partnerships, government and regulatory agencies.

Recognising that people make the difference

107 On the journeys described in this report, progress is not smooth in tackling problem drug use; it can move in fits and starts, accelerate, and even reverse. However, throughout the journey, while processes and systems are necessary, the behaviour of the people engaged with the local drug partnership proves to be more important (Figure 5).

Figure 5
People make the difference



Source: Audit Commission

108 Achieving success or failure depends on how people work together and the way that they interact. Staff attitudes make a considerable difference to the way that drug users perceive a service and to whether they value it sufficiently to continue with treatment. Good leaders can improve failing partnerships. Effective, inter-agency teamwork makes services appear seamless to the user. Harnessing the experience of drug users and carers provides a key body of knowledge. Common characteristics of effective people are their:

- commitment – to achieving change despite difficulties;
- competence – knowing what to do and being capable of doing it;
- capacity – access to resources, including time; and
- co-operation – with others to a common end.

- 109 Improvement takes time and gets easier as trust grows between the people involved (**Figure 6**). Locally elected and appointed members, together with senior managers responsible for local drug partnerships, should respond to the following recommendations to improve local performance. Appendix 5 contains a set of key questions to enable discussion about key issues between local partnership agencies.

Figure 6
Improvement happens when people who...

	...are directly affected by drug misuse (users and carers).	...lead local public services (as officers or elected/appointed members).	...work with problem drug users, in treatment, other public services and the wider community.	...commission services to help people out of problem drug use.	...regulate, monitor or advise the agencies in drugs partnerships.
	Want to complete the journey to heal the damage to the community from drug misuse, and so...				
Commitment	Sustain difficult personal changes.	Share a vision for the area, and allocate appropriate resources.	Treat drug users and their carers with value.	Inspire agreement on how to improve outcomes.	Support improvement and remove barriers to it.
Competence	Know where to find help and are able to get to it.	Give direction and oversight to commissioners.	Know what their role is and train to fulfil it.	Examine overall use of resources.	Challenge with the right questions at the right time.
Capacity	Are involved in designing solutions.	Give personal attention to the big issues.	Respond to needs in good time.	Find information, guidance and sustainable funds.	Apply skilled help where most needed.
Co-operation	Design and implement solutions together at all levels and across agencies.				

Source: Audit Commission

- 110 Delivering local substance misuse services is a complex issue. Delivery involves the CJS, social care, health and housing services. The wall chart accompanying this report describes how all local services have a role in reducing drug misuse. Local drug partnerships should map their provision against that contained in the wall chart in order to identify gaps and to plan improvements.
- 111 Tackling drug misuse needs many different agencies to work together coherently and to tailor services to individual drug users if intervention is to deliver results. It is time to treat the person, not the 'drug problem'. The local crime and disorder strategies for 2005-08 offer an excellent opportunity for local agencies to sign up to strategies that, when implemented through partnerships, will provide drug users with an effective pathway to recovery and good prospects for a sustained and stable lifestyle. This in turn will help to make communities safer for everyone.

Recommendations

To government and national bodies:

To improve user focus

By April 2005, the Home Office and the Welsh Assembly Government should put in place a strategy for user and carer involvement that delivers:

- a system for incorporating user and carer views into the development of national policy;
- effective national and regional structures which involve users and carers in planning and performance management; and
- easy access to the wealth of advice on community and user engagement, and opportunities for peer support.

To provide 'follow-on' services enabling users to complete the journey to recovery

In the planned update of *Models of Care* and the development of treatment standards for Wales, emphasise the importance of 'follow-on' services particularly access to housing and employment.

To reduce reliance on short-term funding streams, encouraging mainstream solutions

The Home Office and Welsh Assembly Government should take further steps to reduce the reliance of drug partnerships on short-term funding through:

- allocating time limited funds for a minimum of three years at local as well as national level;
- announcing new initiatives to a timescale that fits the main planning cycles of local partner agencies; and
- moving towards integration of funding for the drugs strategy with mainstream budgets.

To develop Strategic Regulation

By October 2005 have made the drugs performance management framework a sound basis for better, more Strategic Regulation. This should

see regulators placing a focus on the whole pathway to recovery, focusing on effective use of resources and making links with the existing inspection of mainstream services. This requires

- performance indicators that focus on effective care planning and aftercare outcomes;
- national and local systems which provide high standards of data quality, comparison and sharing;
- planning ahead for best use of increased funding;
- rationalised, more strategic external review arrangements for local partnerships;
- regulators to share information and risk assessments about local drug partnerships; and
- improved capacity of GODTs to provide appropriate and timely support to local partnerships with poor or weakening performance.

To local government, health and criminal justice services providing mainstream services and working in partnership:

To improve user focus

By April 2005, with users, carers and their advocates, develop a user and carer involvement strategy linked to partners' wider community engagement initiatives. Review progress against this annually, including measures of satisfaction with services and care plans.

By April 2005 ensure that up-to-date information about all local services is easily available for problem drug users, their families and frontline staff who advise them.

When commissioning treatment services set contractual conditions that ensure that providers' staff not only meet the relevant occupational standards, but also have a high-quality, user-focused approach. Partnerships should build regular reviews of service standards into their performance monitoring process.

By April 2005 ensure that action to reduce substance misuse is core work for children and young people's partnerships (CYPPs) by :

- setting clear arrangements by which CYPP targets to reduce substance misuse by children and young people mirror those contained in crime and disorder reduction strategies; and
- taking stock of progress to implement the Substance of Young Needs framework, identifying gaps, allocating resources and prioritising action and responsibilities accordingly.

To provide 'follow-on' services enabling users to complete the journey to recovery

By April 2005 ensure that all users receiving treatment have a care plan that covers 'follow-on' services, such as housing, training or family support which will enable them to maintain stability gained in treatment. Inter-agency planning should anticipate the level of services required.

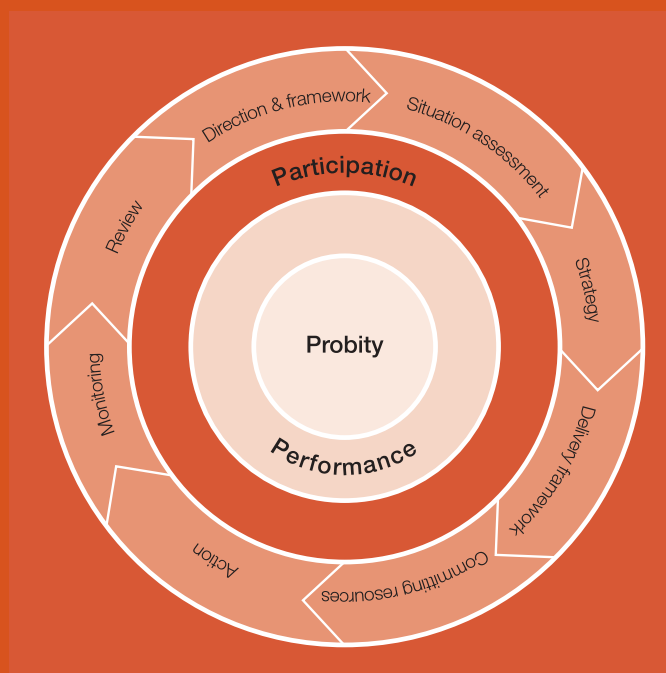
To improve use of resources and to target long-term funding

Local drug partnerships should review their arrangements to:

- determine the effectiveness of strategy and delivery plans;
- identify barriers to progress;
- assess their capacity to improve the use of resources; and
- improve performance.

The Audit Commission approach which has been delivered successfully as part of the annual use of resources audit across a range of partnerships is based on the model set out below (**Figure 7**).

Figure 7
The partnership wheel



Local drug partnerships should make effective use of resources a cornerstone of the local drug strategy through:

- setting local outcome-focused targets for reducing the impact of drug misuse on the community;
- earmarking sufficient resources to achieve these objectives through the 2005/08 crime and disorder/drugs strategy; and
- setting a principle for the effective use of short-term funding to produce additional long-term gains.

Local drug partnerships should ensure that their accounting systems provide accurate and comprehensive assessments of financial performance each month as part of local scrutiny and performance management processes.

Local drug partnerships should ensure that their arrangements for bidding for short-term funding mean that new initiatives are only pursued where there is a clear fit with the partnership's service delivery plan.

Local drug partnerships should ensure that all services they commission provide good value for money, including drug treatment and support services. Regular checks by local drug partnerships to monitor on going value for money performance should include:

- comparison with other partnerships on the volume and cost of services;
- the fitness of services in meeting the need of:
 - drug users and their carers,
 - minority or vulnerable groups and those not yet accessing services;
 - treatment of multiple substance misuse;
 - aftercare provision; and
- the efficiency and effectiveness of the overall local service package.

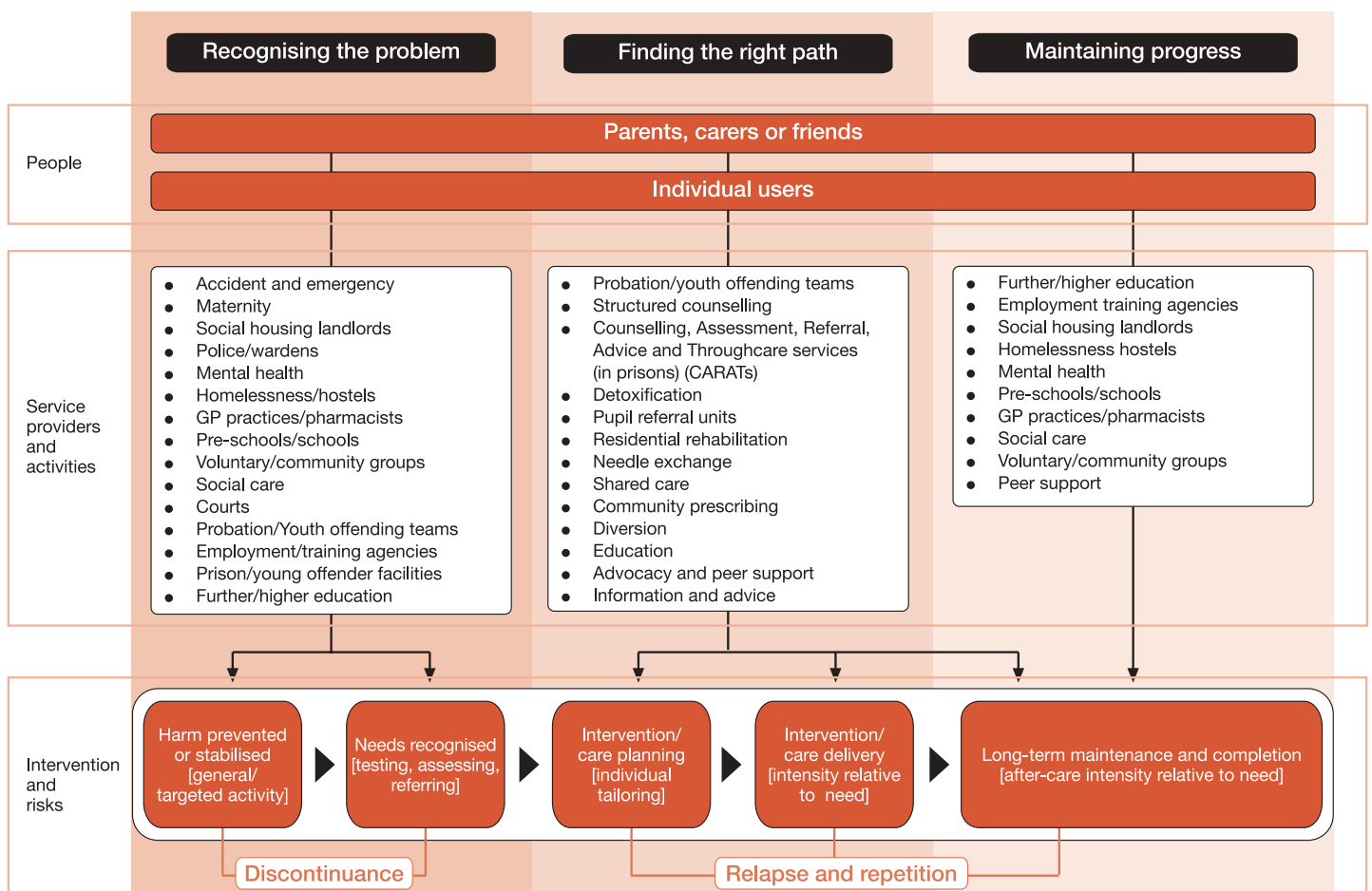
Appendix 1

Figure 1 data sources

Measure	England & Wales estimate	Source	Online link/notes
People who think drug use or dealing is a (fairly big or very big) problem in their area	25%	Dodd T, Nicholas S, Povey D, Walker A, <i>Crime in England and Wales 2003/2004</i> , The Home Office, 2004.	www.homeoffice.gov.uk/rds/crimeew0304.html
Number of crimes of burglary, robbery or theft in a year.	3,362,531 (2002/03)	See above	See above
Number of problem drug users	0.6%	Frischer M, Heatlie H, Hickman M, Estimating the prevalence of problematic and injecting drug use for Drug Action Team areas in England: a feasibility study using the Multiple Indicator Method: Online report 34/04, The Home Office, 2004.	www.homeoffice.gov.uk/rds/pdfs04/rdsolr3404.pdf Note: There is a range of estimates of the number of problem drug users, depending on the definition used and assumptions made.
Proportion of problem drug users who are male	73%	Bellis M et al (ed), United Kingdom Drug Situation. Annual Report to the Europe Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Europe Monitoring Centre for Drugs and Drug Addiction, 2002.	www.cph.org.uk/cph_pubs/reports/SM/focal%20point%202002.pdf This source is a useful summary that provides references to other sources.
Number of children whose parents have a drug problem	250,000 of whom 57% are living apart from their parents/carers.	Hidden Harm (Ref. 23).	www.drugs.gov.uk/ReportsandPublications/NationalStrategy/1054733801/hidden_harm.pdf This is the mid-point estimate.
Prison numbers	130,000 offenders, of whom 70,000 are problem drug users	Drug Strategy Unit, HM Prison Service, 2004.	Unpublished estimates for 2003/04
Number of truants Number of truants using Class A drugs	1,000,000 120,000	Godfrey C, Eaton G, McDougall C, Culyer A, Home Office Research Study 249: The economic and social costs of Class A drug use in England and Wales, The Home Office, 2002.	www.homeoffice.gov.uk/rds/pdfs2/hors249.pdf
Number of young people aged 16 to 24 who have used a class A drug in the past year	9% of age group	Aust R, Sharp C, Goulden C, <i>Findings 182: Prevalence of drug use: key findings from the 2001/2002 British Crime Survey</i> , The Home Office, 2004	www.homeoffice.gov.uk/rds/pdfs2/r182.pdf
Number of pupils aged 11-15 who have used a class A drug in the past year	4% (England)	Department of Health, Drug use, smoking and drinking among young people in England in 2003 Headline Figures National Centre for Social Research/National Foundation for Educational Research, Department of Health, 2004.	www.dh.gov.uk/assetRoot/04/07/96/61/04079661.pdf
Number of people charge with unlawful possession of controlled drugs (class A)	18,100 (UK)	Ahmed M, Mwenda L, Drug Seizure and Offender Statistics UK 2001 & 2002, Home Office, 2004.	www.homeoffice.gov.uk/rds/pdfs04/hosb0804.pdf
Number of drug-related deaths	1,565	Office for National Statistics, Health Statistics Quarterly 21, Spring 2004, page 63, Office for National Statistics, 2004.	www.statistics.gov.uk/downloads/theme_health/H_SQ21.pdf
Number of reported anti-social behaviour incidents classed as drug/substance misuse or drug dealing.	2,920 in one day	Home Office, The One Day Count of Anti-Social Behaviour, 2003, Home Office, 2003.	www.homeoffice.gov.uk/docs2/ASB_Day_Count_Summary.pdf While the value in Figure 1 may include other forms of substance misuse, drinking alcohol in the street or disorderly behaviour are excluded.

Appendix 2

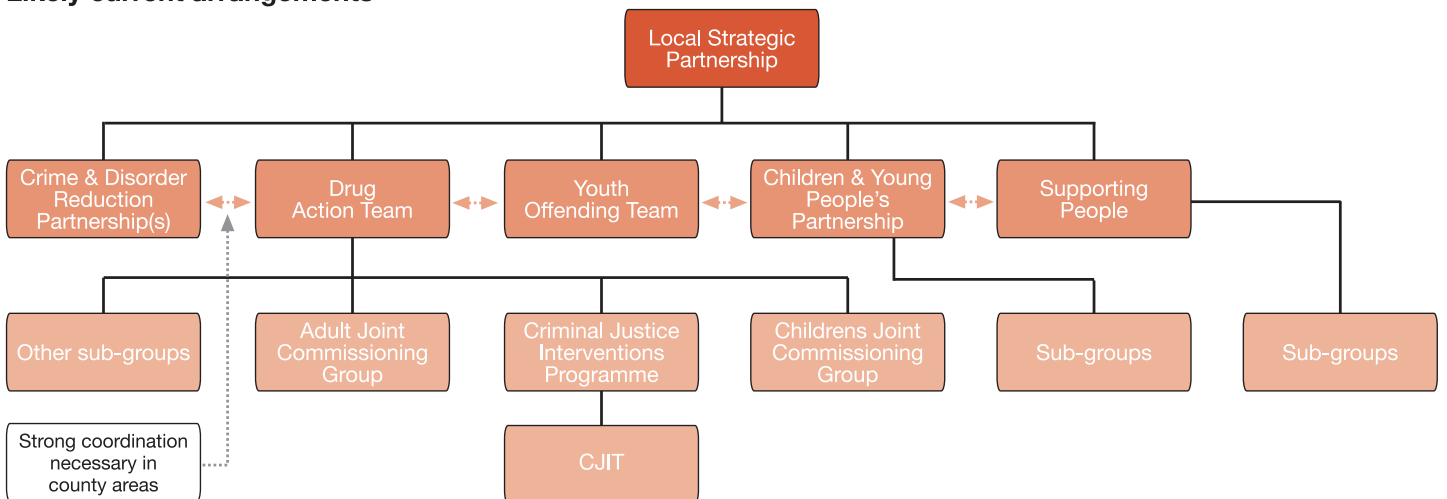
Each drug user's recovery journey involves a wide variety of local services



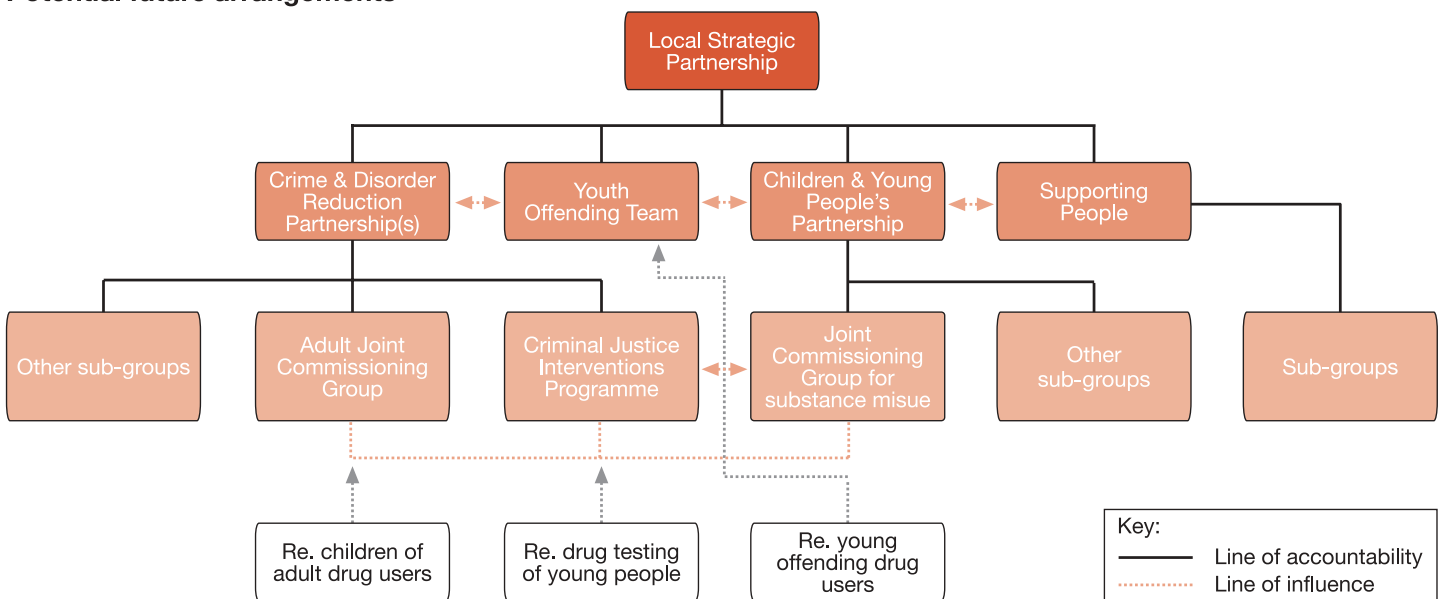
Appendix 3

Creating effective links between local drugs partnerships and CYPPs

Likely current arrangements



Potential future arrangements



Appendix 4

Study methodology

The evidence used to prepare this report is drawn from national, regional and local sources between September 2003 and September 2004 including:

- An analysis of the 2004/05 treatment plans from the 149 English DATs and 2004/05 substance misuse action plans from the 22 Welsh community safety partnerships.
- Visits by the Audit Commission team to eight local drug partnerships and their associated agencies in rural and urban areas in England and Wales.
- Observation of local drug partnership performance reviews in four government office regions in England.
- Meetings with drug user and carer organisations, and focus groups of 49 drug users currently in treatment (**Ref. 6**).
- A survey of 180 senior managers in local government, police and English primary care trusts/Welsh local health boards (**Ref. 15**).
- A review of current literature.
- Interviews of national and regional government staff and national agency representatives.

Research was carried out by Kit Harbottle, Susan Bennett and Sean Quiggin of the Audit Commission, with assistance from Andy Bruce, Anne Chisholm and Kim Vuong. The project was delivered under the direction of Sharon Gernon-Booth.

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Fieldwork sites

Ceredigion CSP
Devon DAT
Liverpool DAT
Manchester DAT
Newport CSP
Reading DAT
Shropshire DAT
Waltham Forest DAT
Wrexham CSP

Members of the advisory group

Alfred Hitchcock	Metropolitan Police Service
Bill Nelles	The Methadone Alliance
David Truscott	The Home Office
Dominic Ford	Healthcare Commission
Glen Goucol	Dorset County Council
Hazel Watson	Avon, Gloucestershire and Wiltshire Strategic Health Authority
Ian Robinson	EATA
Karen Eveleigh	Welsh Assembly Government
Paul Hayes	NTA
Peter Nash	LB Merton
Peter McDermott	NTA
Susan Finn	NTA, West Midlands Region
Victor Hogg	The Home Office
Vivienne Evans	AdFam

Appendix 5: Key questions for discussion by local drug partnerships

Key questions for senior managers

- Do you know what most concerns local people about drug misuse and how well they think you are addressing this?
- Does the public and your staff understand why and how local services are helping problem drug users?
- Are local mainstream services fulfilling their role in preventing drug misuse and helping drug users and their carers effectively?
- If you run drug treatment services, do they provide value for money within the overall pattern of local treatment?
- Is it getting easier for young people to get help to avoid or recover from substance misuse? And for children of drug users to get the help that they need?
- Do other partners speak highly of your organisation's contribution to reducing drug misuse?
- Are you funding your drugs strategy through mainstream budgets? Or are you reliant on short-term funds?
- Does your management team and governing body know how well the local drug partnership is performing and what your organisation should do to improve performance?
- Does the work of the local drug partnership knit well with that of other local partnerships?
- Are you working constructively with regulators to identify ways to further reduce the local impact of problem drug use?

Key questions for people who commission services for problem drug users and their carers

- Do you know if the impact of problem drug use on local communities is changing? How much more will you know this time next year?
- Are you making best use of national sources of expertise, evidence of what works, and benchmarking with other partnerships?

- Are the actions explicit within local plans for children and young people to prevent problem drug use and to provide interventions for those who need it?
- Can you point to decisions you have made that drug users and carers have influenced? Would they give the same answer?
- Are you confident that the services you commission meet the needs of minority groups, the most vulnerable drug users, and their carers?
- Are the reasons soundly evidenced to justify the split of spending between different aspects of adult treatment in your treatment plan/substance misuse action plan?
- Do you have a fair and transparent way of enabling all service providers to contribute to the planning process?
- Will sufficient services be in place to give drug users now starting a recovery journey the support they need right to the end of it?
- Are you clear to whom you are accountable for achieving performance targets, and are they giving you the right support and challenge?
- How do you hold partner agencies accountable for actions they have agreed?

Key questions for managers to ask people who work with problem drug users and their carers

In mainstream services

- How well are you able to direct drug users or their carers to local sources of help?
- When your work involves a drug user in treatment or their carer, are you clear who else is involved and what you need to do to help make treatment effective?
- Are drug users and their carers treated by your service with the same courtesy and respect as other members of the general public?

In services for young people

- Are you clear about what part your organisation plays in preventing drug misuse by young people?
- Does the information given by all local agencies to young people give them a clear and consistent message about drug misuse?
- Can you tell when a young person needs more specialist help with the consequences of their own or a parent's drug use and do you know how to ensure that they get it?

In drug treatment services

- How well do you keep up to date in your field and develop your skills to meet the changing expectations of both your service and service users?
- How do you know whether users or carers, including those from ethnic minority communities, recommend your service to others?
- How much of your work forms part of a pathway of integrated care that you understand and can influence?
- How do you know whether your service is producing better outcomes for those who use it, including those with the most complex needs, than it was a year ago? How much better will it be next year?

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