HM Government

DRUGS: OUR COMMUNITY, YOUR SAY

A CONSULTATION PAPER

July 2007

Contents

Foreword

Illegal drugs cause damage and ruin to individuals, families and communities. And the most vulnerable and deprived among us are often the hardest hit. For individuals, drug misuse means wasted potential, broken relationships and, for some, a life of crime to feed their drug habit. For the wider community, our efforts to lift children out of poverty, promote equality of opportunity and reduce crime are held back when families and communities are in the grip of drug use.

The commitment of this Government to address this complex and wide-ranging problem is unstinting. We remain resolute in our determination to put drug dealers out of business, educate our young people so they can resist drugs, provide effective drug treatment, restore a sense of hope and purpose to the lives of drug users and relieve our communities from the consequences of drugs.

Over the last decade unparalleled levels of funding have seen us make significant inroads. The number of drug users in treatment has more than doubled, with almost 80 per cent remaining in treatment for more than 12 weeks. Drug-related crime has fallen by 20 per cent, and new and innovative powers such as crack house closures and asset seizures have been developed and are working. We have created credible information for young people and parents about the dangers of drugs, which is now widely used and trusted. The use of Class A drugs is now stable among young people with significant falls in the use of other drugs.

We should draw much confidence from this progress. Together, we have proven that we can reduce the harm caused by drugs. We have moved on from a polarised debate and single approaches to a balanced strategy focused on outcomes, based on evidence and delivered through partnership. Government must also remain responsive – alive to new evidence, feedback and trends. This is why we are asking the Advisory Council on the Misuse of Drugs to look again at the classification of cannabis.

The original drug strategy was published in 1998. It is now time for us to take a radical look ahead. Feedback from those living with drugs and those delivering services has already started to shape our ambitions. We are ambitious, for example, to do more to drive out the dealers from our communities and challenge those who promote or glamorise drug use. We want to reach out more effectively to the most vulnerable and the most at risk young people. Effective and efficient drug treatment will remain a cornerstone, but we want to see greater integration across employment, housing and resettlement so that tens of thousands of drug misusers can realise drug-free futures. And we are ambitious to harness the full force of our law enforcement might, from the Serious Organised Crime Agency to Neighbourhood Police Teams, all bearing down on the dealers who profit from the harm and misery they supply.

This consultation paper is the opportunity for you to have *your say*. We want to have an open debate, engaging with everyone who has a contribution to make, from professionals through to those with everyday experience. Alongside this consultation paper, we are publishing a public information leaflet and running a regional programme of events and discussions. Over the summer and early autumn, we are calling on communities, families, experts and current and ex drug users to tell us what they think can be done. We will listen, learn and look forward to building the next drug strategy with you, and with a strong sense of shared purpose.

Rt Hon Jacqui Smith MP
Home Secretary

Building a new drug strategy

Since 1998, departments across Government have worked together to tackle drug abuse. The creation and delivery of a comprehensive, rounded strategy, supported by cross-government Public Service Agreements, record levels of investment and interlinked local delivery structures has transformed the capacity, know how and skills to tackle drugs in this country.

We have now advanced far beyond a time when there was little or no drugs education in schools, limited powers for police and courts, a lack of accessible and credible advice, limited treatment provision and long waiting times.

But significant challenges remain. Too many young lives are blunted and wasted due to drug use, too many relationships and families suffer, and in many communities drug dealers still take hold, bringing violence, disruption, harassment and intimidation.

Nine years on, it is right that Government should now be looking to renew and refresh its approach. Bolstered by the successes achieved under the last drug strategy and with a strong sense of purpose and possibility, we must now sustain what has been achieved and go further.

This consultation document, backed by a wider programme of consultation events over the summer and autumn of 2007, will involve the public, communities, families, experts and current and ex drug users. It will be the largest single consultation exercise on the future of tackling drugs this country has seen.

We are looking for wide-ranging debate and contributions.

We aim to make further progress on:

– reducing the harms drugs cause to the development and well-being of young people and families;
– bringing the full force of law enforcement to bear on drug dealers at all levels;
– reducing the harms drugs cause to the health and well-being of individuals and families; and
– reducing the impact of drugs on local communities – reducing drug-related crime and associated anti-social behaviour.

The following five main chapters of this consultation paper set out in more detail the policies that have been pursued to date and clearly identify the outcomes we are ambitious to realise under the next strategy. These are: better education and intervention for young people and families, especially the most at risk; better public information; improved treatment, social care and support services, especially for the problem drug using population; further reduced drug-related crime and anti-social behaviour; and, finally, greater and more visible disruption of drug supply at all levels.

Throughout the document, we are seeking input on where there may be gaps, examples and ideas of what works, and suggestions for what more we can do. We are also keen to receive feedback and views on the current structures for delivery to support these objectives: what more can we do to mainstream responsibility for drugs? How can we better plan and deliver our services? What more can be done to harness the opportunities for partnership?

QUESTIONS FOR CONSULTATION

1a Are these the right aims for the new drug strategy?

1b Which are the most important and why?

1. Young people, education and families

Doing more to help young people and families avoid problems with drugs.

Overall drug use among young people has fallen in recent years[1] but we can do more. The current strategy aims to make information and education on drugs and other substances, such as alcohol, available to all young people and their families; to promote earlier intervention with those at most risk of developing problems; and ensure that specialist treatment and follow-up support is available to those who have already developed drug problems.

There is a growing evidence base on the most effective ways of helping young people avoid and overcome drug problems. A range of bodies have investigated different aspects of young people and drugs and produced guidance.[2]

Key themes emerging from the evidence base include: the important role played by schools; involving the family in interventions; training in substance misuse issues for the children's workforce; and the need for integrated support, especially at transitional stages.

Alcohol, cannabis and solvents, rather than Class A drugs such as heroin and cocaine, are the substances most commonly used by young people. It is more effective to address **all** substances that are misused by young people, including illegal drugs, alcohol and volatile substances, rather than to focus on one type. Because drug use is often linked to other problems, it is also important to focus on the young person and their family as a whole, rather than just on substance 'use'.

[1] Within the existing drug strategy 'young people' means those in the age groups 11–15 and 16–24.
For 16–24 year-olds, compared with 1998, the proportion reporting:
- that they had ever taken any drug has fallen by 16 per cent;
- that they had ever taken Class A drugs has fallen by 18 per cent;
- use of any drug in the past year has fallen by 21 per cent;
- use of Class A drugs in the past year is stable; and
- use of cannabis in the past year has fallen by 24 per cent.

Among 11–15 year-olds:
- the use of any drug has decreased – in 2006, 17 per cent of pupils said they had taken drugs in the previous year, compared with 21 per cent in 2003 and 20 per cent in 2001;
- cannabis use has decreased – 10 per cent of pupils had taken cannabis in 2006, down from 13 per cent in 2003, 2002 and 2001; and
- frequent use of any drug has decreased from 6 per cent in 2003 to 4 per cent in 2006. The decrease was even more marked among vulnerable young people (those who had truanted or been excluded) declining from 20 per cent in 2003 to 11 per cent in 2006.

Source: Home Office (2007) *Smoking, drinking and drug use among young people in England in 2006: headline figures*, a survey carried out for the Information Centre for Health and Social Care and the Home Office by the National Centre for Social Research and the National Foundation for Educational Research.

[2] The National Institute for Health and Clinical Excellence, the National Treatment Agency (NTA), the National Collaborating Centre for Drug Prevention, the Young People and Drugs High Focus Area Initiative, the Youth Justice Board and the Advisory Council on the Misuse of Drugs (ACMD).

While drugs can affect all young people and families, there is solid evidence showing that some groups of young people are more vulnerable to developing substance misuse problems than their peers.[3]

These groups include:

– young offenders;
– looked-after children;
– young homeless people;
– children who truant or are excluded from school;
– young people who have been sexually exploited or who work in the sex industry; and
– children whose parents misuse drugs or alcohol.

CURRENT APPROACH AND LESSONS LEARNED

EDUCATION

Education in schools and other settings helps young people to acquire the knowledge, skills and understanding they need to keep themselves safe from harm when they encounter illegal drugs and legal substances such as alcohol, tobacco, medicines and volatile substances. Drug education is a statutory part of National Curriculum Science and should be delivered through a Personal, Social and Health Education (PSHE) framework.

The National Healthy Schools Programme promotes a whole-school approach to health improvement and education and includes a PSHE framework covering drug education. The programme is working towards a 2009 target of 75 per cent of schools achieving National Healthy School status and 100 per cent participating in it. The 2006 milestone target of 50 per cent achieving National Healthy School status has already been met.

Similarly, all schools will be providing access to extended services by 2010. These include quick and easy referral to specialist social and health services available on the school site or accessed through the school. The expectations for extended schools and National Healthy Schools are entirely complementary and will rely on many of the same elements to ensure their success.

The schools inspection agency, Ofsted, recognises that schools are making real attempts to address drug issues with pupils. However, not all schools give drug education the necessary profile and/or importance as a tool to keep young people safe when they encounter drugs. The quality of the teaching and learning experience is still variable – some teachers are not adequately prepared to deliver lessons and poor-quality materials are still often used in the classroom. Support materials from a range of commercial and other sources do exist, but they can be of variable quality and may not be effectively distributed or used.

It has been acknowledged that improvements are needed in the evidence base for drug education. Blueprint is the largest research programme ever run in England looking at the delivery and impact of school-based, multi-component drug education. The final 'delivery' report is due in late summer 2007 and the final

[3] Becker J and Roe S (2005) in their report on the 2003 Offending, Crime and Justice Survey found that, while young people in one of the five vulnerable groups identifiable in the survey (those who have ever been in care, those who have ever been homeless, truants, those excluded from school and serious or frequent offenders) represented less than a third (28 per cent) of young people in the sample, they accounted for more than half (61 per cent) of Class A drug users in the last year. While only 5 per cent of those who were not vulnerable used drugs frequently during the past 12 months, 24 per cent of those in vulnerable groups were frequent drug users in the same period. A copy of this report, *Drug use among vulnerable groups of young people: findings from the 2003 Crime and Justice Survey*, HO Research Findings 254, is available at: www.homeoffice.gov.uk/rds/pdfs05/r254.pdf In addition, a recent review of the literature on risk factors, Frisher M et al. (2007) *Predictive factors for illicit drug use among young people: a literature review*, HO Online report 05/07, is also available at: www.homeoffice.gov.uk/rds/pdfs07/rdsolr0507.pdf

'impact' report by the middle of 2008. These research findings will have a key role to play in informing the future of drug education policy and practice in England.

INTEGRATED SERVICES

Reducing substance misuse among children and young people has a positive impact on all areas of young people's lives. Reducing the harms caused to young people by substance misuse is best achieved by working towards the five *Every Child Matters* outcomes – be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being.[4]

The current approach is to address substance misuse issues within the context of integrated children's services, targeted youth support (of which the Government's Young People's Development Programme pilot is a prime example, looking at how trained youth workers and health professionals can best work together to engage those 13–15 year-olds who are most at risk of substance misuse with health advice and support), extended services in schools and the frameworks set out in *Every Child Matters: Young People and Drugs* and further outlined in *Care Matters* and *Youth Matters*.

Since 2004, the Department for Education and Skills (DfES) (now the Department for Children, Schools and Families and the Department for Innovation, Universities and Skills) and the Home Office have shared responsibility for delivering the public service agreement (PSA) target to 'reduce the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially by the most vulnerable young people'. Good progress has been made in achieving this target, which currently includes both young people and young adults: Class A drug use is stable and there have been significant reductions in the frequent use of any drug, especially by vulnerable young people.[5]

The joint approach and shared PSA target have led to significant progress in bringing children's services and drug services closer together. Some 80 per cent of local Children and Young People's Plans now include drugs as a priority but there need to be better incentives for those who are working with children and young people at a local level to identify and address substance misuse. A key issue is ensuring that services and practitioners have the confidence to act on substance misuse issues and provide support to those vulnerable young people who require it most, particularly at an early enough stage.

POSITIVE FUTURES

One example of this rounded approach to meeting needs is Positive Futures, a national social inclusion programme using sport and leisure activities to engage with young people from socially and economically deprived communities. Positive Futures recognises that drug problems cannot be tackled in isolation. It addresses the underlying risk factors, such as vulnerability and social exclusion, that increase the likelihood of a young person later going on to develop problems with drugs. This approach not only helps reduce problem drug use, it also has wider benefits for young people and the communities they live in. There are 121 projects operating in each of the 30 areas worst affected

[4] *Every Child Matters: Change for Children* is a new approach to the well-being of children and young people from birth to age 19. Organisations involved with providing services to children – from hospitals and schools, to police and voluntary groups – will be teaming up in new ways, sharing information and working together, to protect children and young people from harm and help them achieve what they want in life. Children and young people will have far more say about issues that affect them as individuals and collectively. For more information see www.everychildmatters.gov.uk

[5] Man L and Roe S (2006) *Drug Misuse Declared: Findings from the 2005/06 British Crime Survey*, Home Office Statistical Bulletin 15/06 (Home Office). Home Office (2007) *Smoking, drinking and drug use among young people in England in 2006: headline figures*, a survey carried out for the Information Centre for Health and Social Care and the Home Office by the National Centre for Social Research and the National Foundation for Educational Research.

by drug-related crime across the country and the programme has helped thousands of young people to get back into education, employment and training. Almost 30,000 young people have been involved in Positive Futures projects in the last six months alone.

TEENAGE HEALTH DEMONSTRATION SITES

The Department of Health's Teenage Health Demonstration Sites, launched in August 2006, are looking at new ways of delivering health information, advice, guidance and services to all young people, but targeting the 30 per cent most disadvantaged, many of whom will be susceptible to substance misuse. This innovative approach is pushing the boundaries of partnership working, involving new organisations such as the Premier League as well as youth services to further improve delivery. The learning from the work will be available during 2008 and should influence future commissioning of young people's services. A recent development is the piloting of the teenlifecheck which is a lifestyle online questionnaire aimed at 11–15 year olds and which raises awareness of key health issues, including substance misuse, with a view to signposting them to further support. We shall be looking at the options of making this more widely available during 2008.

SPECIALIST TREATMENT AND TRAINING

While prevention and earlier intervention can help young people avoid problems with drugs, specialist treatment provision is essential, both to respond to the needs of those already using drugs and as a source of expertise and support to help mainstream agencies address substance misuse better at early stages. A good example of this is the impact that dedicated substance misuse workers in Youth Offending Teams have made, building confidence in other professionals and leading to improved identification and timely access to appropriate support.

Training is also vital. The Royal College of Paediatrics and Child Health, working with the other relevant medical and nursing colleges, is developing an adolescent health training programme for all doctors and nurses who come into contact with young people. This will help with a more comprehensive approach to dealing with young people, thereby making early intervention more likely and having immediate and significant impact upon substance misuse.

In tandem with the above, the Department of Health has commissioned the National Youth Agency to work with Lifelong Learning UK to define health standards for inclusion in all undergraduate, graduate and NVQ courses, to ensure that all future youth workers will have specific competences in health when dealing with young people.

While there have been improvements in the provision of specialist drug treatment for young people, provision varies considerably. The overall conclusion of a recent DfES and NTA treatment review was that those areas with higher numbers accessing treatment were performing better, based on a good understanding of local need, a clearer definition of specialist treatment, dedicated specialist services and clear routes into treatment through children's services.

As highlighted by the ACMD report *Hidden Harm* (September 2006), there is also a need for adult and children's services to work together to respond to the needs of the estimated 250,000 to 350,000 children affected by parental substance misuse. In some areas the introduction of local safeguarding children boards,[6] together with the requirement on them to develop specific arrangements to respond to parental substance misuse, has been instrumental in improving the response to these children's needs. Adult treatment services have a key role to play through their response to parental drug misuse.

QUESTIONS FOR CONSULTATION

2. What is the most effective way to keep children off and away from drugs?
3. How should parents, guardians and carers be supported to protect children from using drugs?
4. What needs to happen to achieve more effective joint work between children's services and drug services in support of young people?
5. What might an effective local system look like that identifies problems early, provides integrated prevention services and ensures that other specialist services are available when required?
6. What needs to happen to ensure that children's and adult services work together effectively to safeguard and improve the well-being of children and young people affected by substance misuse?
7. What role should education in schools and other settings play in reducing the harms caused by drugs? What should drug education aim to achieve, when should it start and how might it be improved?

[6] The objective of local safeguarding children boards (LSCBs) is to co-ordinate and to ensure the effectiveness of their member agencies in safeguarding and promoting the welfare of children. The core membership of LSCBs is set out in the Children Act 2004, and includes local authorities, health bodies, the police and others.

2. Public information campaigns

Public information campaigns can help prevent drug problems and direct people to support services.

Public information campaigns and education in schools and other settings can be effective in:[7]

- increasing the knowledge and understanding of all drugs, especially the most harmful and most frequently used substances;
- reinforcing existing non-drug-using behaviours and attitudes (drug prevention or preventing use of a specific drug). They can also help to 'rebrand' certain types of drug use or drug-related behaviours, such as debunking the myth that cannabis is harmless;
- increasing the uptake of drug treatment programmes, encouraging 'safer' drug use (harm reduction) and achieving greater professional and public support for drug programmes; and
- increasing knowledge and understanding of substance misuse among parents and giving them the confidence to make a positive contribution.

CURRENT APPROACH

FRANK/PUBLIC HEALTH CAMPAIGNS

The key current government drugs campaign is FRANK, which was launched in 2003. FRANK aims to provide a source of credible information about drugs (both legal and illegal) to all young people and their parents, while supporting the professionals who work with them.

FRANK provides a national telephone helpline and website, as well as campaigns aimed at specific vulnerable groups and delivered in partnership with local stakeholders. It has established high levels of awareness among young people – 70 per cent say they would be very likely to contact FRANK if they had a question about drugs. It also used by many parents and professionals as a source of information and advice about young people's drug use.

In an average week in 2006/07 there were over 9,000 calls to FRANK, 270 callers were referred to services, 43 per cent of calls were made by under-25s, 136,707 visits were made to the website by 58,984 unique visitors, and 9,413 searches were made for local services.

The FRANK campaign and its messages have focused on Class A drug use and cannabis use among 11–18 year-olds, but there is potential for using public health campaigns to address other aspects of drug harms including the following:

- Information campaigns about alcohol targeted at young people aged under 18. Evidence suggests that young people who go on to misuse illegal drugs are likely to have drunk heavily at an early age. Targeting alcohol prevention campaigns at young people may help to reinforce future non-drug-taking behaviour.
- While deaths from volatile substance abuse have fallen from 152 in 1990 to 47 in 2004,[8] 5 per cent of pupils aged 11 to 15 used glue, gas, aerosols or solvents in 2006[9] and volatile substances are responsible for more deaths in young people of school age than illegal drugs. Highlighting the dangers of volatile substance

[7] *Let's Get Real: Communicating with the Public about Drugs* (Home Office).

[8] Field-Smith M E, Butland B K, Ramsey J D and Anderson H R (2006) *Trends in Death Associated with Abuse of Volatile Substances 1971–2004,* Report 19, St George's University of London.

[9] Home Office (2007) *Smoking, drinking and drug use among young people in England in 2006: headline figures*, a survey carried out for the Information Centre for Health and Social Care and the Home Office by the National Centre for Social Research and the National Foundation for Educational Research.

abuse needs to form an integral part of all public health and education campaigns that highlight the risks of substance misuse to young people and those who work with them.

– Parents have a huge influence over their children's beliefs, attitudes and behaviours and, as such, are a key audience for messages and initiatives.

– Harm reduction information and advice for problem drug users is currently another gap. Although there are many organisations that deliver advice to users, government health campaigns have been somewhat limited on this issue. Should more be done to target adult users with information about safer drug use? We know that there will always be some people who abuse legal and illegal drugs. What are the most appropriate ways of reducing the harms these people do to communities and to themselves?

– Although there are examples of local targeted campaigns, at a national level more could be done to target sections of society where drug use is most prevalent. This could focus on individual groups based on lifestyle (clubbers, interest groups) with legal/prevention/harm reduction messages. Vulnerable young people have been targeted through the FRANK campaign, which has achieved some success.

– FRANK has had a relatively high level of engagement with local stakeholders, but there is scope to do more to encourage and support local delivery of national priorities and messages.

– No national campaigns have directly targeted the under-11 age group with education and prevention messages.

QUESTIONS FOR CONSULTATION

8. What role should drug information campaigns play, what should they aim to achieve and how could this be measured?
9. Should there be different approaches to information campaigns, such as harder messages on drugs (e.g. shock tactics or legal consequences)? Who is being missed out?
10. Should drugs and/or substance abuse campaigns be targeted at the under-11 age group? If so, at how young a group?
11. How can information campaigns best help our children to keep away from drugs?
12. Is there a place for role models, including those drawn from peer groups, in drug information campaigns?

3. Drug treatment, social care and support for drug users in re-establishing their lives

A step change in the availability and quality of drug treatment has been achieved since 1998, but treatment needs to be more cost-effective[10] and more needs to be done to help drug users re-establish their lives.

Drug treatment is the cornerstone of our present drug strategy and we strongly believe that it must continue to be.

The harms that both the present and the next drug strategy must set out to tackle are directly related to drug addiction. Individuals who develop a dependence on heroin and crack cocaine, in particular, are among the most vulnerable members of our society. They experience poverty and family breakdown and risk serious infections, blood-borne disease and death. The crimes many problem drug users commit to feed their habit drive up crime, create drug markets and undermine local community cohesion and safety.

International and national evidence has shown that high-quality drug treatment is the most effective way of reducing illegal drug misuse, improving the physical and mental health of drug users. It has a significant impact on drug-related offending, reduces the risk of death due to overdose and blood-borne virus infections and provides the first important steps to drug users re-establishing their lives. Every £1 invested in treatment produces £9.50 of savings in health and criminal justice costs.[11]

During the course of the last drug strategy unprecedented investment and challenging national targets have enabled the NHS, together with the voluntary sector, to deliver a step change in the level and quality of drug treatment. This is making a difference. The number of drug users receiving treatment has expanded from 85,000 to over 180,000 last year, waiting times for treatment now average less than three weeks and almost 80 per cent of drug users remained in treatment for at least three months (the minimum time in treatment which we know is needed to make a difference).[12] Drug users experience has also improved with the implementation of care planning and evidence-based treatment. Since 2003 over 75,000 offenders have been referred into treatment through the Drug Interventions Programme (DIP) and drug-related crime has fallen by 20 per cent. DIP is an innovative programme using a combination of new laws, new working practices, new investment and a renewed emphasis on partnership working and multi-agency delivery at the local level to ensure that drug-misusing offenders reach treatment and get out of lives of crime.

But, even with the most effective treatments, drug users will often relapse and many need support for a number of years. There are also variations in the type and quality of treatment which is available and the support drug users need to re-establish their lives (such as housing, employment, education and training) is not always readily available, meaning that their treatment is less likely to be successful.

[10] Resources are not limitless, so we must be focused on delivering the most effective and cost-effective interventions for those who most need it at a local level. At the present time, there are significant variations in treatment unit costs between areas and our aim is to reduce overall costs whilst improving effectiveness.

[11] Godfrey C, Stewart D and Gossop M (2004) Economic analysis of costs and consequences of the treatment of drug misuse: two-year outcome data from the National Treatment Outcome Research Study (NTORS). *Addiction*, 99(6): 697–707.

[12] National Treatment Agency national media release, 29 September 2006.

CURRENT APPROACH AND LESSONS LEARNED

TREATMENT EFFECTIVENESS

While much has been achieved, we recognise that major challenges still exist, particularly with regard to continuing to improve treatment outcomes and helping drug users to re-establish themselves in the community.

Since its formation in 2001 the National Treatment Agency (NTA) has led the call for 'more treatment, better treatment, fairer treatment'. The NTA works with local partnerships and health commissioners to develop more effective local treatment services and publishes monthly data which shows how well each area, and treatment service, is performing. Local partnerships and health commissioners are also assisted by new guidance, such as the recently published documents from the National Institute for Health and Clinical Excellence on the most effective types of treatment and the NTA/Audit Commission benchmark costs for different types of treatment. Together these are helping to ensure that funds can be used to achieve the greatest benefit. The newly launched 'Treatment Outcomes' tool will also help treatment services monitor the improvement treatment is making to drug users' lives and look for new ways to help drug users get the most from their treatment and to re-establish their lives.

PRISONS

Two-thirds of injecting drug users spend time in prison and prisoners are among the most vulnerable drug users and those most likely to drop out of treatment and to reoffend. Prison-based clinical drug services are now commissioned by local primary care trusts in the same way as community treatment. The National Offender Management Service (NOMS) also funds Counselling Assessment Referral Advice and Throughcare (CARATs) services in all prisons, with at least 117 prison drug rehabilitation programmes and four therapeutic communities. A new Integrated Drug Treatment System has also been developed within 51 prisons and there is an opportunity now to review these arrangements and see whether existing resources can be used more effectively. In particular, there is a need to review how best to meet the needs of prisoners on shorter sentences and to ensure that those receiving treatment in prison are able to access continuing treatment in the community as soon as they are released.

YOUNG PEOPLE'S TREATMENT

Young people's (under-18) specialist substance misuse treatment services have been developing over the past few years, but a recent review has found that the availability of specialist treatment varies widely across the country. More clarity is also needed about the role that both specialist treatment services and other local children's services should play in helping young people who use drugs, how they should link with each other and how the transition to adult services can be managed more effectively.

HARM REDUCTION

Treatment services have a role not only in helping people to stop or control their drug use but also in reducing the harms existing users are causing to their health. The number of recorded drug-related deaths, which rose year on year to 2000, has fallen since but is still only 2 per cent below the 1999 baseline level.[13] Despite increases in needle exchange services and some of the lowest levels of blood-borne disease in Europe, recent increases in blood-borne virus infections and increases in the rate of sharing of equipment are a source of considerable concern. Promoting harm reduction as part of the overall treatment approach will be an important priority and work on this will be taken forward as part of the Government's Harm Reduction Action Plan announced in May 2007.

BALANCE BETWEEN MAINTENANCE AND ABSTINENCE

An important aim is ensuring that the right balance is achieved between treatment services that are able to maintain drug users in treatment, for example through opiate substitute maintenance prescribing, and social care treatment services, such as residential rehabilitation. These social care treatment services are primarily aimed at helping people become and remain abstinent from drug use altogether; they are commissioned by local authorities, or other partners, and provided by the voluntary and community sector. The goal is to optimise outcomes for individuals and the wider community, based on the evidence of what actually works. This means providing a range of clinical and social care treatments to meet both the physical healthcare medical needs of drug users and also their social care needs. Together, these services address their motivation to remain in treatment and to re-establish their lives.

WRAPAROUND SUPPORT

Effective care also requires adequate access to 'wraparound' provision, including education, training, housing and employment support; and to appropriate aftercare for drug service users who have completed structured treatment. Wraparound provision that supports community reintegration is an area where we do not believe the existing drug strategy has achieved anywhere near enough. If we are to sustain the benefits delivered by episodes of drug treatment and care, such effective wraparound provision is vital. Although significant progress has been made (programmes such as Supporting People), much more could be done to improve housing, employment, education and training opportunities for drug users within local communities through regional partnership boards, alliances and local partners working together.

USERS AND CARERS

Users and carers play a vital role in helping drug users remain in treatment and reintegrate into society as their treatment progresses. But, while some providers and commissioners work closely with drug users' families and loved ones and invite user and carer representatives to help in the planning of their services, this is by no means universal.

PARTNERSHIPS

A key lesson learned from the current strategy is that to deliver a step change in the way local treatment services meet the needs of drug users depends on local partnerships and local delivery. The most effective partnerships involve health services, local authorities, the voluntary sector and the criminal justice system and are able to link the provision of drug treatment and the referral of offenders into primary healthcare and other organisations and agencies that can help drug users access appropriate accommodation, training, employment and benefits support. Building these partnerships can only be achieved through strong local

[13] *Deaths Related to Drug Poisoning, England and Wales* (Office for National Statistics website, www.statistics.gov.uk).

leadership and committed and effective services; committed staff with an appropriate caseload; and rapid, well-defined, appropriate information sharing.

QUESTIONS FOR CONSULTATION

13. Where is drug treatment succeeding and where are the gaps?
14. How can drug treatment be made more effective so that our resources can go further?
15. There are many competing priorities within local areas. How should the provision of drug treatment be prioritised locally?
16. What can be done to help local partnerships meet the needs of drug users? How could local accountability and performance management systems support this?
17. How can the needs of under-18s with drug problems be met? What is the role of specialist drug services for young people and what should children's services do?
18. What can be done to ensure that effective drug treatment is provided both to offenders in prison and in the community, ensuring continuity of care between the two?
19. What more should be done to facilitate better access for drug users to the mainstream services they need to help re-establish their lives (e.g. supported housing, employment, education, training and healthcare)? Where are the main gaps?

4. Protecting the community from drug-related crime and re-offending

Reducing drug-related crime and re-offending is a key aim of the current drug strategy. The main means of achieving this is through getting problem drug users into appropriate treatment and providing support.

DRUG/CRIME LINK AND IMPORTANCE OF TREATMENT

The police, other criminal justice agencies and all local and regional partners have a key role in protecting the community from drug-related crime and re-offending. The research evidence linking substance misuse and certain types of offending is well established,[14] as is the potential for effective treatment to reduce levels of offending.

The community-based NTORS[15] study indicated that retention in treatment for 12 weeks was the minimum period required to show some reduction in drug use and offending. The study also showed that for every additional £1 spent on drug treatment there is a saving of more than £3 in the victim costs of crime and reduced demands made on the criminal justice system. Savings of at least £9.50 for every £1 spent are achievable where sustained behavioural improvements after treatment are maintained for two years.

These principles apply to problem drug users whether referred from outside the criminal justice system, spending time in custody, on remand or during a custodial sentence, under supervision on licence or serving a community sentence. They are also appropriate for offenders who are not currently under any form of statutory supervision but are being managed through other schemes such as the Drug Interventions Programme (DIP) or the Prolific and Other Priority Offender (PPO) programme.

DRUG INTERVENTIONS PROGRAMME THE NEW APPROACH

Since its introduction in 2003, the highly regarded DIP programme has developed and integrated measures for directing adult drug-misusing offenders out of crime and into treatment. DIP has successfully brought together criminal justice and drug treatment providers with other services to provide a tailored solution for adults. This innovative programme has been constructed around a combination of new laws, new working practices, new investment and a renewed emphasis on partnership working and multi-agency delivery. Equally important has been the harmonisation between DIP and other offender management schemes, such as the PPO programme, and

[14] For example, in 2003/04 38 per cent of all arrestees reported taking heroin, crack or cocaine (HCC) in the past year. However, 55 per cent of those arrested for acquisitive crime reported HCC use compared with 27 per cent of those arrested for other offences. HCC users also reported much higher rates of acquisitive offending than other arrestees – 22 per cent of them reported committing on average one offence a day or more compared with only 2 per cent of other arrestees. Over a third of arrestees who had used HCC in the past four weeks (36 per cent) said they had committed a crime in order to get drugs in that same time period. (Source: Boreham R et al (2006) *The Arrestee Survey Annual Report: Oct 2003–Sept 2004 England and Wales*, Home Office Statistical Bulletin 04/06.)

[15] NTORS showed that the levels of crime committed by drug users reduced during and after treatment and these reductions could be sustained for up to five years (Gossop M (2005) *Drug Misuse Treatment and Reductions in Crime: Findings from the National Treatment Outcome Research Study (NTORS)*, NTA Research Briefing 8) and that this reduction in self-reported offending was mirrored by a decrease in convictions (Gossop M et al (2006) *Levels of Conviction Following Drug Treatment: Linking Data from the National Treatment Outcome Research Study and the Offenders Index*, Home Office Research Findings 275).

agencies such as HM Prison Service and the National Probation Service, which have statutory responsibilities in respect of some offenders.

PROGRESS TO DATE

There has been a dramatic increase in the number of drug-misusing offenders entering treatment through DIP – some 3,500 drug-misusing offenders a month compared with just over 400 in March 2004. This number has increased markedly since the introduction in April 2006 of testing on arrest and required assessment – new measures designed to bring further new approaches to reducing drug-related crime. By November 2006 the quarterly average number of new clients entering drug treatment through DIP had increased by 44 per cent compared with the period preceding the introduction of those measures. The measures also produced strong growth in the number of offenders entering drug treatment with a lower total volume of offences. This suggests that these new measures are reaching offenders at an earlier stage in their offending careers. Analysis also suggests that well over half of this group are assessed as having a significant enough drug problem to be referred for treatment.

As a result of DIP and the PPO programme we now have a greater understanding of drug-misusing offending and of how to use treatment, criminal justice interventions and case management in promoting and sustaining offender engagement – a key to reducing crime. For example, Home Office analysis based on DIP and other data shows that approximately eight out of ten people entering drug treatment through DIP are being retained in treatment for 12 weeks or more; the proportion remaining in treatment for at least 12 weeks is greatest for those committing the highest volume of crime. This demonstrates that drug misusers entering treatment through the criminal justice system can have positive outcomes when they are retained for a meaningful period.

CRIME IMPACT

The overall level of drug-related acquisitive crime for England and Wales has fallen by around 20 per cent since the start of DIP. This downward trend has slowed in the last 12 months, so that the average monthly year-on-year reduction is just over 3 per cent in the 12 months to November 2006. While it is not possible to be certain of the extent to which these changes can be attributed solely to DIP, research evidence demonstrating the impact of treatment on offending, together with performance data showing increasing numbers entering treatment through DIP and being retained in treatment for a minimum of 12 weeks, indicates that DIP has produced some positive outcomes on offending. This is confirmed by emerging findings from a Home Office evaluation of Criminal Justice Integrated Teams (CJITs), who are multi-agency teams working together, usually in a single location and with the shared aim of meeting the range of needs of offenders – a key part of the DIP approach. These findings show significant reductions in self-reported offending, drug use and drug expenditure among those clients engaged on the DIP caseload for 12 weeks or longer (based on a comparison between the month before and the month after engagement with the CJIT). The analysis indicates that these reductions are in part due to the provision of case management and treatment under DIP.

PRISONS

Since April 2006, commissioning responsibility for prison health services has been fully devolved to primary care trusts, and the Integrated Drug Treatment System (IDTS) has been developed to improve the availability and quality of drug treatment in prison. On average, over half of all those entering prison report a serious drug problem. The custodial drug strategy has developed significantly over the past ten years, with funding up 974 per cent since 1997 (from £7.2 million to £77.3 million). Security measures have been strengthened and more offenders are receiving treatment. In 2005/06, over 53,300 prisoners used clinical services, over 74,500 engaged with Counselling Assessment Referral Advice and Throughcare Services and over 10,700 entered intensive programmes.

The success of current measures is evidenced by the reduction of drug misuse in prisons, as measured by the random mandatory drug testing programme – with positive tests down by around 58 per cent since 1996/97 (from 24.4 per cent to 10.3 per cent in 2005/06).

Prison treatment can have a significant effect on reducing offending. Re-offending rates for graduates of the custodial Rehabilitation for Addicted Prisoners Trust drug rehabilitation programme have been around 40 per cent compared with an expected 51 per cent. These lower rates are only achievable where care is in place, underlining the importance of DIP.

Where additional conditions to address drug misuse are added to post-custodial licences, 86 per cent of offenders attend the first appointment and 69 per cent complete the planned intervention. In addition, some 80 per cent of PPOs who test positive for Class A drugs on licence are subsequently engaging in treatment. This suggests that there is a significant 'grip' by the National Probation Service on a potentially difficult group.

COMMUNITY SENTENCES

There is some evidence that offenders who completed Drug Treatment and Testing Orders (DTTOs), the predecessor of the Community Order with a Drug Rehabilitation Requirement (DRR), have greater reductions in offending and drug use than those who failed to complete. Numbers of offenders starting and completing DRRs are rising. Numbers starting DTTOs/DRRs have increased from about 6,000 in 2000 to nearly 16,000 in 2007. Completions have increased from about 28 per cent to 44 per cent in the same period. Around 90 per cent of offenders on DTTOs/DRRs are retained in treatment for at least 12 weeks. Courts appear to have confidence in the DTTO/DRR. They are made in over 90 per cent of cases where they have been proposed in pre-sentence reports.

Probation monitoring shows that 80 per cent of PPOs who test positive for drugs while subject to a custodial licence subsequently engage in drug treatment.

LESSONS LEARNED

Tackling drug-related crime in our communities requires strong local leadership in agencies and partnerships, committed staff with an appropriate caseload, and rapid, well-defined information sharing. The key lesson learned from the current strategy is the step change that can be achieved when these features are in place.

Central to successful delivery is the ability of a range of agencies, both within and outside the criminal justice system, to work together at national, regional and local levels. Reductions in crime and offending can only be achieved through a rounded approach. During the current strategy, there has been significant progress in this approach and in bringing together treatment for those on community sentences, those in prison and those who are not currently in either but are still in contact with the criminal justice system and in need of treatment and support. The role of regional offender managers, who are responsible for some aspects of drug interventions and who oversee the reducing re-offending drugs pathway work in their regions, offers an opportunity to strengthen and co-ordinate these responses.

As well as co-ordinating responses across the drugs pathway, it is necessary to take a wider approach and to consider the links to the wider educational, housing and health issues that affect offenders. This will mean well co-ordinated working across government, through regional partnership boards and with local partners to deliver results.

QUESTIONS FOR CONSULTATION

20. What are the most effective ways of reducing drug-related crime and re-offending?
21. What is the best way of ensuring that all partners are engaged in dealing with drug-related crime?
22. What is the best way to determine and agree local priorities and strategies?
23. How can local communities better work together to tackle drug-related crime?
24. Are existing funding and delivery structures effective or do changes need to be introduced (in order to truly embed programmes like DIP into 'business as usual')?
25. How can commissioning and co-commissioning arrangements best be applied to the whole drug strategy, and what role should regional offender managers and other stakeholders (e.g. primary care trusts, local authorities and the Department for Work and Pensions) have in commissioning and co-commissioning drug treatment for offenders?
26. Proposals to provide statutory provision on release for offenders with prison sentences of less than 12 months have been deferred. In their absence, are there arrangements – other than DIP – that could help to provide continuity of care on release for this group of drug-misusing offenders?

5. Enforcement and supply activity

Any drug strategy would be incomplete if it did not include a resolute response to drug supply at all levels.

A CO-ORDINATED AND FLEXIBLE APPROACH

Effective action requires a co-ordinated and flexible approach from all the enforcement agencies and government departments involved. In the final analysis, reducing supply means causing shortages of drugs. In those circumstances we would expect the prices of drugs to rise and the purity to reduce. Sustaining those changes should, in conjunction with other elements of the drug strategy, contribute to a reduction in the harms caused to individuals and the community by drug misuse and lead to reduced demand. The fact that we have not yet reached a position in the UK where there has been an appreciable and sustained shortage of drugs means that we do not have direct experience of such effects, but there is some evidence from Australia that a shortage of heroin can lead to reduced harms, for example in terms of reduced consumption of, and expenditure on, the drug and fewer overdoses.

Reaching such a situation cannot be left only to the national authorities, such as the Serious Organised Crime Agency (SOCA), HM Revenue and Customs (HMRC) and government departments. Progress requires the involvement of local police forces, so that there is a 'source-to-street' response. Results are unlikely to be uniform across the country and it will be for police forces to monitor the situation in their localities – for example, in terms of changes in the drugs being misused, or changes in the price or purity of existing drugs of misuse – and adapt to these changes as and when they occur.

Drug trafficking into and across the UK requires a degree of organisation and criminal infrastructure and collaboration. These criminal businesses range in size and complexity and are driven by profit. Measures such as asset confiscation are key tools to visibly demonstrate that those who seek to benefit from the proceeds of drug crime will be pursued. The drugs trade is resilient and able to respond flexibly to the pressures that are applied to it by the law enforcement authorities.

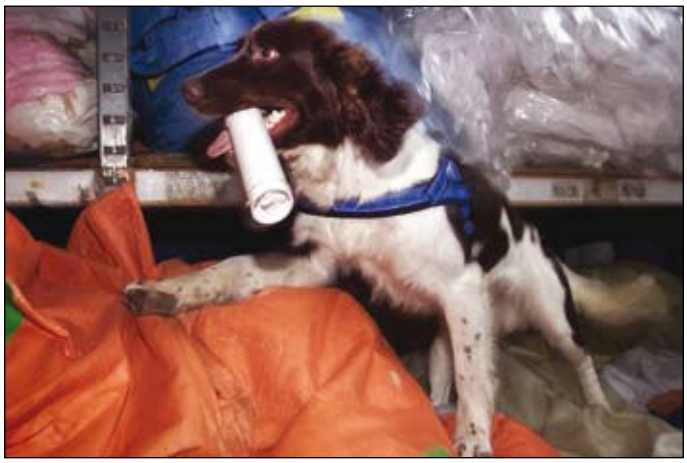
THE UK MARKET AND SUPPLY ROUTES

The UK currently remains an attractive market for drugs. Estimates suggest that the market per year for heroin is in the region of 20 tonnes and those for cocaine and crack about 18 tonnes and 16 tonnes.[16]

While these three drugs are generally held to cause the most harm in the UK, other drugs also have large markets. Those markets are not static: new drugs periodically appear within them and other drugs drop out of them. There is therefore a need to monitor the markets and tailor enforcement responses to new types of harms generated by changes in the types of drug being misused.

About 90 per cent of the heroin that reaches the UK originates in Afghanistan and passes through Turkey and the Netherlands. Cocaine originates from South America, mainly Colombia, and typically arrives in the Iberian peninsula before being distributed within Europe. But these routes are susceptible to change according to the risks perceived by traffickers. Synthetic drugs, such as ecstasy or methamphetamine (a potential threat), are more likely to be produced in Europe, or even in the UK.

[16] Pudney S, Badillo C, Bryan M, Burton J, Conti G and Iacovou M (2006) Estimating the size of the UK illicit drug market. In: Singleton N, Murray R and Tinsley L (eds) *Measuring Different Aspects of Problem Drug Use: Methodological Developments*, Home Office Online Report 16/06.



CURRENT APPROACH AND LESSONS LEARNED

Notwithstanding the tactical successes in taking drugs out of the supply chain and disrupting the criminal organisations involved, the effort that has been put into reducing the supply of drugs has not so far resulted in increased street prices (although street purities of cocaine have generally been reducing since 2003). Changes in prices and purities would be expected to follow from strategic success against drugs markets. It has been difficult to discern a connection, which must exist to some extent, between the tactical successes (e.g. drugs seizures and arrests) and the shape of the market.

ORGANISED CRIME

Drug trafficking is only one form of organised crime that impacts on the UK. The Government set the strategic direction for tackling all organised crime in its 2004 White Paper *One Step Ahead: A 21st Century Strategy to Defeat Organised Crime* and the subsequent Serious Organised Crime and Police Act 2005. The Act widened the range of tools available for tackling organised criminals. It introduced Financial Reporting Orders, which require a convicted offender to report on their financial affairs for a number of years, and put the giving of Queen's evidence on a statutory footing. SOCA was established and became operational on 1 April 2006. Additionally, in the Serious Crime Bill currently before Parliament, the Government is introducing Serious Crime Prevention Orders, through which the courts will be able to impose restrictions on the activities of those involved in serious crime, and improvements to the law on encouraging and assisting crime. The Bill is also being used to absorb the Assets Recovery Agency into SOCA and improve some provisions of the Proceeds of Crime Act 2002.

SOCA ASSESSMENT

A coherent response to the supply of drugs relies on having as good a picture as possible of the problem. Greater effort than ever before is going into acquiring and assessing this knowledge. A number of formal mechanisms contribute to the process, the key being the annual UK Threat Assessment, drawn up by SOCA, which describes and assesses the threats posed by serious organised crime on the basis of information from a wide range of sources in the UK and abroad with whom SOCA collaborates.

SOCA PROGRAMMES

Using this assessment, SOCA has engaged with partners to produce a UK control strategy for serious organised crime. It comprises 20 programmes of activity, four of which are specifically targeted at drugs and reflect current priorities. These concentrate on the heroin trade from Afghanistan to the EU, the cocaine trade from South America to the EU, cocaine, heroin and synthetic drugs trafficking from the EU to the UK, and the illegal drugs trade within the UK.

Each of the programmes has four common overarching and linked objectives:

- to build knowledge and understanding of the crime and the harm it causes and to use that knowledge and understanding to direct and prioritise the UK response;
- to establish co-ordinated, collaborative ways of working in the UK and internationally to maximise efforts to reduce harm, based on shared knowledge, common interests and mutual support;

– to make serious organised crime that is causing harm to the UK unprofitable, by targeting proceeds and increasing the amount of criminal assets recovered; and

– to increase the risks to serious organised criminals operating in or against the interests of the UK, by making best use of established law enforcement methods and by developing new and 'non-traditional' means.

The Government will look to all law enforcement partners and departments with a contribution to make to participate fully in the programmes. Only a fully collaborative approach that uses and develops the capabilities of each organisation to maximum effect is likely to produce the desired results.

The programmes will build on the successes of the past without being constrained by them and will encourage innovative approaches domestically and in collaboration with international partners.

Technology exists to detect drugs, but reliability needs to be refined. Further development is required to detect deep concealments and to create equipment capable of scanning all border passengers and goods traffic into the UK. HMRC intends to work with the EU and the private sector to continue to develop appropriate technology.

THE POLICE

Local police forces will be expected to play a prominent part in the programmes. Robust and effective enforcement, including confiscation of assets, demonstrates to local communities that those involved in drug dealing and other associated criminal behaviour will be held accountable for their actions and will not profit from their crimes. It also encourages local communities to take an active role in tackling drug-related criminality and provide information about those involved in drug dealing in their areas. Well-planned enforcement operations that build on experience and effective precedents are key to success.

Police forces are increasingly recognising the importance of seizing the opportunity to tackle local drug supply and demand problems at the same time, by engaging drug users and guiding them into treatment services. During and after an operation focused on street-level dealing, the availability of drugs in a locality can be significantly reduced. Although this may be for only a relatively short period of time, it is nonetheless an opportunity worth exploiting to get users into treatment. Some forces go further by taking a comprehensive, intelligence-led approach (utilising the National Intelligence Model), facilitating the identification and monitoring of those offenders causing the most harm and those at risk of becoming the high-harm offenders of the future. This also provides a suitable contact point for the operational teams undertaking enforcement operations, allowing a two-way flow of information.

EUROPEAN AND FOREIGN POLICY

At an international level, effective counter-drugs policies cannot be separated from broader foreign policy. It cannot simply be an operational issue, but should be an integral part of good governance and relations between sovereign nations. Illegal drugs tend not to be produced in areas where there is strong state control. Much can be achieved at the foreign policy level.

As a major European importer of illegal drugs and a target country for traffickers, the UK seeks to secure the co-operation of producer and transit countries in helping to stem the flow of drugs to its shores, engaging with them bilaterally and multilaterally (for example through the United Nations). The Government attaches considerable importance to working with and through EU drugs mechanisms, both at policy/political level and through operational capacity-building initiatives (such as the EU Latin American and Caribbean Intelligence-sharing Working Group).

The Foreign and Commonwealth Office has a specific role in international counter-drugs activity by providing the operational base for SOCA work, influencing international policy, promoting regional co-operation and co-ordination, working with UN agencies and helping to build capacity by providing training and equipment in top priority countries.

Afghanistan is a particular priority for the UK and we are its partner nation on counter-narcotics, working with the Afghan government and the international community. The UK has provided assistance in the implementation of the Afghan government's national drug control strategy and its four priorities: targeting the drug trafficker; strengthening and diversifying rural legal livelihoods; building institutions; and reducing demand. The experiences of Pakistan and Thailand have demonstrated that ridding the country of illegal opium production is a long and difficult process.

QUESTIONS FOR CONSULTATION

27. How can police forces best build confidence that drug supply is being effectively tackled locally? Do the police and local communities have all the powers they need to tackle anti-social behaviour related to drug dealing and use?
28. What role should communities play in tackling drug dealers and drug supply?
29. Which organisations might be able to assist in assessing the impact of supply-side activities in communities?
30. To what extent and how should the UK tackle potential emerging threats (such as methamphetamine) as opposed to established drugs (such as heroin)? Methamphetamine is commonly referred to in the media as 'crystal meth'; it has many street names including 'ice'.
31. Do you think that there are ways in which the UK's broad approach to working with governments in priority drug producing, transit and consumer countries to tackle the causes and effects of drug problems and the harms caused to the UK can be developed and improved? How might this be achieved?
32. How might we better measure the impact of supply and enforcement activity?

Broad strategic questions

This section invites you to consider the drug strategy as a whole and address some broader questions.

STRATEGIC CONTEXT

There is a need to balance the responses and interventions within each strand of the strategy with the challenges we will face, while ensuring that the strands are properly co-ordinated and joined to deliver our aims and ambition.

QUESTIONS FOR CONSULTATION

33. What are the most effective ways of preventing and reducing the harms caused to young people and families by drugs? Do young people's and adult services need to work more closely together?
34. How can we improve the effectiveness of specialist drug treatment services and help drug users to re-establish themselves in the community?
35. What more could be done to reduce the impact of drugs and associated crime on local communities?
36. How can we further reduce the supply of drugs and improve detection and the prevention of importation?
37. What could we do more efficiently? Where is value for money not being delivered?
38. Have we got the right national, regional and local structures to ensure effective delivery of the drug strategy? How could these be improved?
39. The Prime Minister announced on 18 July that he will ask the Advisory Council on the Misuse of Drugs to look at whether cannabis should be reclassified from a Class C drug to the more serious Class B. This is because of concern about stronger strains of the drug, particularly skunk, and the potential mental health effects they can have. Do you think that cannabis should be reclassified and, if so, why? Are there any other changes that you would wish to see and, if so, why?

How to respond

Responses to this paper should be submitted by Friday 19th October 2007.

THE CONTENT OF THIS DOCUMENT AND THE QUESTIONS IT ASKS

The chapters of this document describe the main areas of the current drug strategy and how they might be developed. Each chapter asks specific questions and we have tried to make these as straightforward as possible, but some do require understanding and experience of the subject matter. This reflects the wide spectrum of views we are seeking to canvass.

Your response may cover as few or as many questions as you wish.

WHERE TO FIND THIS DOCUMENT

This document can be found at: http://drugs.homeoffice.gov.uk and www.homeoffice.gov.uk

WHERE TO RESPOND

The Home Office has appointed Ipsos MORI to facilitate this consultation. Ipsos MORI is an independent research and consultation agency with many years' experience in government consultation work and in engaging with a wide range of people to seek their views on policy initiatives.

Please respond to this consultation document directly to Ipsos MORI, which will be independently collecting, collating and analysing the responses.

There are four main ways to submit your comments:

- Complete the online consultation form, which can be found at http://drugs.homeoffice.gov.uk, and e-mail it back.
- Download the response form and send back the completed form by post to Ipsos MORI at the address shown below.
- Complete an interactive PDF of the consultation form and e-mail it to DrugStrategyConsultation2008@ipsos-mori.com
- Complete the response form in the printed consultation document and post it to Ipsos MORI at the address below.

The postal address for responses is:

Susie Clark
Drug Strategy Consultation 2008
Ipsos MORI
MORI House
79–81 Borough Road
London SE1 1FY

Alternatively, you can e-mail Ipsos MORI directly using the e-mail address above, or call them on freephone 0808 238 5412.

Please address any correspondence for Ipsos MORI to Susie Clark.

ALTERNATIVE FORMATS

Please contact Ipsos MORI if you require a copy of this consultation paper in any other format, e.g. Braille, large print or audio.

Ipsos MORI will also be conducting an innovative outreach programme that will draw in the views of front-line deliverers, individuals, families, communities and service users. The programme will include in-depth interviews, workshops and discussion groups with selected key stakeholders, front-line deliverers, service users and communities.

This combination of approaches ensures that there is a genuine opportunity for a wide range of people to influence and shape the new strategy that, one way or another, affects all of our lives.

RESPONSES: CONFIDENTIALITY AND DISCLAIMER

The information you send us may be passed to colleagues within the Home Office, the Government or related agencies.

Furthermore, information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Home Office.

Please ensure that your response is marked clearly if you wish your name to be kept confidential. Confidential responses will be included in any statistical summary of numbers of comments received and views expressed.

The Home Office will process your personal data in accordance with the DPA – in the majority of cases this will mean that your personal data will not be disclosed to third parties.

OTHER INFORMATION FOR RESPONDENTS

In making your response, particular attention will be given to the evidence you provide to support the opinions expressed.

WHAT WILL HAPPEN NEXT?

The consultation period will end on Friday 19th October 2007.

We expect to publish a summary of responses received within three months of the closing date for this consultation. This will be made available on the Home Office website and at http://drugs.homeoffice.gov.uk

Annex A: Key facts and evidence

– Class A drug use among young people is stable, while the use of other illegal drugs has fallen – cannabis use is down by 24 per cent among 16–24 year-olds compared with 1998.[1]

– The Government has achieved huge success in delivering treatment services – a national treatment target of 170,000 people receiving treatment has been exceeded two years earlier than anticipated.

– Drug-related crime is falling – recorded acquisitive crime has fallen by 20 per cent since the introduction of the Drug Interventions Programme.[2]

– There are estimated to be around 327,000[3] problem drug users (opiate and/or crack users) in England. There is a particular focus on these problem drug users because they are responsible for 99 per cent of the costs to society of Class A drug misuse (estimated to be around £15.4 billion in 2003/04), 90 per cent[4] of which is drug-related crime.

– We know that effective treatment works and is highly cost effective. For every £1 spent on treatment, at least £9.50 is saved in crime and health costs.[5]

KEY OVERALL ACHIEVEMENTS

– The Drug Harm Index, which measures the harms caused by drug misuse, has fallen by 24 per cent since the introduction of the Updated Drug Strategy in 2002 and forecasts indicate that we are on track to achieve the overarching 'reduce the harm caused by illegal drugs' Public Service Agreement (PSA) target.[6]

– The harms captured by the Drug Harm Index include domestic and commercial drug-related crimes, community harms (such as community perceptions of drug use and drug dealing) and health impacts such as blood-borne viruses and drug-related death. Drug-related deaths have fallen from 1,538 in 1999 to 1,506 in 2005.[7]

YOUNG PEOPLE

– The overall picture from the 2005/06 British Crime Survey is one of stability, with a number of positive changes, and some significant reductions for specific drugs.

– For 16–24 year-olds, compared with 1998, the proportion reporting:
  - that they had ever taken any drug has fallen by 16 per cent;
  - that they had ever taken Class A drugs has fallen by 18 per cent;
  - use of any drug in the past year has fallen by 21 per cent;

[1] Man L and Roe S (2006) *Drug Misuse Declared: Findings from the 2005/06 British Crime Survey*, Home Office Statistical Bulletin 15/06 (Home Office).

[2] Walker A, Kershaw C and Nicholas S (2006) *Crime in England and Wales 2005/2006*, Home Office Statistical Bulletin 12/06 (Home Office).

[3] Hay G, Gannon M, MacDougall J, Millar T, Eastwood C and McKeganey N (2006) Local and national estimates of the prevalence of opiate use and/or crack cocaine use (2004/05). In: Singleton N, Murray R and Tinsley L (eds) *Measuring Different Aspects of Problem Drug Use: Methodological Developments*, Home Office Online Report 16/06 (Home Office).

[4] Gordon L, Tinsley L, Godfrey C and Parrott S (2006) The economic and social costs of Class A drug use in England and Wales, 2003/04. In: Singleton N, Murray R and Tinsley L (eds) (2006) *Measuring Different Aspects of Problem Drug Use: Methodological Developments*, Home Office Online Report 16/06 (Home Office).

[5] Godfrey C, Stewart D and Gossop M (2004) Economic analysis of costs and consequences of the treatment of drug misuse: two-year outcome data from the National Treatment Outcome Research Study (NTORS). *Addiction*, 99(6): 697–707.

[6] Macdonald Z, Collingwood J and Gordon L (2006) *Measuring the Harm from Illegal Drugs Using the Drug Harm Index: An Update*, Home Office Online Report 08/06 (Home Office).

[7] Office for National Statistics (2006) *Health Statistics Quarterly*, Spring 2006 (available from www.statistics.gov.uk).

- use of Class A drugs in the past year is stable; and
- use of cannabis in the past year has fallen by 24 per cent.

Chart 1: Class A drug use in the last year among 16–24 year-olds (Source: British Crime Survey)

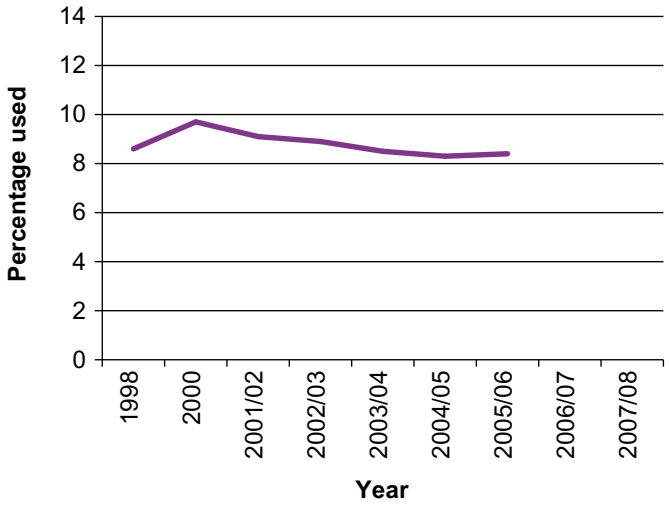
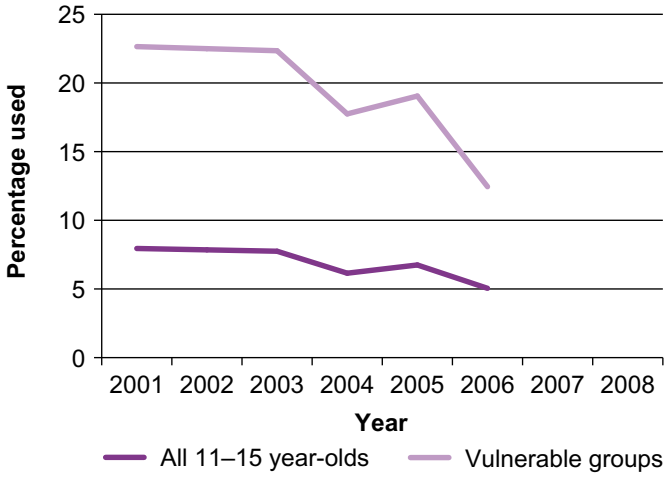


Chart 2: Frequent use of any drug in the last year among all 11–15 year-olds and those in vulnerable groups (Source: Survey of smoking, drinking and drug use among young people in England)



– Among 11–15 year-olds:
  - the use of any drug has decreased – 17 per cent of pupils said they had taken drugs in the previous year in 2006, compared with 21 per cent in 2003 and 20 per cent in 2001;[8]
  - cannabis use has decreased – 10 per cent of pupils had taken cannabis in 2006, down from 13 per cent in 2003, 2002 and 2001;[8] and
  - frequent use of any drug has decreased from 6 per cent in 2003 to 4 per cent in 2006. The decrease was even more marked among vulnerable young people (those who had truanted or been excluded), declining from 20 per cent in 2003 to 11 per cent in 2006.[8]

TREATMENT

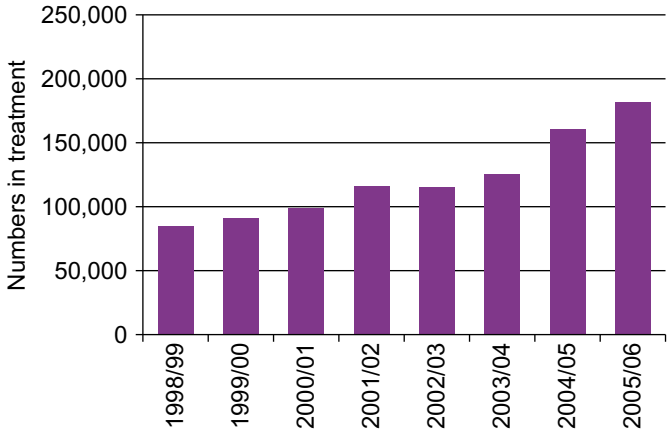
– The number of individuals receiving structured treatment has increased by 13 per cent from 160,450 in 2004/05 to 181,390 in 2005/06. This represents an increase of 113 per cent on the 1998/99 baseline of 85,000 people receiving structured treatment. These figures demonstrate that the Government is succeeding in delivering treatment services and has actually exceeded a national treatment target of 170,000 people receiving structured treatment in 2007/08.[9]

– We are also increasing year on year the number of users who successfully complete or are retained in structured treatment for 12 weeks or more, when treatment is more likely to be effective. In 2005/06, 141,500 individuals (78 per cent of those treated in the year) either successfully completed treatment in that year or were retained in treatment on 31 March 2006. The 2004/05 figures reported 120,700 (75 per cent of those treated in the year).[9]

[8] Home Office Smoking, *drinking and drug use among young people in England in 2006: headline figures* (a survey carried out for the Information Centre for Health and Social Care and the Home Office by the National Centre for Social Research and the National Foundation for Educational Research).

[9] National Treatment Agency national media release, 29 September 2006.

Chart 3: Total retained in structured treatment

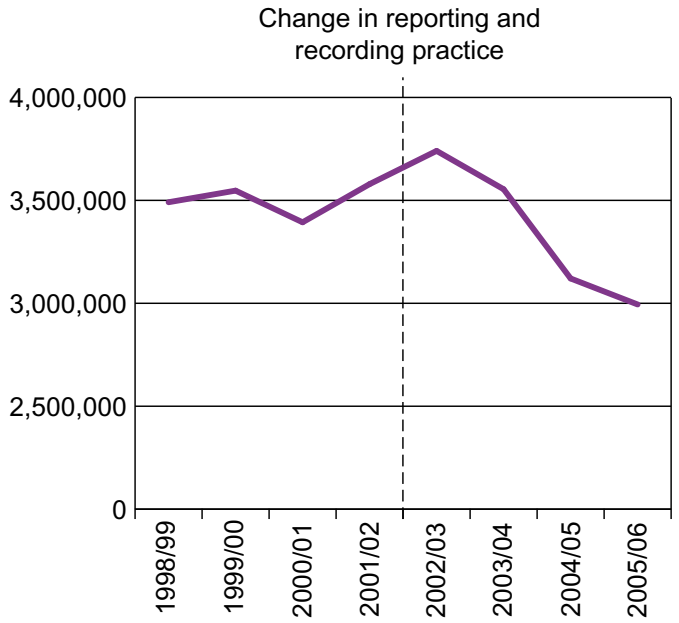


DRUG-RELATED CRIME

– Around 3,500 drug-misusing offenders are entering treatment each month through the Drug Interventions Programme. This is on track to achieve our ambition to direct around 1,000 drug-misusing offenders into treatment every week by March 2008.

– Drug-related crime is falling: acquisitive crime – to which drug-related crime makes a substantial contribution – has fallen by 20 per cent since the introduction of the Drug Interventions Programme.

Chart 4: Total recorded acquisitive crime



– There have been substantial reductions in the level of self-reported commission of acquisitive crime after drug treatment. Reductions of up to 33 per cent of pre-treatment levels have been observed.

AVAILABILITY

– The total number of drug offenders convicted of producing or dealing cocaine, crack or heroin rose by 6 per cent between 2003 and 2004.

– Last year SOCA was responsible for more than 240 persons being charged for drug trafficking offences.[10]

– Enhanced intelligence has led to increasing numbers of trafficking groups being disrupted and dismantled, rising from 193 in 2002/03 to 299 in 2004/05.[11]

[10] Answer to Parliamentary Question, 20 April 2007, *Hansard* Volume 459, column 844W.

[11] HM Customs and Excise (2006) (information available from www.hmrc.gov.uk).

– Over the last three years (2004/05 to 2006/07) £90 million worth of confiscation orders have been enforced against drug traffickers.

– The Middle Market Drugs Project, comprising staff from HMRC, the National Criminal Intelligence Service and the Metropolitan Police Service, was set up in September 2004 to concentrate on the 'middle market' that acts as a link between international drug traffickers and street-level dealers. Between September 2004 and May 2005, the project was successful in taking out over 329kg of Class A drugs and disrupting and dismantling 19 organised crime groups.

– In November 2006 British naval forces on the high seas uncovered cocaine worth almost £60 million. The joint operation with SOCA and Spanish customs revealed a haul of 1.3 tonnes of the drug on a supply vessel, *MV Orca II*.

– HMRC operations Airbridge and Westbridge have been run to reduce drug couriers bringing Class A drugs from Jamaica and Ghana to the UK. These have involved working closely with the Jamaican and Ghanaian Governments and the supply by the Foreign and Commonwealth Office of equipment to detect couriers with internal concealments at Kingston, Montego Bay and Accra airports before they board flights to the UK. In the case of the former the number of cocaine swallowers detected in the UK has dropped from 730 in 2002 to 5 in 2006. Operation Westbridge began in November 2006 and the early signs are of a similar degree of impact.

– In 2006/07 in excess of 74 tonnes of Class A drugs were seized, which if sold in the UK on the illicit market would have realised over £3 billion.[12]

[12] Serious Organised Crime Agency (2007) Annual Report 2006/07 (see www.soca.gov.uk/assessPublications/downloads/SOCAAnnualRep2006_7.pdf).

Annex B: Geographical scope of the new strategy

The formulation and delivery of the new drug strategy will reflect the devolution of powers to the Assemblies in Wales and Northern Ireland and the Parliament in Scotland. The UK Government is responsible for setting the overall strategy and for delivery in the devolved administrations only for the areas where it has reserved power.

The scope of the new strategy is that:

– health, education and social care are areas confined to England;

– policing and the criminal justice system (including all areas of offender management) cover England and Wales; and

– the work of the Serious Organised Crime Agency and HM Revenue and Customs in addressing drug supply covers the whole of the UK.

Annex C: Code of Practice on Consultation

This consultation follows the Cabinet Office Code of Practice on Consultation, the criteria for which are set out below.

THE SIX CONSULTATION CRITERIA

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.

2. Be clear about what your proposals are, who may be affected, what questions are being asked and the timescale for responses.

3. Ensure that your consultation is clear, concise and widely accessible.

4. Give feedback regarding the responses received and how the consultation process influenced the policy.

5. Monitor your department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.

6. Ensure that your consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

The full Code of Practice is available at www.cabinetoffice.gov.uk/regulation/consultation

Annex D: Consultation co-ordinator

If you have any complaints or comments specifically about the consultation **process**, you should contact the Home Office consultation co-ordinator Christopher Brain by e-mail at christopher.brain2@homeoffice.gsi.gov.uk

Alternatively, you may wish to write to:

Christopher Brain
Consultation Co-ordinator
Performance and Delivery Unit
Home Office
3rd Floor, Seacole Building
2 Marsham Street
London SW1P 4DF

Annex E: Consultation response form

Please include your contact details in case we need to ask you for further information or clarification.

Name:

Organisation (if any):

Job title (if any):

Address:

E-mail address:

Phone number:

SECTION A: BUILDING A NEW DRUG STRATEGY

1a. Are these the right aims for the new drug strategy?

1b. Which are the most important and why?

SECTION B: YOUNG PEOPLE, EDUCATION AND FAMILIES

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

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

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

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

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

7a. What role should education in schools and other settings play in reducing the harms caused by drugs?

7b. What should drug education aim to achieve, when should it start and how might it be improved?

SECTION C: PUBLIC INFORMATION CAMPAIGNS

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

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

9b. Who is being missed out?

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

10b. If so, at how young a group?

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

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

SECTION D: DRUG TREATMENT, SOCIAL CARE AND SUPPORT FOR DRUG USERS IN RE-ESTABLISHING THEIR LIVES

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

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

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

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

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

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

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

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

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

19b. Where are the main gaps?

SECTION E: PROTECTING THE COMMUNITY FROM DRUG-RELATED CRIME AND RE-OFFENDING

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

21. What is the best way of ensuring that all partners are engaged in dealing with drug-related crime?

22. What is the best way to determine and agree local priorities and strategies?

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

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

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

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

SECTION F: ENFORCEMENT AND SUPPLY ACTIVITY

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

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

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

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

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

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

31b. How might this be achieved?

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

SECTION G: BROAD STRATEGIC QUESTIONS

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

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

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

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

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

37a. What could we do more efficiently?

37b. Where is value for money not being delivered?

38a. Have we got the right national, regional and local structures to ensure effective delivery of the drug strategy?

38b. How could these be improved?

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

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

ISBN: 978-1-84726-340-7
Published by the Home Office

Product code: 281828
Product description: Drug Consultation 2007

Number: CDSD2

View online: http://drugs.homeoffice.gov.uk

recycle
When you have finished with this publication please recycle it

50% recycled
This publication is printed on 50% recycled paper

HM Revenue & Customs

Ministry of JUSTICE

DWP Department for Work and Pensions

Communities and Local Government

department for children, schools and families

DH Department of Health

Home Office