2010 Drug Strategy consultation
PRO FORMA FOR RESPONSES

For a full version of the consultation paper, please visit our website at:
http://www.homeoffice.gov.uk/publications/consultations/cons-drug-strategy-2010/

Pro forma contents

How to respond

- Using the online form
- Emailing this pro-forma complete with your responses to DrugConsultations@homeoffice.gsi.gov.uk
- Sending a hard copy to:

Consultation
Drug Strategy Unit, Home Office
4th floor, Fry building
2 Marsham Street
LONDON SW1P 4DF

The closing date for responses to reach use by is **30 September 2010**.

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About you

What is your gender? (please tick one)

Female ☐
Male ☐

How old are you? (please tick one)

Under 18 ☐
18 – 24 ☐
25 – 34 ☐
35 – 54 ☐
Over 55 ☐

Where do you live? (please tick one)

North East ☐
North West ☐
South East ☐
Yorkshire and the Humber ☐
West Midlands ☐
East Midlands ☐
East of England ☐
South West ☐
London ☐
Wales ☐
Northern Ireland ☐
Scotland ☐
Channel Islands ☐ Please name island: _____

Please tell us your occupation (if relevant)

Drug and Alcohol Strategy Manager

Please tell us which organisation you represent (if applicable)

Drug and Alcohol Action Team Haringey Council & NHS Haringey

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Vision for the new drug strategy

The Home Office will lead the new Drug Strategy to prevent drug taking, disrupt drug supply, strengthen enforcement and promote drug treatment with the focus on enabling people to become free of their addictions, including alcohol, to recover fully and contribute to society. It aims for:

- Greater ambition for individual recovery whilst ensuring the crime reduction impact of treatment.
- Actions to tackle drugs being part of building the "Big Society".
- A more holistic approach with drugs issues being assessed and tackled alongside other issues such as alcohol abuse, child protection, mental health, employment and housing.
- Budgets and responsibility devolved wherever possible, with commissioning of services at a local level.
- Budgets and funding streams simplified and outcome based.
- The financial costs of drug misuse reduced.

QUESTION A1: ARE THERE OTHER KEY ASPECTS OF REDUCING DRUG USE THAT YOU FEEL SHOULD BE ADDRESSED?

☐ Yes
☐ No

Please outline any suggestions below

The general principles around acknowledging that drug and drug related issues need to be tackled in conjunction with many other policy areas are welcomed. Recognition of the very close relationship between alcohol use and illegal and legal drugs is particularly welcomed. A fully integrated substance misuse strategy makes sense at a national and local level Approaches to reducing drug use and associated harms should be based upon the best evidence and research available. Drugs should be categorised in terms of the actual /physical/emotional harm they cause. It would be helpful if the strategy took more of a public health stance and aimed to reduce health inequalities/life chances that arise as a result of substance misuse.

QUESTION A2: WHICH AREAS WOULD YOU LIKE TO SEE PRIORITISED?
PLEASE SELECT AS MANY AS APPLY

- ☐ Greater ambition for individual recovery whilst ensuring the crime reduction impact of treatment.
- ☐ Actions to tackle drugs should be part of building the "Big Society".
- ☐ A more holistic approach, with drugs issues being assessed and tackled alongside other issues such as alcohol abuse, child protection, mental health, employment and housing.
- ☐ Budgets and responsibility devolved wherever possible, with commissioning of services at a local level.
- ☐ Budgets and funding streams simplified and outcome based.
- ☐ The financial costs of drug misuse reduced.
- ☐ None of them

All of the above areas have merit. It is important that we are ambitious in terms of the outcomes for those who have experienced drug problems. We should also be ambitious in terms of the outcomes for their families and communities.

The role of the voluntary sector and the public in responding to drug problems is critical. More work needs to be done to help support understanding of the realities of substance use and promote awareness of what can be done and where help is available. This requires there to be a mechanism to allow ready access to evaluated, good quality advice on a range of substance use issues.

Clearly local areas and local partnerships are better placed than central government to identify and respond to local issues. We would agree that there has been too much emphasis on central targets and a burdensome weight of bureaucracy. However, it needs to be acknowledged that certain highly specialist areas may benefit from systems that promote regional or sub regional collaboration. Substance misuse cannot be allowed to fall off local agendas; this does not require a vast apparatus but will need consistent and positive support.

The simplification of budgets and funding streams is to be welcomed. We would ask that budgets are made as dependable and reliable as possible. Previous experience demonstrates that fluctuations in budgets and uncertainty of future funding renders efficient planning impossible and results in less than optimum returns on investment. The move toward outcome targets is a positive one. However, we do need to bear in mind that some areas of work benefit from innovation and its important to ensure that any outcome based system does not stifle the development of new approaches (which maybe potentially more cost effective).

QUESTION A3: WHAT DO YOU THINK HAS WORKED WELL IN PREVIOUS APPROACHES TO TACKLING DRUG MISUSE?

The experience of the Communities Against Drugs initiative was positive in its ability to galvanise local activity – and indeed helped promote activity that would seem to fall within the Big Society agenda. CAD enabled DAATs to work with communities at a very local level in both identifying and finding solutions to localised drug problems.

The establishment of local partnerships has been positive and been central to the gains that have been made in the last 15 years. It has enabled DAAT Strategy Managers and commissioners to be supported in this challenging area of work and remove blockages. While concerns may still remain about aspects of commissioning there is no disputing that it has improved from the very low level of the 1990's. There has likewise been improvement in terms of a larger and more skilled workforce. Models of Care and Treatment Outcome Profiles have represented step changes in service delivery. In particular MOC and MOCAM gave commissioners/service users and providers a sense of what should be available at a local level in terms of drug and alcohol provision. While the impacts of narrowly ring fenced budgets may not always be positive, certainly in terms of building robust local partnerships there is no doubt that dedicated resources targeted at drug use have ensured improvements which would otherwise have been in doubt .

Without disputing the scope for improvement it is vital to acknowledge that great strides have been made in tackling drug issues since the 1990's. While seeking to build on this progress we should ensure we do not lose these gains.

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QUESTION A4: WHAT DO YOU THINK HAS NOT WORKED SO WELL IN PREVIOUS APPROACHES TO TACKLING DRUG MISUSE?

There has been an over emphasis on the link between drug misuse and offending to the detriment of wider public health issues – e.g. the spread of hepatitis C. The Home Office lead for the Drug Strategy may not have helped in this matter.

Previous approaches have tended to not promote the work relating to alcohol issues or mental health and broader health and wellbeing priorities. At a local level for example the drugs agenda is tied into the CDRP, whilst alcohol feeds into the Wellbeing Board. Arguably substance misuse work would should sit within the wellbeing/health improvement arena at a national and local level.

There was insufficient focus on scientific and research evidence and the issues relating to the ACMD and the media coverage of such was unhelpful.

There has been a lack of consistent "championing" of drug issues centrally. This is an area which needs to be constantly promoted in terms of the benefits it brings across a broad range of policy.

The concentration on outputs rather than outcomes was also a problem as was the narrow focus on treatment and narrow definitions of what constituted drug treatment and therefore what got 'counted'. Micro-management from the centre stifled creativity and made it difficult to commission against real local need e.g. beyond class A drug users. Having no dedicated money for alcohol has also been problematic. In summary we would like to see drug/alcohol policy linked into other cross cutting policy areas at the centre and locally.

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Prevent drug use – Department for Education lead

Acting early, particularly with young people, can help stop drug and alcohol problems from developing. However there are many different factors that can lead people to misuse drugs or alcohol and a range of different approaches to prevention.

The reasons that people come to misuse drugs or alcohol are complex, influenced by personal, community and societal factors. And while we know that adolescence is typically the point at which misuse starts, prevention strategies need to consider the full range of these factors.

The government has already set out some proposals for tackling the supply of drugs or alcohol to young people including a system of temporary bans on so called 'legal highs' and licensing measures to increase the penalties for those selling alcohol to underage young people.

QUESTION B1: WHAT ARE THE MOST EFFECTIVE WAYS OF PREVENTING DRUG OR ALCOHOL MISUSE?

As with many areas of health inequalities it is impossible to ignore the added risks associated with poverty in relationship to drug and alcohol misuse. Work to tackle poverty and address entrenched inequality will contribute significantly to reducing problem use. Likewise drug and alcohol related work are essential components in reducing poverty, inequality and promoting regeneration.

Evidence clearly indicates the importance and benefits of a good school and educational experience. Likewise the importance of keeping children within the school system. Therefore a major priority should be the prevention of individuals dropping out of school. Schools should be supported to develop good pastoral care. The decision not to proceed with a compulsory PSHE curriculum does highlight a key issue. We have a duty to educate young people about the substances and risks associated they will face in society, we also need to assist in developing young peoples sense of social responsibility and their ability to make informed decisions in complex situations. There is a clear read across to issues of under age pregnancy, sexual health as well as tobacco and diet. Progress has been made but again this is an area where there is a need for good quality and accessible information to support professionals. Also steps should be taken to improve the training of teachers (and other professionals) to enhance their capability around responding to substance use issues.

Building upon the Every Child Matters agenda and supporting Children's Services can make an important contribution to reducing substance misuse. It is surely wrong that it is possible to identify multiple risk factors in young people as regards substance misuse (as well as other harms) without putting in place effective interventions. Specifically our experience locally suggests the following is effective:

- ***Life skills drug education as part of a planned time-tabled programme of Personal Social Health Economic education. Provided from Year One to Year 13 on a spiral curriculum. Drugs and alcohol education to include tobacco and other legal drugs.***
- ***Specialist PSHEe teachers with on-going professional development are best placed to provide this education supported by specialist outside agencies, for example drug and alcohol treatment services, police service, school nurses.***

- ***Parental engagement, especially through schools, is important to ensure information, skills and attitudes are common and up-to-date.***
- ***Theatre in Education and well-supported near peer educators can also play a positive role in reducing misuse and can also enrich and reinforce key messages about harm and safety.***
- ***Models of drug education that seek to minimise harm and equip young people with the skills and knowledge they need to make the right healthy choices.***
- ***Specialist support in schools /colleges including provision of counselling and mentoring schemes.***
- ***Early intervention programmes that provide advice and guidance to vulnerable and 'at risk' children and young people.***

QUESTION B2: WHO (WHICH AGENCIES, ORGANISATIONS AND INDIVIDUALS) ARE BEST ABLE TO PREVENT DRUG OR ALCOHOL MISUSE?

In relationship to this question (and B1) we feel it is vital to define reductions in harm not merely in prevalence. The harms that accrue to individuals and communities should be the priority for an effective strategy.

In terms of organisations Health and Wellbeing Boards should have a major role and there is a clear and vital role for local partnerships (DAATs) with a focus on substance use who work with all appropriate partners. However, the real need is to embed the issues across all services and organisations who work with young people and indeed beyond into those working with the community in general.

We should also work to ensure that parents, carers, family members can readily access advice and information relating to substance use. In addition:

- ***Schools/teachers and specialist support (drug/alcohol agencies, school nurses) have a key role to play in providing effective drug and alcohol education in a planned PSHEe curriculum, with prevention or deferred use as likely outcomes***
- ***Family support services with staff having specialist knowledge***
- ***Informed and confident families***
- ***Integrated youth support organisations***
- ***FRANK or equivalent national drug/alcohol information service with public advertising campaigns***
- ***National phone lines e.g. Drinkline; Smoking Quitline***

QUESTION B3: WHICH GROUPS (IN TERMS OF AGE, LOCATION OR VULNERABILITY) SHOULD PREVENTION PROGRAMMES PARTICULARLY FOCUS ON?

There are a range of indicators which identify those young people at particular risk and resources should be directed at these. The ACMDs Pathways to Problems report provides clear indication of these factors. It is important that services that deal with major traumas which may effect young people, e.g. sexual abuse, are linked to substance misuse responses. Rather than focussing on specific age groups (while acknowledging factors such as transition to secondary school) we should be seeking to ensure that all young people are aware of where they can get advice and where appropriate support.
In relationship to this question (and B1) it is vital to define reductions in harm not merely in prevalence. The harms that accrue to individuals and communities should be the priority for an effective strategy.
Specifically the following should be targeted:

- ***Universal intervention through schools for all children and young people***
- ***Children in families of substance misusing parents/carers***
- ***Looked After Children***
- ***Young people excluded from school***
- ***Teenage parents***
- ***Young people and families with mental health problems***
- ***Young tobacco smokers***
- ***Young people who are NEETS***
- ***Young people involved in the criminal justice system***

QUESTION B4: WHICH DRUGS (INCLUDING ALCOHOL) SHOULD PREVENTION PROGRAMMES FOCUS ON?

☐ All drugs

Please explain your view below

As previously stated there should be an emphasis on harms. However, it needs to be recognised that different drugs may cause different individuals, cohorts and communities different levels of harms. This will vary across the country. With the development of a public health approach we need to balance work around whole populations (prevalence, which may of course reduce the pool from which individuals will go on to experience harms) against the acute needs of those with drug problems, their families and communities. We need to ensure that all substances are considered and that our systems and responses are reactive to changes in terms of patterns of use. Universal education concerning the nature of all drugs, including alcohol and tobacco, legal and illegal, is crucial to enabling young people to make informed and healthy choices. The drugs that cause most harm—and heaviest cost to the health and criminal justice services—are alcohol and tobacco. Illegal drugs also cause great harm, but it is important not to create double standards in the eyes of young people. Demystification of what drugs are, their relative harm, risks and legal status should be at the centre of education and prevention programmes. The information provided about all drugs should be honest, up to date and accurate.

QUESTION B5: HOW CAN PARENTS BEST BE SUPPORTED TO PREVENT YOUNG PEOPLE FROM MISUSING DRUGS OR ALCOHOL?

QUESTION B6: HOW CAN COMMUNITIES PLAY A MORE EFFECTIVE ROLE IN PREVENTING DRUG OR ALCOHOL MISUSE?

Communities need to be actively engaged. To be supported in identifying the problems they face and then determine effective (and wherever possible evidence based) responses. The experience of Communities Against Drugs did demonstrate that relatively modest investment could galvanise communities and achieve clear benefits.

QUESTION B7: ARE THERE ANY PARTICULAR EXAMPLES OF PREVENTION ACTIVITY THAT YOU WOULD LIKE TO SEE USED MORE WIDELY?

There are a number of approaches being developed which show some promise – often around more positive engagement with the education process. More specialist provision needs to be targeted at those known to be at highest risk (e.g. those within Pupil Referral Units or out of school). Diversion activities are also considered worthwhile, though we would flag that these should consist of more than just sport related programmes. Outcomes for such approaches need to look at a range of positives, not merely drug prevalence rates.

- ***Haringey Drug Education Team trained over 500 teachers and helped embed drug/alcohol education in all school's PSHEe curriculum***
- ***Theatre in Education and other creative methods of active learning***
- ***Trained counsellors in schools***
- ***Specialist drug/alcohol advice workers for vulnerable young people***
- ***Youth-friendly websites. For example, Haringey has www.herbonline.info***
- ***Advertisements, posters, films and leaflets that young people have helped design (Haringey has examples)***
- ***Peer educators (with ongoing support)***

QUESTION B8: WHAT BARRIERS ARE THERE TO IMPROVING DRUG AND ALCOHOL PREVENTION?

- ***Not being compulsory in schools, drug and alcohol education provision can be patchy and inadequately provided***
- ***Lack of time on curriculum and trained teaching staff***
- ***Popular misconception, sustained by much of mass media, that alcohol and tobacco are not drugs or that they are not as dangerous or significant as illegal drugs***
- ***Media scare stories and lack of balance in reporting drug/alcohol issues***
- ***Lack of trained counsellors and other specialist staff in schools, colleges, youth and community centres to support vulnerable young people***
- ***Adult double-standards, particularly over alcohol use/misuse and other drugs***
- ***Insufficient funding for drug/alcohol education and prevention programmes and staff***

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Strengthen enforcement, criminal justice and legal framework – joint Home Office and Ministry of Justice lead

As part of the full assessment on sentencing policy, we will ensure that sentencing for drug use helps offenders come off drugs.

QUESTION C1: WHEN DOES DRUG USE BECOME PROBLEMATIC?

Drug use becomes problematic when it impacts on the individuals own health/wellbeing, their family, or comes to the attention of the Criminal Justice system, health or other public services. Some problems will be acute (e.g. overdose) others may be longer term or chronic (e.g. disengagement from school/work or long term liver damage). The previous focus on criminal justice related problematic use has left a gap that could be closed with a public health focus – for example in relation to Blood Borne Viruses.

QUESTION C2: DO YOU THINK THE CRIMINAL JUSTICE SYSTEM SHOULD DO ANYTHING DIFFERENTLY WHEN DEALING WITH DRUG-MISUSING OFFENDERS?

We believe that a considerable amount of human and financial resource is wasted around the current level of drug testing.
We also believe that there is considerable scope to develop conditional cautioning.
There is a need to improve the filter process that separates those who are arrested and have used substances (including alcohol) from those whose criminal activity is related to use that would benefit from treatment. Other interventions need to be enhanced for this first group.

- ***recognise the inappropriateness of sending users to prison for breaching an order***
- ***there could be better join up between the prisons and community post release of prisoners***
- ***more investment in CARATS***
- ***DIP is effective – however, could be even more effective if courts services were better engaged in the process***.

In order to ensure that the UK has an effective statutory framework able to respond to emerging threats we will introduce a system of temporary bans on new psychoactive substances or so called "legal highs". This will enable us to take early legislative action to curb availability of potentially harmful emerging substances whilst waiting for full advice from the Advisory Council on the Misuse of Drugs. Offences will apply to the "trafficking/supply offences" and not simple possession. (Further information about government's proposal is available at www.homeoffice.gov.uk)

QUESTION C3: DO YOU HAVE A VIEW ON WHAT FACTORS THE GOVERNMENT SHOULD TAKE INTO CONSIDERATION WHEN DECIDING TO INVOKE A TEMPORARY BAN ON A NEW SUBSTANCE?

No

Please explain your views below

As an overall approach the temporary banning of substances is unhelpful and potentially puts people more at risk. Drugs are constantly evolving and any real research into the effects takes at least 18 months. More importantly banning makes them more expensive and encourages further attempts at creating similar substances, meaning the government would effectively be chasing it tail trying to keep up with the new drugs. There needs to be enhanced systems to detect changes in trends/emerging drugs early. Currently we have a largely retrospective and reactive approach. Good analytical services should be able to help identify emerging substances of most concern. There is also a need to try and ensure that the process of banning – and associated media interest – does not act as advertising for such products. It seems likely that the developments around new substances in recent years will have a significant impact in drug use and drug markets and these should be monitored.

We will explore alternative forms of secure, treatment-based accommodation for mentally ill and drug-misusing offenders.

QUESTION C4: WHAT FORMS OF COMMUNITY BASED ACCOMMODATION DO YOU THINK SHOULD BE CONSIDERED TO REHABILITATE DRUG OFFENDERS?

There is scope to develop places of safety within the community (these should be provided for both adults and young people). Issues around stable and safe accommodation are important for those going through treatment, and only by addressing accommodation issues can we maximise gains from investment in treatment. However, much could be achieved through use of tenancy support programmes etc. The use of secure residential accommodation needs to be carefully considered. More support for drug free wings within the existing secure estate would be welcomed.

We will strengthen enforcement by targeting all points along the drug supply chain from disrupting street level dealers to tackling organised crime groups.

QUESTION C5: WHERE DO YOU THINK WE MOST NEED TO TARGET ENFORCEMENT EFFORTS TO REDUCE THE SUPPLY OF DRUGS?

The short answer to this question is that enforcement appears not be working – if it was the price of drugs on the street would have gone down considerably – this has not happened. Street level dealers are by definition often users themselves – the drugs trade is international and is often linked with other forms of crime. There needs to be greater efforts at an international level. In terms of communities street level issues are a priority and while allowing for the realities of drug market displacement tackling open and nuisance creating drug markets must remain a police priority

We will also ensure law enforcement responds swiftly and flexibly to the changing drugs landscape, including emergence of new drugs, and the cyber-threat.

QUESTION C6: WHAT ELSE DO YOU THINK WE CAN DO TO KEEP ONE STEP AHEAD OF THE CHANGING DRUGS MARKETS?

Police could liaise with their local drug action team who often have intelligence about new drugs coming onto the market from the drug service providers they commission. . There would be clear benefit in developing an early warning system (this would also have public health benefits). As with other professionals those engaged with enforcement would benefit from enhanced training around this issue.

We will reduce drug-related re-offending by incentivising local criminal justice, voluntary and other partners to work together in a more joined-up and targeted way to deliver cost effective services, including models such as Integrated Offender Management (IOM).

QUESTION C7: WHICH PARTNERS – IN THE PUBLIC, VOLUNTARY AND COMMUNITY SECTORS - WOULD YOU LIKE TO SEE WORK TOGETHER TO REDUCE DRUG RELATED REOFFENDING IN YOUR LOCAL AREA?

We would welcome a scheme similar to Communities Against Drugs to help engage the voluntary and community sectors. Modest investment here could deliver significant gains. Work to support the engagement of those working across the broad social policy framework (housing, social services, education, employment) is essential. Improvements would be welcomed around liaison with those involved in offender management. Key partners would be the Police, Job centre Plus, the community including ex users, Probation, Housing, the DAAT, and Supporting People.

QUESTION C8: WHAT RESULTS SHOULD BE PAID FOR OR FUNDED?

There is no in principle objection to rewarding positive outcomes. However, it needs to be acknowledged that simplistic outcome targets can potentially penalise those delivering effective services. There is also a very wide spectrum of individuals to be worked with and many external factors (e.g. employment) that are beyond services control. Work could be developed on a basket of indicators, including health (e.g. entry into Hep C treatment) as well as training and social functioning outcomes. We would argue these need to be flexible and negotiated at a local level (albeit within a potential national framework).

Many of the outcomes on Treatment Outcome Profile give a good indication of changes in behaviour and are about outcomes rather than targets. However, some are inevitably more difficult to measure than others.
Government should continue to fund a range of prevention and treatment interventions from lower level harm reduction services through to Tier 4 rehabilitation services.

We will reduce drug supply in prison by deploying a comprehensive range of measures based on local risk assessment, working closely with law enforcement partners, and developing intelligence gathering capability.

QUESTION C9: WHAT MEASURES DO YOU THINK SHOULD BE TAKEN TO REDUCE DRUG SUPPLY IN PRISON?

There is already clear evidence of what helps reduce supply in prison. Effective use of staff (which requires adequate resources) and technology has been shown to reduce supply significantly. There is support for the development of drug free wings – which again require adequate support. A particularly significant concern around prison drug use is the associated health problems. Addressing these should be a priority. More activities in prisons making it less likely that drug markets would flourish

QUESTION C10 (IF APPLICABLE):
WHAT IMPACT WOULD THE MEASURES SUGGESTED HAVE ON:

a) offenders?

b) your local community?

a) ***Improve their health and so increase likelihood of successful reintegration.***
b) ***The above would help reduce re-offending, save resources and improve public health.***

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Rebalance treatment to support drug free outcomes – Department of Health lead

Harm reduction services are more generally available (though these would benefit from being greater valued for their public health gains and new challenges require innovation).

- ***Local commissioning frameworks based on sound needs assessment***
- ***Models of care***
- ***User involvement in the planning and commissioning process***
- ***outcome based commissioning***
- ***DAAT Partnerships***
- ***Crack/stimulant specific services***
- ***Accessibility***

QUESTION D2: THINKING ABOUT THE CURRENT TREATMENT SYSTEM, WHAT IS IN NEED OF IMPROVEMENT AND HOW MIGHT IT NEED TO CHANGE TO PROMOTE RECOVERY?

(E.g. how commissioners get the most out of community and residential rehab)

Better support is required for mainstream services, much more could be achieved within primary care settings.
There is a clear need to improve the linkages between drug services and those working with alcohol and mental health. The role of non-specialist services also needs to be recognised.
We should value the existing evidence base, seek to ensure it is implemented – but not at the expense of stifling innovation and look at new methods.
Greater local autonomy offers the opportunity of more tailored local responses but treatment and recovery initiatives will benefit from central championing.
Looking at access we should seek to develop routes into advice and treatment which are low threshold to try and intervene prior to the development of more acute problems.

- ***Integrated treatment system***
- ***More GP Prescribing and involvement***
- ***Education, training and employment opportunities – that are endorsed and supported by central and local government***
- ***more and wider range of accomodation for current and ex-users***
- ***funding for community care could be simplified (pooling of LA and NHS monies)***
- ***The recovery capital of users and their families needs investment. Start up funding to make personalisation real and available to ex-substance misusers.***
- ***Benefit system needs to facilitate gradual entry into the job market and to acknowledge that volunteering etc is a valuable***

QUESTION D3: ARE THERE SITUATIONS IN WHICH DRUG AND ALCOHOL SERVICES MIGHT BE MORE USEFULLY BROUGHT TOGETHER OR ARE THERE SITUATIONS WHERE IT IS MORE USEFUL FOR THEM TO BE OPERATED SEPARATELY?

Combined services could work for polydrug use, counselling, recovery agenda, but separate services may be needed for specific group work or work in GP settings., e.g. tranquillisers users often need a lot of ongoing intensive one to one support as well as group work. Feedback from service users has sometimes favoured separate drug and alcohol services. The main priority is that if we have combined services we must have the necessary expertise and understanding of drug and alcohol issues within the staff team.

QUESTION D4: SHOULD THERE BE A GREATER FOCUS ON TREATING PEOPLE WHO USE SUBSTANCES OTHER THAN HEROIN OR CRACK COCAINE, SUCH AS POWDER COCAINE AND SO CALLED LEGAL HIGHS?

Yes

Please explain your response below

Yes – cannabis, ketamine, khat and cocaine can be extremely problematic for the individual user and their family both in terms of mental and physical health. Commissioners should be able to treat people based on their local needs assessment.

QUESTION D5: SHOULD TREATING ADDICTION TO LEGAL SUBSTANCES, SUCH AS PRESCRIBED AND OVER-THE-COUNTER MEDICINES, BE A HIGHER PRIORITY?

☐ Yes

Please explain your response below

Not necessarily higher – more that treatment services should be able to treat and work with anyone who comes through their door for help with a substance misuse problem. The previous strategy made this nigh on impossible with its focus on class A drug users to the exclusion of other drugs, including alcohol.

QUESTION D6: WHAT ROLE SHOULD THE PUBLIC HEALTH SERVICE HAVE IN PREVENTING PEOPLE USING DRUGS IN THE FIRST PLACE AND HOW CAN THIS LINK IN TO OTHER PREVENTATIVE WORK?

Substance misuse prevention should be a core part of public health/health improvement activity. It could easily link in with other preventative work e.g. cardiovascular disease/high blood pressure screening can and should be linked to alcohol screening/screening for stimulant use. Specifically this work should be linked to tackling health inequalities e.g. Haringey DAAT have recently worked with the Somali community re prevention of TB within Mafrishes – where khat is chewed and poor ventilation contributes to spread of TB). Reducing Teenage pregnancy and obesity can and should be linked into drugs and alcohol work. Prevention of blood borne viruses e.g. HIV, Hep B and Hep C.
Clean water and injecting equipment.

We will build a skilled workforce to deliver better results and improve treatment (both medical and psychosocial), offering more ambitious and individual services, building on the evidence of what works and is cost-effective.

QUESTION D7: WE WANT TO ENSURE THAT WE CONTINUE TO BUILD THE SKILLS OF THE DRUG TREATMENT AND REHABILITATION SECTOR TO ENSURE THAT THEY ARE ABLE TO MEET THE NEEDS OF THOSE SEEKING TREATMENT. WHAT MORE CAN WE DO TO SUPPORT THIS?

- ***Ensure NVQ's available through the Skills Council***
- ***Ensure evidence based research continues and offer free conferences***
- ***Focus on drug and alcohol should be part of GP/other health and social care staff training not just specialist drug and alcohol workers***

We will improve the "patient experience" of treatment and recovery, ensuring better continuity of care when moving between treatment settings (e.g. prison and community, with appropriate services for young people, and promoting a more holistic approach that includes effective support for reintegration).

QUESTION D8: TREATMENT IS ONLY ONE ASPECT CONTRIBUTING TO ABSTINENCE AND RECOVERY. WHAT ACTIONS CAN BE TAKEN TO BETTER LINK TREATMENT SERVICES IN TO WIDER SUPPORT SUCH AS HOUSING, EMPLOYMENT AND SUPPORTING OFFENDERS?

Central government needs to ensure that all Whitehall departments who relate to policy around housing, employment and support of offenders work together. Previously agendas have often competed against each other and on occasion actively discriminated against those working toward recovery/social reintegration. Championing the case that recovery and social reintegration is a reality and delivers real results for individuals, families and communities is essential.
Government could incentivise employers to take on people with previous offending/drug using history as there is often a great deal of prejudice regarding this group. .A dedicated Work Placement Officer whose task it is to support the employee and employer has proved helpful in Haringey Funding for social enterprises can also be helpful. There needs to be a push from central government re housing of people with former substance misuse problems, as this is not something that can simply be tackled by the local Drug and Alcohol Action Team. Locally we have been fortunate in being able to redesign SP accommodation based support services to better meet the needs of people with drug/alcohol and mental health problems. However, unless there is move on accommodation this scheme will quickly develop a waiting list.

We need to ensure that commissioners across different Government programmes are working effectively together and can access funding without excessive restrictions on use.

QUESTION D9: HOW DO YOU BELIEVE THAT COMMISSIONERS SHOULD BE HELD TO ACCOUNT FOR ENSURING THAT OUTCOMES OF COMMUNITY-BASED TREATMENTS, FOR THE PROMOTION OF REINTEGRATION AND RECOVERY, AS WELL AS REDUCED HEALTH HARMS, ARE DELIVERED?

Essentially commissioners need to be held account by their local communities via their local authorities (with their expanding remit into public health). This can only be achieved by promoting a clear understanding of the scale of the problems faced, the links into related areas and an expectation of what effective interventions can provide. Targets should be agreed at a local level as each London borough is different. The outcomes should be based on the findings of our local needs assessment. In terms of accountability for the wider recovery agenda this cannot be solely the commissioners responsibility, as stated above

employees need to be incentivised and we need more jobs and housing – particularly in the current climate.

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Support recovery to break the cycle of drug addiction – Department for Work and Pensions lead

The Coalition Government believes in an approach to tackling drug and alcohol dependency that is firmly rooted in the concept of recovery and reintegration, as a process through which an individual is enabled to overcome the symptoms and causes of their dependency, and become an active and contributing member of society.

It is however, important to recognise that recovery can mean different things, to different people, at different points in their journey, and is most effective when an individual's needs and aspirations are placed at the heart their care.

The end result should also be the focus, rather than the means, which is why we will seek to embed appropriate outcome-based incentives into the delivery and commissioning system.

Recovery does not begin or end with treatment and applies equally to employment, housing, education and skills, family support, probation and wider health services that need to wrap around treatment in a holistic fashion to support sustained recovery.

QUESTION E1: WHAT INTERVENTIONS CAN BE PROVIDED TO BETTER SUPPORT THE RECOVERY AND REINTEGRATION OF DRUG AND ALCOHOL DEPENDENT OFFENDERS RETURNING TO COMMUNITIES FROM PRISON?

Better pre-release planning should be developed. We welcome the recognition of the vital role of services beyond drug treatment.

- ***Properly funded carat teams***
- ***meet and greet teams –***
- ***better join up between the prisons and community re release dates.***
- ***treatment plans that have been agreed whilst offender is still in prison***
- ***support networks in place***
- ***housing in place –(particularly if prisoner already has accommodation – more work is needed to ensure they do not loose there tenancy or are not discriminated against in terms of housing because they have been in prison***

QUESTION E2: WHAT INTERVENTIONS COULD BE PROVIDED TO ADDRESS ANY ISSUES COMMONLY FACING PEOPLE DEPENDENT ON DRUGS OR ALCOHOL IN RELATION TO HOUSING?

- ***Much more could be done to help people maintain existing housing and with their transition to managing a home. Tenancy support work can pay significant dividends. We need a greater recognition that housing is often the issue that secures individuals progress/recovery and so realises the gain on other investment. Continuation of funding for Supporting People***
- ***services that are targeted at substance misusers and offenders***

QUESTION E3: HOW MIGHT DRUG, ALCOHOL AND MENTAL HEALTH SERVICES BE MORE EFFECTIVE IN WORKING TOGETHER TO MEET THE NEEDS OF DRUG OR ALCOHOL DEPENDENT SERVICE USERS WITH MENTAL HEALTH CONDITIONS?

There is a real gap in terms of alcohol services for those with Dual diagnosis. Alcohol services and particularly voluntary sector alcohol services are not funded to deal with complex needs and given that may cases include the use of cannabis and alcohol it is crucial that these services are better resourced. In addition CMHT's could be better resourced to deal with these issues, GP's could be better trained to recognise and work with this group, psychology could have an input into dual diagnosis services. Ultimately what is needed are integrated drug/alcohol dual diagnosis services that are fully resourced.

QUESTION E4: DO APPROPRIATE OPPORTUNITIES EXIST FOR THE ACQUISITION OF SKILLS AND TRAINING FOR THIS GROUP?

Often not, or where they do exist with very limited capacity. The experience of initiatives such as Progress 2 Work show that such interventions can be beneficial. We need to have a wide range of interventions to cope with the breadth of the problems faced, ranging from basic literacy and numeracy through to coaching and confidence building. People with a dual diagnosis are often more stigmatised than those with drug or alcohol problems..

In respect of employment, we will reform the welfare system so that those with drug and alcohol problems receive the help and support they need to overcome their dependency and get back to work.

QUESTION E5: SHOULD WE BE MAKING MORE OF THE POTENTIAL TO USE THE BENEFIT SYSTEM TO OFFER CLAIMANTS A CHOICE BETWEEN:

a) some form of financial benefit sanction, if they do not take action to address their drug or alcohol dependency; or

b) additional support to take such steps, by tailoring the requirements placed upon them as a condition of benefit receipt to assist their recovery (for example temporarily removing the need to seek employment whilst undergoing treatment).

We do not believe applying benefit sanctions is a sensible proposition with this client group. It could lead to more drug related crime/ pressure on carers and other family members. Some of this group cannot read or write and have never worked. We would like to see the development of more apprenticeship schemes for this group. It is senseless to pretend that employers are going to welcome them with open arms – there needs to be a concerted media campaign to change attitudes toward people with substance misuse problems.

QUESTION E6: WHAT IF ANYTHING COULD JOBCENTRE PLUS DO DIFFERENTLY IN ENGAGING WITH THIS CLIENT GROUP TO BETTER SUPPORT RECOVERY?

(For example, greater use of specialist advisers and outreach, use of different communication channels for benefit advice and administration)

- ***Specialist JCP advisors could come into treatment services and be part of the service users reviews***
- ***JCP staff need more training on effects of substance misuse and its impact on this group***
- ***JCP staff need to talk to newly unemployed JCP clients re the risk of escalating alcohol/drug use linked to unemployment***

QUESTION E7: IN YOUR EXPERIENCE, WHAT INTERVENTIONS ARE MOST EFFECTIVE IN HELPING THIS GROUP FIND EMPLOYMENT?

- ***life skills training***
- ***personal development***
- ***dealing with conflict***
- ***developing self-esteem/confidence***
- ***help with completing CV's***
- ***basic literacy and maths***
- ***voluntary work/ training for short periods***
- ***benefits tailing off as employment becomes more secure***
- ***having a dedicated work placement officer that the person* can check back in with – not necessarily linked to treatment services.**

QUESTION E8: WHAT PARTICULAR BARRIERS DO THIS GROUP FACE WHEN WORKING OR LOOKING FOR EMPLOYMENT, AND WHAT COULD BE DONE TO ADDRESS THESE?

(For example, how could employers be encouraged to look beyond stigma to employ recovering addicts)

As previously stated employers might need to be incentivised and receive some training re drugs and alcohol. The could be supported by knowing that the new employee had a Work Placement Officer who was supporting them and the new employee deal with any conflict etc. The barriers they face are – criminal record, low paid or exploitative work opportunities, child care, fear of poverty if they come off benefits.

New approaches to supporting families with multiple problems will be developed. The cost-effectiveness of children's services will be improved and the number of children requiring safeguarding or taken into care reduced, with child protection and safeguarding addressed across the strategy.

QUESTION E9: BASED ON YOUR EXPERIENCE, HOW EFFECTIVE ARE WHOLE FAMILY INTERVENTIONS AS A WAY OF TACKLING THE HARMS OF SUBSTANCE MISUSE?

The 'Think Family' model has started to work very well locally and we would like to see it's coverage widened. In addition targeted services to work with children and families affected by substance misuse are affective in ensuring intergenerational substance misuse problems do not develop.

QUESTION E10: IS ENOUGH DONE TO HARNESS THE RECOVERY CAPITAL OF FAMILIES, PARTNERS AND FRIENDS OF PEOPLE ADDICTED TO DRUGS OR ALCOHOL?

No – there is a need for more systemic work in substance misuse services and input from wider support services. It is difficult for family to help service users when they themselves are affected by the users drug or alcohol use.

QUESTION E11: DO DRUG AND ALCOHOL SERVICES ADEQUATELY TAKE INTO ACCOUNT THE NEEDS OF THOSE CLIENTS WHO HAVE CHILDREN?

(e.g. are they afforded sufficient priority; is there adequate access to childcare; are the design and opening hours of services appropriate; and could more be done, taking into account child protection issues, to ensure that service users maintain contact with their children whilst engaged in treatment)

There are minimal resource to do all of the things that substance misuse services would like to be doing if they were truly offering a family friendly service. In terms of safeguarding – this has moved on tremendously and we are confident that all of the staff within the services are aware of the potential risk to children and what to do if they have concerns.

QUESTION E12: WHAT PROBLEMS DO AGENCIES WORKING WITH DRUG OR ALCOHOL DEPENDENT PARENTS FACE IN TRYING TO PROTECT THEIR CHILDREN FROM HARM, AND WHAT MIGHT BE DONE TO ADDRESS ANY SUCH ISSUES?

- ***Problems –*** *Poverty*
- *poor housing*
- *poor access to childcare*
- *poor family support*
- ***Solution –*** *in reach of childcare professionals into services, specialist team midwives, drug worker, health visitor, social worker, parenting support worker peer support volunteers*

2010 Drug Strategy consultation
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The Co-ordinator can be emailed at:
Nigel.Lawrence@homeoffice.gsi.gov.uk

Alternatively write to him at:

Nigel Lawrence, Consultation Co-ordinator
Home Office
Performance and Delivery Unit, Better Regulation Team
3rd Floor Seacole
2 Marsham Street
London, SW1P 4DF