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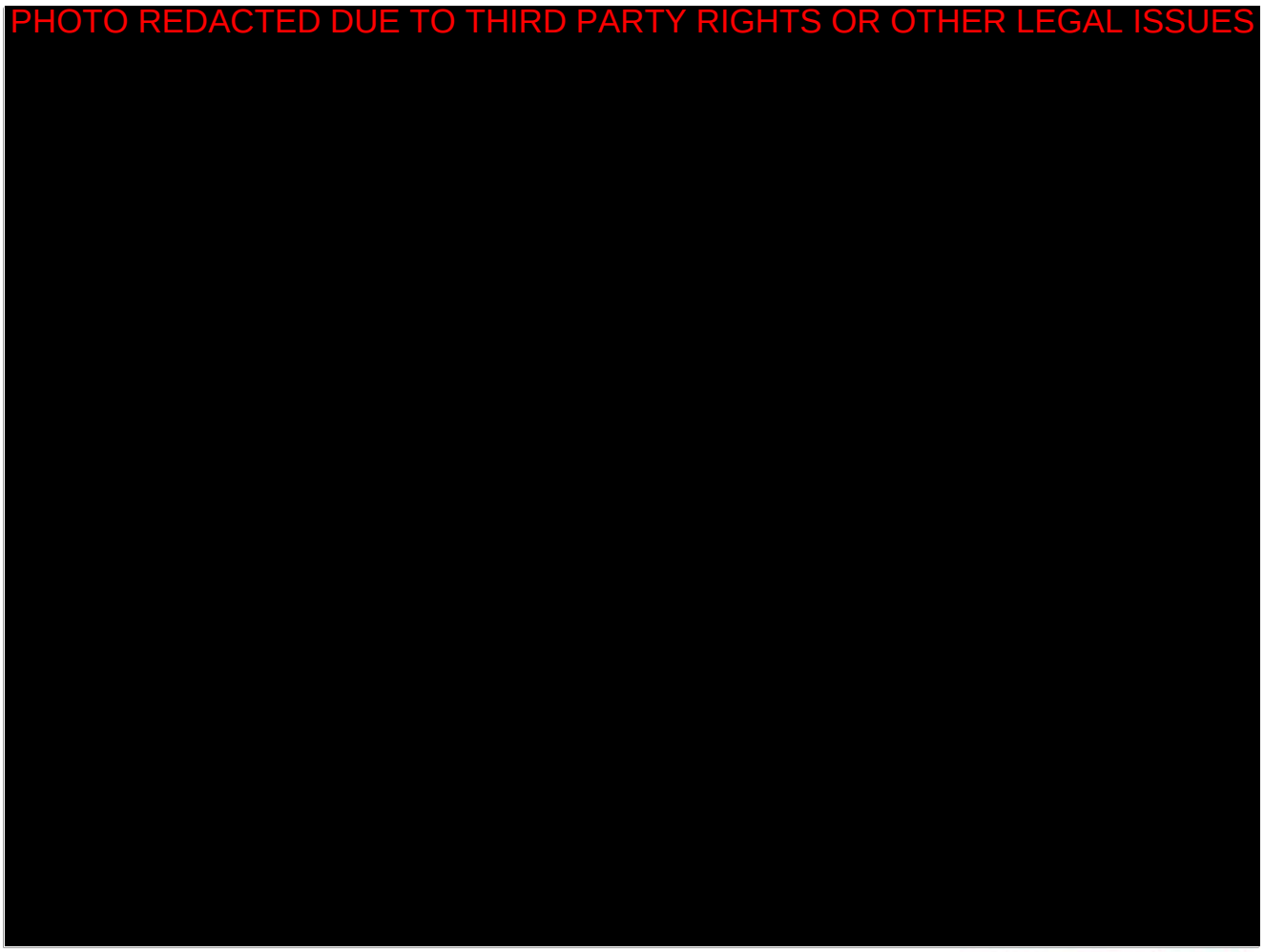


Drugs: protecting families and communities

The 2008 drug strategy

TACKLING DRUGS CHANGING LIVES

Contents

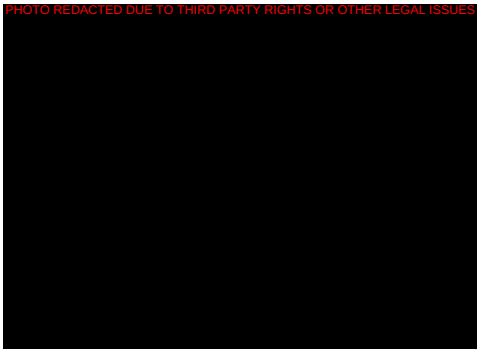
Home Secretary's foreword

Drug misuse wastes lives, destroys families and damages communities. It costs taxpayers millions to deal with the health problems caused by drugs and to tackle the crimes such as burglary, car theft, mugging and robbery which are committed by some users to fund their habit. The drug trade is linked to serious organised crime, including prostitution and the trafficking of people and firearms. Drugs remain a serious and complex problem that we – along with all modern societies – must face.

We now know that we can succeed in tackling drugs because the last ten years have seen progress and some notable successes. The percentage of people – including young people – who use illegal drugs has fallen since 1998. Because we have invested in drug treatment, we are getting people into treatment faster, with people waiting on average less than two-and-a-half weeks for treatment, rather than nine weeks in 2001. Overall, we have more than doubled the numbers of people accessing drug treatment. We have targeted those who commit crime to feed their addiction by using compulsory drug testing on arrest and assessment by a drugs worker. This is backed up by tough sanctions for those who do not comply, including, in some cases, custodial sentences. This has contributed to a fall in recorded acquisitive crime of around 20 per cent. And because the police and their partners are making full use of new powers introduced by the Government, communities are seeing action and tangible results – over 1,000 crack houses have been closed since 2003, and we are seizing more of the assets of drug dealers.

But we also know there is more to be done. Overall drug use is down, but the use of cocaine and heroin has remained stable in recent years. And although cannabis use is down overall, we know that stronger types of cannabis are available. The number of cannabis factories being detected has also risen dramatically in the past two years. While we have been successful at fast-tracking people into treatment, we need to focus more upon treatment outcomes, with a greater proportion free from their dependence and being re-integrated into society, coming off benefits and getting back to work. We have also sometimes focused too much on the individual drug user and not enough on their family and the wider community.

Our ambition is clear. We want a society free of the problems caused by drugs. Our aim is that fewer and fewer people start using drugs; that those who do use drugs not only enter treatment, but complete it and re-establish their lives; and that communities are free of drug-related crime, anti-social behaviour and the fear these cause. We know that this is long-term work and will mean dealing not just with drug problems, but with the problems in societies, communities and families that can make people susceptible to drug use, and can act as barriers to recovery. All societies face these problems, and there are no instant solutions.



Our new strategy will build on the success of the past ten years, but also learn lessons. The difference that the new strategy brings is that we will:

- focus more on **families**, addressing the needs of parents and children as individuals, as well as working with whole families to prevent drug use, reduce risk, and get people into treatment;
- give a stronger role to **communities**, protecting them from the damage that drugs cause through strong enforcement action, using all available powers, sanctions and levers, giving them a voice and listening to their concerns;
- **target money and effort** where we will make the most difference by making sure people are successfully completing treatment and re-establishing their lives, and by focusing on the drug users causing the most harm to communities;
- **work together** on shared problems across institutional boundaries – for example, ensuring that children's social services know about drug-using parents where children are at risk as a result of their drug use, or local communities can work with police and other agencies to disrupt and dismantle open street markets and close down cannabis factories and crack houses; and
- be clear that drug users **have a responsibility** to engage in treatment in return for the help and support available.

On **enforcement**, we will:

- prosecute drug dealers and those committing crime to feed their addiction, drug-test on arrest, getting drug-misusing offenders into effective treatment and improving prison treatment programmes, while increasing the use of community sentences with a Drug Rehabilitation Requirement (DRR);
- use Neighbourhood Policing to gather community intelligence leading to more drug dealers' assets being seized as well as more dealers going to prison – with more powers to seize assets more easily, making it clear that money cannot be earned from drugs with impunity;
- work with international partners to intercept drugs before they reach the UK's borders and disrupt and dismantle serious and organised crime through the Serious Organised Crime Agency (SOCA), police forces and HM Revenue and Customs (HMRC); and
- back parents and communities who want to take action, supporting the use of local campaigns such as 'Rat on a Rat', allowing communities to report dealers anonymously in their local area.

On **treatment**, we will:

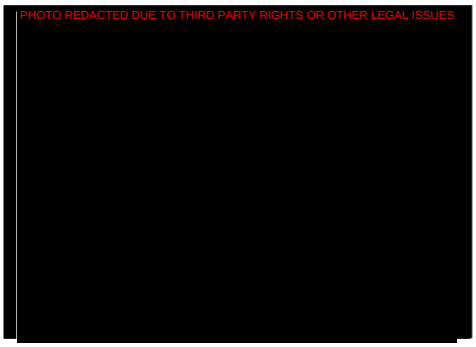
- clearly prioritise those who are causing the most harm to communities and families – getting offenders, and parents whose drug use may put their children at risk, into effective treatment quickly;

- pilot the use of individual budgets to help those successfully completing treatment to access housing, employment, education and training, to support them in re-establishing their lives, free from dependency;
- use all emerging and all available evidence to make sure we are supporting the treatment that is most effective, targeted on the right users – with abstinence-based treatment for some, drug-replacement over time for others, and innovative treatments including injectable heroin and methadone where they have been proved to work and reduce crime;
- involve families and carers in the planning and process of treatment, for young people and for adults; and
- ensure that the benefits system supports our new focus on re-integration and personalisation. In order to ensure that it provides the right level of support and creates incentives for people with drug problems to move towards treatment, training and employment, we will at a minimum:
  - require drug misusers on out-of-work benefits to attend a discussion with an appropriate specialist treatment provider or partner organisation as part of the Jobseeker Direction or Work Focused Interview requirements; and
  - encourage closer links between relevant agencies so that drug misusers who are claiming benefits can be referred to specialist services.

These changes are a first step in helping clients to overcome barriers to work and ensuring Jobcentre Plus engages more closely with local drug partnerships and treatment providers in all areas where this is not already happening. However, we do not think it is right for the taxpayer to help sustain drug habits when individuals could be getting treatment to overcome barriers to employment. So, we will explore the case for introducing a new regime which provides more tailored and personalised support than that which is currently provided by the existing Incapacity Benefit or Jobseeker Allowance regimes. In return for benefit payments, claimants will have a responsibility to move successfully through treatment and into employment. Further proposals will be announced regarding these measures.

On **prevention**, we will:

- expand our approach so that it increasingly focuses on young children and families before problems have arisen;
- take a wider preventative view that is not focused just on illegal drugs, but on all substances and the risk factors that we know can lead to drug use, alcohol misuse and volatile substance abuse (gases, glues and solvents) as well as other problems later in life;
- look at the whole family, ensuring prompt access to treatment for drug-misusing parents with treatment needs and particularly those whose children are at risk, with assessments taking account of family needs, and providing intensive parenting support alongside drug treatment; and

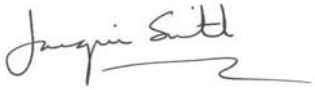


- ensure drug-misusing parents, and other at-risk parents, including offenders and their partners, are a target group for new parenting experts and in plans to develop Family Intervention Projects – which are already working intensively with around 1,500 families engaged in anti-social behaviour – and Family Pathfinders for wider types of families at risk.

On **communications**, we will:

- send a clear signal about the damaging consequences of all harmful substances, working with parents and children to give information and advice and with communities to build reassurance and show that action is being taken. The successful FRANK campaign will continue to provide honest and confidential information to children and young people; and
- give parents and extended families better and more accessible advice about how to talk to children about drugs, and about what to do if they suspect their child may have a problem.

Through our new drug strategy, and the action that will flow from it, we will continue to send a clear message that drug use is unacceptable; that we are on the side of communities; that we demand respect for the law and will not tolerate illegal or anti-social behaviour; but that we will provide help for those who are trying to turn their lives around, to get off drugs and into work, to ensure drug problems are not handed on to the next generation; and that we expect drug users themselves to take responsibility, and will help them to do so.



Jacqui Smith
Home Secretary

Executive summary

Illegal drugs bring with them a range of problems and they are a major issue of public concern. The harms they cause are significant, wide-ranging and costly, with the use of Class A drugs generating an estimated £15 billion in economic and social costs. While all drugs have damaging impacts, the most harmful drugs, including heroin and crack cocaine, bring untold misery to individuals, their families and communities. Problem drug use is an issue which has an impact on society as a whole, but disproportionately affects the most deprived communities, disadvantaged families and vulnerable individuals.

Illegal drugs are part of a global industry that relies on the exploitation of the poorest people in producer and transit countries and traps many others in a cycle of crime and deprivation in target countries such as our own. The most damaging effects for communities are those caused by drug dealing, drug-related crime and anti-social behaviour, which can undermine stable families and cohesive communities.

Drug misuse can prevent parents from providing their children with the care and support they need and greatly increases the likelihood that their children will grow up to develop drug problems themselves. It creates chronic health problems that destroy lives and it prevents young people from succeeding in education, being healthy and fulfilling their potential.

Our challenge

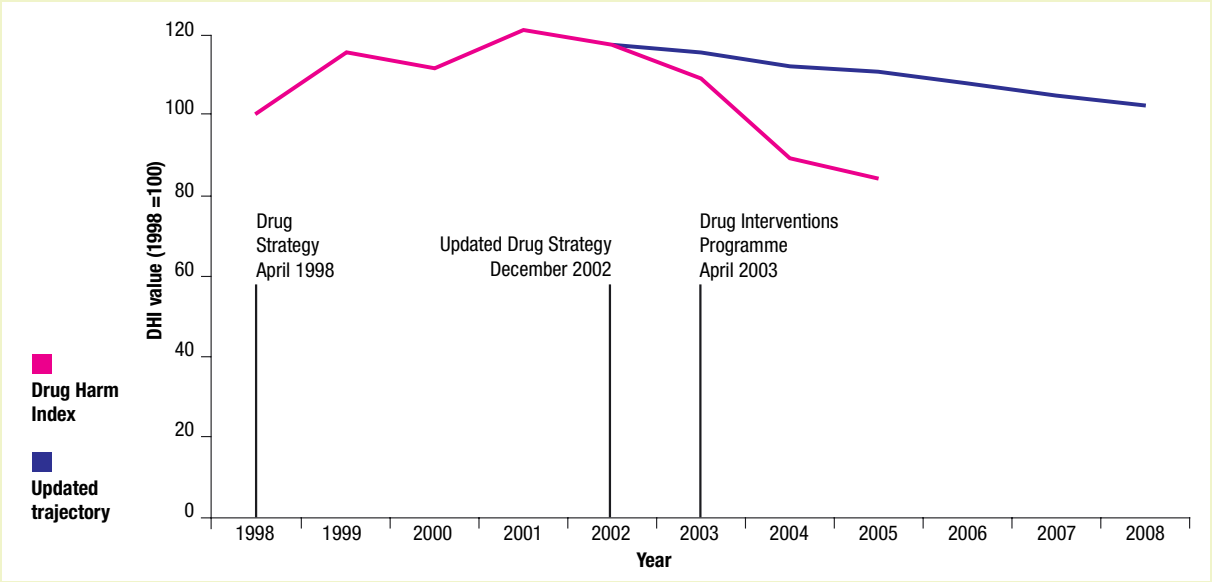
We know from the latest available evidence that:

- there are an estimated 332,000 problem drug users in England;
- Class A drug use generates an estimated £15.4 billion in crime and health costs each year, of which 99 per cent is accounted for by problem drug users;
- between a third and a half of acquisitive crime is estimated to be drug related;
- around a quarter (24 per cent) of young people aged 16–24 have used an illegal drug in the last year;
- 10 per cent of people aged 16–59 have used an illegal drug in the last year;
- 17 per cent of school children aged 11–15 have used an illegal drug in the last year; and
- the UK illicit drug market is estimated to be worth between £4 billion and £6.6 billion.

The Government's 1998 drug strategy, with its 2002 update, set a framework to address the harms caused by the supply of and demand for drugs. This has allowed the Government and its partners to achieve many of the strategy's aims and there is much for us to build upon. We have seen reductions in drug-related harm and drug-related crime and increased treatment provision, with increasing numbers of offenders referred into treatment from the criminal justice system.

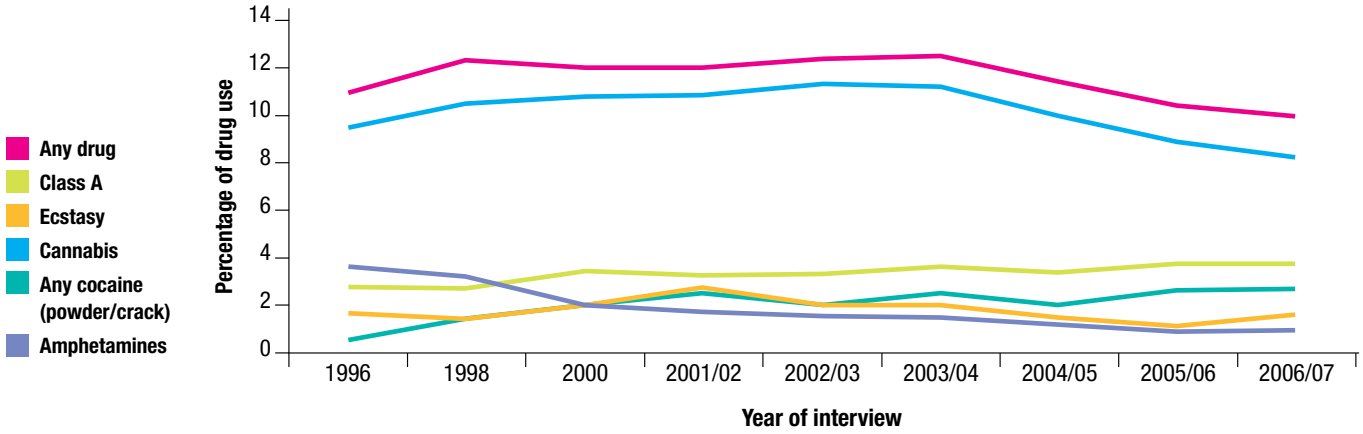
Public Service Agreements – meeting our targets

Significant progress has been made against our Public Service Agreement (PSA) targets. Drug-related harm is measured by the Drug Harm Index, which shows a reduction of 28.4 per cent between 2002, the reference year for the PSA, and 2005, the latest available measurement. Drug-related crime has fallen significantly since the introduction of the Drug Interventions Programme (DIP) in 2003 (see below) and we are on track to meet our target to direct 1,000 drug-misusing offenders into treatment each week.



The target to double the number of people accessing drug treatment was achieved two years early and, for young people, frequent use of illicit drugs has decreased, while the use of Class A drugs has been stabilised following a prolonged period of sustained increases.

Percentage of 16–59-year-olds reporting use of the most prevalent drug types in the last year, 1996 to 2006/07 BCS



Crack houses are closed more rapidly using new enforcement powers and drug dealers have had their assets seized and reinvested in the communities they have damaged. We have focused on identifying and intervening with the young people who are most at risk of developing substance misuse problems, to prevent such problems occurring.

While we have made a great deal of progress, more remains to be done. Despite drug use being at its lowest level since 1998, it remains high, with 10 per cent of people using an illegal drug in the past year (see graph) and more than a quarter of people thinking that drug use or dealing is a very or fairly big problem in their area.[1]

Although drug-related crime continues to fall, that reduction has recently slowed. We must therefore continue to prioritise efforts to identify problematic drug users and get them into treatment, driving down drug misuse, drug-related crime and the associated costs.

The impact of substance misuse on children and families can be significant and long-lasting, but has previously been underestimated. Parental drug use can cause children a wide range of health and developmental problems. It also limits the capacity for effective parenting, and many of the impacts of parental drug use, such as emotional insecurity, irregular school attendance and lack of suitable role models, can be drivers for other problems, including involvement in youth crime or low educational attainment. We must prioritise efforts to identify children and families at risk from substance misuse and provide appropriate interventions to address the challenges they face.

Drugs: our community, your say

To inform the development of the drug strategy, and to ensure that it is responsive to the issues that are of concern to communities, the Government launched a public consultation in July 2007. More than a thousand written responses were received and interviews were conducted with stakeholders, communities and service user representatives. A summary of responses received is available on the Home Office drugs website.

Priorities identified during the consultation process, to which this strategy responds, include:

- visible and effective action against dealers, responding to community concerns and providing timely feedback on action taken;
- action to support the children of drug misusers and to intervene with families at risk of suffering harms;
- targeted interventions for vulnerable young people;
- local information and prevention campaigns;
- more personalised treatment services, with better support to help people to complete treatment and to re-establish their lives;
- improved guidance on commissioning and flexibility in the use of resources;
- a commitment to improve the evidence supporting the strategy; and
- a clear commitment to meet the needs of all our diverse communities.

1 British Crime Survey 2006/07.

Our vision is to produce a long-term and sustainable reduction in the harms associated with drugs; helping to promote drug-free futures and drug-free streets for children, families and communities. We will combine tough enforcement action against those whose dealing and offending threatens communities with strong prevention and early intervention to address problems before they develop, intervening swiftly when they do. We will maximise the impact of the significant resources spent on treatment by better targeting and tailoring interventions and supporting users to move on from treatment and re-integrate into communities.

In order to achieve this vision, we will strengthen those areas where we have been effective, but also test and implement new interventions where changes need to be made. In practice, this means:

- **Protecting communities through robust enforcement to tackle drug supply, drug-related crime and anti-social behaviour.** Developing ways to regularly engage and respond to the needs of communities and to increase the seizure of criminal assets, delivering visible benefits to communities and strengthening the capacity of agencies to tackle crime in their areas and the supply of drugs into and within the UK. We will reduce drug-related offending through more effective targeting and offender management, continuing to identify and grip drug-misusing offenders, so that we drive down anti-social behaviour and crimes such as burglary and robbery, which have such a corrosive effect on the confidence of communities.
- **Preventing harm to children, young people and families affected by drug misuse.** Targeting interventions on those young people and families most at risk of suffering harms caused by substance misuse. We will intervene earlier with young people to prevent immediate harms and to avert future problematic drug use and we will provide prompt and tailored support to families with substance-misusing parents. Providing a family focus will ensure that the needs of the children and families of drug users are given a greater priority than they have previously received.
- **Delivering new approaches to drug treatment and social re-integration.** We will further reform the way treatment is provided, offering services such as training and support in getting work, alongside drug treatment. We will also use the benefits system to support this new focus on re-integration, providing the right level of support for people with drug problems to move towards treatment, training and employment. This will allow us to respond more directly to individual needs, helping drug misusers to overcome dependence and re-establish their lives. The previous strategy successfully delivered an expanded and accessible treatment system. This strategy builds on this to focus more on the longer-term outcomes of treatment, including its impact on crime, health and harms caused to families.

- **Public information campaigns, communications and community engagement.** Developing communication and education campaigns, involving young people, communities, families and parents to make clear the harms that all drugs can cause, supporting informed decisions and determining locally appropriate responses to drug misuse.

We will concentrate our efforts on supporting communities and families. We firmly believe that when communities work together, they are more able to prevent and resist the harms caused by drugs. Local areas will have greater autonomy and flexibility to respond to the local needs and to the priorities of local communities, and this flexibility will underpin our new approach.

While our focus will remain on the drugs that cause the greatest harms to communities, families and individuals, local areas will have more flexibility to determine their response to the drugs which are causing the greatest harm to their communities. For young people, all substances should be addressed, including alcohol and volatile substances such as gases, glues and solvents. The Pooled Treatment Budget will continue to be available to support treatment for all forms of substance misuse among young people below the age of 18. Although the Pooled Treatment Budget for adults will remain beyond use for the provision of primary alcohol misuse treatment, it may be right in some communities for plans to tackle drug use to be developed alongside action to tackle harmful drinking.

This strategy underpins action to reach our new PSA targets for 2008–11, which, for drugs, are measured by the following indicators:

PSA 25	Reduce the harm caused by alcohol and drugs	The number of drug users recorded as being in effective treatment
		The rate of drug-related offending
		The percentage of the public who perceive drug use or dealing to be a problem in their area
PSA 14	Increase the number of children and young people on the path to success	The proportion of young people frequently using illicit drugs, alcohol or volatile substances

These targets reflect our new focus on protecting communities and on preventing harm to young people, while stepping up action against drug dealers and offenders and increasing our efforts to achieve better treatment outcomes. The new Local Performance Framework, which has a single set of 198 national indicators, includes a number of indicators that are also common to the Assessments of Policing and Community Safety (APACS) framework. This framework moves us towards localised service delivery, which will result in more effective local engagement and identification of priorities. This will allow local areas to make the most efficient use of resources to meet local needs. Within this new delivery regime, any action taken at a local level to prioritise and tackle issues related to drug misuse, such as crime, anti-social behaviour and social exclusion, will also have an impact on drug and substance misuse.

The national and local voluntary sector makes a significant and valuable contribution to the delivery of the drug strategy. Organisations in this sector are able to work flexibly across all themes of the strategy and can respond quickly to changing demands and environments. They can work effectively in partnership with other agencies and organisations, including those from the statutory and private sectors, to contribute to delivery of the objectives of the strategy, to build service and workforce capacity and to support the process of mainstreaming substance misuse.

Across the entire strategy – including how it is delivered at a local level – we will enhance our knowledge of what works and what delivers the most effective and efficient services by conducting a cross-government programme of research and pilot programmes. More information on the evidence which supports the strategy and our priorities for developing a programme of research are set out in an appendix to this strategy.

This strategy provides an overarching framework of objectives and aspirations. Within this framework is a series of three-year Action Plans, which will run concurrently with the Government's Comprehensive Spending Review cycles and new PSA targets. This will ensure resources and priorities are aligned. The strategy will be implemented in the context of the comprehensive national legislation on drugs and the obligations of international drugs Conventions.

Responding to the challenge

Protecting communities through robust enforcement to tackle drug supply, drug-related crime and anti-social behaviour

Key strategy actions

- Use multi-agency and intelligence-based approaches to identify the drug-misusing offenders at greatest risk of causing the most harm and improve our responses to divert them out of crime.
- Embed action to tackle drugs within the Neighbourhood Policing approach, responding to community concerns about drugs, acting on intelligence provided by the community and giving feedback on how such intelligence was used.
- Support communities who wish to take action against drug dealing by promoting local campaigns such as 'Rat on a Rat'.
- Create more international partnerships to intercept drugs being trafficked to the UK and to implement border controls in countries of departure.
- Extend asset seizure powers, including entering asset-sharing agreements with other countries to allow the seizure of criminal assets sequestered overseas, and introducing powers to seize high-value goods at arrest.

Meeting our targets

This section of the strategy drives delivery against the 2008–11 PSA targets relating to:

- the rate of drug-related offending (PSA 25); and
- the percentage of the public who perceive drug use or dealing to be a problem in their area (PSA 25).

National indicators relating to this section include:

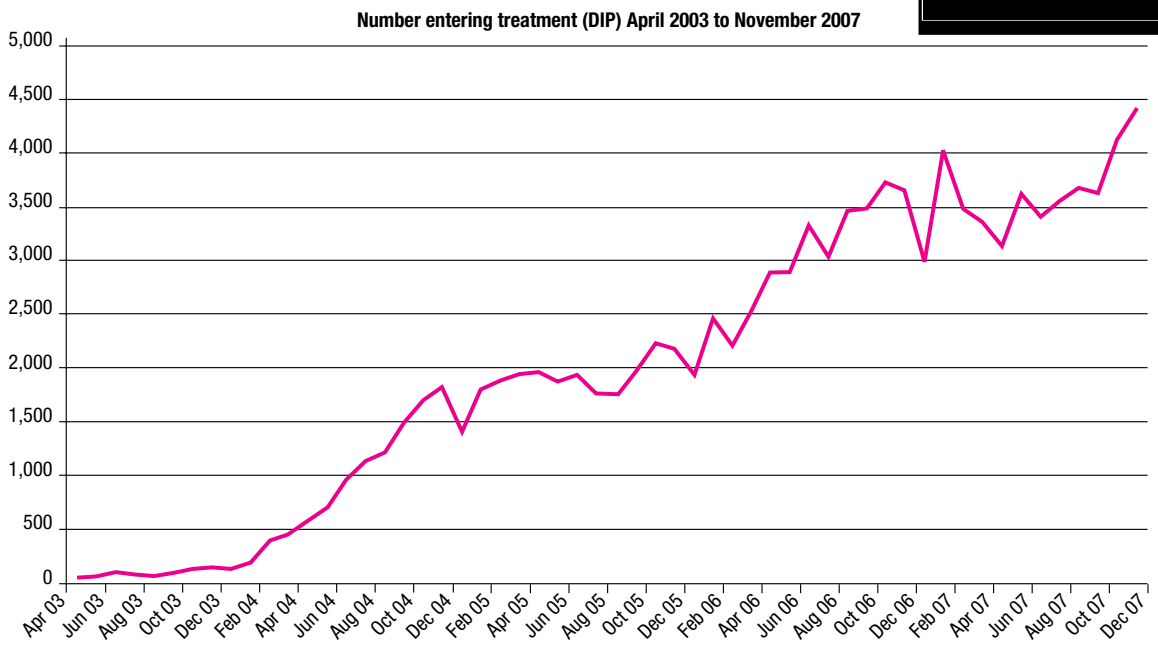
- NI16 – serious acquisitive crime rate;
- NI17 – perceptions of anti-social behaviour;
- NI18 – adult re-offending rates for those under probation supervision;
- NI21 – dealing with local concerns about anti-social behaviour and crime by the local council and police;
- NI30 – re-offending rate of prolific and priority offenders; and
- NI38 – drug-related (Class A) offending rate.

Drug-related offending, violence and anti-social behaviour have the greatest visible impact on communities. Interventions to address these harms need to span supply and demand reduction, with action to tackle the supply of drugs from overseas combined with local enforcement activity and interventions to address drug-related offending.

The previous drug strategy delivered some notable successes in addressing drug supply and drug-related offending and identifying effective approaches:

Reducing drug-related offending and re-offending

- The Drug Interventions Programme (DIP) has made drug-misusing offenders face tough choices about their drug use and need for treatment, and research shows that offending levels can fall substantially following contact with the programme.



- The introduction and improving performance of both the Drug Treatment and Testing Order (DTTO) and the Community Order with a Drug Rehabilitation Requirement (DRR) has seen rising completion rates. This is encouraging, as we know from research that offenders who have completed DTTOs have significantly lower reconviction rates than those who have not.
- Increased funding for prison drug treatment has enabled a further roll-out of the clinical elements of the Integrated Drug Treatment System (IDTS), supported by a flexible framework of supply reduction measures, and an extensive programme of mandatory and voluntary drug testing.

A growing body of evidence shows that retaining offenders in treatment through the criminal justice system can reduce drug-related offending. For example, the DRR, which is part of a community sentence, or the range of DIP interventions, can be effective in reducing re-offending by engaging offenders in treatment and addressing the underlying causes of their offending. The Strategic Plan to Reduce Re-Offending emphasises the role of effective offender management as the primary means to co-ordinate drug-related interventions both in custody and the community.

Local enforcement

Existing legislation gives powers to the police and other law enforcement agencies to:

- apply tougher sanctions against those dealing drugs on or in the vicinity of school premises, protecting young people from dealers;
- rapidly close crack houses and other drug dens, restoring community safety and confidence; and
- seize the assets of convicted criminals and reinvest them in crime reduction programmes.

We know that the Neighbourhood Policing approach, whereby the police seek to build closer relationships with the communities they serve, is effective. We will embed action to tackle drugs within this approach and promote the development of communications which will strengthen this relationship, showing communities where action is being taken to respond to local priorities, and building confidence.

Supply reduction

There is some evidence that enforcement activity can affect drug prices. Debriefing of drug traffickers shows they are in no doubt that enforcement effort has an impact on price; there is evidence of the UK wholesale price being greater than that in continental markets, and there is evidence from other countries of enforcement-driven price effects. As part of the wider drug strategy the Government believes that taking action to increase the price of drugs is worthwhile. We would expect higher prices to deter new users, encourage those reaching the end of their drug-using career to stop and reduce to some degree the consumption of current users.

Our future approach

Building on our successes and our knowledge of what works, the Government will work with local and regional partners to ensure that a co-ordinated approach is taken to addressing drug-related offending and anti-social behaviour, to identifying and intervening with drug-misusing offenders, both in the community and in custody, to tackling the supply of drugs and to taking stronger measures against dealers. The approach will consist of the following four key elements:

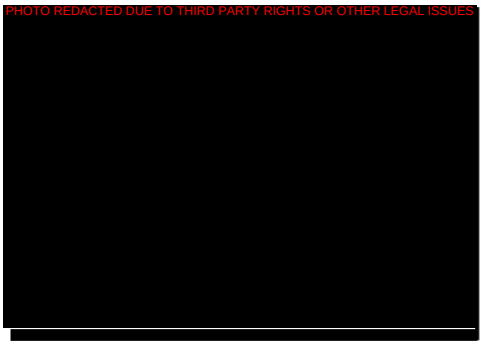
Proactively targeting and managing drug-misusing offenders

To ensure that those who cause the most harm are identified, properly managed and receive appropriate and timely interventions, the Home Office, Ministry of Justice, prosecutors, police and partners will:

- continue to present drug-misusing offenders with tough choices to change their behaviour or face the consequences;
- ensure that DIP-based powers, such as drug testing, required assessment and restriction on bail, are effectively applied at a local level; and
- keep those powers under review, for example by considering the range of substances for which an offender is tested, where emerging new drugs pose a threat to continued reductions in offending.

We will increase the number and range of offenders brought within these arrangements by:

- promoting an integrated approach to managing offenders, sharing information and risk assessments across different agencies to better identify priority offenders and the interventions needed to address their offending;
- supporting new areas and partnerships to expand the range of DIP interventions available locally, including, for example, through self-funding of drug testing regimes;



- increasing the number of offenders whose drug-related offending is addressed through the use of DIP conditional cautions; and
- managing offenders better at crucial times, such as on discharge into the community from prison, when the risks of relapse and re-offending are high by improving the continuity of case management of drug-misusing offenders and reviewing and strengthening links between prisons, local Criminal Justice Integrated Teams and probation services.

Maximising the effectiveness of prison and community sentences

The Ministry of Justice will lead on maximising the impact of prison and community sentences to reduce drug misuse and its related harms. In conjunction with the Department of Health and other partners, this will be achieved by:

- maximising the use of community sentences with DRRs;
- ensuring that all prisoners have access to a minimum standard of clinical drug treatment;
- exploring the scope for streamlining funding and commissioning arrangements for the National Offender Management Service, Primary Care Trusts and Joint Commissioning Groups through commissioning and delivery pilots;
- extending the use of successful interventions throughout the criminal justice system, including further rolling out of the IDTS;
- piloting the introduction of the National Drug Treatment Monitoring System into prisons and ensuring that community-based treatment services are notified when a drug user is released from prison, to provide a better link between prison and community-based services;
- raising the quality of interventions in the prison estate and developing the skills of the workforce in prisons and probation services, so that they can deliver quality drugs services;
- examining the potential of offering sentencers additional community-based options for substance misusers within the intensive alternative to custody programme;
- extending the successful Dedicated Drug Court pilots, in which courts look to address drug misuse as a cause of offending, to up to four further areas, subject to evaluation of the Leeds and West London pilots; and
- improving measures to control the supply of drugs into prisons, including looking at conducting more rigorous searches, employing more sniffer dogs, and, where possible, extending the use of drug-free wings.

Engaging and empowering communities with stronger, locally-responsive law enforcement

The Neighbourhood Policing approach means the police and other enforcement agencies will listen and respond to community concerns about drugs, act on intelligence supplied, provide information on the results of action taken and seek

Cannabis factories

Intelligence from the community will be used to target drug markets and the sources of domestically-produced drugs, such as cannabis factories. Cannabis factories represent a worrying development. It is clear that serious, organised criminals are investing in the production of cannabis on a commercial scale. Law enforcement agencies report that Vietnamese organised criminal groups provide the main sources of cannabis throughout England and Wales and this market is well established. Cannabis factories are often operated by illegal immigrants or trafficked individuals, including children.* These factories operate in local communities and all agencies, together with local communities themselves, must work together to combat this significant threat.

* Kapoor, A, 2007, *A scoping project on child trafficking in the UK*. Child Exploitation and Online Protection Centre, London

feedback on it. All relevant agencies will ensure that action to prevent and tackle drugs sits at the heart of this policing strategy and that all available powers, levers and sanctions will be used to:

- maximise the use of intelligence gathered from the community;
- disrupt and dismantle drug markets;
- seize the cash and assets of drug dealers; and
- make greater use of post-conviction Anti-Social Behaviour Orders (ASBOs), to prevent those convicted of drug dealing from re-establishing their business.

We will seize more of the cash and assets generated by drug dealing and bring greater pressure to bear on dealers by implementing and building on measures set out in the Asset Recovery Action Plan and by strengthening the powers contained in the Proceeds of Crime Act 2002. Measures which will be introduced to enable law enforcement agencies – working closely with the Crown Prosecution Service and the Revenue and Customs Prosecutions Office – to remove the financial benefits enjoyed by drug dealers will include:

- powers to physically seize high-value goods at the time of arrest, when it is anticipated that a confiscation process will be initiated, to prevent assets being removed;
- widening the categories of assets liable to civil recovery and extending the time limits for their recovery to take place; and
- creating a new principle of sentencing that all criminal gains should be removed.

Post-conviction ASBOs set out conditions which an individual must adhere to. For those convicted of drug offences, these conditions may include refraining from specific activity linked to their conviction or from entering specific areas. We will make greater use of these orders, to make it difficult for those convicted of drug dealing to re-establish their business.

More robust local law enforcement will result in:

- **Drug dealers identified and markets disrupted by maximising community intelligence**. Local communities can provide good quality intelligence and local media initiatives, such as the 'Rat on a Rat' campaign, have been successful.
- **Open drug markets disrupted and crack houses and cannabis factories closed, targeting those causing the greatest harm to communities**. Well-planned, intelligence-led, multi-agency

operations can have a significant sustained impact on the elimination of entrenched drug markets.

- **Drug dealers' cash and assets seized, demonstrating to communities that crime doesn't pay**. We will use all available powers and introduce further powers to seize the assets of drug dealers, stripping them of their visible signs of wealth and reinvesting the proceeds to benefit communities.

Preventing harm to communities by reducing the supply of drugs into and within the country

Our approach to tackling the supply of drugs will focus on five key elements:

- **Tackling the drugs which cause the greatest harm.** Class A drugs, particularly heroin, cocaine and crack, will remain the focus for enforcement. We will monitor emerging drug threats such as cannabis factories, methamphetamine or the misuse of prescription drugs, redirecting resources as appropriate.
- **Maintaining strong UK border controls.** The UK's border controls are a line of defence against drugs entering the country. HM Revenue and Customs (HMRC) will continue to use intelligence and assessments of risk in operating these controls. The creation of the UK Border Agency, which will bring together parts of HMRC and the Border and Immigration Agency, will provide better integrated border controls.

  Implementing UK border controls overseas can be very effective in reducing trafficking. Operations Airbridge and Westbridge, joint operations between the UK and the governments of Jamaica and Ghana, have significantly reduced the number of people from those countries swallowing packets of drugs to smuggle them into the UK. The Government plans to create similar partnerships with other governments in key countries in the supply chain.

  The Home Office will continue to encourage and promote research to develop technology to improve detection capabilities and lead to more drugs being detected that have been concealed on or in passengers, in freight and in postal packets.
- **Expanding international co-operation to further reduce trafficking into the UK.** We will target the drugs leaving producer countries and passing through transit countries on their way to the UK. SOCA, supported by HMRC and the Foreign and Commonwealth Office (FCO), will maintain a network of liaison officers in priority countries around the world whose work will include interrupting the supply of drugs to the UK through, for example, developing the enforcement capabilities of those countries.

  The FCO will continue to help the government of Afghanistan implement its National Drug Control Strategy, which includes a range of activities required to combat the drug trade. It is based on the successful approaches of Pakistan and Thailand, which included a strong element of rural development.

  We will develop the value and effectiveness of international co-operation through established multilateral organisations, such as the United Nations and the European Union, as well as through ad hoc multilateral groupings. A recent successful example of such

co-operation is the establishment of the Maritime Analysis and Operation Centre – Narcotics (MAOC-N), based in Lisbon. This brings together seven countries, including the UK, to gather intelligence and mount joint operations against shipments of cocaine crossing the Atlantic. We will extend the involvement of the UK in such collaborative efforts where they are of clear benefit.

- **Ensuring closer working between the agencies involved in tackling drug supply.** Action to tackle drug supply within the UK involves the collaboration of a range of national and international partners and drugs will remain a strategic priority for SOCA, working with HMRC and the police. SOCA will continue to improve identification of the key criminals involved in the importation of drugs and improve the efficiency of investigations and operations against them. Work will also continue to identify and target drug dealers operating within the UK at regional level. A senior cross-agency police and law enforcement group has been established to ensure a co-ordinated operational response to drug trafficking.

  The new UK Border Agency will work closely with the police to tackle serious immigration-related crime, including the links between this type of crime and drug trafficking. This work will add another law enforcement dimension to efforts to prevent the supply of drugs into and within the country, particularly with respect to our efforts to reduce the criminality associated with cannabis factories.

Street Level Up Approach

The pilot phase of the Street Level Up Approach (SLUA) ran for a year from August 2004. The aim was to test how multi-agency working can build a comprehensive picture of a local drug market, which can inform enforcement agencies' decisions on where intervention would be most effective in dismantling and disrupting the supply chain.

The second phase is now being implemented, with SLUA being rolled out across a number of police forces. It will have a sustained impact on the drug trade and drug-related offending and on the harm caused to communities by:

- gathering evidence to support the disruption and eradication of criminal businesses at all levels of the supply chain;
- providing information on the links between drugs and crime;
- using innovative tactics, such as financial investigations and asset recovery;
- mainstreaming SLUA principles into day-to-day policing; and
- identifying and sharing good practice across all forces to maximise outcomes.

- **Targeting criminal assets.** Evidence suggests that asset recovery is one of the measures which most worries criminals at the higher levels of criminal networks, such as those involved with the importation of drugs. In addition to the extension of asset seizure powers detailed above, we will enter asset-sharing agreements with other countries, as we have done with the United Arab Emirates, allowing the seizure of assets sequestered overseas.

Preventing harm to children, young people and families affected by drug misuse

Key strategy actions

- Ensure prompt access to treatment for all drug-misusing parents with a treatment need, with parents who are problem drug users and whose children are at risk having rapid access, and all assessments taking account of the needs of the family.
- Deliver a package of interventions for families at risk, to improve parenting skills, helping parents to educate their children about the risks of drugs, supporting families to stay together and breaking the cycle of problems being transferred between generations, drawing on learning from innovative programmes and providing intensive interventions where needed.
- Support kin carers, such as grandparents caring for the children of substance-misusing parents, by exploring extensions to the circumstances in which local authorities can make payments to carers of children classified as 'in need', backed up by improved information for carers and guidance for local authorities.
- Support parents with substance misuse problems so that children do not fall into excessive or inappropriate caring roles.

Meeting our targets

This section of the strategy drives delivery against the 2008–11 PSA targets relating to:

- the proportion of young people frequently using illicit drugs, alcohol or volatile substances (PSA 14); and
- the number of drug users in effective treatment (PSA 25).

National indicators relating to this section include:

- NI110 – young people's participation in positive activities;
- NI111 – first-time entrants to the Youth Justice System aged 10–17;
- NI114 – rate of permanent exclusions from school;
- NI115 – substance misuse by young people; and
- NI117 – 16–18-year-olds who are not in education, training or employment.

Drug misuse can damage an individual's ability to work, to maintain relationships and to care for dependants. Substance misuse – whether legal or illegal – can have a significant negative impact on the development and achievement of young people. This not only affects those who use drugs, but also their families, their children and wider society.

For young people using and misusing drugs, alcohol and volatile substances, harms may include:

- low educational attainment, truancy or exclusion from school;
- involvement in criminal activity and anti-social behaviour which, combined with poor educational outcomes, can lead to foregone earnings and worklessness, lasting well into later life;
- greater levels of ill-health or risk-taking behaviour leading to accidents, infection

or pregnancy, with the potential for mental health problems and psychosis, developmental damage and even overdose or death;

- the heavy or frequent use of alcohol or drugs, or progression to heroin or crack cocaine use; and
- the risk of sexual exploitation.

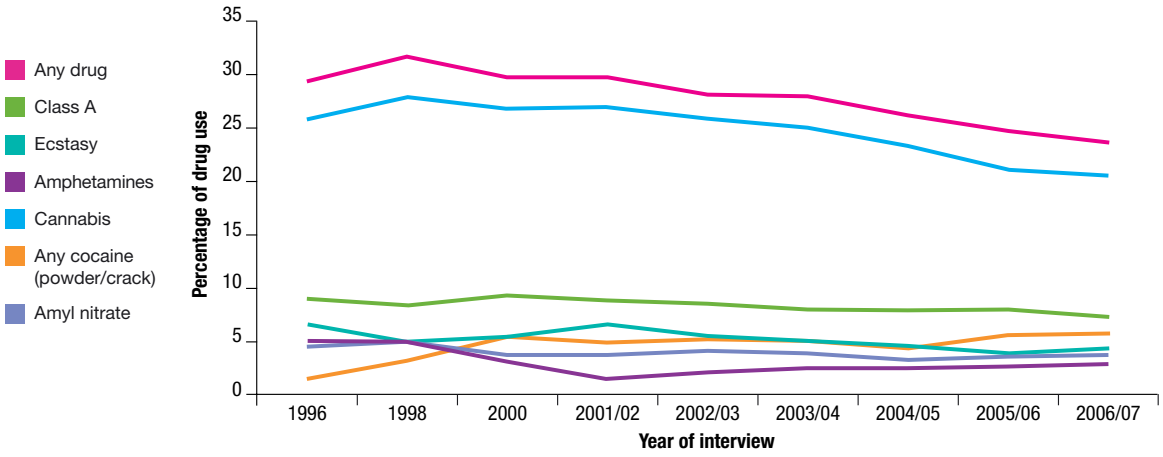
Children of parents who have problems with substance misuse can suffer from specific harms, which may include:

- intergenerational transmission of harms, where substance misusers increase the risk that their children will experience poor lifetime outcomes or develop substance misuse problems themselves;
- abuse or neglect, behavioural problems and long-term developmental problems;
- exposure to health harms associated with substance-misusing parents, such as accidental overdose;
- separation from parents, including removal to local authority care, which is estimated in recent research to occur in around 60 per cent of cases;
- an increased risk of eviction or housing in temporary or unsuitable accommodation;
- responsibility for caring for a parent with substance misuse problems, which has been shown to lead to a higher incidence of educational difficulties; and
- a greater risk of experiencing domestic violence or foetal alcohol syndrome where a parent is a problematic drinker.

Since the introduction of the 1998 drug strategy, we have seen reductions in young people's drug misuse with, for example, sharp falls in the frequent use of drugs by vulnerable young people, which fell from 21 per cent in 2003 to 11 per cent in 2006. However, Class A drug use among young people aged between 16 and 24 has remained relatively stable, falling from 8.6 per cent in 1998 to 8 per cent in 2006/07.

We know from the available evidence that, for young people, there are strong predictive

Percentage of 16–24-year-olds reporting use of the most prevalent drug types in the last year, 1996 to 2006/07



factors for the misuse of drugs. These allow us to identify those at greatest risk of developing substance misuse problems and offer them and their families targeted preventative support, including:

- young people in families at risk, such as those facing multiple disadvantages or where parents or siblings misuse drugs or alcohol;
- young people from specific vulnerable groups, such as those involved in offending or anti-social behaviour, truants, those excluded from school, or those looked after by local authorities;
- young people at key transitional stages, such as moving from primary to secondary school or on leaving school;
- young people subject to specific risk factors, including where their peer group have normalised substance misuse or where drugs are readily available in the area they live in.

We also know more about what works in preventing harm to children and young people. Specific targeted interventions which have been shown to contribute to reduced substance misuse and improved wider outcomes include:

- early intervention targeting those most likely to develop substance misuse problems, based on predictive factors and routine screening and assessment;
- drug and alcohol education programmes delivered by teachers trained to use normative, life-skills based approaches, and supported by wider communications campaigns and by parental and community involvement;
- interventions and intensive support with at-risk families, to build independent living, parenting and monitoring skills and to support them to sustain stable accommodation;
- individually-tailored programmes for specific vulnerable groups, such as young offenders;
- reducing absenteeism, developing school-based social work programmes, and inclusive school policies to maintain engagement with young people who are most at risk.

Two strong messages came out of the strategy consultation: parents wanted better support to educate their children about drugs and to know what action to take if their child gets involved in drugs; and young people were clear that they wanted places to go and things to do so that they did not start using drugs because there was nothing better to do.

Our new approach

Many improvements have been made to services for young people, but to make a sustainable difference to the challenge posed by substance misuse, we must place a sharper focus on effective prevention and on intervening before problems become entrenched. Our new approach will emphasise family support, intervening earlier with families at risk, such as those where children may experience harm as a result of parental substance misuse, providing targeted youth support for

vulnerable young people in all areas and providing effective treatment for those who do develop problems. We will take a whole-family approach, intervening to meet the needs of the entire family, involving the family in the planning and process of treatment, extending family interventions and introducing better support for parents to access drug treatment. This new approach will be based on four key elements.

A new package for families

The Department for Children, Schools and Families (DCSF) leads on work to prevent substance misuse among young people and on family-based interventions. Within this work, families will be supported and strengthened, so that they can build young people's resilience and reduce the harms caused by substance misuse by:

- providing better information to parents and other carers to strengthen their role in preventing young people's substance misuse;
- where appropriate, involving families in the treatment of young people and other family members; and
- developing additional support for families at risk, drawing on learning from a range of pilot programmes.

Where parental substance misuse exists, we will prevent intergenerational harm and support access to treatment by:

- ensuring that drug-misusing parents have prompt access to treatment, where it is required, and that parents who are problematic drug users and whose children are at risk have rapid access to treatment, with assessments taking account of family needs;
- encouraging the provision of more 'family-friendly' drug treatment services, reducing barriers for those unable to engage in treatment due to caring responsibilities;
- delivering a package of interventions and providing intensive and integrated support for families at risk, to improve parenting skills, reduce risk factors for children, support families to stay together and break the cycle of problems being transferred between generations, drawing on learning from innovative programmes, (including Family Intervention Projects, Family Drug and Alcohol Courts and Family Pathfinders);
- supporting kin carers, such as grandparents, who take on care responsibilities for the children of substance-misusing parents, with improved information and support;
- prioritising the protection of children of substance-misusing parents through early identification and improved information-sharing between children's and adult services;
- improving access to additional support services, including help and advice with accommodation, employment and education, for parents who are undergoing treatment; and
- addressing pre-natal harms through improved links between maternity and treatment services.

Mainstreaming prevention

We will strengthen the role of mainstream provision, in particular schools and children's services, in preventing substance misuse by:

- reinforcing the role of schools in delivering effective substance misuse education and in identifying young people at risk, through the review committed to in the Children's Plan;
- supporting directors of children's services in exercising their local lead on action to reduce young people's substance misuse through the delivery of PSA 14, which aims to increase the numbers of young people on the path to success, with each area tailoring prevention activity to meet local needs;
- ensuring that National Service Framework standards for children, young people and maternity services and relevant clinical management guidance are applied by health service providers to families affected by substance misuse;
- intervening earlier through mainstream services, such as schools and youth services, rather than solely through specialist services only once substance misuse problems occur;
- improving integrated responses for vulnerable young people, through Targeted Youth Support, including joined-up local approaches to related issues, such as youth crime, teenage pregnancy or those not in education, employment or training, supported by improved links with the development of the children's workforce;
- reducing the availability of substances to young people through policing drug supply and through enforcement activity on underage sales of cigarettes, alcohol and volatile substances; and
- improving access to social inclusion programmes, such as Positive Futures and the roll-out of Positive Activities, as outlined in the ten-year youth strategy, *Aiming high for young people*.

We will also promote activity that helps young people to feel like, and to be seen as, members of the community. Evidence shows that crime and substance misuse are lower in cohesive communities where young people feel included.

Making improvements to the treatment system for young people

The Department for Children, Schools and Families has lead responsibility for drug treatment for young people, including those subject to community sentences, and will work with the National Treatment Agency to make this treatment more effective by:

- developing the workforce, improving access and developing a more outcome-based approach;
- improving transitional arrangements for those transferring from young people's to adult services;
- strengthening links between young people's treatment and mental health services;

- ensuring a seamless transition from the secure estate to community-based treatment services, including the provision of support to aid resettlement, learning lessons from Resettlement Aftercare Provision (RAP); and
- supporting and involving young people and their parents and carers more in the planning and process of treatment for young people, and involving carers' and users' groups in the design and planning of treatment services. Where no such groups exist, we will encourage local areas to establish them.

Building our evidence base of what works

We will continue to build the evidence base and develop our understanding of the factors affecting young people's substance misuse, the harms experienced and the most effective interventions in education, prevention and treatment. We will also review the impacts of family-based interventions working with families at risk of substance misuse. A review of the key gaps in the evidence base will inform the planning of a cross-government research programme.

Drugs in sport

Doping undermines the integrity of sport. Sport can be a positive activity for children and young people and can provide alternatives to risky behaviour that can lead to drug misuse and, for many young people, athletes are seen as role models.

As we approach London 2012 and beyond to the Glasgow Commonwealth Games in 2014, there will be increasing international focus on our anti-doping policies and programmes. We are committed to protecting our athletes from the impact of trafficking, supply and the manufacture of prohibited substances. The Government will work with key agencies, including the National Anti-Doping Organisation, to respond robustly to those who tarnish our national image by cheating in sport.

To do this we will ensure that we strengthen the mechanisms in place to:

- tackle doping in sport;
- target those facilitating doping;
- tackle trafficking, supply and manufacture of doping substances, and those involved in such activities.

Delivering new approaches to drug treatment and social re-integration

Key strategy actions

- Develop pilots to test new approaches which can provide better end-to-end management through the system, including a more effective use of pooled funding and individual budgets, and with a sharper focus on outcomes.
- Develop a package of support to help drug users, and particularly those causing the most harm, to access and complete treatment and to re-integrate into society.
- Use opportunities presented by the benefits system to provide support and create incentives to move towards treatment, training and employment.
- Ensure treatment is personalised and outcome-focused, making full use of new treatment approaches that are shown to be effective.
- Draw on significant new funding to support research into developing better forms of treatment.

Meeting our targets

This section of the strategy drives delivery against the 2008–11 PSA targets relating to:

- the number of drug users in effective treatment (PSA 25).

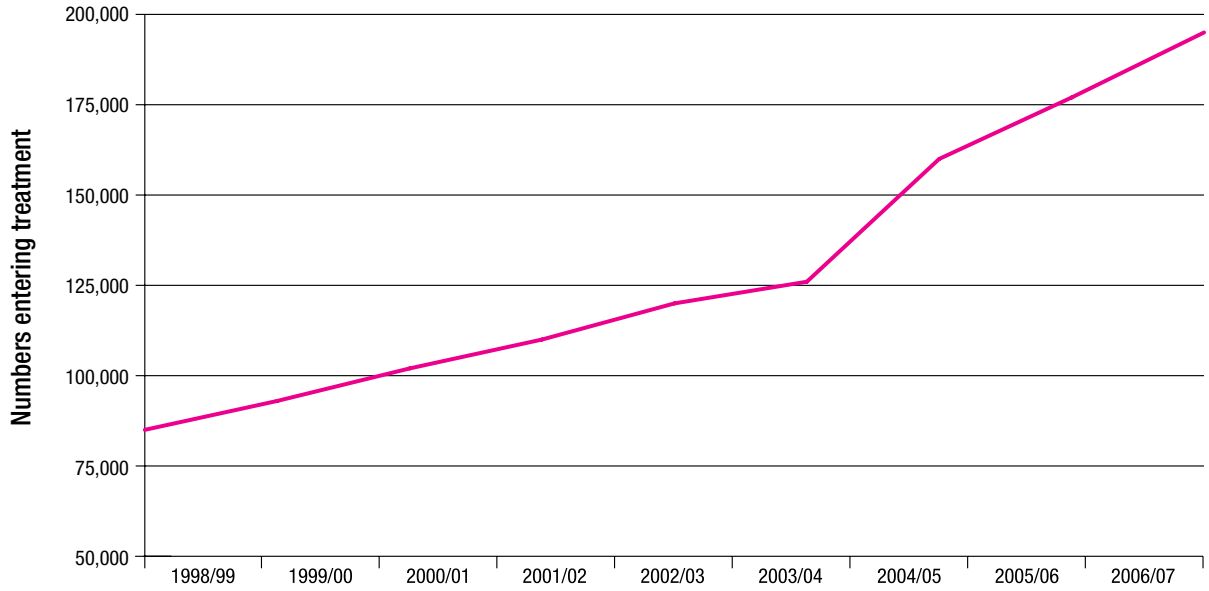
National indicators relating to this section include:

- NI40 – drug users in effective treatment;
- NI120 – all-age all-cause mortality rate;
- NI141 – number of vulnerable people achieving independent living;
- NI143, 145, 147, 149 – socially excluded adults living in settled and suitable accommodation;
- NI144, 146, 148, 150 – socially excluded adults in employment, education or training; and
- NI152 – working-age people on out-of-work benefits.

In addition to the crime harms associated with drug dependency, drug use causes a wide range of health and social harms. It causes short and long-term damage to physical and mental health, it affects unborn babies and it exposes drug users to risk of death from overdose and blood-borne viruses. This in turn creates wider public health risks caused by discarded drug paraphernalia, drug driving or infections caused by unprotected sex with an intravenous drug user. Drug use also limits the ability to work, to parent and to function effectively in society. It contributes to social exclusion and makes it difficult for people to play full and active roles in society.

To address these harms, the Government's 1998 drug strategy established the National Treatment Agency and introduced significant increases in investment in drug treatment,

Numbers entering drug treatment 1998–2006/07



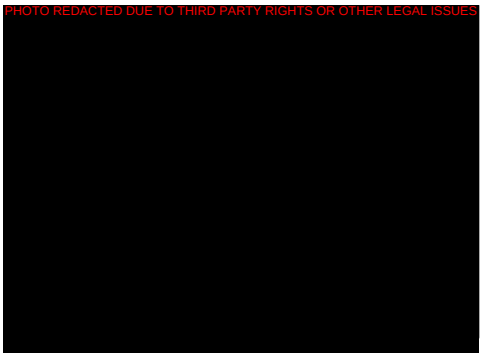
Note on methodology
In 2005, the National Treatment Agency commissioned the National Drug Evidence Centre, University of Manchester, to re-examine the baseline for the number of people in drug misuse treatment in 1998/99. This revision in the baseline was quality assured by the Office for National Statistics and had approval from the then Home Secretary, Charles Clarke. The estimated figures above are a projected trajectory from an adjusted baseline of 85,000 in treatment in 1998/99.

with a particular focus on helping as many drug users as possible to access treatment. This has delivered significant benefits:

- More people are receiving treatment, with the number in contact with treatment services increasing from 85,000 in 1998 to 195,000 by 2006/07 with the target to double the numbers in treatment achieved two years early.
- Three-quarters of new entrants to treatment are now retained in treatment for 12 weeks or more, which is the minimum period that can have a lasting impact on entrenched drug use.
- The average national waiting time for drug treatment has been reduced from nine weeks to less than two and a half weeks.
- The steep and continuing rises in the rates of drug-related deaths that occurred throughout the 1990s have now been halted.
- A new qualifications framework and suite of occupational standards is improving the professional skills of treatment workers.

Our new approach

The goal of all treatment is for drug users to achieve abstinence from their drug – or drugs – of dependency. For some, this can be achieved immediately, but many others will need a period of drug-assisted treatment with prescribed medication first. Drug users receiving drug-assisted treatment should experience a rapid improvement in their overall health and their ability to



work, participate in training or support their families. They will then be supported in trying to achieve abstinence as soon as they can.

While large numbers are entering drug treatment, with most deriving significant benefit from it, too many drug users relapse, do not complete treatment programmes, or stay in treatment for too long before re-establishing their lives. The challenge for the new strategy is to maximise the impact of treatment for those who receive it, seizing the opportunity treatment provides to reduce the harms caused to communities, families and individuals. We will therefore work to develop more personalised approaches to treatment services, which have the flexibility to respond to individual circumstances. We will examine how we can best support those leaving and planning to leave treatment with packages of support to access housing, education, training and employment. We will deliver better outcomes, with more people becoming re-integrated into society, through a focus on four key objectives.

Targeting those most at risk

The Department of Health has lead responsibility for delivering effective drug treatment and will continue to prioritise heroin and crack use, while improving access for under-represented groups and those with complex needs by:

- addressing unmet treatment needs and barriers to treatment, which may include the needs of young people, women, crack or poly-drug users, particular black and ethnic or other minority communities, sex workers or parents with dependent children;
- removing barriers to accessing services for users with children, and acting promptly to protect children where they are found to be at risk;
- targeting services for those with complex needs, such as drug users with mental health problems; and
- prioritising access to treatment for those drug-misusing offenders who enter through DIP and those leaving prison or completing the DRR of a community sentence or a period on licence.

Improving the quality and effectiveness of treatment

We will achieve better outcomes for those entering treatment by:

- improving retention of clients in treatment, with more clients overcoming drug dependence and successfully completing treatment programmes and re-integrating into communities;
- driving up standards across all treatment providers through new local clinical governance arrangements and by monitoring a range of treatment outcomes, including re-offending, employment and health;
- improving, where appropriate, the sharing of information between agencies to facilitate the management of clients;
- continuing to promote harm minimisation measures including needle exchange and drug-assisted treatments that encourage drug users to enter treatment, in order to reduce the risk of overdose for drug

users and the risk of infection for the wider community; and

- improving commissioning skills and continuing to engage service users in the planning and delivery of services at a local level, to ensure that services are responsive to local needs.

A wider use of new treatment approaches

We will build on new evidence of what works and maximise the range of approaches used, including by:

- using contingency management pilots, in which positive reinforcement techniques are used to encourage clients to maintain a course of treatment, to identify and reinforce good practice and address concerns about the inappropriate use of rewards in treatment;
- encouraging clients and family members to make wider use of mutual aid support networks, such as abstinence programmes and local support groups, to improve treatment outcomes;
- developing and delivering a significant new initiative to support research that will boost our understanding of addiction and identify opportunities for new forms of treatment or prevention. Building on the major expansion of health research funding from the last Spending Review, the Medical Research Council and the National Institute for Health Research have agreed that addiction should be one of the joint priority areas for health research funding, led by the Medical Research Council;
- applying learning about what works gathered through the routine monitoring of treatment outcomes through, for example, the National Drug Treatment Monitoring System; and
- rolling out the prescription of injectable heroin and methadone to clients who do not respond to other forms of treatment, subject to the findings, due in 2009, of pilots exploring the use of this type of treatment.

A radical new focus on services to help drug users to re-establish their lives

The ambition of this strategy is to achieve sustainable reductions in the harms caused by drugs. Drug problems do not occur in isolation, and may be both the cause and the consequence of wider social and personal problems. The Government's programmes to tackle social exclusion among adults and at-risk families recognise that people or places can become trapped in a cycle of related problems, such as unemployment, poor skills, low incomes, poverty, poor housing, high crime, bad health and family breakdown – all factors which can be related to higher levels of drug use.

In order to address the wider problems faced by those affected by drugs, we will link this strategy with the framework set out in *Reaching Out: An Action Plan on Social Exclusion* and the Families at Risk Review and we will draw on the Adults Facing Chronic Exclusion Programme as part of a package of action, social care and support to help individuals and families to re-integrate and re-establish themselves in the community.

We will also make full use of the Working Neighbourhoods Fund, a £1.5 billion contribution to the Area Based Grant launched in November 2007 to help local authority areas facing some of the greatest challenges in terms of worklessness and low levels of skills and enterprise. The Working Neighbourhoods Fund has been allocated to 87 local authority areas for the period from 2008 to 2011.

For drug misusers, the Department of Health, the Department for Work and Pensions and the Department for Communities and Local Government will take the lead on work to support drug misusers' re-integration into society by:

- encouraging joint working between treatment agencies, Jobcentres and sources of housing advocacy and advice, to plan and manage clients' journeys through treatment and into work, helping them access the wider support they need to re-establish their lives;
- encouraging local authorities to work with partners to meet locally-identified need for housing and support for those affected by drug misuse;
- allowing the Pooled Treatment Budget to be used alongside other funding streams to provide advice on re-integration support and case management;
- ensuring that all local partners are aware of the need to assess the wider needs of drug misusers and those in treatment; and
- exploring the potential, initially through pilot projects, of the use of pooled budgets, end-to-end case management and individual budgets linking treatment benefits, training and employment support, with a focus on achieving positive outcomes for clients.

A new approach to delivering services – pilot project

Existing drug funding, commissioning and delivery systems have helped to deliver an unprecedented increase in drug treatment, but they are complex and characterised by a multitude of rules, funding streams, commissioning and process targets. This can result in a 'one-size-fits-all' service with limited choice in the type of treatment and broader social support available. Over time, we need to ensure the drug treatment system and these services work more closely together and become more focused on improving outcomes, which could include a more personalised and innovative service. Therefore, we will develop pilots to test a variety of new approaches at the strategic level, relating to relationships between central and local government, and at the delivery level, to provide more end-to-end management through the system, with more reliance on local outcome targets. The pilots will also include the use of individual budgets, held by drug workers rather than the user, which can be used to personalise interventions in a more flexible way.

The benefits system must support our new focus on re-integration and personalisation. In order to ensure that it provides the right level of support and creates incentives for people with drug problems to move towards treatment, training and employment, we will at a minimum:

- require drug misusers on out-of-work benefits to attend a discussion with an appropriate specialist treatment provider or partner organisation as part of the Jobseeker Direction or Work Focused Interview requirements; and
- encourage closer links between relevant agencies so that drug misusers who are claiming benefits can be referred to specialist services.

These changes are a first step in helping clients to overcome barriers to work and ensuring Jobcentre Plus engages more closely with local drug partnerships and treatment providers in all areas where this is not already happening.

However, we do not think it is right for the taxpayer to help sustain drug habits when individuals could be getting treatment to overcome barriers to employment. So, we will explore the case for introducing a new regime for drug misusers which provides more tailored and personalised support than is currently provided by the existing Incapacity Benefit or Jobseeker Allowance regimes. In return for benefit payments, claimants will have a responsibility to move successfully through treatment and into employment. Further proposals will be announced regarding these measures.

Public information campaigns, communications and community engagement

Key strategy actions

- Extend the use of FRANK to provide access to support and interventions, to support local campaigns and school-based education, and to target key audiences.
- Improved support and information for parents. We will bring together a partnership of leading organisations pledging to support and provide information for parents.
- Develop better community-based communications to build community confidence and engagement in the work being done to tackle drug misuse.

Meeting our targets

This section of the strategy drives delivery against the 2008–11 PSA targets relating to:

- the proportion of young people frequently using illicit drugs, alcohol or volatile substances (PSA 14); and
- the percentage of the public who perceive drug use or dealing to be a problem in their area (PSA 25).

Communications have a key role to play in addressing the harms caused by drugs, but present unique challenges. Communications compete in a crowded media space, vying for the attention of a range of target audiences and competing against misleading sources of information. Communications activity needs to transmit clear information and advice, often in opposition to sometimes contradictory media messages.

Young people need credible, balanced information about the risks posed by drugs, which complements drug education delivered in school and other settings. Parents need information to build knowledge, to provide reassurance and to develop the confidence to address drug use issues within the family. Communication also plays a key role in the community, providing reassurance and strengthening confidence and resilience, where communities are aware of the action that is being taken to tackle drug dealing and drug-related crime.

Our knowledge of what works in communications has developed substantially since the publication of the 1998 strategy. We are now offering credible and well-used drug advice and information, using the kinds of media most used by the target audience, including the internet, magazines and social networking sites. As an example, FRANK has become established as a widely recognised and trusted helpline and website, and its advertising and related activity has brought about a shift in young people's attitudes to drugs, with more perceiving drugs negatively. Following a FRANK multi-media cannabis campaign, research showed there was a 12 per cent increase in the number of young people agreeing with the statement that 'cannabis can damage the mind of someone who uses it', and 89 per cent reported that they knew about FRANK and what its purpose was.

We know that:

- campaigns are effective at reinforcing existing non-drug using behaviours and attitudes and at dispelling inaccurate perceptions of the harms posed by individual drugs;
- campaigns can increase the uptake of drug treatment, encourage safer drug use and achieve greater professional and public support for drug programmes; and
- information can increase parents' confidence in making a positive contribution to preventing drug use and changing young people's attitudes towards drug use.

The difference communications will make to the public:

- We will reach parents across the country with information on drugs to give them the confidence and know-how to talk to their children about this issue and understand where to get help.
- Increased FRANK communications will raise awareness among young people of the dangers of drugs.
- A leaflet will be available to every community on what the new drug strategy means for them.
- In areas where drug misuse is a significant problem and a priority for local people, visible policing teams will be taking action and engaging the community.
- Communities will see benefits as a result of increased visible enforcement activity to crack down on drug dealers and to increase the seizure of criminal assets.

Our new approach

Young people and families

DCSF, the Home Office and the Department of Health lead on the delivery of communications campaigns and activity targeted on young people and families.

- We will bring together a partnership of leading young people's and parents' organisations to engage and communicate with parents. They will find out what more information and support can be provided to parents and will recommend ways in which families and parents can be called on to tackle this issue.
- The Government will target parents – particularly those whose children may be at increased risk – to give them the facts about drugs and their use. We will increase the knowledge and understanding of drugs, enabling parents to have a positive influence over their children in an informed and credible way. DCSF will explore the feasibility of combining messages to parents across a range of issues.
- We remain committed to the FRANK campaign, which will use a mix of media and technologies to talk to young people about the risks and effects of drug use. Local partnerships will receive support and encouragement to run local drug awareness campaigns with links to FRANK where appropriate.

- In line with the Government's alcohol strategy, *Safe. Sensible. Social*., we will commission strategic research with young people and stakeholders to develop an evidence base for a campaign targeting under-18s about alcohol.
- Following completion of the DCSF review of drug education, FRANK activity will be developed to complement wider drug education objectives.
- FRANK will become a portal for young people to access the drug treatment or targeted support that they need. For young cannabis users who wish to stop or cut down their use, FRANK will offer a supported online programme based on successful models in the Netherlands.

Communities

The Home Office and partner agencies have lead responsibility for effective communications to make communities safer.

- We will develop wider communications for communities affected by drug-related crime. With the roll-out of the Neighbourhood Policing approach, we will ensure that communities know how to report drug-related crime and what will be done to tackle it.
- We will also work with local agencies to bring about a reduction in the percentage of the public who perceive drug use and dealing to be a problem in their area. Local partnerships have a role to play in informing and reassuring the communities they serve that drug use and dealing is being tackled. We will support and champion the roll-out of local campaigns such as 'Rat on a Rat', which maximise community intelligence, identify drug dealers and disrupt drug markets.
- The public will be made aware that assets seized from drug traffickers will be invested back into their community.
- National communications platforms including National Tackling Drugs Week in May and the Tackling Drugs, Changing Lives Awards will ensure that communities are fully informed and engaged in work being done locally to make their communities drug-free. The Government will also work with national and local role models to bring to life the difference being made across the country.
- By sharing with the community the positive outcomes achieved for drug misusers through a range of interventions, we will demonstrate the effectiveness of coherent interventions and the role of the community in supporting those outcomes.

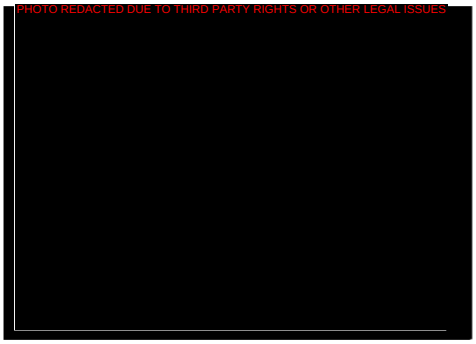
Drug driving – communicating safety messages

Drug driving is reported to be an increasing problem. A Department for Transport (DfT) research study published in 2000 found traces of illegal drugs in the bodies of 18 per cent and medicinal drugs in 6 per cent of the road fatalities in the study, a substantial increase from data reported ten years previously. However, the study was unable to establish the victims' level of impairment.

Enforcement methods are improving, with police officers being trained to make arrests that can lead to convictions. Severe penalties – with disqualification for at least 12 months – are imposed on those convicted.

Publicity and education are central to changing perceptions of the dangers posed by driving under the influence of drugs, and these are channelled towards groups who are more likely to take drugs. The DfT campaign targets young drivers and passengers who are planning nights out, and who might be tempted to drive or accept lifts. During the summer music festival period and in the build-up to Christmas and New Year, a range of media, including an information website, aim to persuade drug users of the risks associated with driving under the influence of drugs. To date, these have proved effective in raising awareness of the issue and are seen by the target groups as an appropriate intervention.

To support enforcement and education activities, DfT will begin a consultation process to establish whether the current process of police enforcement for drug impairment could be made more effective.



Devolved powers

The delivery of the 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 its delivery in the devolved administrations only in the areas where it has reserved power. Thus, the scope of the strategy is that:

- health, education, housing and social care are confined to England;
- policing and the criminal justice system, including all aspects of offender management, cover England and Wales;
- the work of the Department for Work and Pensions applies to England, Wales and Scotland; and
- the work of SOCA and HMRC to address drug supply covers the UK.

Appendix 1

Delivery mechanisms

To continue to drive progress in preventing and tackling the harms caused by drugs, delivery of the drug strategy needs to be firmly embedded within the mainstream delivery frameworks of all partners. Many drug-specific delivery structures have been developed and have provided focus at national, regional and local levels. To build on the achievements of the previous strategy and to bridge some of the delivery gaps highlighted by the strategy consultation process, we must now ensure that action to tackle substance misuse is at the core of national, regional and local planning and delivery processes in all departments and agencies that have a role to play in delivering the drug strategy.

At a **national level**, policy and delivery are the responsibility of a number of central government departments. For the period 2008–11, the departments with ownership of Public Service Agreement (PSA) targets directly relating to drugs and alcohol are:

- the Home Office (PSA 25);
- the Department of Health (PSA 25); and
- the Department for Children, Schools and Families (PSA 14).

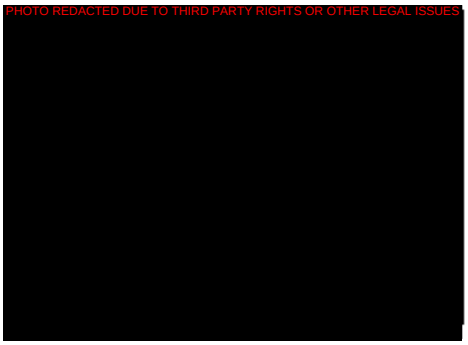
Other departments with a significant role to play in the delivery of the strategy include:

- the Ministry of Justice;
- HM Revenue and Customs;
- the Department for Communities and Local Government;
- the Department for Work and Pensions;
- the Department for Innovation, Universities and Skills;
- the Foreign and Commonwealth Office; and
- the Department for International Development.

PSA 25 Reduce the harm caused by alcohol and drugs	• The number of drug users in effective treatment. • The rate of drug-related offending. • The percentage of the public who perceive drug use or dealing to be a problem in their area.
PSA 14 Increase the number of children and young people on the path to success	• The proportion of young people frequently using illicit drugs, alcohol or volatile substances.

A range of agencies within the delivery structures of government departments are more directly involved with delivering the drug strategy. These include the Serious Organised Crime Agency, the UK Border Agency and the National Treatment Agency for Substance Misuse.

Indicators relating to the delivery of the drug strategy and the related PSAs are embedded within the Local Government Performance Framework, the Assessments of Policing and Community Safety framework, and the Department of Health performance framework, and in the frameworks of other key partners, such as the National Offender Management Service and the Youth Justice Board.



The key indicators which demonstrate performance against current PSA targets include:

- the level of drug-related offending (PSA 25);
- the number of drug users in effective treatment (PSA 25);
- community perceptions of drug use or drug dealing as a problem (PSA 25); and
- levels of substance misuse among young people (PSA 14).

There are many additional indicators which support delivery of the strategy, including:

Outcome	National indicators	PSA	LAA indicator
Safer communities	Serious violent crime rate	23	NI15
	Serious acquisitive crime rate		NI16
	Perceptions of anti-social behaviour		NI17
	Adult re-offending rates for those under probation supervision		NI18
	Rate of proven re-offending by young offenders		NI19
	Dealing with local concerns about anti-social behaviour and crime by the local council and police		NI21
	Re-offending rate of prolific and priority offenders		NI30
Children and young people	Young people's participation in positive activities	14	NI110
	First-time entrants to the Youth Justice System aged 10–17		NI111
	Rate of permanent exclusions from school		NI114
	16–18-year-olds who are not in education, training or employment		NI117
Adult health and wellbeing	All-age all-cause mortality rate	18	NI120
Tackling exclusion and promoting equality	Proportion of socially excluded adults (offenders under probation supervision, adults with learning disabilities, care leavers and adults in contact with secondary mental health services) in settled accommodation	16	NI143 NI145 NI147 NI149
	Proportion of socially excluded adults (offenders under probation supervision, adults with learning disabilities, care leavers and adults in contact with secondary mental health services) in employment, education or training		NI144 NI146 NI148 NI150
Local economy	Working-age people on out-of-work benefits	8	NI152

Local authorities and their partners will continue to make a significant contribution to tackling the harm caused by illegal drugs. From June 2008, Local Area Agreements (LAAs) will be the mechanism by which central government will set improvement targets for outcomes to be delivered – either alone or in partnership – through local government in England. These targets are selected from a single set of national indicators for local authorities and their partners. Primary Care Trusts will also be required to report to Strategic Health Authorities on progress against national priorities relevant to the drug strategy which are within Vital Signs, the NHS operating framework.

The Comprehensive Area Assessment (CAA), which will be introduced from 2009, will assess the likelihood of a local area achieving the targets for improvement identified in their LAA and will identify barriers to that improvement. The focus of the CAA will not, however, be restricted to the LAA, and will reflect inspectorates' assessments of, for example, the quality of engagement with local communities or the degree to which risks to people in vulnerable circumstances are being addressed. Further information on the new local government performance framework can be found at www.communities.gov.uk/localgovernment/performanceframeworkpartnerships/.

There is a very strong and reciprocal relationship between drug misuse and related issues, such as crime, anti-social behaviour and social exclusion. Any action to tackle the prevalence or severity of any related issue will help to address drug misuse. Action to address drug misuse will also have an impact on related issues, such as the level of crime.

The reciprocal nature of this relationship supports the embedding of responses to drug misuse within the agendas of delivery partners. This mainstreaming process is essential to establish and maintain a long-term and sustainable response to drug misuse, and the process is supported by the new local government performance framework. While it is unlikely that any local area will select all of the drug-specific indicators within its LAA improvement targets, it is also extremely unlikely that any area will not select any of the related indicators and, therefore, in taking measures to improve performance against those indicators, will deliver improvements in relation to drug misuse.

At a **regional level**, Government Offices will work with top-tier Local Strategic Partnerships, Crime and Disorder Reduction Partnerships and Drug (and Alcohol) Action Teams to provide them with the support to ensure that their internal structures are robust and that all relevant partners are appropriately involved in both the partnership and in LAA negotiations. This will include helping local authorities and partners in their negotiation of improvement targets in LAAs, reviewing progress and, where necessary, co-ordinating action to respond to underperformance. Government Offices will identify and share good practice and will work with regional partners to support delivery. Key regional partners

include Regional Offender Managers, the Youth Justice Board, the National Treatment Agency, Strategic Health Authorities and Regional Improvement and Efficiency Partnerships.

At a **local level**, local partnerships – whether Drug Action Teams or crime and drugs partnerships – played a critical role in delivering the previous drug strategy. To build on the progress that has been made through this enhanced focus, we need to examine whether further improvements could be made through a greater integration of drug issues within the wider local delivery framework. This would ensure that provision for tackling substance misuse forms part of the core planning and delivery arrangements within a local area. The National Audit Office will carry out a study to evaluate the cost-effectiveness of Drug Action Teams and to identify where efficiencies and improvements might be made.

Local Strategic Partnerships, through their role in developing Sustainable Community Strategies and LAAs, will have overarching responsibility at local level for delivering the strategy, supported by other local partnerships, which will include Drug Action Teams, Crime and Disorder Reduction Partnerships (or merged crime and drugs partnerships), local Criminal Justice Boards and local Safeguarding Children Boards. It should be noted that Crime and Disorder Reduction Partnerships have a specific statutory responsibility with regard to substance misuse. Where Crime and Disorder Reduction Partnerships and drugs partnerships are not merged there needs to be effective joint working between the partnerships. The precise local delivery arrangements should be determined by individual areas in accordance with local needs and structures.

National Audit Office study

The National Audit Office will conduct a study to evaluate the effectiveness and value-for-money of Drug Action Teams (DATs), by examining costs and outcomes achieved. The study will aim to:

- identify examples of good practice and examine the risks to the delivery of objectives;
- examine trends in funding against the timing of funding announcements, to identify the effect on planning and commissioning;
- examine the variability in demands for services and the deployment of funds across all DATs;
- examine collated performance reports against key performance targets;
- determine the costs of performance monitoring and reporting and the robustness and constraints of such reporting mechanisms; and
- take follow-up action on the success factors, conclusion and recommendations made in the 2004 Audit Commission report *Drug Misuse 2004: Reducing the local impact*.

Appendix 2

Legislative framework

A detailed framework of legislation underpins the Government's approach to tackling the harms caused by drug misuse. This framework helps determine the priorities of the police and other law enforcement agencies, and directs the judiciary's sentencing practices.

The key piece of legislation is the **Misuse of Drugs Act 1971** and its Regulations. The 1971 Act identifies those drugs that are 'dangerous or otherwise harmful' – referred to as 'controlled drugs' – and proscribes their unlawful possession, supply and production. Controlled drugs are classified in one of three categories – Class A, B or C – according to how harmful they are considered to be either to the individual or to society more generally.

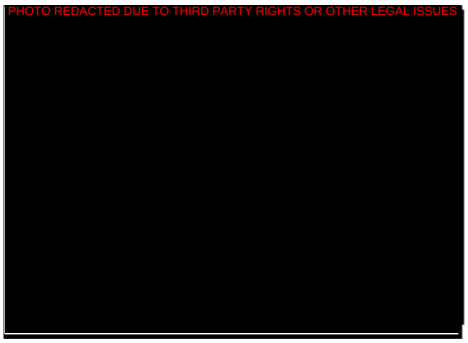
The following refers to other relevant legislation but is not exhaustive:

- the **Medicines Act 1968**, which governs the manufacture and supply of medicines;
- the **Bail Act 1976** (as amended by the Criminal Justice Act 2003), which provides for a restriction on court bail for Class A drug users;
- the **Customs and Excise Management Act 1979**, which together with the 1971 Act proscribes the unauthorised importation or exportation of controlled drugs;
- the **Police and Criminal Evidence Act 1984** (as amended by the Drugs Act 2005), which provides for persons in police detention to be tested for specified Class A drugs on arrest/after charge;
- the **Road Traffic Act 1988**, which makes it an offence to drive, attempt to drive or be in charge of a vehicle on a road or public place when unfit ('ability impaired') to drive through drink or drugs;
- the **Proceeds of Crime Act 2002**, which provides powers to confiscate the property of those convicted of drug trafficking;
- the **Anti-Social Behaviour Act 2003**, which gives the power for courts in England and Wales to issue orders for the closure of premises where Class A drugs and serious nuisance or disorder are a problem;
- the **Criminal Justice Act 2003**, which enables courts to impose a drug rehabilitation requirement as part of a Community Order (replacing the Drug Treatment and Testing Order originally introduced by the Crime and Disorder Act 1998); and
- the **Drugs Act 2005**, which provides for assessments by a drug worker of those testing positive for specified Class A drugs and amended the Crime and Disorder Act 1998 to allow for intervention orders to be attached to Anti-Social Behaviour Orders issued to adults where behaviour is drug-related.

Three United Nations Conventions (on narcotic drugs in 1961, on psychotropic substances in 1971, and against trafficking in narcotic drugs and psychotropic substances in 1988) provide the international legal framework for the prevention of drug misuse and trafficking.

Appendix 3

Diversity and equality



Success in meeting our objectives depends upon achieving the best outcomes for all members of all communities, and upon anticipating and meeting the specific needs that any group may have. It is of central importance that we consider what is meant by diversity and how it applies to everything that we do.

Key legislation relating to diversity includes:

- **The Race Relations (Amendment) Act 2000**, which amends the 1976 Act prohibiting race discrimination by placing a duty on public authorities (or bodies providing public services) to eliminate race discrimination, promote equality of opportunity, promote good relations and have systems in place to meet these obligations.
- **The Sex Discrimination Act 1975 (as amended)** prohibits discrimination on the basis of sex and places a duty on public authorities to proactively promote equality. It is permissible for a service to be delivered separately for either sex where this is the most effective way for the service to be delivered, as in the case of a refuge for victims of domestic violence.
- **The Disability Discrimination Act 1995 (as amended)** offers similar protection to people with disabilities as are offered under the Acts described above. It also places similar obligations with regard to people with disabilities on public authorities or private bodies delivering public services.
- **The Equality Act 2006** outlaws discrimination on the basis of religion or sexual orientation in the provision of goods, facilities and services. It complements the **Employment Equality (Religion or Belief) Regulations 2003** and the **Employment Equality (Sexual Orientation) Regulations 2003**, which make it unlawful to discriminate in employment on the basis of, respectively, religion or sexual orientation.

Other legislation which, while not being directly relevant to the drug strategy, may have an impact on the agencies involved in its delivery, includes:

- The Gender Recognition Act 2004;
- The Sex Discrimination (Gender Reassignment) Regulations 1999;
- The Equal Pay Act 1970 (as amended); and
- The Civil Partnership Act 2004.

The Home Office Diversity Manual contains more detailed information on diversity legislation, along with guidance and sources of further information. The Government will update this source of information, drawing on examples of best practice from across the sector, and highlighting the responsibilities that local areas have to meet the needs of their local communities.

Local planning and delivery

Local areas are responsible for meeting the needs of all communities and should be aware that the provision of universally available services does not necessarily, by itself, meet those needs. For example, members of particular groups may be

culturally inhibited from approaching mainstream drug services and may, as a result, suffer discrimination. Service providers have a **duty to proactively tackle** such discrimination.

For many areas, existing sources of information will be insufficient for the effective planning of services to meet community needs. This may be the case where, for example, a specific group is under-represented in treatment or access to other services, or where there has been significant demographic change. Commissioners and providers of local services should consider putting in place systems to determine the baseline level and nature of needs, and should plan and deliver services accordingly. However, where data and information are not available at a local level, this should not inhibit the provision of appropriate services to meet assumed or anticipated needs. The extent to which this provision meets the needs of all communities should be monitored, and this information should inform ongoing delivery.

Commissioners and providers of local services should consider further the individual and social harms that may be brought about by the use of khat, where local assessments identify needs related to the use of this substance. Particular consideration should be given to culturally appropriate responses to the needs of khat users and members of a user's family.

A number of responses to the drug strategy consultation raised issues relating to diversity and equality. Further issues were raised during the Equality Impact Assessment process which accompanied the development of the strategy. While these issues will be addressed in greater detail in each of the three-year action plans underpinning the delivery of the strategy, consideration should be given by commissioners and providers of services to key issues, including:

- access to services for women with children;
- the provision of culturally competent services, including meeting language needs;
- addressing wider issues of identity, particularly for those of dual heritage;
- providing family-based services which address the needs of all families, as most widely defined; and
- investigating the means by which information might be obtained which will determine patterns of drug use and service needs, particularly where there are significant gaps in evidence, such as the needs of lesbian, gay, bisexual, transgender and transsexual (LGBT) people.

Government commitments

In order to improve our understanding of the degree to which needs are being met, the Government will conduct an analysis of the sources of data and information relating to diversity that are available at a national and local level. We will also consider conducting a qualitative study of the experiences of key equality target groups in accessing drug services, to inform future planning and provision.

In 2008, the National Treatment Agency and the Healthcare Commission are conducting a national Improvement Review into diversity in drug treatment. Each local partnership's performance on diversity and drug treatment will be benchmarked and results will be available in September 2008. Each area found to be scoring below average will be required to produce an action plan setting out steps to be taken to improve. The lowest 10 per cent will receive a plan of targeted improvement work covering the period from September 2008 to January 2009. Progress against action plans will be monitored thereafter through regional mechanisms. Guidance on good practice, drawn from the best performing local partnerships, will be published by March 2009.

In addition, an independent national Drug Strategy Diversity Forum will meet on an ad hoc basis to consider specific issues which have arisen or which pose risks to delivery and to advise the Government on issues relating to diversity and equality.

The action plans that will support delivery of the strategy, and the reports on progress against those plans, will be published on a regular basis, demonstrating the Government's commitment to ensuring equality in the provision of services for all communities.

Community engagement

In planning services to meet the needs of local communities, consideration should be given to the role of community engagement in this process. While this may be conducted on an informal basis, engagement of all communities should be integral to the commissioning process. Not only does such engagement inform the planning process, but it can also provide evidence of the degree to which needs are being met, and can provide a route to demonstrate accountability to the community. Further information and resources on community engagement can be found on the website of the University of Central Lancashire's Centre for Ethnicity and Health (www.uclan.ac.uk/facs/health/ethnicity/communityengagement/) and the Home Office Crime Reduction website (www.crimereduction.homeoffice.gov.uk/learningzone/passporttoce.htm).

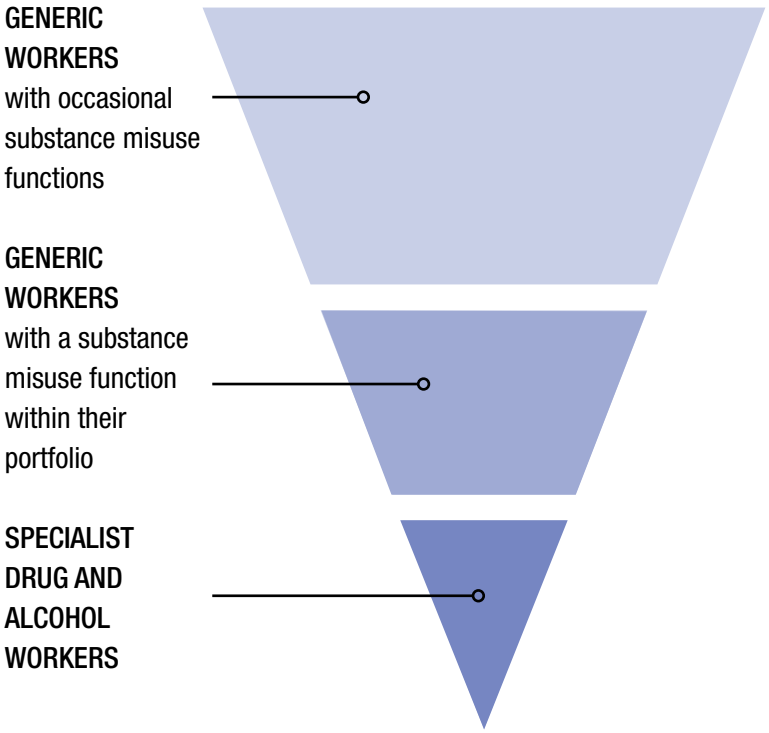
Appendix 4

Workforce issues

Providing appropriate, safe and effective drug interventions is a key objective of the drug strategy and the availability of an adequately skilled workforce is essential to meet this objective.

The workforce involved in addressing substance misuse is broad, encompassing those working with adults, children and young people and those in specialised and mainstream services in education, treatment and justice. They provide a range of services across prevention, early intervention, specialist treatment, enforcement and reintegration. This requires a workforce that is drawn from a wide range of practitioners from diverse backgrounds and with diverse skills and knowledge.

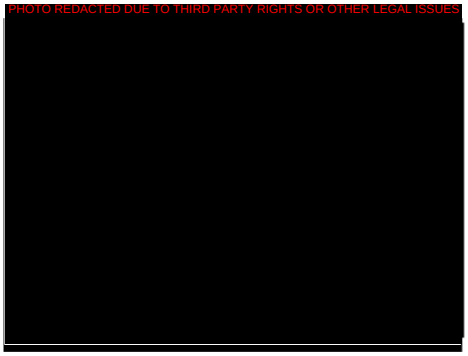
Within each sector, there are roles ranging from substance misuse specialist workers to those professionals whose work brings them into contact with drug and alcohol misuse less frequently or only occasionally. The following diagram represents the workforce which will be involved in addressing substance misuse:



This wider group includes those who, as part of their work, will occasionally deal with substance misuse. This group of practitioners will encounter the impact of substance misuse and therefore have a significant role to play in addressing and preventing substance misuse.

Others are employed in posts with a more significant substance misuse role. The successful implementation of the drug strategy is reliant upon all related sectors recognising and fulfilling their roles in relation to substance misuse. The substance misuse field relates not only to the specialised treatment of problematic drug users but also to the broader approaches of prevention and aftercare.

This group is made up of specialist practitioners whose roles primarily involve working with substance misuse.



The competence of the workforce has a crucial relationship to the achievement of the aims of the drug strategy. A very broad range of workers have a role to play in addressing substance misuse. Substance misuse should, therefore, be regarded as core business for many services, including those that do not have a primary drug or alcohol focus.

Core competencies have been identified for the adult health and social care sector and the children's workforce, which are also considered to be core competencies for the substance misuse field. In addition, every role in the drug and alcohol field requires a particular set of role-specific competencies. Depending on role and setting, some of these will be generic, others more specific to the substance misuse field. Many whose work brings them into contact with drug and alcohol misuse already have professional qualifications. They may be social workers, youth workers or probation officers, but they may lack the skills, knowledge and understanding to deal with the impact of substance misuse problems on their day-to-day work and duties. For example, all those working with vulnerable individuals need to have a basic knowledge and understanding of substance misuse.

Developing a competent substance misuse workforce, including both generic and specialist practitioners, is crucial to ensuring a high standard of service delivery. Local areas should take the necessary steps to ensure there are adequate numbers of appropriately skilled, competent and trained staff to meet local needs. It is also important to seek to ensure that the workforce reflects the diversity of the local population and each agency should ensure that drugs and the drugs workforce are reflected in their equality schemes.

Sources of information, guidance and support are available on the http://drugs.homeoffice.gov.uk website or from the relevant sector skills council.

Appendix 5

Evidence review*

This appendix summarises the most recent evidence on illicit drug use, supply, intervention and prevention. It is divided into seven sections:

- prevalence of drug use in key populations;
- drug use in young people
- drug-related harms;
- prevention and young people;
- what works in drug treatment;
- drug-related crime and interventions to reduce offending; and
- drug supply and enforcement.

Prevalence of drug use in key populations

The primary sources of measurement of trends and changes in the prevalence of self-reported drug use in the general population of adults and young people are: the British Crime Survey (BCS: population aged 16–59); the Offending, Crime and Justice Survey (OCJS: those aged 10–25); and the Smoking, Drinking and Drug Use Survey of young people of school age (those aged 11–15). The prevalence of drug use among those arrested by the police is measured by the Arrestee Survey.

In addition to these prevalence measures, national estimates are produced for the numbers of problematic drug users (those using opiates and/or crack cocaine) as these groups are relatively small in number, hard to reach and thus estimates of their numbers can provide a useful supplement to household surveys such as the BCS.**

Drug use in 16–59-year-olds

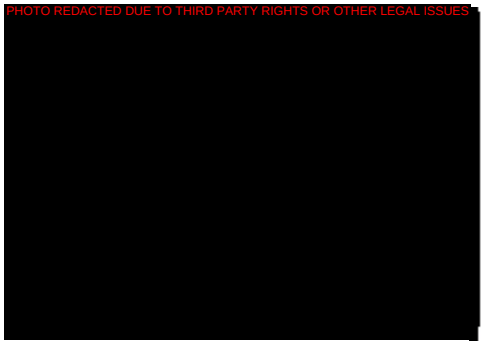
The latest BCS survey[1] (2006/07) shows that **overall reported drug use** in the past year is down since the previous drug strategy commenced from 12.1 per cent in 1998 to 10 per cent in 2006/07. This is the lowest reported level of illicit drug use since the BCS started measurement in 1996. Declining cannabis use, which is the most widely used drug in this population, has driven this trend.

The 2006/07 BCS estimates that more than one third (35.5 per cent; this equates to around 11.3 million people) of 16–59-year-olds have used one or more illicit drugs in their lifetime, 10 per cent in the last year (just under 3.2 million people) and 5.9 per cent in the past month (almost 2 million people).

The proportion of those reporting the **use of Class A drugs** in the last year increased between 1996 and 2005/06, but has remained stable since then. The rise in Class A drug use was largely due to an increase in the self-reported use of powder cocaine between 1998 and 2000 (self-reported use in the last month was 0.4 per cent in 1998 compared with 0.7 per cent in 2000: self-reported lifetime 'ever used' was 3.7 per cent in 1998 compared with 5.5 per cent in 2000). Nearly 14 per cent (just under 4.5 million people) reported using a Class A drug at least once in their lifetime; 3.4 per cent (just over 1 million) in the past year, and nearly 2 per cent (just over half a million) in the past month.

* This paper has been peer reviewed by academic experts in the field.

** Please note that all figures are reported as in original publications.



Drug use in young people

Drug use in young people (16–24-year-olds)

We know from the 2006/07 BCS that in terms of **overall drug use**, young people are the largest consumers of illicit drugs. Young people are far more likely to report recent drug use (in the last month and the last year) than the older age groups: 24 per cent of young people surveyed by the BCS in 2006/07 reported using illicit drugs in the last year compared with 10 per cent of the overall BCS population. The average age for first drug use is 16[2] and the typical first drugs tried are cannabis and solvents.[3]

Use of **Class A drugs** among young people is currently stable: in 2006/07, 8 per cent of young people reported using a Class A drug, compared with 8.6 per cent in 1998. The 20–24-year-old age group report a higher level of Class A drug use than the 16–19-year-old age group.

Drug use among school children and youth

Around one in four (24 per cent) of secondary school children in 2006 reported using one or more drugs in their lifetime, 17 per cent in the past year, and 9 per cent in the past month, and a small minority of school children were using drugs regularly, with 4 per cent reporting taking drugs usually once a month. However, the prevalence of illicit drug use among secondary school-age children has fallen in recent years. The 2006 Schools Survey[4] shows that, since 2001, prevalence of drug use in the past year in this age group has fallen from 20 per cent in 2001 to 17 per cent in 2006. This is mainly due to a drop in cannabis use.

School children tend to use alcohol and tobacco more than they use illicit drugs, but the likelihood of all self-reported substance use increases with age through adolescence. The Schools Survey shows that, at the age of 11, 21 per cent had ever drunk alcohol, 13 per cent had smoked and 10 per cent had tried drugs at least once. By the age of 15, the comparable figures were 82, 61 and 40 per cent.

Vulnerable young people

Some groups of young people are particularly vulnerable to drug use: looked-after children, homeless children, those who truant and are excluded from school and those who are serious and frequent offenders are particularly at risk of drug use. For example, 5 per cent of **non**-vulnerable young people in the 2003 Offending, Crime and Justice Survey (OCJS) used any drug frequently in the 12 months prior to interview, while 24 per cent of vulnerable young people were frequent users of any drug in the same time period.[5]

Truanting and exclusion appear to be particular markers for illicit drug use in the Schools Survey, but other factors are associated, including: poor parental discipline or monitoring; parental drug use; peer drug use; and drug availability. There is more mixed evidence for the role played by mental health, school performance and socioeconomic status.[6]

Problem drug users

Problem drug users (PDUs) are defined as those using opiates (e.g. heroin, morphine, codeine) and/or crack cocaine. PDUs are of particular interest because it is estimated they account for 99 per cent of the costs to society of Class A drug misuse.[7]

While this group is difficult to estimate with precision, we know from the PDU estimates work[8] that nationally there are significant numbers of people engaging in this type of drug use – estimated to be approximately 332,000 PDUs in 2005/06, with these estimates remaining stable over the last two annual data sweeps.

Various factors impact on the prevalence estimates of PDUs. For example there are large regional variations. It is estimated that there are 14.35 PDUs per 1,000 population in London, whereas in the South East Government Office Region it is estimated there are 6.4 PDUs per 1,000 population. Prevalence varies according to demographic factors; for example it is estimated that there are three times more male than female PDUs and the estimated rate of problem drug use among people aged 25–34 is much higher than for those aged between 10–24 and 35–64.

Criminal Justice System and drug use

High rates of drug use tend to be found among those within the criminal justice system.

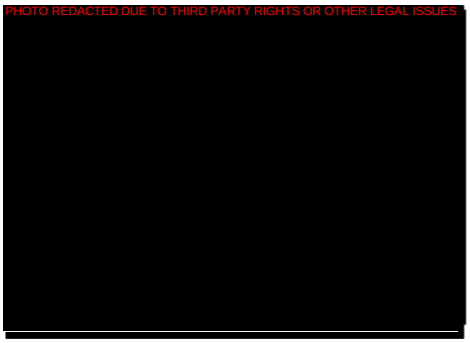
Around half (52 per cent) of those surveyed for the Arrestee Survey reported using drugs within the past month.[9] The most commonly reported drug used within the previous month was cannabis (41 per cent), but 26 per cent had taken heroin, crack, or powder cocaine (HCC). Of those reporting drug use within the year previous to arrest, 15 per cent reported heroin use and 15 per cent reported crack use. This is a higher rate than that reported in the general adult population – heroin 0.1 per cent and crack 0.2 per cent. Polydrug use among arrestees who had used heroin and/or crack (HC) in the past month was 15 per cent. The link between dependent alcohol use and cocaine among arrestees was also highlighted in the survey – 78 per cent of those who had used powder cocaine in the past year were dependent drinkers.

In addition to high rates of reported drug use in those arrested, very high rates of drug use are found among people entering prison. Around 73 per cent of prisoners have used drugs in the year before entering prison, nearly half of whom report using HCC (47 per cent). Of the 73 per cent, half reported committing offences connected to their drug use.[10]

Drug-related harms

Drug use, particularly of Class A drugs, is responsible for considerable socio-economic harms. For example, the economic and social costs of Class A drug use were estimated to be around £15.4 billion in 2003/04.[11]

Drug-related deaths are also a major concern: there were 1,608 drug-related deaths in 2005[12] and recent research indicates that about 15 per cent of these



deaths occur in people who have recently left prison.[13] Drug users also tend to have higher rates of mental health problems than the general population.[14]

The Drug Harm Index (DHI) has been used to measure Government performance in reducing drug harms. It measures drug harms by combining national indicators of the harms generated by illicit drugs into a single-figure time-series index. The harms include drug-related crime, community perceptions of drug problems and the various health consequences that arise from illicit drug use (e.g. HIV, overdoses and death). The DHI captures a subset of all the harms generated by drug use for which the most robust data (or information) are available. Data from the DHI[15] show that drug harms have decreased since the introduction of the *Updated Drug Strategy* in 2002, although the rate of this decline eased in 2005.

Evidence surrounding the harms, particularly the health harms, associated with young people's illicit drug use indicates that deaths related to drug misuse among those aged under 20 almost halved between 2000 and 2004, falling from 70 to 37,[16] and as with adults, involvement in crime is a significant drug-associated harm for the young. Additionally, long-term mental health problems may be a consequence of young people's drug use. For example, regular use of cannabis has been found to predict an increased risk of depression and anxiety.[17]

Prevention and young people

The Government has funded several prevention programmes for young people through the Young People and Drugs Programme, including FRANK (the national drug awareness campaign), Blueprint (a multi-modal school-based education programme), Positive Futures (a social inclusion programme for at-risk young people), and the High Focus Area Initiative.

Evidence on the delivery of these programmes and activities indicates that:

- FRANK is a well-regarded and well-used campaign;[18]
- Blueprint has been well-received by practitioners;[19, 20] and
- the High Focus Area Initiative[21] has improved services for young people in 48 priority areas.

The UK evidence on effectiveness is limited, but the wider evidence base suggests that, in general, the benefits of prevention programmes outweigh the costs, even where there is only a small change in behaviour.[22]

What works in drug treatment

General drug treatment

Treatment to address drug use can take many forms and an extensive evidence base informs the policy and clinical decisions that are made to provide the best outcomes for those using drugs.[23] We know that drug treatment can be cost-effective and that evidence suggests for every £1 spent on

drug treatment at least £9.50 in crime and health costs can be saved.[24]

In terms of specific treatments, methadone maintenance is effective in reducing illicit opiate use, criminal behaviour, injecting and sharing behaviours, HIV infection rates, and mortality.[25, 26, 27] Psychosocial approaches can also be successful. For example family therapy, mutual aid, the community reinforcement approach and contingency management, when paired with pharmacological interventions have been found to be successful in reviews of the treatment of opiate addiction.[28, 29] A recent review of psychosocial interventions for those with problems related to a number of drugs of misuse has found positive evidence for the impact of brief interventions including self-help, contingency management and behavioural couples therapy for drug-specific problems.[30]

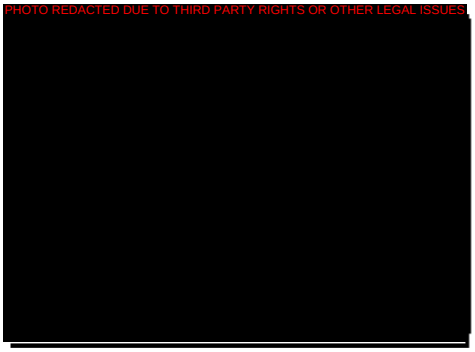
Drug treatment is often most effective when combined with additional support to tackle the underlying contributory factors for drug use – factors such as homelessness, long-term unemployment or mental health problems. For example, the majority of rough sleepers are problem drug users and homelessness is a barrier to other elements of wraparound care.[31] Most treatment seekers (77 per cent) are unemployed and more than one-third (38 per cent) have left school before the age of 16.[32] Furthermore, mental health problems suffered by drug users, left unaddressed, can impact negatively on drug treatment outcomes.[33]

Services are developing which are aimed at supporting drug users in treatment and in re-establishing their lives. We know that drug users are more likely to stay in treatment, and the treatment is more effective, if wraparound care is part of the treatment strategy.[34, 35] For example, meeting the housing needs of drug users significantly reduces drug use[36, 37] and drug users who receive specialist outpatient mental health care have been found to achieve better outcomes than those who do not complete treatment.[38] Employment and treatment are also linked. For example, successful completion of treatment significantly improves the probability of employment after treatment.[39]

Treatment specific to young people

Young drug users make up a significant number in the population of treatment service users. Figures from the National Drug Treatment Monitoring System 2003–04 show that 5 per cent of those in drug treatment were aged 11–17; this equates to 6,530 11–17-year-olds.

In terms of what works in treating drug users, there is evidence that simultaneously addressing individual, familial and extra-familial risk factors can successfully reduce drug use.[40] Behaviour therapy, culturally sensitive counselling, family therapy and group and individual therapy have also been found to reduce drug use among young people, while family therapy is effective in reducing young drug users' psychological problems.[41] Brief interventions can help to divert young people with less severe substance misuse problems away from



developing more severe problems[42] and there is some evidence of effectiveness of brief interventions, such as a short session of motivational interviewing, in producing short-term reductions in frequency of cannabis and stimulant use among young people.[43]

By contrast, it has been suggested that purely educational programmes are generally ineffective in reducing drug use[44, 45] and there is little research which evaluates the effectiveness of pharmacological treatment for young people, although extrapolation from the evidence base on adults can be considered.[46]

One of the challenges for the future of effective drug treatment in all populations will be how evidence-based practice can be consistently rolled out across the drug treatment sector so as to achieve the benefits seen in research trials.

Drug-related crime and interventions to reduce offending

Drug use and crime

The relationship between drug use and crime is complex. It is widely accepted that there is a correlation between the use of certain drugs and offending, particularly acquisitive offending.[47] However, the exact nature and direction of the link between drugs and crime is less clear.[48] So while studies[49, 50] have shown a correspondence between drug use and offending behaviour, not all drug users commit crime.

There is undoubtedly a population of drug users for whom drugs and crime are closely intertwined. Around three-quarters of new entrants to custody report using heroin or cocaine in the 12 months prior to interview.[51] Arrestees report high levels of drug use, and particularly those arrested for acquisitive crimes; the majority (73 per cent) of those using HC at least once a week were arrested for an acquisitive crime. Twenty-six per cent of those arrested for committing acquisitive crime reported taking HC weekly.[52]

Interventions to reduce offending

There is evidence that interventions which aim to reduce offending by addressing the drug use of dependent users who offend, do work to reduce offending.[53] Research shows that drug treatment can achieve reductions in offending behaviour.[54, 55, 56] There is also evidence that semi-coercive approaches, such as the Drug Interventions Programme (DIP), 'Tough Choices' initiative and community drug treatment orders, can produce good rates of engagement in treatment and that DIP and community drug treatment orders are also associated with reductions in offending behaviour.[57] There is also international evidence for the effectiveness of drug courts in reducing drug-related crime.[58] More generally, aftercare and wraparound provision are associated with better outcomes for prisoners.[59]

In terms of effective treatment approaches, a National Institute of Clinical Excellence (NICE) 'Technology Appraisal' of methadone and buprenorphine reported that the level of criminal activity decreased in people on methadone maintenance treatment (MMT) compared with those on placebo or no therapy,[60] and that substitute (methadone or buprenorphine) treatment, heroin treatment, therapeutic communities with psychosocial approaches, drug courts and probation supervision can all be effective in reducing drug-related re-offending and other harms.[61, 62, 63, 64] For example, there is evidence of a reduction in offending among prisoners entering methadone treatment in prison prior to release (and retention in MMT was also associated with reduced mortality, incarceration rates and hepatitis C infection).[65, 66]

Other studies have found that prison-based substitution treatment, especially prison-based methadone maintenance treatment, can reduce re-incarceration rates[67] and that, in particular, prison-initiated high-dose methadone maintenance had a statistically significant impact on re-incarceration versus lower-dose methadone maintenance therapy.[68]

There is little evidence on the impact of routine monitoring drug testing (i.e. drug testing undertaken pre-trial or in conjunction with treatment).[69] However, there is evidence to show that drug testing in the custody suite, through DIP, increases the numbers of individuals entering treatment when combined with other appropriate interventions, such as required assessment.

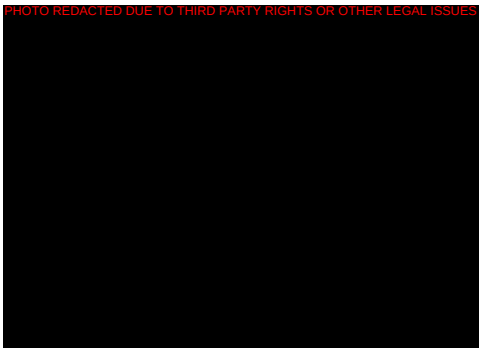
Drug supply and enforcement

Our evidence base on the supply of drugs to and within the UK (including the nature of supply networks) has been developed partly from intelligence from law enforcement agencies and other government sources, and partly from empirical research including self-report data from drug users and dealers.

The illicit drug market

The illicit drug market in the UK, based on a combined market for cannabis, cocaine powder, heroin, crack, ecstasy and amphetamines in 2003/04, was worth between an estimated £4 billion and £6.6 billion; the estimated figure for England and Wales is between £3.5 billion and £5.8 billion. Crack and heroin accounted for the largest expenditure share, 28 per cent and 23 per cent respectively.[70]

Between 25 and 35 tonnes of heroin and 35 and 45 tonnes of cocaine powder enter the UK each year. The UK heroin market is supplied almost exclusively by Afghanistan, which produces over 90 per cent of the world's heroin. Colombia supplies the majority of the cocaine that comes into the UK.[71] Crack cocaine is rarely imported but is produced in the UK from cocaine powder. Cannabis is imported to the UK from Europe, both in bulk by serious organised criminals and in smaller amounts for sale and personal use. In addition, some cannabis is cultivated in the UK.[72]



Drug prices and purity

Law enforcement data indicates that the price of drugs at street level has fallen over the past decade. In recent years (2003–2006), the prices of heroin, cannabis resin, ecstasy and cocaine have also fallen, while those of crack and amphetamines have remained broadly stable.[73]

These data are supported by the views of drug users and dealers. Those interviewed for the 2005/06 Arrestee Survey reported a perceived drop in the price of drugs compared with six months previously.[74] Similarly, drug dealers interviewed in prison claimed a reduction in drug prices over time, particularly wholesale prices.[75]

The purity of most drugs at street level is falling, with the exception of heroin. Respondents in the Arrestee Survey (2005/06 sweep) also reported a drop in drug purity levels compared to six months previously.

The relationship between drug prices, drug purity and demand for drugs is complex, although there is evidence that increases in drug prices can reduce adverse outcomes of drug use.[76] Interviews with drug dealers and traffickers have suggested that law enforcement activity can impact on how drugs are priced.[77] However, dealers working at different levels of the market handle price fluctuations in different ways, for example, dealers operating at the upper levels of the market (i.e. importation) may raise prices in response to a reduction in availability, while street level dealers are more likely to keep prices stable to keep their customers while adjusting the purity or the weight of drugs sold.

Enforcement activity

Since the introduction of the drug strategy in 1998, the Government has implemented a number of initiatives aimed at reducing and disrupting the supply of drugs in the UK. These initiatives have sought to adopt a multi-agency approach to enforcement, working in partnership with local agencies in the community to tackle drug supply. A systematic review of the international evidence on law enforcement interventions has shown that adopting this approach to enforcement to tackle specific problems in the community, e.g. street level dealing, is more successful than enforcement in isolation.[78]

Enforcement activity in the UK has included the introduction of the Anti-social Behaviour Act (2003), which enables the police to enforce the rapid closure of crack houses. These increased powers enable the police to tackle drug supply and drug taking in communities and reduce anti-social behaviour. However, some displacement has occurred with cases involving crack houses opening in neighbouring areas. Effective partnership working with local agencies, including treatment providers, proved key in the period following these operations, providing support for drug users and the local community.[79]

In addition, middle market police operations that focused on dealers distributing drugs from upper-level to street-level dealers were set up in the West Midlands, Merseyside and Wales. These operations signified a move towards intelligence-led policing, targeting key players in the supply chain, and led to significant arrests and large seizures of drugs.[80] The longer-term impacts of such initiatives on drug markets and those supplying them are not yet known.

In terms of the deterrent effect of enforcement activity, drug dealers claim that the risk of having their assets seized is a greater deterrent than is the risk of imprisonment.[81]

Next steps

Looking ahead, the Government will seek to develop a strategic research programme over the next ten years that draws on enhanced partnership working between government, academia and the wider international research community in order to further develop our evidence base and support the delivery of our new drug strategy. A first stage of such work will be to identify the priority areas for future research.

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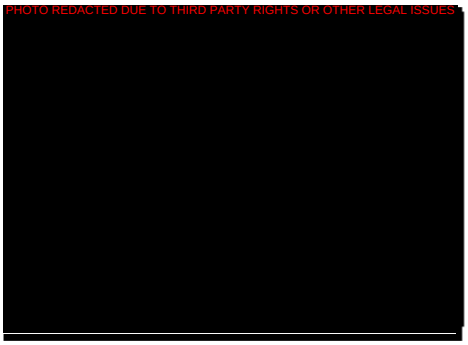

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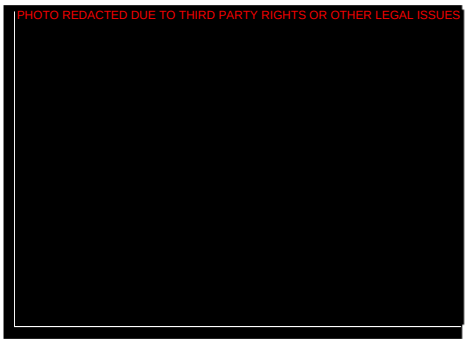
Appendix 6

Links to other strategies



The drug strategy and the Public Service Agreements (PSAs) underpinning its delivery are closely related to a number of strategies and PSAs across a broad range of areas. Action to meet objectives and targets set out in the drug strategy and its supporting action plans will contribute to the objectives set out in a number of other strategies. Conversely, the delivery of several strategies will support the achievement of the drug strategy objectives.

The closest links are between the drug strategy and the alcohol strategy, and the single PSA that informs the content of both strategies sets out the Government's vision to reduce the harms caused by alcohol and drugs.

The strategies, plans and programmes linked to the drug strategy are listed below:

Crime and offending

- *Working Together to Cut Crime and Deliver Justice: A Strategic Plan for 2008–2011*, Criminal Justice System, 2007
- *Cutting Crime: A New Partnership 2008–2011*, Home Office, 2007
- *National Community Safety Plan 2008–2011*, Home Office, 2007
- *Youth Crime Action Plan*, Department for Children, Schools and Families (DCSF)/ Home Office/Ministry of Justice (MoJ), summer 2008
- *Reducing Re-Offending Strategic Plan 2008–2011*, MoJ, spring 2008
- *Reducing Re-Offending by ex-prisoners*, Social Exclusion Unit, 2002 and *The National Reducing Re-offending Delivery Plan*, National Offender Management Service (NOMS), 2005
- *Reducing Re-Offending Through Skills and Employment: Next Steps*, Department for Education and Skills (DfES), 2006
- *Strategy for the Management and Treatment of Problematic Drug Users Within the Correctional Services*, NOMS, 2005
- *Saving Lives, Reducing Harm, Protecting the Public. An action plan for tackling violence 2008–2011*, Home Office, 2008
- *Working together to protect the public. The Home Office Strategy 2008–2011,* Home Office, 2008

Young people and families

- *Reaching Out: Think Family*, Cabinet Office, 2007 and *Think Family: Improving the life chances of families at risk*, Cabinet Office, 2008
- *Hidden Harm – responding to the needs of children of problem drug users*, Advisory Council on the Misuse of Drugs (ACMD), 2003 and *Hidden Harm Three Years On*, ACMD, 2007
- *The Children's Plan: Building brighter futures*, DCSF, 2007
- *Aiming high for young people: A ten year strategy for positive activities*, HM Treasury/DCSF, 2007
- Guidance for schools on the duty to promote well-being, DCSF, spring 2008
- Drug education review, DCSF, spring 2008

- Sex and relationships education review, DCSF, spring 2008
- Pupil well-being guidance, DCSF, spring 2008
- *Staying Safe: Action Plan*, DCSF, 2008
- *Every Child Matters: Change for Children – Young People and Drugs*, DfES, 2005
- *Youth Alcohol Action Plan*, DCSF, summer 2008
- *Care Matters: Time for Change*, White Paper, DCSF, 2007
- *Children and Young People's Health Strategy*, Department of Health (DH)/ DCSF, summer 2008
- *Every Parent Matters*, DCSF, 2007
- Duty to provide information, advice and assistance: guidance for local authorities, DCSF, 2008
- Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies, DfES, July 2006
- *Teenage Pregnancy: Accelerating the Strategy to 2010*, DfES, September 2006
- Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts, DCSF/DH, July 2007

Health

- *Our health, our care, our say*, DH, 2005
- Government response to *Facing the future: A review of the role of health visitors*, DH, 2007
- *Treatment effectiveness strategy*, National Treatment Agency (NTA), 2005

Substance specific

- *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*, Home Office, 2007
- *Children, Young People and Volatile Substance Abuse (VSA)*, DH, 2005
- *Addressing Alcohol Misuse: A Prison Service Alcohol Strategy for Prisoners*, HM Prison Service (HMPS), 2004
- *Working with Alcohol Misusing Offenders – a strategy for delivery*, NOMS, 2005

Wider context

- *Strong and Prosperous Communities:* The Local Government White Paper, Department for Communities and Local Government (CLG), 2006
- *Reaching Out: An Action Plan on Social Exclusion*, Cabinet Office, 2006
- *Independence and Opportunity: Our Strategy for supporting people*, CLG, 2007
- *Sustainable Communities: settled homes; changing lives – A strategy for tackling homelessness*, Office of the Deputy Prime Minister (ODPM), 2005
- *Home for the Future: more affordable, more sustainable*, CLG, 2007
- *Housing for vulnerable people: Strategy statement*, Housing Corporation, 2007
- *The Home Office Overarching Race, Disability and Gender Equality Scheme*, Home Office, 2007
- *The diversity strategy 2007–10*, Home Office, 2007

International

Relevant international strategies:

- *EU Drugs Strategy 2005–2012*, adopted by the Council on 22 November 2004; Council document number 15074/04
- The EU drugs action plan 2009–12, to be developed between July and December 2008

Appendix 7

National governance

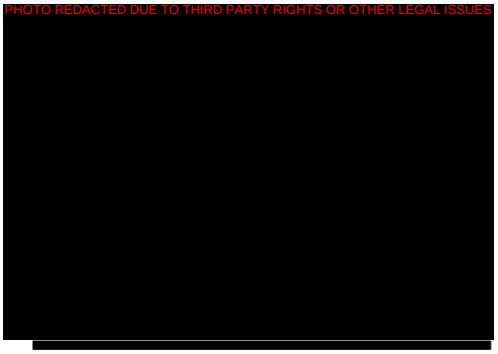
Within central government, a system of governance has been put in place for the drug strategy that provides a mechanism by which cabinet ministers, junior ministers and senior officials retain oversight of the development and delivery of the strategy, and within which issues may be resolved at the most appropriate level.

The governance arrangements are closely related to, and in some cases combined with, the governance systems relating to crime and alcohol. This recognises the fact that the drivers and effects of drug misuse are closely related to those for alcohol and crime. Departments and agencies representing young people and families are represented at each level of the structure, which ensures shared objectives and a close link between officials and ministers.

Issues relating to drugs will also be within the remit of boards and governance systems with a focus on related issues. Examples of this relationship are the Reducing Re-Offending Programme Board and the Inter-Ministerial Group on Reducing Re-Offending, which monitor progress, provide direction and drive strategy at, respectively, official and ministerial level across the seven pathways to reduce re-offending, one of which is alcohol and drugs.

The governance structure is represented in the table below.

BOARD	CHAIR	LEVEL
Domestic Affairs Cabinet Sub-Committee (Justice and Crime)	Secretary of State for Justice	Cabinet
National Crime Reduction Board	Home Secretary	Ministerial
Inter-Ministerial Group: alcohol and drugs	Parliamentary Under-Secretary of State for Crime Reduction (Home Office) or Minister of State for Public Health (Department of Health)	
Public Service Agreement strategic board (PSAs 23 and 25)	Director General, Crime Reduction and Community Safety Group (Home Office)	Senior official
Alcohol and drug strategies delivery group	Director, Crime and Drug Strategy Directorate (Home Office) or Department of Health equivalent	
Individual programme boards – alcohol and drugs	Departmental policy leads	Operational



Appendix 8

Impact assessment

Addressing the harms caused by drugs is a long-term problem. This strategy replaces the existing ten-year strategy, which was published in 1998 and updated in 2002.

It builds upon the existing strategy and seeks to balance tough enforcement action to tackle dealers, reduce crime and anti-social behaviour and reduce the supply of drugs, with interventions to prevent drug use, educate and intervene early and reduce the demand for illegal drugs. The overarching aims are to grip existing drug users more firmly, increase the numbers already re-establishing their lives and reducing the number of new problem drug users. It is focused on the drugs which cause the greatest harm to communities. The strategy is arranged around four strategic themes:

- protecting communities through robust enforcement to tackle drug supply, drug-related crime and anti-social behaviour;
- preventing harm to children, young people and families affected by drug misuse;
- delivering new approaches to drug treatment and social re-integration; and,
- public information campaigns, communications and community engagement.

The strategy document makes explicit reference to the public consultation process which helped to inform its development and it addresses the priority issues raised.

While the strategy will cover a ten-year period to 2018, its delivery will be underpinned by a series of three-year action plans, which will run concurrently with the Spending Review cycles. The first such action plan is published with this document.

Key **actions** include:

- identifying and targeting the drug-misusing offenders causing the greatest harm to communities, improving prison treatment programmes and increasing the use of community sentences with a drug rehabilitation requirement;
- extending powers to seize the cash and assets of drug dealers, to demonstrate to communities that dealing doesn't pay;
- embedding action to tackle drugs within the neighbourhood policing approach, to gather community intelligence, engage with and increase community confidence;
- strengthening and extending international agreements to intercept drugs being trafficked to the UK;
- focusing on the families where parents misuse drugs, intervening early to prevent harm to children, prioritising parents' access to treatment where children are at risk, providing intensive parenting guidance and supporting family members, such as grandparents, who take on caring responsibilities;
- developing a package of support to help people in drug treatment to complete treatment and to re-establish their lives, including ensuring local arrangements are in place to refer people from Jobcentres to sources of housing advice and advocacy and appropriate treatment;

- using opportunities presented by the benefits system to support people in re-integrating into communities and gaining employment, while also exploring the case for introducing a new regime for drug users that provides more tailored support for people; and, in return, putting the responsibility on claimants to move successfully through treatment and into employment; and
- piloting new approaches which allow more flexible and effective use of resources, including individual budgets to meet treatment and wider support needs.

We have carefully considered the impact of the strategy upon all sectors. There are no adverse financial impacts on the private or third sectors. The private sector benefits from the impact of less need to cope with the disruption caused by drug-related acquisitive crime, reduced impact of anti-social behaviour upon business premises and their surroundings and reduced health harms. The third sector benefits in similar ways.

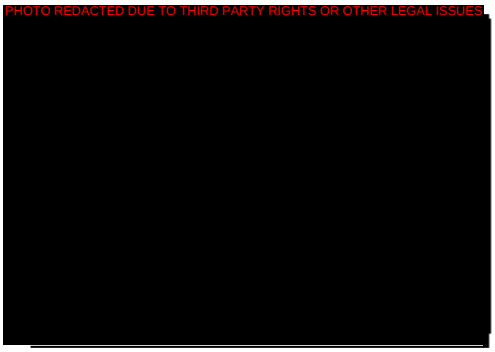
Evidence suggests that for every £1 that is spent on drug treatment, at least £9.50 is saved in crime and health costs.

Anticipated beneficial **outcomes** include:

- Police and other enforcement agencies' resources more efficiently deployed in addressing all aspects of drug-related crime. This will result in better targeting of drug-misusing offenders causing greatest harm, reducing their impact upon communities; and all levels of drug supply being disrupted more effectively. Criminal assets, the proceeds of drug supply, will be seized and re-invested for

The impact of the key strategic themes are:

STRATEGIC THEMES	IMPACT
Protecting communities through robust enforcement to tackle drug supply, drug-related crime and anti-social behaviour.	Reduced drug-related crime, anti-social behaviour and safer communities. Improved public confidence and reduced perceptions of drug problems in local areas.
Preventing harm to children, young people and families affected by drug misuse.	Fewer young people becoming involved in drugs, leading to fewer problem drug users in the future.
Delivering new approaches to drug treatment and social re-integration.	Problem drug users successfully completing treatment and re-establishing their lives.
Public information campaigns, communications and community engagement	General public and at-risk groups better informed on drug problems, and communities more motivated to collaborate on crime.



the benefit of enforcement agencies and local communities.

- Better use of family-oriented initiatives. Our understanding of those who are most at risk has improved. We are now able to target resources more effectively, intervening earlier to prevent harm, prioritising parents' access to treatment and supporting family members to take on caring responsibilities.
- Maximising the benefits of treatment and the development of more outcome-focused, personalised and innovative provision, including the piloting of individual budgets to support end-to-end management to help those successfully completing treatment to re-integrate by accessing housing, employment, education and training support. The medium-term impact is that former problem drug users make fewer calls on support services and cause less harm to themselves and others.
- Better information support for parents, as well as young people, to help them to talk about drugs. We will broaden the use of information campaigns to better equip those surrounding our vulnerable young people to support and help address drug issues.
- Strengthened community confidence through improved local communications about the way drug harms are being tackled, so that communities are more strongly motivated to engage with enforcement agencies in tackling local drugs crime and anti-social behaviour.

We are confident that the overall package of measures set out will produce the benefits we describe. We do not anticipate the need for further legislation nor any additional costs or unwanted impacts falling on frontline services. However, if further more detailed proposals are required we will produce robust impact assessments as necessary.

Appendix 9

Resources

The following tables set out estimates of the resources being invested by government departments in the various component programmes and funding streams which enable delivery of the drug strategy. There is also significant mainstream and LAA funding which is used to support action to tackle drugs.

While funding decisions have been made for 2008/09, the first year of the strategy, it is not possible for us to determine precisely the funding that will be available for each strand or constituent programme of the strategy, so figures for later years are therefore indicative. However, tackling drugs is a key element of government policy and we therefore expect that total expenditure will remain broadly constant.

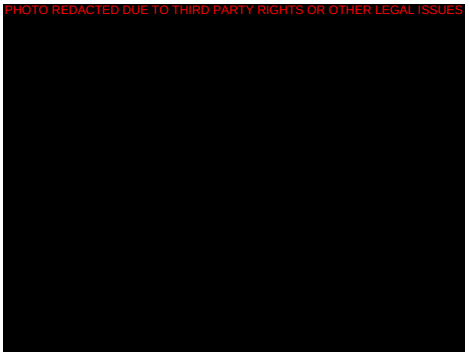
Labelled expenditure is defined as that which is:

- included in budgets and/or end-of-year reports;
- drug-specific; and
- proactive, in that it is linked to the achievement of specific policy aims.

Additional related expenditure may be proactive, such as drug education, or reactive, in that it arises as a result of drug misuse, such as enforcement or health costs.

Departmental expenditure	£ million			
	2007/08	**2008/09**	**2009/10**	**2010/11**
Department of Health and other mainstream treatment	568.22	568.22	568.22*	568.22*
Young People drug-specific services funding for local delivery (combined Department of Health, Department for Children, Schools and Families, Youth Justice Board and Home Office funding)	55.20	55.10	55.10*	55.10*
Young People central programmes funding (combined Department of Health, Department for Children, Schools and Families, Youth Justice Board and Home Office funding)	33.81	31.61	31.61	31.61
Home Office	160.39	160.39	160.39	160.39
Prison funding and community sentences (combined Ministry of Justice and Department of Health funding)	118.10	127.10	141.60*	145.60*
Foreign and Commonwealth Office	6.00	3.00	2.00	2.00
Total labelled expenditure	**941.72**	**945.42**	**958.92**	**962.92**

* Note that the Pooled Treatment Budget for 2009-11 is due to be confirmed in July 2008.



During the course of the previous drug strategy, the Government made significant year-on-year increases in funding, and this has enabled robust and effective delivery mechanisms and systems to be put in place. We would now expect that, as this system reaches maturity, expansion costs should be minimised and substantial efficiency savings should be generated. This will allow the available resources to be more effectively used.

Additional related expenditure	£ million			
Departmental expenditure	**2007/08**	**2008/09**	**2009/10**	**2010/11**
All relevant agencies – tackling supply	380	380	380	380
DCSF – teacher time, school-based training and schools Standards Fund	49	49	49	49
Re-integration support and community-based services	122	122	122	122
DWP – providing help to find jobs	20	20	20	20
Prisons re-integration	0	0	2	2
DCSF – investment in youth†		606.66	606.66	606.66
DCSF – investment in families†		52.66	52.66	52.66
FCO – Support to Afghanistan†	16.5	16.5	16.5	16.5

†We have shown DCSF investment in youth and families, and FCO investment to support the government of Afghanistan, as constant expenditure over the three year period for indicative purposes only. Detailed content over each year has yet to be defined.

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