



# The National Drug Strategy

a guide for local  
partnerships

2007/8



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### What Is... the London Drug Policy Forum (LDPF)?



LDPF assists, supports and advises policy makers on drug issues affecting the capital, and works with the London boroughs,

Drug Action Teams, health organisations, drug agencies and government departments to promote good practice on education and prevention, commissioning, community safety and improving services for drug users.

**In 2005**, the LDPF published '*National Drug Strategy – a guide for local partnerships*'.

Produced for those new to local drug strategy development and implementation, it also proved to be a handy reference for those who'd been around a bit longer and was an instant hit.

In early 2007 we ran out of copies and people began asking us for an updated version and while we're still planning to produce a new version when the new strategy is published, we couldn't make you wait any longer.

This then is an interim guide that we hope will help you keep the momentum going in your area towards tackling drug issues during this period of change.

You will find the landscape has changed considerably since we last produced the guide. Not all of those changes have settled down yet and we expect more. This means the picture can look confusing. That said, some information is better than none, and whether you are a Drug Action Team (DAT) Coordinator, a Joint Commissioning Manager, a Community Safety Manager, or in related areas, we hope you will find this guide makes your job easier to do.

It should give you some ideas as well about the sort of partnerships you need to generate locally, and who you need to involve to deliver an effective response to drugs in your area.

The London Drug Policy Forum, your Government Office Team or NTA Deputy Regional Manager are there to help you through setting up systems and structures that will help you meet the national agenda locally.

They should also help you begin to identify and address the local issues you need to tackle, but that's not their day job. It's yours. Good luck.

## The National Drug Strategy

The National Drug Strategy represents the Government's commitment to provide resources and legislation to tackle the problems related to drug use.

The current Drug Strategy was developed in 1998, and updated in 2002. It identified the key central aims for Government in connection with reducing drug misuse as being:

- Reducing drug use amongst young people
- Having a sustained impact on the supply of Class A drugs to the UK
- Targeting drug misusing offenders via the Criminal Justice System and
- Providing treatment for people with drug problems

This drug strategy ends in April 2008.

### What's going to happen next?

In the summer of 2007, a consultation on the Drug Strategy was started by the Government.

The consultation was published on July 15th 2007 and the official period for responding ends on the 19th October. As the Comprehensive Spending Review has not reported yet, and therefore the Public Sector Agreement (PSA) target for drugs (or possibly drugs and alcohol) has not yet been set, this is not so much about a new strategy but a broad ranging consultation on priorities.

### What is... the timetable?

Consultation published	13 <sup>th</sup> July 2007
Statutory 12 Weeks consultation period	19 <sup>th</sup> October 2007
Comprehensive Spending Review (Sets PSAs and budget)	by November 2007
New Strategy published	March 2008
New Strategy begins	April 2008

### What is... a Public Service Agreement (PSA)?

A PSA is an agreement between the Treasury and the Departments who receive public funding. It's established to enable better performance management of public services where additional and substantial investment has been made. A PSA has an overall aim, a set of objectives, and a set of targets. Accompanying this and published alongside this information by the Treasury is a Technical Note explaining the methodology for measuring the targets.

As part of the move away from central to local planning promised by the current government, the number of PSA targets has been reduced from over 200 PSAs to around 30. However, many of the new PSA targets are expected to be composite, including multiple targets and all will be interdepartmental – so the reduction in central government control may be more cosmetic than substantial.

The **Comprehensive Spending Review (CSR)** is carried out by the Treasury and sets three-year departmental expenditure limits and, through **Public Service Agreements (PSAs)**, defines the key improvements that can be expected from these resources. It is expected that the 2007 CSR will be completed by November 2007, after which the new PSA relating to drugs will be announced and from this will flow the next drug strategy.

It is generally accepted that significant progress has been made over the past ten years. However following Gordon Brown's announcement in June 2007 that the time had come for a 'radical review' of drug strategy, people began to agree that despite the progress, we needed to be open to change some of the ways we deal with drug use. This change however is likely to be evolutionary rather than revolutionary.

So we expect the focus of the 2008 Drug Strategy to be broadly similar to that of the previous one, but with a renewed emphasis on 'localism' and a stronger focus on young people and public information. The new strategy is unlikely to be a ten year strategy. We are currently working under the impression that it will run from 2008 – 2011, but this has yet to be confirmed.

### What is... Localism?

The drive for localism grew out of concerns that British public service provision was bureaucratic, overly centralized and that this made services less cost effective in meeting the needs of communities than it could be. Localism suggests that more decisions about funding, service provision and strategy should be taken locally – not just by local

government and local partnerships but by communities and individuals. Much of the machinery for localism has been created by the Department for Communities and Local Government and sits at a local level with the LSP (Local Strategic Partnership) and the LAA (Local Area Agreement).

The consultation document – *Our Community, Your Say - A Consultation Paper* gives the following as the suggested aims of the next UK Drugs Strategy:

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

At the time of going to press it is strongly rumoured that the new PSA for drugs will cover alcohol as well as illegal drugs. However, a separate alcohol strategy – *Safe. Sensible. Social. The next steps in the National Alcohol Strategy* was published in June 2007 – which raises some questions about how the implementation of work to support any joint alcohol and drugs PSA would be measured and financed.

## National government departments and their responsibilities

The **Department of Health** has been responsible for the treatment target of the PSA – It manages this partly via the National Treatment Agency and partly with Primary Care Trusts and Strategic Health Authorities. Drug misuse also features as one of the public health priorities for the Department of Health.

The **Home Office** takes the lead in driving forward the Drug Strategy and meeting the current PSA, but responsibility for implementation is shared between the Home Office, Department of Health and what was the Department for Education and Skills. Home Office specific responsibilities include the Drug Intervention Programme (DIP) and enforcement and availability. There is currently some confusion about what the role of the newly created Ministry of Justice will be around drugs. While overall responsibility for drugs remains with the Home Office, given their role leading on prisons, NOMS (National Offender Management Service), courts and sentencing, the new ministry is bound to play a large role in implementation, if not policy formation.

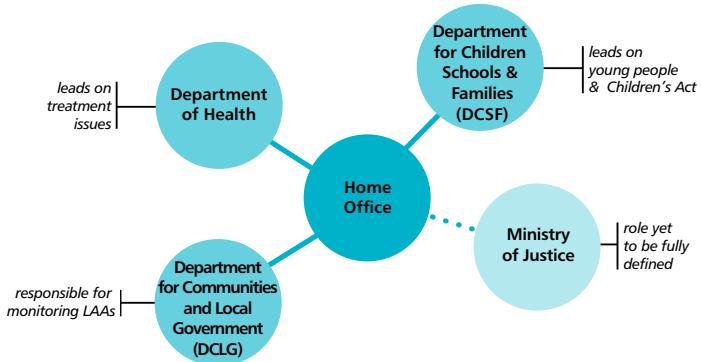
### What is... The Drug Interventions Programme (DIP)?

The Drug Intervention Programme (DIP), is a centrally funded programme of work delivering to the criminal justice performance measure of the PSA. Its main focus is in providing enhanced case management and rapid, seamless access to treatment, support and aftercare for all drug using offenders (arrested for trigger offences and who test Positive for

Class A drugs). DIP is often quoted as the main success of the last strategy – however its full impact on repeat offending and primary offenders has yet to be fully felt – evaluations are currently underway. Much of the credit for the growth of and emphasis on DIP must go to the NTA whose work has become increasingly focused on this area of the strategy.

The **Department for Communities and Local Government (DCLG)** will be responsible for ensuring, through Government Offices, that any new substance use PSA targets are reflected in the planning and performance management of Local Strategic Partnerships. CLG is also responsible for making sure that LAAs do ‘what they say on the tin’ and genuinely enhance service delivery through effective partnership, revitalizing local democracy and enabling people to have a real say.

The **Department for Children, Schools and Families (DCSF)** is responsible for improving the focus on all aspects of policy affecting children and young people. Although they have recently entered into an agreement with The National Treatment Agency for Substance Misuse (NTA) that they will jointly work to ensure all young people have access to specialist substance use treatment, this agreement also reinforces the department’s responsibility for ensuring that substance use is recognized in the holistic support of young people by Children’s Trusts – including responsibility for the provision of adequate drugs education, diversionary activity and harm reduction interventions.



## National specialist agencies and departments

**The National Treatment Agency for Substance Misuse (NTA)** was established in 2000 to ensure delivery of the treatment strand of the Drug Strategy. It is sponsored by the Department of Health and the Home Office who manage its performance via a service level agreement. The National Treatment Agency (NTA) is a special health authority. This means that:

- a publicly accountable board of directors – not within the Department of Health – manages it
- people who work for it are not civil servants
- it has a time-limited brief (currently extended to 2008 but with every sign that it will continue to lead and monitor drug treatment until at least 2011).

The current functions of the NTA include:

- performance management of the treatment planning process
- effective performance management of DIP
- development of effective policy to support treatment (Clinical standards, creation of evidence base)
- inspection of treatment services (with the Healthcare Commission)
- monitoring of the effectiveness of treatment
- leadership on specialist treatment for young people.

While the NTA's head office is based in London, they have teams in each of the English regions – these are co-located with the Government Offices for the Regions. There will be an imperative over the life of the next strategy for NTA regional teams to work very closely with the regional SHAs – indeed the Department of Health have suggested that they should amalgamate, however it is not clear currently how this will be achieved.

**The Crime and Drug Strategy Directorate (CDS)** is the section of the Home Office responsible for drugs – not just in terms of treatment, but also availability, organised crime and young people (jointly with NTA/DCSF). CDS currently:

- performance manages (via the regional teams) the responsible local partnerships (usually DATs or CDRPs)
- has oversight of the Government Office Home Office Regional Director
- manages DIP
- performance manages supply interventions
- co-ordinates activity
- is responsible for the overall monitoring and delivery of the Drug Strategy.

**[www.homeoffice.gov.uk/about-us/organisation/directorate-search/crcsg/cdsu](http://www.homeoffice.gov.uk/about-us/organisation/directorate-search/crcsg/cdsu)**

The **Serious Organised Crime Agency (SOCA)** was launched by the Prime Minister in 2006. The creation of SOCA was intended to improve co-ordination and bring further pressure to bear on organised crime. SOCA identifies drug trafficking in heroin and cocaine, particularly crack cocaine, as the greatest single threat to the UK in terms of the scale of serious organised criminal involvement, the illegal proceeds secured and the overall harm caused. SOCA is also a key agency in improving the seizure of criminal assets. SOCA's stated priorities include working with partners within the UK and internationally to reduce harm.

**HM Revenue and Customs (HMRC)** was created in 2005 and amongst other responsibilities enforces border security and as such has an important role in seeking to stop drugs coming into the UK. Most of the investigation functions from HM Customs and Excise have transferred to SOCA, however HMRC remain an important agency in terms of seizures.

**The National Offender Management Service or NOMS** is part of the new **Ministry of Justice**. NOMS is the commissioning body for the Prison and Probation Services and will endeavour to see more Criminal Justice System work (CJS) provided on a competitive basis from any sector (including Voluntary/Charitable and Private providers). Regional delivery will be through Regional Offender Managers (ROMs). Delivery and management of services will be based on Service Level Agreements (SLAs) between the provider (Prison/Probation/Voluntary/Private sector) and the ROM.

**The Youth Justice Board (YJB)** oversees the youth justice system in England and Wales. Their role is to prevent offending and re-offending by children and young people under the age of 18, and to ensure that custody for them is safe, secure, and addresses the causes of their offending behaviour.

**The Healthcare Commission** is the health watchdog for England (and Wales, but it has slightly different powers there). Its job is to promote improvements in the quality of healthcare and public health in England and Wales. In England, they are responsible for assessing and reporting on the performance of both NHS and independent healthcare organisations, to ensure that they are providing a high standard of care. In partnership with the NTA they undertake a programme of health improvement work with drug service providers.

### What's this about... health and social care reform?

The UK health and social care system has been undergoing radical reform over the past few years. The aim of this has been to improve outcomes for patients and consumers by putting them at the centre of the system. The key mechanism for this in healthcare has been anticipated as being the establishment of a plural market (one with a number of providers) for healthcare where the consumer has a choice and the provider is paid for the numbers of individuals that they see and the outcomes they achieve. In

social care, the focus has also been on the individual service user as an empowered purchaser at the centre of a system of care with multiple providers. The greatest impact this has had in the drugs field has been in establishing the principle of the plural market – with most DATs having gone through multiple procurement processes. However as yet the position of the commissioner as the arbiter of quality and appropriateness has not been superseded by the principle of individual choice.

## Non governmental national bodies

**DrugScope** is the UK's largest independent charity focussing on substance use. They provide drug information, promote effective responses to drug taking, undertake research at local, national and international levels, advise on policy-making, encourage informed debate and represent a broad group of organisations in the drugs field. [www.drugscope.org.uk](http://www.drugscope.org.uk)

**European Association for the Treatment of Addiction (EATA)** is an umbrella organisation for the independent drug and alcohol treatment and aftercare sector. EATA is a membership organisation representing 500 services provided by its members in the UK and Internationally. [www.eata.org.uk](http://www.eata.org.uk)

**Alcohol Concern** provide information and encourage debate on the wide range of public policy issues affected by alcohol; including public health, housing, children and families, crime and licensing. They support specialist and non-specialist service providers helping to tackle alcohol problems at a local level, whilst also working to influence national alcohol policy. [www.alcoholconcern.org.uk](http://www.alcoholconcern.org.uk)

**Adfam** are the national charity representing and working with families affected by substance misuse. They provide direct services and also seek to influence policy particularly as it affects children and parents. [www.adfam.org.uk](http://www.adfam.org.uk)

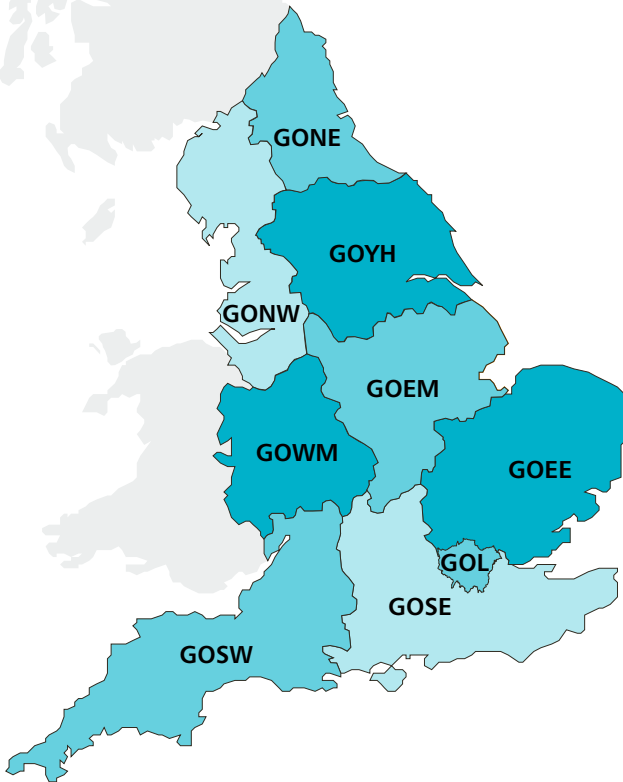
**The Alliance** is a user led organisation which provides advocacy, training and helpline services to those currently in drug treatment, those who have accessed drug treatment in the past and those who may access drug treatment in the future. [www.m-alliance.org.uk](http://www.m-alliance.org.uk)

**The Association of Chief Police Officers (ACPO)** is an independent body that represents the most senior officers within the police service. It works with central government and the Association of Police Authorities. ACPO leads and co-ordinates the development of the police service in England, Wales and Northern Ireland. It has had an important role in drug policy development and produced the national guidance on the policing of cannabis. [www.acpo.police.uk](http://www.acpo.police.uk)

## Regional agencies

**The Government Offices for the Regions (GORs)** are intended to bring implementation and decision-making closer to 'the people'.

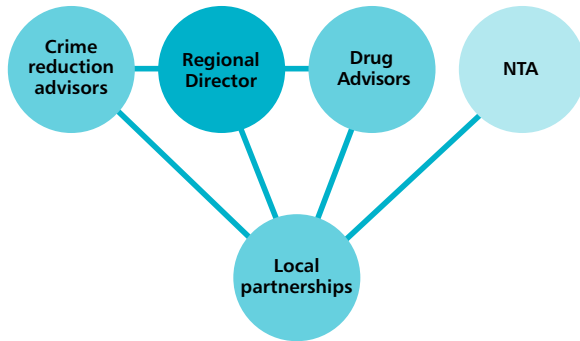
There are 9 Government Offices in England – South East (GOSE), London (GOL), South West (GOSW), East (GOEE), East Midlands (GOEM), West Midlands (GOWM), Northwest (GONW), Yorkshire and Humberside (GOYH), and North East (GONE).



Each regional Government Office is organised slightly differently. But all have a Home Office Regional Director who is responsible for working with local partnerships (CDRPs, YOTs, LSPs, DATs) to develop and implement effective crime and drug reduction strategies. Within the unit managed by the Regional Crime Director are the Crime Reduction Advisers and the Drugs Advisers. Co-located within Government Offices are the NTA regional team, featuring anything from 1 to 9 Deputy Regional Managers, the Regional Administrator and the Regional Manager.

In terms of the Drug Strategy, the key functions of the Government Offices are performance management, co-ordination of programmes and the approval and monitoring of Home Office funding.

The Government Offices have a particular responsibility for negotiating and performance managing the local performance targets in the Local Area Agreements (LAAs).



**Regional Public Health Groups (RPHG)** are the regional presence of the Department of Health and they sign off all health related targets in LAAs. They are also co-located within Government Office and each regional team has a lead for alcohol and drugs issues.

The **NOMS Regional Offices (NOMROs)** and **Regional Offender Managers (ROMs)** are the individuals charged with commissioning the services for punishment, rehabilitation and supervision in the community and in prisons. They will also produce Reducing Re-offending Plans for each region. NOMROs map to the Government Offices for the Regions.

The **Youth Justice Board (YJB)** Regional Teams map onto the nine Government Office areas (though currently East of England and east midlands share one YJB Regional Manager). The YJB regional Teams monitor the performance of YOTs through the YOT Performance Framework (and the National Standards for Youth Justice) and help them improve where necessary.

**Strategic Health Authorities (SHAs)** are part of the NHS and are charged with the fiscal and strategic management of health provision in each of the regions. With the exception of South of England, the SHAs map onto the Regional Government Offices (in the South region, there are two SHAs to deal with the scale of the area – South Central, and South East Coast). The SHAs oversee all the NHS bodies in their areas including Hospital Trusts, Ambulance Services Trusts, Care Trusts, Mental Health Services Trusts but the relationship which is arguably their most critical is that with the Primary Care Trusts (PCT). PCTs manage the Pooled Treatment Budget as they are allocated the budget from the Department of Health 'to hold on behalf of their local drug partnership'. In real terms their involvement so far with drug treatment or strategy has been minimal. It is possible that any increased focus on health within the new drug strategy would see SHAs have a greater role in monitoring expenditure and outcomes.

**Public Health Observatories (PHOs)** are tasked with supporting PCTs, local government and local strategic partnerships with information and analysis to enable effective local health strategies to be put in place. There are nine PHOs in England, which map to the Government Office areas. In most areas PHOs hold the contract for production and analysis of NDTMS data – the exception to this is London.

### **Regional Policing**

As the Police Service operates at county/regional and municipal levels so all areas have a local Police Authority. Police Authorities are comprised of members drawn from local authorities, magistrates, plus independent members (often recruited via open competition), in London the Home Office appoints one member directly. In County/2 Tier areas the Police Authority operates at county level and usually covers unitaries within the geographical county. Police Authorities have an important role in setting policy for their respective police services, in holding the police to account for their activities (scrutiny) and in consulting with the public. Their role and interest around drug issues varies across the country, but they are an important partner in establishing local policies and practice.

Local police involvement is essential to any partnership. Senior management help set the priorities for the region and this will influence what happens at Borough/Basic Command Unit level (BCU).

### **What is... The National Intelligence Model ?**

Basically a model to help provide strategic direction and inform tactical resourcing. It should help promote strong links with partners. In terms of drugs it defines three levels of activity.

**Level 1** is defined as local crime being dealt within a basic command unit (e.g. street level dealing).

**Level 2** is defined as crime affecting more than one basic command unit (e.g cross borough dealing of 1-3 kilos – also referred to as the middle market).

**Level 3** serious and organised crime operating on a national or international level (e.g. importation of drugs or moving multi kilos quantities within the country).

## Local partnerships working around drugs

### **Crime and Disorder Reduction Partnerships (CDRPs) and Drug Action Teams (DATs)**

Since the Police Reform Act 2002 (amending The Crime and Disorder Act 1998) all local authorities are statutorily bound to have a partnership *The Crime and Disorder Reduction Partnership (CDRP)*, which is responsible for:

- carrying out a review of the level and patterns of crime and disorder and drug misuse and
- formulating and implementing a strategy for the reduction of crime and disorder and for combating drug misuse and
- submitting an annual report on implementation of their strategies.

However since 2003, partnerships have been relieved of the obligation to complete plans and report on progress in this way. In 2006, the sections of the Police Reform Act requiring them to do so was repealed. This does not relieve partnerships of the responsibility to develop plans or monitor progress. A new system for doing so is currently being devised – please see section on CDRP reform for more details.

## What is... all this CDRP reform?

The Police and Justice Act 2006 set off a process of reform of Crime and Disorder Reduction Partnerships, more firmly placing their work within the context of Local Strategic Partnerships and taking away the responsibility to produce a biennial crime audit and strategy. Instead CDRPs and their local drugs partnership will be required to produce annual strategic assessments and an annually amended 3 year rolling community safety plan (known as the Partnership Plan). A new National Standards Framework for local partnerships will be published in September 2007 which will identify key performance standards against which Local Strategic Partnership will be able to assess the performance and capacity of their CDRP. These will focus on:

- empowered and effective leadership
- intelligence led business processes
- effective and responsive delivery structures
- community engagement
- visible and constructive accountability
- appropriate knowledge and skills.

However, performance will likely be centrally assessed against a single PSA focusing on local community perceptions of crime and disorder. A new central performance management framework (Assessment of

Policing and Community Safety or APACS) looking at crime and community safety will be in place by 2008. This will align closely with the Comprehensive Area Assessment – the new, single and coordinated performance framework for local authorities that replaces the old comprehensive performance assessment.

In Spring 2007 an additional list of co-operating agencies with the responsible authorities (bodies with whom the CDRP is obliged to jointly work) was published by the Home Office.

- Probation Board
- Parish Councils
- NHS Trusts
- NHS Foundation Trusts
- Governing bodies of schools
- Proprietors of independent schools
- Governing bodies of an institution within the further education sector
- Registered Social Landlords.

In addition a list of some 27 other organisations who should be invited to participate has been circulated.

See the Home Office microsite.

[www.crimereduction.gov.uk/regions/regions00.htm](http://www.crimereduction.gov.uk/regions/regions00.htm)

The responsible local partnership (whether it's a DAT or a CDRP) will deal with issues across all four areas of the current Drug Strategy. This will include working in partnership to look at harm reduction, demand reduction and supply reduction.

### A DAT by any other name...

In some areas, drugs issues are dealt with entirely through the Crime and Disorder Reduction Partnership (CDRP). In other areas, the Drug Action Team (DAT) leads on drug issues. Often the DAT is subordinate to the CDRP, but in some areas the DAT is a freestanding body. In some areas where alcohol is dealt with by the DAT as well as illicit drug use, the Drug Action Team is known as the Drug and Alcohol Action Team (DAAT).

DATs will have representatives from most of the responsible agencies with the addition often of HM Revenue & Customs and Local Drug Treatment providers. In non-unitary authorities the DAT is often located at county level. CDRPs are currently required to be located at district level – though suggestions have been made that county level may be more appropriate in non-unitary authorities.

Inevitably because of the current emphasis on demand reduction strategies, and because of the overall balance of drugs spending, a large part of any local partnership's workload is currently around the commissioning of drug treatment against local mainstream budgets allocated for drug treatment and the Pooled Treatment Budget (PTB) - a cross departmental central government funding stream for drug treatment which replaced separate drugs budgets for local agencies like Police, Local Authority and Probation. Few CDRPs or even DATs have the capacity themselves for contracting and so it is generally done on their behalf by the local Primary Care Trust (PCT).

### What is... all this 'reduction' about?

There are three key areas of responsibility for every local drugs partnership. These are:

**1 Harm reduction** – reducing the harm people do to themselves, their families and the community through their use of illegal drugs and alcohol. The key harms this type of work seeks to reduce are:

*physical (health) harms to the individual and the community e.g. by the provision of needle exchange*

*community and social harms associated with substance misuse e.g. by the provision of maintenance prescribing.*

**2 Demand reduction** – reducing the level of demand for illegal drugs. This refers to initiatives aimed at:

*preventing people starting to misuse drugs e.g. drug education in schools; programmes of diversionary activity*

*supporting people who are misusing drugs to stop e.g. residential and community detox, rehabilitation, structured day services.*

**3 Supply reduction** – reducing the availability of illegal drugs. This will largely focus on criminal justice agencies' work to:

*prevent drugs being traded or distributed*

*prevent drugs being produced in, or entering, the UK.*

## What is... a good DA(A)T?

New National Standards for CDRPs will go some way towards defining how a good local partnership working to tackle drugs issues should look – when they're published. Until they are, here are some ideas from us.

### A good DA(A)T...

- has effective, informed, enthusiastic senior level representation from the range of agencies that deal with drug issues locally. The members of a good DAT don't just dump everything on the DAT co-ordinator – they get involved
- is about more than crime and treatment – its role is to co-ordinate treatment, availability/supply side interventions, young peoples interventions and local strategy in areas such as housing, regeneration, education and environment to ensure the best joined -up responses to drug problems for your area
- understands the local drug problem – from the circumstances of its drug markets to the level of blood borne viruses
- recognizes it cannot just wait for the government to tell it what to do but is never caught out when the NTA calls them to their quarterly review
- delegates power to commission services to its Joint Commissioning Group but it performance manages the work – and keeps an eye on service provision itself
- has an effective information function – so it can keep up to date on progress.
- plans and implements a realistic programme of activities and a range of services which primarily addresses local needs while responding to the demands of central government and regulators
- ensures the DAT links into other local strategic partnerships – particularly the LSP.
- communicates with its stakeholders and Government.

### A good DAT meeting...

- does not go on for 6 hours, leaving everybody looking like they've been 10 rounds with the Beast of Bodmin, not understanding a word that's been said since the coffee break
- has a clear, brief, meaningful agenda that everyone can take part in
- takes advantage of its membership to take a 360 degree view of issues.
- is held regularly – and at least quarterly
- makes decisions!

Most Local Drugs Partnerships nominate one of their constituent bodies to be the budget holder for the PTB, usually the Primary Care Trust (PCT). They will also establish a **Joint Commissioning Group** (with budget holding representatives of all the agencies), supported by a Joint Commissioning Manager who will manage the process on their behalf. This post holder will usually be employed within an integrated commissioning team housed in either the Local Authority or the PCT.

In most areas a Joint Commissioning group takes delegated responsibility from the senior officers attending the CDRP/DAT to commission drug treatment on their behalf.

### **Treatment Commissioning**

Treatment should be commissioned in response to local need and in line with Models of Care (2002 + 2005).

### **What is... 'Models of Care' (MoC)?**

National Service Frameworks are the strategies by which the Department of Health identifies a timetable and specific activities to improve specific areas of healthcare. The closest the drugs field has to a National Service Framework is Models of Care, however this does not set out a timetable for improvement or a set of measures. These are established as required by the NTA.

Models of Care and its 2005 update is an 'evidence-based' strategy setting out national criteria for the care that drug users can expect to receive from treatment providers.

The framework of Models of Care comprises definitions of four tiers of treatment, integrated care pathways through them, care planning and co-ordination and monitoring.

The four tiers of treatment identified in Models of Care are:

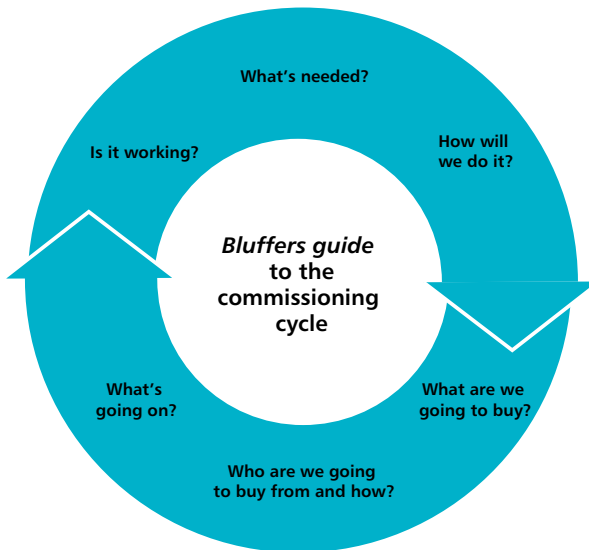
**Tier 1:** Non substance-misuse specific services requiring interface with drug and alcohol treatment

**Tier 2:** Open access drug and alcohol treatment services

**Tier 3:** Structured community-based drug treatment services

**Tier 4:** Residential services for drug and alcohol misusers

Treatment commissioning is like the commissioning of any kind of service. You're trying to find out what's needed, and how you can meet this need with the best quality for the best value. You also want to make sure that whoever is providing this service does it well and that it keeps doing what you need it to do. If it stops working well, you need to take a look at what's happening and maybe, if it doesn't fit your needs anymore, go out and buy something different. Sometimes though, it's better to do a bit of work to get it to fit your needs rather than simply chuck it out and start again. That's what's called the commissioning cycle. It's not rocket science but it does require you to have a good needs assessment – and an ongoing evolutionally, developing understanding of what's going on in your patch both in the services you commission and in the world of the people who use them. You also need to be up to date on best practice in the types of services you commission and the needs they meet. Everyone was thrilled when the first Word Processor came out, but no one's going to choose to work on one today...



### **Youth Offending Teams (YOTs)**

YOTs were established by the 1998 Criminal Justice Act. Prior to this, most Youth Justice issues were dealt with by departments within Local Authorities – usually located in Social Services. The YOT is a multi agency team (made up of probation staff, social services staff, healthcare workers, education workers, drug and alcohol services, police and housing officers) charged with tackling all aspects of youth crime and disorder including prevention of offending and re-offending, supervision of offenders and resettlement of young offenders leaving custody if they are under the age of 16. YOTs are inspected on a 5 year rolling programme by a Joint Inspectorate. YOTs are performance managed by the Youth Justice Board (YJB). Drugs are a big issue for many YOTs and your DATs partnership with your local YOT should be an ongoing priority.

**Local Criminal Justice Boards (LCJBs)** were first set up in 2003.

Broadly speaking they cover county areas – there are 38 altogether in England. The Court Service, the Crown Prosecution Service, the Police, the Prison Service, the National Probation Service and Youth Offending Teams (YOTs) are all members of LCJBs. Each LCJB has a ‘liaison’ judge, with whom they work closely. Their interest is the effective operation of the Criminal Justice System. Thus far their impact on drug issues has been marginal, however, should DIP shift further towards The Ministry of Justice, potentially their involvement could become greater.

## Local police structures

Organisation of the police on a local or borough level varies enormously across England. Check with the police representative on your CDRP what structure applies in your area and who would be your best contact. Many areas will not have a dedicated drug squad – with drugs being seen as part of mainstream policing. All police areas are now committed to working in partnership – however in reality what this means differs from area to area. Remember drugs is not always a local policing priority however the police are often very keen to work supportively around treatment, harm reduction and co-ordinated intervention with you and your DAT.

### What is... a BCU?

It depends on where you are. In some areas a **BCU** is a **Basic Command Unit** – this is the usual model for shires (but not always). A basic command unit is often led by a Chief Superintendant reporting to a Chief Constable at County or Regional Force level. Most have considerable autonomy to set their own priorities within the boundaries of the Local Policing Plan.

In other areas – mainly metropolitan ones – a BCU is a **Borough Command Unit**. They share local authority boundaries.

Both BCUs and – er - BCUs produce an annual policing plan setting out the priorities for the area. These are submitted to the Force command at regional/county level. BCU's are the level at which local partnerships need to effectively engage.

Safer Neighbourhood Teams – outside of London Neighbourhood Policing Teams (SNT/NPT) are an initiative that aims to effectively root local policing within communities. They do provide an opportunity for the public to engage with the local police/community safety officers. There is scope for communities to help set SNTs priorities, however partnerships will need to ensure that this is based on an accurate and informed understanding of what local problems are and not just perceptions (which may be ill founded).

## Local drug plans and budgets

**The Treatment Plan** is the annual document required by the NTA for all planned commissioning of drug treatment in your area. It comes in three sections, each of which relate to a function of the commissioning process:

- (i) *The Strategic Summary* – this is where you (or your Joint Commissioner) summarise all the information available around substance use – specifically with regard to treatment - in your area. This very important section of the Treatment Plan enables you to contextualise your commissioning decisions in the light of local need. This section also provides you with an opportunity to summarise all your drugs spend locally.
- (ii) *The Self-Assessment Checklist* – this is where you have an opportunity to assess your area's progress against an NTA checklist. This is a really useful exercise if you are new to either your local area, or drug policy.
- (iii) *The Planning Grids* – this is where you will detail all your commissioning activity for the year ahead and identify the cost and time scale for each activity.

The Treatment Planning Template is released by the NTA in October of each year. A draft is required by the first week in January. This draft will go to a regional panel (senior managers in regional organisations) that will assess it. If it's believed by the panel that your plan is good and accurate and represents a responsible use of the budget they will approve it at this stage. Otherwise early in March a series of recommended changes will be laid out and you will be required to amend your plan by the start of the new financial year in April. However, your funding is not dependant on the state of your plan. What happens if you don't comply or you get it wrong is that your life and that of your partnership is made difficult, but you will still receive the PTB.

### What is... NDTMS?

The **National Drug Treatment Monitoring System** is the system by which data is collected from drug treatment providers about every individual in treatment on a monthly basis. Compliance with making

returns has previously been patchy, however the majority of providers and DAT areas now use electronic data transfer (EDT) which is ensuring that the system can provide much more up to date and accurate information.

### Children and Young People Substance Misuse Plans

Local authorities must develop Children and Young People Plans. DATs/CDRPs will be asked to jointly agree local priorities and targets around substance use to include in the unitary children's plan and where appropriate the YOT plan. Most DATs and partnerships produce a specific and separate Young Persons Substance Misuse Plan, but there is currently no central imperative to do this.

**Performance management of the drugs strategy is undertaken by the Home Office with the NTA.** It almost exclusively focuses on treatment and crime and is delivered via a number of different and unconnected systems. Performance management of the treatment elements of National Strategy is undertaken by the NTA through their regional teams. Partnerships have been required to submit returns to the NTA which have identified partnership performance against a range of real output targets and proxy outcome indicators such as retention in treatment and waiting times. However the reliance on proxy outcome indicators is shortly to be replaced with the national roll out of TOPS.

**The Treatment Outcomes Profile (TOPs)** is a national system applied to each individual coming into treatment via the care management and assessment process which will record the key outcomes of their engagement in treatment across 4 key domains:

- drug and alcohol use
- physical and psychological health
- social functioning
- offending and criminal involvement.

In principle the gathering of this information throughout an individual's treatment journey should enable a clear national picture of the impact of treatment to emerge. This will in turn enable better estimation of the value for money of the investment by government in this area of public policy.

TOPs data will be collected via routine returns to NDTMS.

The Drug Intervention Programme (DIP) is directly performance managed by the DIP team in the Policing Standards Unit within the Home Office – but much of the groundwork is undertaken by the NTA. DIP client work is recorded on the Drug Intervention Records (DIR) which is completed by all the agencies who work with an individual. These reports are collated to produce monthly 'Dashboard Reports' for every DIP area and service detailing the number of individuals who are assessed, present for treatment and successfully complete treatment.

## Local drug budgets

**The Pooled Treatment Budget (PTB)** – is a central government funding stream for drug treatment that replaced separate drugs budgets for local agencies like Police, Local Authority and Probation. Starting in April 2007 the PTB is allocated to PCTs on a ‘value for money’ basis. Those partnerships who achieved ‘poor value’ received a reduction in their PTB for 2007/08; those considered to achieve ‘good value’ received an increase. In this change to the allocation process ‘value for money’ is calculated as the governments contribution per person treated (PTB divided by numbers in treatment).

Local Budgets Allocated to Drug Treatment from General Allocations – in addition to the PTB central programme budget, PCTs and other local partners fund drug treatment services from their general allocations e.g. Local Authorities are responsible for funding residential rehabilitation and probation provide/commission treatment services for their clients.

**The (SSCF) Safer and Stronger Communities Fund** and the **Young People’s Substance Misuse Partnership Grant** – are two pots of funding previously given directly to DATs and CDRPs which will now be pooled in the LAA fund. Whether this money is still spent on drugs will depend on the priority of substance use to your LSP and in your Sustainable Communities Strategy – and also, frankly what the status is of your partnership locally. Please note however, that for the foreseeable future, young people’s drug treatment will be funded via a locally ‘top-sliced’ portion of the PTB.

**Drug Intervention Programme (DIP) Funding** – All DAT areas receive DIP funding – this is to cover the costs of providing the DIP programme to the required level in your area. At the time of going to print there has been discussion about moving DIP funding to NOMS. However it is currently not clear when or if this will happen.

All of the above schemes of funding are subject to change and the timetable of planning for Local Drugs and Crime Partnerships is fast moving. This means that it’s possible for you to need to draw up local plans before you are aware of your budget allocation – or even if you have a budget. Try not to panic too much – you just have to plan on the basis of last years allocation and need and ensure partners are aware that successful implementation is predicated on confirmed funding.

## Mainstream local partnerships and plans

**Local Strategic Partnerships (LSPs)** are multi-agency bodies which cover local authority areas and bring together at a local level the different parts of the public, private, voluntary and community sectors. They provide a single local co-ordination framework within which joined up planning for service delivery can take place. LSPs can tackle deep-seated, multi-faceted problems that require a range of responses from different bodies working together. Don't expect that drugs and drug related issues will be a large part of your LSP's discussions. Drugs and even Community Safety are a small part of a very wide agenda that encompasses everything from public transport to school dinners to ambulance services.

One of the main jobs of the LSP is the production and co-ordination of the **Sustainable Community Strategy** (sometimes also called the Community Plan). It's critical that if you are the person who is responsible for drugs strategy, service development and commissioning in your area that you engage with your Local Strategic Partnership. If you are not based in the Local Authority, find out who the lead for the LSP is in your agency and speak to them about it.

### What is the... Sustainable Community Strategy?

Sustainable Communities Strategies are designed to promote or improve the economic, social and environmental well-being of local residents through sustainable development. They set a long term (up to twenty years) vision for the area, which aims to improve the quality of life of local people and identify local priorities for service

delivery. They also include an action plan with shorter-term (1, 2 and 3 years) priorities and activities that will contribute to the achievement of the vision. The responsibility for developing the Sustainable Community Strategy lies with the Local Authority, but other members of the LSP must work with them to prepare and implement it.

Because it can seem like every man and his dog (Spot) is a member of the LSP nowadays, meetings can be long, tiring and unproductive affairs. LSPs have an awful lot of work to do, so a lot of LSP business will be conducted outside of the main meeting in a sub group. LSPs all have different structures – but the majority will have a number of subgroups covering issues as shown opposite.



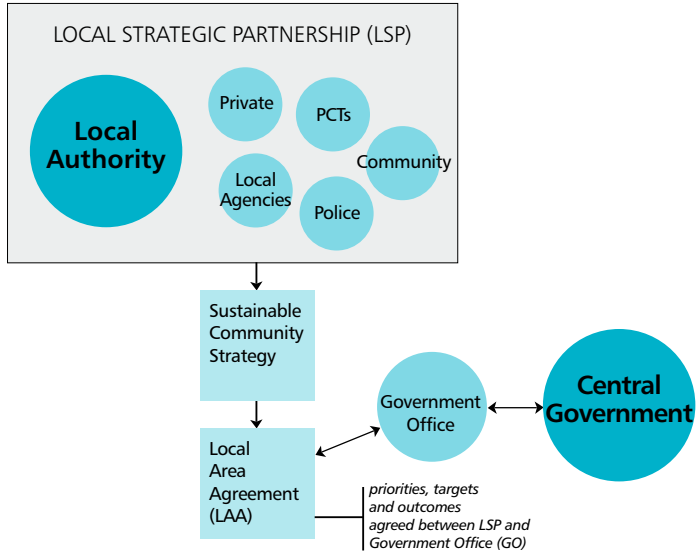
You need to find out what the subgroup is that is charged with tackling drugs in your area. It may be that the CDRP itself is a subgroup of the LSP – in which case you need to make sure that drugs is well up the CDRP agenda. It may even be that the DAT is a subgroup of the LSP (particularly in some of the shire counties).

It's likely however that no one group will be responsible for the whole of drugs in your area. The Community Safety Group will be responsible for drugs and crime, but the health group would probably have responsibility for blood borne viruses. Young People's drug issues will almost certainly be dealt with by the Young People's sub group. You might need to work with the housing group to get an issue around housing dealt with.

Your job with the LSP is to get each of the sub groups to recognize and accept their role in tackling local drug problems. You will need to talk to chairs of the sub groups. You will need to show them WHY drugs is a priority issue but also help them understand they can do something about it.

One way you can do this is by demonstrating the impact that drug use has on their area of concern. You might want to make sure that whatever needs assessment you undertake locally it clearly identifies not just the position of the area in terms of treatment and offending, but also housing, anti-social behaviour, education and healthcare.

**The Local Area Agreement (LAA)** is the agreement made between local partners and Central Government that makes a reality of the Sustainable Community Strategy. An LAA is a three year agreement that sets out the priorities, targets and outcomes for a local area agreed between central government, represented by the Government Office (GO), and a Local Strategic Partnerships (LSPs). LSPs agree to deliver to a series of Mandatory Outcomes (including targets around crime and disorder, anti-social behaviour and drug use) and in return they are given the freedom to pool budget streams and to achieve the agreed outcomes in a way that they define as meeting local needs and circumstances. It is possible that the Pooled Treatment Budget will become a pooled budget stream under the LAA which makes it critical that you get involved in the development of your Sustainable Community Strategy – or essentially, you could lose your budget. It is unclear at the moment whether DIP spending will be pooled – but it is unlikely to remain completely separate as long as it remains with DATs and local authorities. There has been an expressed intention on the part of government to shift DIP funding from local authorities to NOMs Regional Managers, however it is uncertain how, when or if this will now be done.



## What's all this about... community consultation?

One of the key ways in which LSPs are changing local policy making and service provision is in the requirement placed on them by legislation to consult with their local community to develop and update the community strategies. This consultation may take place differently in each area but it is likely to include

- public meetings (which anyone can come along to) in community venues
- setting up a forum of local people and businesses who can be regularly polled for their views at meetings, by phone or through questionnaires
- conducting a general household survey
- inviting organisations and individuals to comment on specific proposals
- talking directly to groups affected by specific areas of policy.

Essentially consultation is as real as the people undertaking it want it to be – but if its conducted properly it can really help you understand what's going on in your local community and how people feel about it. Consultation should also help the LSP prioritise their work. You may find people in your area think drugs is a priority even if your LSP doesn't.

There are some cautions around this however. For example, one of the mandatory outcomes from the last round of LAAs included 'lowered local perceptions of drug

use as a problem' as an indicator of success in dealing with drugs. This might not always be the case. If you set up a new treatment service in an area local people will almost certainly initially at least have a heightened perception of drug use as a problem, so look carefully at the responses you get to consultation and the targets that you grow from it. This is also where all that data you've been collecting can really come in useful, if there's anything that influences people more than a flourish of semi relevant views it's a flourish of relevant data. Remember, the information you collect for government may feel like a pain at times, but its your information for you to use to help make the local response stronger and better, so use it, and augment it and think about what it means.

Drugs is a difficult issue for people to deal with in consultations – and it could be useful to get involved in the group designing and working on consultation in your area. Drug users and their families are likely to find it difficult to come forward and speak openly about their experiences, so it's worth exploring innovative ways in which you can reflect their views and experiences in the work you do. This might mean talking to both those out of, as well as in, treatment what they think about local problems and provision, as well as about housing, education and policing etc.

**The Comprehensive Area Assessment (CAA)** takes place at the same time as the JAR of Children’s Services. This inspection/reporting process measures how effectively the council is working both as a distinct corporate entity and with its partners, to improve services and deliver improved outcomes for local people. The corporate assessment uses Key Lines of Enquiry (KLOE) to provide a framework to gather and assess evidence about how the council is working.

**The KLOEs are:**

Theme 1 Ambition for the community

Theme 2 Prioritisation

Theme 3 Capacity

Theme 4 Performance management

Theme 5 Achievement

Achievement is assessed by exploring how the Local Authority is delivering local priorities and outcomes across five sub-themes:

- sustainable communities and transport
- safer and stronger communities
- healthier communities
- older people
- children and young people.

The Local Authority will then be graded against each theme.

The grades are:

- inadequate performance
- adequate performance
- performing well
- performing strongly.

## Children's Trusts

By 2008 every local area will have a Children's Trust whose job will be to bring together all services for children and young people in an area with a focus on improving outcomes for all children and young people. Lots of Children's Trusts have different structures, but all of them will have:

- a joint needs assessment for young people
- shared decisions on priorities
- pooled resources
- joint commissioning.

Children and Young People's Plans (CYPPs) are a statutory requirement. The CYPP is a single, strategic, overarching plan for all services which affect children and young people in the area, provided by the local authority and all partners. The Local Authority prepares the CYPP jointly with its partners (not just the regular statutory partners like the YOT and the PCT but all organisations working with young people such as colleges, culture, sport and play and recreation organisations, registered social landlords and the voluntary and community sector).

Children's Trusts are committed to delivering against the five key outcomes defined in 'Every Child Matters' – The Government's Strategy for Children and Young People published in 2003. This ground-breaking green paper – which became The Children's Act 2004 established the principle that it is the responsibility of all agencies who work with children and young people to ensure that they have the support to be able to:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being.

Performance against the five key outcomes for children and young people is assessed through the **Annual Performance Assessment (APA)** and the **Joint Area Review (JAR)**.

APA focuses on how much council's services have improved outcomes for children and young people. The APA uses data (with a framework of key indicators), the Children and Young People's Plan, any reviews of this plan and other supporting information. It's a desk based exercise and doesn't involve site visits.

Young people's substance use strategy should be governed by the local Children's Trust and will need to be fully integrated into local young people's services. Every Child Matters – the Government Strategy for Children's Services - is already having a significant impact on the way services dealing with drug and alcohol issues for children and young people are delivered. Instead of setting up specialist services, the focus is on making sure mainstream services and interventions deal with drugs as part of the range of issues facing young people.

*Every Child Matters: Change for Children – Young People and Drugs* gives guidance on co-operation and joint planning.

[www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)

### What is the Joint Area Review (JAR)?...

The Joint Area Review (JAR) is a three-year programme running until December 2008 and all 150 local authority areas will have one joint area review during this time. It also looks at local progress towards the 5 key outcomes but uses a different and more focused methodology including on-site investigative visits, direct consultation with young people, front line workers, parents, elected members and others. There is a random case audit and

a review of casework. Areas which show poor performance in the APA are likely to get a more intense JAR. The JAR will generally take place at the same time as a Comprehensive Area Assessment. Even if you are not aware of the timetable for this locally, you will be able to tell it's going on by the huddles of senior officers in corridors all over the building and the look of painful exhaustion on your Chief Executive's face.

## Local Health Plans

The role of PCTs is to make sure that the local population get the best health and healthcare available - while managing the local budget for services. On behalf of the Department of Health Strategic Health Authorities make sure the PCTs do this effectively.

PCT planning involves the development, review and approval of three connected pieces of work:

- The Commissioning Strategy establishes the direction and priorities for at least the next five years. PCTs develop the plan at least every three years and update it annually. This is the big vision healthcare plan for your area.
- The Operating Plan sets out how the PCT plans to achieve the health outcomes and financial goals for the year listed in the Commissioning Strategy. It includes targets, financial and activity schedules and action plans. It is updated annually.
- The Development Plan describes the organisational capabilities needed to deliver the Commissioning Strategy Plan, the current capability gaps and how they will be filled. It is developed every three years and updated annually.

Confused? You may well be. Put simply, your local PCT (and other health trusts for that matter) is engaged in what pans out as an annual planning cycle against a very tight budget. They have to:

- analyse need and plan strategy
- effectively manage all local healthcare budgets
- integrate key national priorities with local needs.

The PCT, alongside their NHS colleagues from Acute and Mental Health Trusts will be represented at a senior level on the Local Strategic Partnership. They are a statutory member of the CDRP. Your DAT or other responsible local partnership will need a representative from the PCT. This will usually be the Director of Commissioning or the Director of Public Health. Sometimes the PCT will nominate a Lead GP for Substance Misuse to sit on the DAT.

Other than central DH targets, arrangements for performance management and delivery are a matter for local determination alongside other local organisations such as the Local Authority. Which means that for PCTs, just like the rest of us, the LAA is close to the only game in town.

So that's where we are today, a little bit (!) different to last time, but hopefully moving in the right direction. Good Luck! And don't worry its probably all going to change again – oh - about 6 months.... So we'll be back again next year – if there's anything we can do in the meantime, please get in touch.

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## Useful contacts

The central source of information is the Drug Strategy Directorate. A wealth of information which should be able to help with a wide range of queries, including identifying local contacts.

**[www.drugs.gov.uk/Home](http://www.drugs.gov.uk/Home)**

The National Treatment Agency for Substance Misuse **[www.nta.nhs.uk](http://www.nta.nhs.uk)**

The London Drug Policy Forum **[www.cityoflondon.gov.uk/ldpf](http://www.cityoflondon.gov.uk/ldpf)**

For drug information and advice, the government funds FRANK  
**080077 66 00 [www.talktofrank.com](http://www.talktofrank.com)**

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‘One thing  
has not changed:  
a national strategy  
can only be  
successful when  
it is delivered  
effectively locally’

(As true today as is it was 2 years ago)



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Working together for a safer London

Thanks to those working in local partnerships, the Metropolitan Police, Government Departments and Agencies who have contributed to this guide.

It has been written by Sara McGrail with David MacKintosh.  
Any errors are probably theirs!