

Section G: Broad strategic questions

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

Please see section on young people.

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

Please see section on young people.

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

Please see section on treatment.

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

Please see section on protecting the community.

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

Please see section on availability.

37a. What could we do more efficiently?

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

As we have detailed elsewhere in this document **DrugScope** believes there are a number of areas where strategy could be implemented with greater efficiency.

Firstly the strengthening of local partnerships will enable better tailored interventions to be delivered to more individuals and communities across the UK. Strengthened central partnerships will reduce the silo mentality that is once again allowing performance management systems to proliferate. Currently the performance management system for DIP operates separately to the performance management system for mainstream treatment and interventions, though both are overseen by the NTA. Most DATs have at least a full time data analyst to satisfy central demands for information. In addition to this, drugs partnerships are also required to report through the CDRP framework and in some cases through the PCT framework. These multiple systems are wasteful and inefficient. The production of a single annual DAT plan and report aligned to the local area agreement containing the range of information required centrally should be sufficient to ensure adequate performance.

The multiplicity of performance management systems at a partnership level seems to be being replicated for individuals within the treatment system. In 2002, the NTA with NIMHE (now the Modernisation Agency) launched a programme called Opening Doors. This programme sought to bring process modernisation techniques to local treatment systems. This programme encouraged partnerships, providers and service users to identify the client experience of treatment – mapping excessive assessments, duplicated interventions, and inappropriate referrals. The purpose was to ensure that local treatment systems were efficient and person centred. This initiative was not continued far beyond the inception of DIP when it began to identify that the new criminal justice interventions teams were effectively establishing new carved-out treatment systems that created duplication and caused blockages and log jams in the mainstream treatment services. Given the levels of duplication and repeated assessment we have observed, **DrugScope** believes that now may prove a good opportunity for the Opening Doors programme to be repeated – enabling local partnerships to get a better grip on cost savings and creating a more streamlined service user experience.

As detailed in our section on treatment, we understand that there are efficiencies that could be achieved within the commissioning system. Setting a tariff for treatment and supporting smaller non-statutory providers to compete with the NHS

and large independents on a level playing field will produce more competitive markets and also drive efficiencies. This would require sign up to the voluntary sector compact and a better recognition that small charities can often provide better

Comment [R.S.A.1]:

more locally appropriate services than large national bodies or the NHS.

Incentivising multi area partnership commissioning in key areas will reduce waste.

DrugScope welcomes the inclusion of substance use in the new Health and Social Care Outcomes and Accountability Framework.

We also believe that observed in the round, better overall value for money would be observed if the strategy was less focussed on purchasing treatment in order to reduce the economic and social costs of crime and more focussed on deploying resources to meet local need across a range of indicators including crime, health, social inclusion, safeguarding children and regeneration. Value for money for direct investment in drugs services will also be enhanced by a central and local challenge to mainstream services to play their part in supporting people who have experienced problems due to substance use to access their services.

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

38b. How could these be improved?

DrugScope believes that the most effective mechanism for delivery of the national drug strategy at a local level is the multi agency partnership reporting into the Local Area Agreement and being performance managed through the same systems as other areas of local policy. There is currently a debate about whether the Pooled Treatment Budget should be ring fenced, ringfenced transitionally or just included in the Local Area Agreement from 2008/9. Our position on this is that it will depend on the local partnership. Just as local area agreements were phased in over three stages, so the pooled treatment budget can be combined with the LAA at different points in different areas. If a local partnership is confident that it can safeguard outcomes and meet local needs through the LAA then unless there are any huge objections in terms of performance they should be able to use the same freedoms and flexibilities around their pooled treatment budget as they would around other

parts of LAA spend. Where there are concerns locally – or regionally at a Government Office level - integration with the LAA can be a staged process.

In terms of national structures, **DrugScope** believes that there will always be a need for a health-focussed body to look at the growing evidence base around drug treatment and disseminate it to those responsible for delivery. This may be an appropriate role for the NTA or alternately could be delivered by NICE whose work on the new clinical guidelines has been so successful. In terms of standards and inspection **DrugScope** believes the new merged regulatory authority should be able to take forward the work of the Healthcare Commission (HCC) and Commission for Social Care Inspection (CSCI) in inspecting residential and clinical services. Local regulation and standards should be in place for all other services. There is a need for a single national body whose role should be to support local partnerships through a transitional period between now and mainstreaming. This body could be a statutory agency – however given that this work should take place outside the current performance management regime it may be more appropriate to have a non governmental body deliver this support and foster a strong, open and confident environment for the local and regional implementation of the National Drug Strategy.

In terms of the leadership from central government and the departmental home of the strategy, we are, as we have said before, less concerned with this than we are that there is a genuine commitment to real partnership working at a national level. Obviously however there is a need to have “the buck stop somewhere”. **DrugScope** believes that strategy should either remain where it is currently at the Home Office – in order to reduce disruption at what is in all going to be a period of great challenge – or move to a department with a cross cutting remit such as DCLG or even back to the Cabinet Office. It is critical that wherever the strategy is located there are individuals with skills of diplomacy, knowledge of local systems, a good reputation for honest brokerage with local authorities and PCTs, that they can work in a cross cutting role, and have a real community focus. The ability to know which levers to pull will now, more than ever, be more important than the ability to yank them really hard. **DrugScope** does not believe it would be useful to transfer responsibility to either the Department of Health or the Department of Justice but both departments

clearly have an important role to play. However **DrugScope** does believe that young people's drug strategy must be managed and monitored through the ECM structures and that of necessity means it should be located at a central government level in the new department for Children Schools and Families.

DrugScope understands that in the shift from a centrally driven strategic system to a locally driven one, some areas of duplication are unavoidable, however we believe it will be critical for government to rationalise the continuing role of the NTA as described within the PSA on Drugs and Alcohol in order to ensure that the commitment to local evolving strategy is not undermined by continued central process driven performance management and inappropriate ringfencing.

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

We note that the question does not ask why cannabis should *not* be reclassified.

The classification of cannabis was last reviewed in 2005. In a statement to Parliament in January 2006 the then Home Secretary, Charles Clarke, accepted the advice of the ACMD to keep cannabis at Class C. The ACMD carefully considered all the available evidence on, for example, the effects on physical and mental health, cannabis potency and trends in use. The ACMD noted an increase in the potency of skunk (sinsemilla)¹ and, although it has long been established that cannabis use can worsen existing mental health problems, it considered more recent research data on the relationship between cannabis use and the triggering of the onset of psychotic symptoms. The ACMD concluded that, at worst, the risk of an

¹ Forensic Science Service data showed that the mean THC content of sinsemilla increased from 5.5 per cent to 14.2 per cent between 1995 and 2005. There was no evidence that the potency of cannabis resin had changed in any significant way.

individual developing schizophrenia as a result of using cannabis was very small. Recently published studies, including a review of the evidence on cannabis use and psychotic outcomes published in the Lancet in July 2007, echo and do not contradict the ACMD's findings.² It is unclear what new evidence has emerged since 2005 to merit a further review or a reclassification from class C to B. The downward trend in cannabis use, including among young people, has continued since reclassification.

The ACMD included among its recommendations that there should be 'a substantial research programme' into the relationship between cannabis use and mental health, to better determine the link between cannabis use and mental health problems and the development of preventative measures. DrugScope continues to support the recommendation – nearly two years on we are not aware that such a programme is underway.

In his statement to Parliament in January 2006 Charles Clarke announced a review of the drug classification system, saying "The more that I have considered these matters, the more concerned I have become about the limitations of our current system...For these reasons, I will in the next few weeks publish a consultation paper with suggestions for a review of the drug classification system, on the basis of which I will make proposals in due course."³

The review was welcomed by **DrugScope** and, among others, the ACMD and the Science and Technology Select Committee (which was conducting an inquiry into the way government uses evidence to inform drug policy). It was a surprise and disappointment when the Government reversed this decision.

There has never been a review by government of the Misuse of Drugs Act or the appropriateness of the drug classification system. Numerous inquiries and reports (most recently by the Science and Technology Select Committee and the RSA Commission on Illegal Drugs) have questioned the evidence base for the

² Cannabis use and the risk of psychotic or affective mental health outcomes: a review, The Lancet Vol 370 July 28 2007

³ Hansard, 19 January 2006, column 983.

classification of some drugs and the mechanisms for keeping them under review - the Misuse of Drugs Act was described as 'not fit for purpose'. Although the legal framework for classifying drugs is not addressed in the consultation document, DrugScope believes that the Misuse of Drugs Act should – as the government announced in 2006 – be reviewed. The review should include consideration as to whether – as recommended by both the RSA Commission and the Science and Technology Select Committee – there should be a new scale of harms including alcohol and tobacco.

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

DrugScope notes the intention to create a cross cutting framework of PSA's that will support the drug strategy. However, while some linkages are implicit some key areas of crossover are missing. **DrugScope** recommends that the range of PSA Delivery

Agreements that could contain measures that would support the intentions of the drug strategy could include:

PSA 10. Raise the educational achievement of all children and young people

- Measures might include the number of young people assessed as vulnerable to or at risk of developing problems related to substance use thriving in education.

PSA 16. Increase the proportion of socially excluded adults in settled accommodation and employment, education or training

- Measures might include the number of people leaving or being stable within drug treatment accessing, for example, secure employment and housing.

PSA 19. Ensure better care for all

- Measures might include the numbers of drug users able to access the whole of their drug treatment through primary care or the numbers of people experiencing chronic or acute health problems as a result of substance use accessing health interventions through primary care.

PSA 21. Build more cohesive, empowered and active communities

- Measures might include the percentage of people who have experienced problems with substance use who feel they belong in their communities or the percentage of people who have experienced problems with substance use who feel they have been involved with the design of local services. In addition, measures could be included which assess an expanded role for the third sector in relation to substance use.

The inclusion of measures relating to substance use in these and other of the new PSA Agreements would make a huge contribution to driving mainstream efforts to improve treatment, community resilience and integrated young people's service.

DrugScope asserts that the inability of government to drive and monitor activity across these areas in pursuit of its aim of reducing the harm and impact of substance use would represent a missed opportunity in any new strategy.

DrugScope is extremely grateful to Sara McGrail who not only prepared this document (September – October 2007) but played such a crucial role in devising and facilitating the consultations with our members and stakeholders.