Kent County Council

NHS OVERVIEW & SCRUTINY COMMITTEE

SELECT COMMITTEE

on

DRUG USE and MISUSE

Summer 2003

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Select Committee Membership

The Committee is made up of seven County Councillors (4 Conservative, 2 Labour and 1 Liberal Democrat), 1 Community Health Council Representative

Dr. Tony Robinson, Chairman
Mrs. Frances Dick
Mr. John Kirby
Mr. Ronnie Norman
Mr. Ray Parker
Mr. Geoff Rowe
Mr. John Simmonds
Mrs. Margaret Stevens

Terms of reference and membership

NHS Overview and Scrutiny Select Committee – DRUG USE AND MISUSE

In March 2003 a Select Committee was established to look into the important and complex issue of Drug Use and Misuse. The committee will be undertaking this extensive review in consultation with a wide range of key stakeholders and will report to County Council in July 2003.

Select Committee's Terms of Reference
To examine the issues regarding the misuse of class A, B and C drugs and make recommendations regarding how Kent's approach to the prevention, treatment and enforcement of drugs misuse could be improved. In doing this the Select Committee will in terms of both National and Local Policy:-

(a) Identify the scale, nature and social issues of Kent's drugs problem;
(b) Gain an understanding of the National, Regional and Kent approach to the prevention, treatment and enforcement of drugs misuse;
(c) Seek a balanced range of views from key Kent and Regional agencies, practitioners, users, young people, experts and pressure groups;
(d) Gain an overview of the variety of approaches to the prevention, treatment and enforcement relating to the misuse of drugs in the UK and internationally.

Recommendations

1. All schools in the County must put in place a drug policy by March 2004 in line with the Governments drugs strategy. The Committee feel strongly that governors, head-teachers and parents at primary and secondary schools across the County have a responsibility to engage with the support that is available and develop, or adopt, a coherent drugs policy. This recommendation applies to all schools regardless of whether or not the school perceives it has a drug problem. (2.3:3)

2. Drug education must be credible to young people; opportunities should be taken to share and learn from their experiences. (2.2:6)

3. There are effective and proven strategies in place to respond to young people's drug related problems such as the Drug Intervention Support Programme. Fixed-term or permanent exclusion from school should only be considered as a last resort. (2.3:1) However, the Committee supports the recommendation made in the "Next Four Years" that dealing is not to be tolerated on school premises or youth centres. Young people guilty of supplying drugs to other young people should be removed from school in order to receive comprehensive support and for the protection of others. (2.3:2)

4. Operation Caddy (2.4), the drug awareness initiative developed by Kent Police, is welcomed, and the Committee would support its use in secondary schools across the County. There are two important qualifications to be added here

    - The project should be used as part of a wider programme of drug education.

    - The use of passive dogs is only an aspect of this initiative. Schools should only seek to implement the full programme including proper recognition of protocols established by the LEA, integration with the Drug Intervention Support Programme, and follow up activities with parents. (2.4:4)

5. Schools should seek to establish and maintain constructive links with their local Youth Crime Reduction Officer and include the police in drugs education initiatives, however this should form part of a balanced drugs education programme that not only considers criminal justice but also health, and social and personal responsibilities. (2.4:4) Schools have a responsibility to maintain an effective network of pastoral support. Schools should engage with the issue of drug, alcohol and substance misuse at the level of the newly created cluster groups across the community through partnerships with relevant agencies.

6. The Committee would welcome dialogue between Kent Drug Action Team, LEA, Initial Teacher Training Providers and the Teacher Training Agency to raise awareness of drug prevention and early identification for newly qualified teachers and support staff. However, effective induction and coherent schools drug policies are fundamental if teachers are to understand local drug prevention issues. (2.6:4). Kent is establishing its own modular training for teachers leading to accreditation recognised by the Department for Education and Skills (DfES).

7. Young Persons Treatment Services across the county should be determined by common guiding principles of community based delivery, harm reduction and seamless transition between the tiers that structure service delivery. The introduction of a pooled budget for young people's treatment should support this transition (2.8:4)

8. The Committee strongly supports the use of sport and other recreational activities as catalyst for engaging marginalised young people with positive and meaningful opportunities and raising their aspirations. (2.10:2)

9. The Committee recognises the overwhelming anxiety and confusion experienced by parents with children who use drugs. The Committee would like the DAAT to explore the potential for services/projects that promote parental support and involvement in all tiers of drugs treatment and prevention.(2.8:5)

10. Capital investment must be increased if there is not to be a trade off between increasing capacity and improving treatment facilities. The Committee would welcome a distinction between funding for treatment and funding for capital investment and recommends that the NTA represents the concerns of the Committee to the Department of Health in order to seek mainstream capital funding for the improvement of treatment facilities. (3.7:3) (3.3:9)

11. The Committee supports continued efforts by the DAAT to engage with GP's and promote involvement in Shared Care. (3.5:9) Particular efforts should be devoted to increasing the GP participation in Shared Care in East Kent. (3.5:9)

12. The application of performance management measures by national and regional agencies should be moderated and funding bodies should ensure that data collection requirements complement rather than compromise service delivery. (3.6:4)

13. Further consideration should be given to promoting the role of the Drugs Co-ordinator developed in West Kent using CAD funding in other areas to focus the anti-drugs activities at a local level. The model developed in West Kent is an initiative that has been led by the Police.(4.2:1)

14. Inter-agency co-operation between enforcement agencies and treatment providers should be a priority at a local level across the county to

complement the partnerships that already exist at the strategic level. (4.3:2)

15. Kent DAAT should have a role in deciding the best clinical model for arrest referral to promote harm minimisation among detainees. (4.5:3)

16. Treatment and enforcement need to be properly resourced, but drugs policy should not become too narrowly focused; policy is best directed at strategies that aim to address social exclusion, supports families and provides meaningful opportunities for young people living in deprived communities. (4.6:6)

17. The Committee believes that government's proposals for the re-classification of cannabis sends out the wrong message and only serves to add to confusion. Evidence to the Committee does not support the re-classification of cannabis. If cannabis is re-classified drug information, advice, and education programmes should continue to emphasise that cannabis is both illegal and harmful.

18. The lack of supervision for offenders serving sentences of less than twelve months is a dangerous anomaly and action needs to be taken to improve the arrangements for resettlement support generally and for this group of offenders in particular if cycles of re-offending are to be stopped. (4.9:6) The cycle of addiction, re-offending, and short term sentences is damaging for individuals and communities. The Kent and Medway Resettlement Programme is an example of partnership working that should be supported and the work of all the agencies involved is recognised. The Committee urges local Crime and Disorder Reduction Partnerships to consider the input necessary at a local level to promote the training and support of mentors through the Probation Service.

Executive Summary

The purpose of this review is to identify how effectively strategies are being implemented to address the problem of drug use and misuse in Kent. Kent's drug problems are no worse than many other parts of the UK, however the social and economic costs of drug use are huge. The government estimates the overall social and economic costs of drug misuse nationally to be between £10 billion and £18 billion annually. [1] Based on these figures the total annual cost of drug use in Kent is over £90m possibly as high as £160m. This figure includes spending on treatment, education and enforcement and the hidden costs associated with crime, labour market disruption and social exclusion.

The Government's 1998 Drugs Strategy (updated in 2002) has significantly altered the way in which all agencies concerned with drug education, prevention, treatment and enforcement work together. The strategy has introduced comprehensive monitoring regimes and encouraged a level of partnership and co-operation that did not exist before.

Kent has had a Drug Action Team since 1995, chaired by KCC since 2001; the team includes representatives from all the key agencies involved in tackling drugs who work together to develop strategy. The team has appointed Commissioners to purchase and monitor treatment services and much of the funding for drugs now goes in to a pooled budget to better integrate the delivery of services.

This review has looked at the four defining themes of the Drugs strategy:

1. Young People

Young people are the most vulnerable to the dangers of drugs. Drug use amongst the young has grown significantly over the last ten years and there are indications that the average age of first use is getting younger. Young people need stable families and thriving communities to help them develop. A combination of factors can heighten the risk of a young person using drugs. But the drugs problem can not be marginalised; it is pervasive. Young people from all backgrounds use drugs.

Schools based drug education and support is vital. Not enough schools in Kent recognise their role in protecting young people from drugs; in 2002 only 59% of schools in Kent had a drugs policy. All schools will have to have a policy in place by Spring 2004. The LEA is making considerable efforts to provide support and advice to all schools to help them deal with drug prevention issues. The Committee recognises that many other agencies are involved in the support of young people including KCC Social Services 16 Plus Service for Care Leavers, the Youth Offending Service, and the Youth and Community Service. Kent Police run educational programmes for young

[1] Updated Drug Stategy 2002

people with identified drug problems and have also developed a programme to help schools raise young people's awareness of drugs and criminal justice.

The Committee recognise that the main business of schools is not the delivery of drug education. Schools already play an important role in protecting young people from becoming involved in drug misuse through including them in a supportive environment and helping them to obtain academic qualifications.

Kent is part of the national pilot to pool multi-agency funding for young peoples drug education, intervention and treatment (2003/04). This means that all agencies and KDAAT (Kent Drug and Alcohol Action Team) are able to take a strategic and co-ordinated approach to commissioning, monitoring and evaluating service delivery. This has not been the case in the past and is welcomed as a route to achieving better quality services for young people.

Despite the best efforts of many agencies and individuals young people will experiment with drugs. 376 young people accessed treatment with young people's treatment services last year. Only a small proportion of young people who try drugs will progress to a sustained use of hard drugs. Treatment services for young people are increasing their size and scope to be able to reach more young people, particularly those at most risk.

Diversionary activities using sport and other recreational pursuits are being developed to encourage young people to develop their aspirations.

2. Treatment

Treatment is the most effective approach to help users stop taking drugs. There is no single model of treatment and users require support to find the form of treatment that suits their needs best. Users who seek treatment need access to immediate support. Treatment providers across Kent are working hard to provide treatment options but there are shortfalls in capacity. More needs to be done to encourage GP's to participate in Shared Care arrangements and provide primary health care and substitute prescribing for drug users. Treatment is held to be crucial to the success of the drugs strategy but it is under-resourced. To sustain the growth in treatment, services will need to expand; this will place an increasing strain on facilities and staff. There are discrete treatment services for young people across the county. Treatment is now funded from a pooled treatment budget, administered by the Commissioning team; the pooled budget includes funding sources that are pooled centrally and locally. In addition to health funding a significant proportion of local funds come from KCC Social Services. Treatment services are broadly delivered by different agencies in the east and west of the county.

3. Availability

Much is being done to stifle the availability of drugs in Kent. There is a renewed emphasis on the disruption of supply networks. There is an

increasing threat to Kent's communities, particularly in the North and West, from London based dealers. Kent Police are taking positive action to inhibit the movement of drugs in and around Kent and undercover enforcement techniques are being used to target areas where dealers have become established. But the Police also have a role in supporting individuals to access treatment. Dedicated Drugs Liaison Officers add value to the police's fundamental enforcement role through their contact with treatment providers. Youth Crime Reduction Officers work closely with schools, and young people to raise awareness of the dangers of drugs and when necessary to make early interventions to prevent further harm.

4. Communities

Kent's communities suffer from the effects of drug misuse. Statistically drug use is most prevalent in the most deprived wards. Many of these are in the east of the county but pockets of high drug use exist in all the urban areas. Drug related crime, anti-social behaviour and drug dealing contribute to the corrosion of local communities. Local Crime and Disorder Reduction Partnerships are able to make best use of direct funding to address drug related problems at a local level.

- Based on their investigations the Committee has sought to make constructive recommendations recognising the good work that has already been done and the significant challenges faced by all agencies that deal with the drug problem in Kent.

1.0
National and Kent Drugs Policy Overview

1.1:1
The first section of this report will identify the key agencies involved at a national and local level in the implementation of the Government's Drug Strategy. This section also includes a summary of the Governments Drug Strategy, updated in 2002, and a summary of the key information available about the scale of the drugs problem in Kent.

1.1:2
Subsequent sections will go on to look at the four key themes identified in the Drugs Strategy: Youth, Treatment, Availability and Communities and will consider what has been done in Kent to meet the challenges set by the Drugs Strategy agenda.

1.1:3
Given the time available the Committee felt unable to give full consideration to the serious issue of alcohol misuse. The Committee has found that issues associated with the supply and use of alcohol are often closely connected with drug use. The Committee has also found that the scale and costs of alcohol misuse are as great, if not greater than, drug use and misuse. However the Committee felt that the issues surrounding the use and misuse of drugs are distinct enough to warrant separate consideration in the time available. This in part reflects the absolute illegality of classified drugs. While there may be a connection between drugs and the illegal supply of alcohol (i.e. under-age drinking, smuggling) the use of alcohol is socially sanctioned.

1.1:4
This report will make reference to the classifications of illegal drugs and the proposed changes to the classification of certain drugs. The current classifications were identified in the 1971 Misuse of Drugs Act. The following chart sets out the classifications as they are now.

Class of Drug	Drug Type	Maximum Penalties
Class A	• Amphetamines (speed) if prepared for injection • Cocaine and Crack • Ecstacy and drugs similar to ecstacy • Heroin • LSD (acid) • Magic Mushrooms (if prepared for use)	• Possession: 7 years and/or fine • Possession with intent to supply or supply life imprisonment and/or fine
	• Amphetamines	• Possession: 5 years

Class B	(speed) • Cannabis	and/or fine • Possession with intent to supply or supply 14 years and/or fine
Class C	• Anabolic steroids • Benzodiazepines	• Possession 2 years prison and/or fine • Possession with intent to supply or supply 5 years prison and/or fine

1.1:5
In 2002 the Government published its updated Drugs Strategy, the agenda established by the original Drugs Strategy published in 1998 was re-enforced and re-focused and is directing drugs policy in Kent. In order to place this work in the national policy context the next section will summarise the key points arising from the Drugs Strategy and the Updated Drugs Strategy.

1.2
The Drugs Strategy - Summary

1.2:1
Although many of the central government departments contribute to the development of drugs policy the responsibility for co-ordination and development lies between the Home Office and the Department of Health (the Home Secretary presents the forward to the Updated Drugs Strategy). This structure is inevitably complex but it will be necessary to have a broad understanding of the origins of national policy and the way that national developments are interpreted at a local and district level.

1.2:2
As is typical within government thinking; targeting and ongoing monitoring are central to the implementation of the drugs strategy. The DAAT now provides a focal point for the collection of data at the local level and this innovation means that detailed local data is being gathered in way that previously was not feasible. The DAAT's role is to act as the forum that locally co-ordinates drug strategies. An important aspect of policy at a local level is the delivery of treatment services. Previously local health authorities commissioned the majority of treatment while Social Services also commissioned some day care and residential rehabilitation provision. Under the new integrated structure treatment services are now monitored and supervised by a commissioning team appointed by the DAAT. In Kent this team includes representatives of the lead Primary Care Trust, the Probation Service, Social Services and the Police.

1.2:3

The 1998 Drugs Strategy signalled a significant change to drugs policy across the UK. It established the principle of central accountability through the development of the National Treatment Agency, a special Health Authority with overall responsibility for quality assurance and performance management. Alongside this the strategy recognised the need to develop and co-ordinate practice at a local level.

1.2:4
The Strategy laid out a ten-year plan; during that period it aimed to:

- Halve the number of people using the most dangerous illegal drugs such as heroin and cocaine
- Double the number of drug misusers in treatment
- Halve the level of re-offending by drug misusing offenders
- Halve the availability of the most dangerous drugs, such as heroin and cocaine on our streets[2]

In 2002 the Government updated the Drugs Strategy. The updated strategy placed a greater emphasis on Class A drugs, particularly crack-cocaine; a renewed emphasis on criminal justice as part of an overall increase in funding; more support for families and young people; and an increase in treatment; and a focus on areas of greatest need.

1.2:5
The updated Strategy identified four key themes, these are

- Youth - to help young people resist drug misuse in order to achieve their full potential in society

- Communities – to protect our communities from drug related anti-social and criminal behaviour

- Treatment – to enable people with drug problems to overcome them and live healthy crime free lives

- Availability – to stifle the availability of illegal drugs on our streets

1.2:6
The strategy attempts to pull together and balance a range of attitudes and perspectives towards drug use and misuse these recognise the damage that drugs do to society, communities, families and individuals; and seeks to minimise their availability. But, the strategy also recognises the difficulties experienced by drug users who need the ongoing support of treatment agencies to overcome their problems. Although funding for the drug strategy has significantly increased there is scope for a debate over how the balance of this funding is applied. This balance of priorities is at the heart of the debate about the best way to address the drug problem.

[2] Communities Against Drugs UK Anti-Drugs Co-ordination Unit Cabinet Office 2001

1.2:7
The Audit Commissions 2002 Report on treatment services, "Changing Habits" is critical of the current balance of priorities in existing expenditure

> "Since the introduction of the new drugs strategy, the bulk of the new funding has been targeted at criminal justice initiatives while investment in mainstream drug treatment services has been much smaller"[3]

Evidence of the scale of expenditure on criminal justice as compared to treatment can be seen in the chart below

Total anti drugs expenditure 2001-2002 3,478m						
Home Office £1923m	**Dept. of Health £217m**	**Lord Chancellors Office £265 m**	**Customs and Excise £201m**	**Dept. Work & Pensions £738m**	**Dept for Education and Skills £37m**	**Dept. of Transport London and the Regions £87m**
Enforcement £1703m	Hospital A&E £41 m	Courts £66m	Anti-smuggling £95m	Benefits £738m	Teacher time £29m	SRB/NDC £41m
Partnership £50m	HIV £11m	Legal Aid £117m	Investigations £80m		Standards fund £8m	Rehab £18m
Prison Regimes £61 m	Prescribing and Dispensing £49m	Prosecution Costs £22m	Intelligence/ other £26m			Other £28m
NCIS £109m	Prevention £7m					
	Advice/ Assessment/Referral £30m					
	Detox £25m					
	Needle Exchange £16m					
	Other inc.rehab £38m					

from "Changing Habits" Audit Commission 2002
Source: Comprehensive Spending Review 1998
KEY:

GREY = Reactive expenditure - dealing with the consequences of drug misuse

CLEAR = Proactive expenditure – attempting to prevent or reduce drug misuse

1.2:8

[3] Changing Habits Audit Commission 2002 p.60

The Strategy's priorities give some practitioners in Kent cause for concern. For some there is a feeling that the motivating force determining treatment priorities is the reduction of crime and there is concern over the impact this has on treatment.

> "The growing emphasis nationally upon reducing levels of offending through engaging drug users in treatment has changed the focus of service provision. Given that the Trust provides health and social care services, crime reduction has not previously been one of the key targets. However increasingly the 'drugs causes crime' sound bite has been deployed and the location of the NTA within the Home Office has required some re-consideration of service philosophy."[4]

1.2:9
A recent Guardian article highlights the Government's understanding that drugs and disaffection are the "two huge social turbines generating criminality"[5] The report goes on to say

> "fuelled by the belief that by promoting treatment alongside law enforcement it could finally generate success where criminal justice alone had failed." [6]

This raises a second more fundamental challenge to the point made earlier regarding balance. On the one hand there is the argument that the dual approach of treatment and enforcement is necessary and effective, the only debate being over which gets the larger slice of the budget; on the other is the fundamental concern that a criminal justice led agenda inevitably compromises clinical decisions.

1.2:10
The Updated Strategy emphasises a stronger focus on class A drug use and introduces the term "problematic drug users" (PDU's). Problematic drug users are, according to the strategy,

> "class A drug users with the most severe problems who account for 99% of the costs of drug use in England and Wales and do most harm to themselves, their families and communities."[7]

The strategy says that there are 250000 problematic drug users in England and Wales. The precise definition of this term is unclear and appears to be the cause of some uncertainty. A recent Guardian article said

> "There are specialist academics and drug workers who will tell you that this a gross underestimate, that the true figure may be as high as 500000"[8]

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[4] John Wilkes Chief Executive West Kent Health & Social Care Trust evidence 190503
[5] Nick Davies Guardian 22 May 2003
[6] Nick Davies Guardian 22 May 2003
[7] Updated Drugs Strategy, Home Office 2002 p 4
[8] Nick Davies "How Britain is losing the drugs war" Guardian 220503

Using the government's overall figure would imply that there are 7000 problematic drug users in Kent. Such a figure is in excess of current treatment capacity.[9]

1.2:11
In Kent while there seems to be agreement with the general principle that class A drug users cause the most damage to themselves, their families and their communities there is no working definition of the term problematic drug user. The DAAT was asked by the Committee to identify how many PDUs there are in Kent but these figures are not available. The DAAT has collated detailed data on drug misuse in Kent but does not yet specifically record problematic drug use. This reflects the non-specific, catchall nature of the term, which attempts to describe drug use, lifestyle and criminal activity. The DAAT Chairman told the Committee that

> "a problem drug user is defined as an individual who uses a substance and does harm to themselves, their families and the community."[10]

This definition is broader than that implied in the Drug Strategy. It is clear that the DAAT have a clear understanding of their priorities but the precise totals in the Drug Strategy appear inconsistent with such an unfocused definition.

1.2:12
Home Office Research in 2002 confirms that there is no precise definition and moreover that any estimates are likely to be based on the amount of people in contact with either treatment or enforcement agencies

> "Problem drug use would ideally be defined in relationship to an individual's experiences. There is no agreed definition of a problem user. Problem drug users are generally understood to be those whose drug use is no longer controlled or undertaken for recreational purposes and where drugs have become a more essential element of an individual's daily life. Estimates are generally based on the numbers of people in treatment or with other identified major drug related problems." [11]

1.2:13
The strategy significantly emphasises a focus on the supply of crack-cocaine. Use of crack has grown significantly in recent years and there are serious concerns about the levels of violence and chaotic behaviour associated with crack use and the increasing infiltration of markets by "Yardy" gangs who adopt particularly violent and ruthless techniques.

1.2:14

[9] Anton Derkacz Chief Executive KCA 160503
[10] Evidence from Peter Gilroy, Chair of Kent DAAT 090503
[11] Home Office Research Study 249 The Economic and Social Costs of Class A Drug Use in England and Wales, 2000. Home Office Research, Development and Statistics Directorate July 2002. P9

More broadly efforts and funding will be directed towards "stifling" the availability of drugs by increasing co-operation with countries on supply routes, working to eliminate opium production in Afghanistan by 2013, and targeting middle market supply (this refers to the secondary distribution of drugs to regional markets across the UK).

1.2:15
The strategy seeks to strengthen the linkages between the criminal justice system and treatment

> "To break the link between drugs and crime we are investing in a major new programme of interventions for adults and young people, which will move offenders out of the criminal justice system and into treatment." [12]

These initiatives include doubling Drug Treatment and Testing Orders (DTTOs) by March 2005, increasing treatment provision in prison, and making arrest-referral schemes more proactive.

1.2:16
The strategy is positive about the potential of treatment in addressing drug use and misuse on a national scale.

> "Treatment works. It is the key to reducing the harm drugs cause to users, families and communities. Investing in treatment is cost effective - for each £1 spent, an estimated £3 is saved in criminal justice costs alone."[13]

The strategy aims to double the amount of people receiving treatment (based on 1998 figures) by 2008, an increase of 8% on average per year. In addition the targets are to reduce waiting times, increase the involvement of GP's and improve the quality of prison based provision.

1.3

The next four sections include an outline of Kent Drug Action Team; the partner agencies involved and some comments on performance. This is followed by data made available by the DAAT and partner agencies that highlight the scale of the drug problem in Kent. In addition to the local partners the DAAT works closely with the regional agencies that monitor and support the effective delivery of strategy.

Kent Drug Action Team (KDAAT)

1.3:1
The Kent Drug & Alcohol Action Team is the responsible body in Kent for the implementation of the governments drug strategy. There are 149 DAATs

[12] Updated Drugs Strategy, Home Office 2002
[13] Updated Drugs Strategy, Home Office 2002

across England. The Kent DAAT "brings together Chief Officers and Senior Managers with responsibility to deliver a broad National agenda and to focus on local issues in Kent" [14]

1.3:2
The agencies represented on the Kent DAAT are

- Kent Police
- Kent Education and Libraries
- Kent Probation Service
- Youth Justice Service
- HM Customs and Excise
- HM Prisons
- Connexions
- Kent Social Services
- District Councils
- Voluntary Sector Providers
- Primary Care Trusts
- Crown Prosecution Service

The Primary Care Trusts and District Councils are represented by single lead authorities on the DAAT who feed back to their respective partners; Dartford, Gravesham and Swanley PCT represents PCTs and Swale Borough Council represents Kent Districts. Through these linkages the DAAT is tied in to the network of Crime and Disorder Reduction Partnerships and informs Local Strategic Partnerships.

1.3:3
Although the network of partnerships appear to work well, the Director of Kent Social Services and DAAT Chairman told the Committee that

[14] Evidence from Peter Gilroy, Chair of Kent DAAT 090503

> "There are limitations in relation to Drug Action Team sub-structures with one District Council Chief Executive representing twelve Districts and one Primary Care Trust Chief Executive representing eight Primary Care Trusts."[15]

This comment reflects the difficulties associated with maintaining a wide breadth of contacts in support of the drugs strategy agenda. However part of the success of the DAAT has been in gaining and maintaining the participation of such a broad range of agencies. The DAAT is also the conduit for funding for treatment and the DAAT Board Commissions funding for treatment from a pooled budget.

1.4
Kent DAAT Commissioning Team

1.4:1
The DAAT became responsible for commissioning adult treatment services in April 2001 and the majority of funds for treatment were pooled at a central or local level, this included the previously ring-fenced element that had gone directly to health. The Commissioning team set up by the DAAT includes representatives from the police, health, social services, and probation.

1.4:2
The health input to the DAAT is managed by the lead PCT (Dartford, Gravesham and Swanley); the role of lead PCT was established because of the "specialist nature of the agenda"[16]. The lead PCT ensures that drugs targets are included in other PCT's Local Delivery Plans. The lead PCT will monitor the effectiveness of the PCT's performance against these targets.

1.4:3
The Commissioners have overall responsibility for drawing up the Annual Treatment plan which is monitored on a quarterly basis by the NTA. The NTA told the Committee that

> "I am pleased to say that the treatment plan for Kent for 2003/4 is one of the best in the region providing a high quality of detail relating to financial and other activity." [17]

The Commissioning team meets weekly. All the main agencies second senior managers part time in to the team; in addition to this the team meets regularly with the treatment providers to discuss clinical issues and service development in the Treatment Services sub-group. This inclusive approach and the commitment from a wide range of partners adds value and has been recognised as an effective model.

[15] Evidence from Peter Gilroy, Chair of Kent DAAT 090503
[16] Commissioning Team evidence 090503
[17] Hugo Luck Regional Manager NTA evidence 090503

> "This system is seen as a model of good practice nationally and represents a resource investment by partners in excess of most DAAT areas."[18]

1.4:4
The NTA supported the view that the Kent Commissioning model is successful

> "The Joint Commissioning Framework for Kent is in the opinion of the NTA a model of good practice and one that has been recommended to other DAAT areas. The systems of planning, monitoring and financial control are of the highest standard." [19]

Evidence from the NTA goes on to point out that practice in Kent was used as one of eight pilot sites to inform the development of the Models of Care document that establishes a national standards framework for the delivery of drug treatment services.

1.5
The National Treatment Agency

1.5:1
The National Treatment Agency (NTA) has the status of a special Health Authority and was established in 2001 with the aims of

- ensuring equality of access to drug treatment services,
- equality in the provision of treatment services,
- increasing the capacity and competence of the drug treatment workforce,
- increasing accountability at all levels of the drug treatment systems, and
- increasing the effectiveness of drug treatment.[20].

1.5:2
The agency has a central responsibility to oversee the development of drug treatment services and is responsible for the treatment targets of the Government's drug strategy. The DAATs plan and deliver the NTA agenda at a local level and the NTA provides support and direction.

1.5:3
The NTA Regional Manager told the Committee that the support, which the NTA offers local teams, could be broadly divided in to three categories:

- the development of a robust performance management framework

> The DAATs submit their treatment plans to the NTA each year and these are assessed by a regional management group including representatives from the national probation service, regional public

[18] Commissioning Team evidence 090503
[19] Hugo Luck Regional Manager NTA evidence 090503
[20] NTA Business Plan NHS

health, social services inspectorate and the Regional Drugs Team. The DAATs submit quarterly returns and review meetings are held every six months.

- the development and implementation of a national agenda

  This is exemplified by the development of the Models of Care document, which sets out a framework for treatment of substance misuse. Other examples of establishing a national agenda include workforce development, development of management information systems, commissioning and disseminating research, and practical guidance on clinical matters.

- informing all key local and regional partners of the national agenda

1.5:4
One of the key measures of service efficiency is waiting times. These are assessed across the 6 key treatment modalities. The table below indicates Kent's current performance and the targets set by the NTA:

Treatment Modality	**–Longest Wait KDAAT**	**Average Wait**	**Target**
In-Patient Detoxification	5 weeks*	3 weeks	2 weeks
Community Prescribing – Specialist	13 weeks	3.9 weeks	3weeks
Community Prescribing - GP's	8 weeks*	7 weeks	2 weeks
Structured Care Planned Counselling	10.2 weeks	7.7 weeks	2weeks
Structured Day Programmes	9 weeks	1.4 weeks	3 weeks
Residential Rehabilitation	2 weeks	1 week	3 weeks

***where available**

The Committee recognises the progress that has been made towards achieving these targets since December 2002.

Staff shortages and lack of appropriate training opportunities will be a significant barrier to a successful implementation of the governments drug strategy

> "It is now apparent that shortages of appropriately skilled and motivated staff is a bigger threat to achieving the drug strategy target than shortage of financial resources."[21]

To address this issue the NTA has developed a Workforce Strategy to increase the treatment labour force.

> "The national drug strategy … aims to double the number of places available in drug treatment by 2008. This rapid expansion is dependent on the development and availability of competent drug treatment practitioners, commissioners and managers. The current demand for staff already outweighs supply, so it is crucial to support and retain existing workers and start building the drug sector workforce of the future now."[22]

1.5:5
The NTA is the strategic body with responsibility for increasing the accessibility and availability of treatment. Within the NHS this role is complemented by a number of agencies with responsibility for improvement in quality, these include the National Institute for Clinical Excellence, the Commission for Health Improvement, the NHS Modernisation Agency, and the Health Development Agency.

1.6
The Regional Drugs Team

1.6:1
Until March this year the Drug Prevention Advisory Service (DPAS) performed the role of the Regional Drugs Teams. The team is now based within the regional Government Office (GOSE) and this reflects their integration across the government departments represented with the regional Government Offices. The Regional Team has responsibility for the co-ordination and effective delivery of the National Drugs Strategy. The remit of the regional teams is to co-ordinate the delivery of the whole of the National Drugs strategy. This involves some overlap with NTA but also provides the linkages in to relevant government departments at a regional level and helps to make the connections between the four priorities identified within the Drugs Strategy.

1.6:2

[21] NTA Business Plan - Board Meeting March 27 2003
[22] NTA Workforce strategy for the drug treatment sector Phase 1: 2002-2005

The Regional Adviser told the Committee that she currently has responsibility for the co-ordination services in Kent, Surrey and East Sussex but the team will soon be reorganised and she will be based within the Kent team.[23] This will enable better co-ordination and communication of the Drugs Strategy agenda across the range of central government departments within the Kent team. The Regional Advisers attend DAAT meetings and Commissioning group meetings to provide advice and guidance and also to monitor performance.

1.7:0
Scale and nature of drug use in Kent

1.7:1
The DAAT Chairman made the point that in trying to identify the scale of Kent's drug problem it should be remembered that "drug use is an illegal, hidden activity with the obvious difficulties in establishing baseline measures."[24] The DAAT provided much of the following figures outlining the scale and nature of the drug problem in Kent. The DAATs ability to collect such complex data is evidence of effective partnership and increased in investment in the monitoring the scale of use and the effectiveness of treatment. Accurate data regarding the scale of the problem is a necessary part of the planning process and demonstrates that the commissioning and delivery of services in Kent is based on a sound evidence base.

1.7:2
The latest figures identify that in 2002 1,815 adults accessed treatment in Kent and Medway, of these 48% presented problems with heroin use. An increasing proportion (10%) accessed treatment, reporting problems with crack-cocaine use. 80% of those accessing treatment were male. In addition to this 376 young people under the age of 18 were supported by young peoples services.

1.7:3
The geographic distribution of these figures indicates that significantly higher numbers of people are accessing treatment in the East of the county although in some instances they could reflect non-compliance with data collection. In many instances there is a correlation between high levels of drug use and areas with identified high levels of economic deprivation.

Clients reported local area of authority when entering Adult Treatment Services in 2001/02

Local Authority	In treatment	Population	Per head
Thanet	202	126800	1:627
Dover	187	104600	1:559

[23] Gillian Weaver Regional Drugs Team evidence 160503
[24] Peter Gilroy DAAT Chairman evidence 090503

Maidstone	139	139100	1:1000
Canterbury	125	135400	1:1083
Swale	116	123100	1:1061
Shepway	90	96400	1:1071
Ashford	77	103000	1:1337
Gravesham	76	95800	1:1260
Tunbridge Wells	61	104100	1:1706
Medway Towns UA	57*	249700	1:4380
Dartford	38	86000	1:2263
Sevenoaks	34	112900	1:3320
Tonbridge and Malling	26	107800	1:4146
No Fixed Abode	35		
Outside of Kent	72		
Total:	1301		

**These figures reflect difficulties with treatment provision in Medway, this problem is now being addressed.*

- 70% of clients entering treatment were aged between 20 and 34 years of age in 2001/02

- 83% of clients entering treatment in 2001/02 were male

- 95% of clients entering treatment stated their ethnicity as white

- 51% of clients entering treatment reported their primary drug as heroin, 5% cocaine, and 4% crack.

- 11% of 11-15 use drugs

- By the age of 15 25-30% smoke regularly

- 8% of 17 year olds drink alcohol more than three times per week

- Government funding for young people's treatment in 2003: £936,400

Drug Related Deaths in Kent

- 1998/99 – 77
- 1999/00 – 77
- 2000/01 – 93
- 2001/02 – 68
- 2002/03 – 64 (provisional figure as at end of April 2003)

Prosecutions for Drug Specific Offences 2002/03

- 2757

2.0
Youth

2.1:1
Overview

In 2000 Kent County Council Education and Libraries and Social Services published a document called “A Shared Purpose” in partnership with Kent County Constabulary, and the, then, East and West Kent Health Authorities. This document identifies the shared commitment to increase the effectiveness of drugs prevention initiatives targeted at young people in Kent and identified six key themes for development

- Providing quality drug education and supporting parents, carers and staff
- Positive local responses to experimental drug misuse
- Community interventions - (vulnerable groups)
- Treatment Services

- Identifying needs and good practice
- Ensuring best value through a multi-agency approach

2.1:2
The Shared Purpose Document was a response to the issues identified in the Drug Strategy and concern about increasing drug use amongst young people, a decline in the age of first use, and a wider recognition that agencies needed to know more about the scale of the problem.

2.1:3
Drug prevention and support services are based on a 4-tier model. This approach had its origins in the Governments 1998 Drugs Strategy and intended to make services more clearly defined and accountable. Kent Council on Addiction (KCA; treatment provider East Kent) Young People's Service told the Committee that the tiered approach

> "has helped to separate targeted provision from treatment and provided a structure to develop these areas of work"[25]

2.1:4
The tiered model describes the range of services from universal information and support, through targeted services to increasingly specialised inputs. Typically schools would have most involvement at tier one, while more specialised agencies like treatment providers have a role across all four tiers. In line with the Committee's concern to look at issues across the whole of the government's drug prevention agenda the review gathered evidence of practice across each of the four tiers and recognised that specialist research is being carried out to improve the delivery of services at each level.

Tier 1 Drugs Education; information, identification and referral of young drug misusers
Tier 2 All tier one, plus drug related prevention and targeted education, advice and general counselling services.
Tier 3 Young people's specialist drug services and other specialised services that work with complex cases requiring multi-disciplinary team-based work.
Tier 4 Very specialised and intensive forms of intervention for young drug misusers with complex care needs. Services may include specialist residential services and mental health teams. [26]

[25] Matt Scott KCA evidence 230503

2.1:5
The Committee received contributions from agencies concerned with supporting young people in a variety of contexts: through formal education, outreach and community work, treatment, and criminal justice. The Committee also spoke to a representative of the Kent Youth Council.

2.2
School-based drug education programmes and drug policies

2.2:1
The Committee was particularly concerned to identify what the current situation and practice is in Kent schools. The Committee spoke to a panel of Kent County Council Education and Libraries staff about school's drug policies, drugs education and the role of the LEA. The Committee was told that the LEA's principal role in drugs prevention "is to provide education, which protects children and young people from becoming problem drug users".[27] As identified above schools responsibility is the effective delivery of tier one.

2.2:2
There is a statutory responsibility for schools to provide drugs education as part of the National Curriculum Science Orders. The majority of Kent schools deliver drugs education as part of Personal, Social, Health and Citizenship Education Curriculum (PSHCE), this is a non-statutory area of the curriculum. The evidence from the LEA panel indicated that there is significant time pressure on this area of the curriculum, which also includes important topics such as sex and relationships education, careers choices and advice, personal safety etc. A GOSE representative told the Committee that as of next year OFSTED would assess schools on their drugs education programmes. This may have an impact on the consistency and quality of drugs education programmes.

2.2:3
The Committee had an initial concern that drugs education varies in style and content across the county and the evidence received confirmed this. Responding to the challenge of drug use among young people is broader than drugs education in schools, however this forms an important plank of the range of strategies there are available to address drug use in young people. The Drugs Strategy says that all schools will have drugs education policies by March 2004.

2.2:4
There is an awkward interface between the aim to develop a coherent national drugs strategy on the one hand and on the other the independence of schools to determine their own priorities. The Committee are concerned that some schools may still be reluctant to acknowledge problems and involve support agencies because of the stigma that may be attached to the school,

[26] Health Advisory Service 1996 from "A Shared Purpose"
[27] Evidence LEA Panel 050503

or simply because of lack of time and competing priorities. Drugs education was recently criticised in the House of Commons for lacking a sense of national coherence.

> "As far as I can see, there seem to be as many different drugs education programmes as there are illicit drugs, and they are delivered by bodies as diverse as the police and reformed addicts."[28]

2.2:5
The Under Secretary of State for Education and Skills responded to this point by saying that

> "It is not appropriate for central Government to prescribe models." [29]

and went on to add that the government is seeking to identify examples of best practice and has commissioned a number of research projects.

In April 2003 the DfES published new draft drugs guidance for schools. Its key points are summarised here:

- Drug education is a statutory requirement and is best delivered through the PSHCE curriculum
- Parents and pupils should be consulted in the development of drugs education programmes and schools drug policies
- All schools should appoint a designated member of staff to plan and co-ordinate drug education
- Illegal and unauthorised drugs are not acceptable in schools
- All schools should have a drugs policy
- Schools should ensure that their policy is clearly communicated, widely distributed, readily accessible and updated regularly. "

The purpose of this report is to give an overview of the current situation regarding drug use and misuse in Kent. This key development warrants, and is receiving, extensive consideration by the LEA. The Committee has identified that much still needs to be done in Kent to establish a meaningful baseline for drugs education and schools drug policies (see below). The Department for Education and Skills (DfES) has asked for responses to the draft guidance, a Kent response is now being prepared by the LEA.

2.2:6
In Kent the LEA has carried out a comprehensive mapping assessment of drugs education activity in Kent during 2002. The report made detailed recommendations for the development of drug education policy in Kent. This process was supported by the DAAT. The mapping assessment found that 91% of schools have a drug education co-ordinator and that 59% of schools have drug policies in place although their content varied widely, "and many are due for review."

[28] Pete Wishart MP Hansard 22 May 2003
[29] Ivan Lewis MP Under Secretary of State for Education and Skills Hansard 22 May 2003

2.2:7
The final report was critical of the content and development process that some schools had gone through to develop their drugs policies.

> "Most policies have been written by school staff and governors, with little evidence of the involvement of others in the consultation and development of policy, in particular young people and parents." [30]

2.2:8
The Committee was told that the LEA has made a template of a school drug policy available to schools, the report recommended that this be updated and the range of support available to schools should be re-launched and promoted to schools.

2.2:9
The report found that numerous agencies were used to deliver drugs education including Kent Police, Theatre-in-Education Companies, Kent Advisory Service, Youth & Community Service, Kent Healthy Schools Scheme, and Life Education Centres. Schools perceived that the support on offer was inconsistent and uncoordinated and the content of programmes is variable. The Mapping and Needs Assessment has enabled the Authority to establish an overview of the provision of drug education in the county and has led to increased efforts to raise the profile of drug education, schools responsibilities and the support available from the LEA and other agencies.

2.2:10
The Committee recognised that progress still needs to be made on the implementation of tier 1 drug prevention strategies in schools but that significant steps have been taken to identify the deficiencies in provision and to establish the necessary connections between agencies to facilitate referral. It is apparent that individual schools have very different ways of dealing drug-related incidents, although in 2000 - 01 only 4% of schools made drug related exclusions. Significant progress has been made with the innovation of the Drug Intervention Support Programme (DISP) which was developed partly to offer a credible alternative to school exclusions.

2.3
Drug Intervention and Support Programme

2.3:1
The DISP programme is co-ordinated by Youth Crime Reduction Officers from Kent Police on an area basis. The programme is an educational initiative that young people can be referred to when there are concerns about drug use. The programme is designed for young people between the ages of 10

[30] KCC Mapping and Needs Assessment

and 18. Young people found to be involved with drugs and/or alcohol and solvents can be referred to the programme from any setting. The programme itself will encourage young people to "consider the issue of drugs from a health, crime and social perspective."[31]. Anyone is able to refer a young person to the DISP

- Police
- Parent
- Young Person
- Youth Offending Team
- School
- Carer

The programme aims to prevent school exclusions but over and above this the approach has proven to be an effective way to handle drug related incidents with young people. The Committee supports this constructive approach to drug incidents in schools but recognises and agrees with the recommendation in the "Next Four Years" that schools and youth centres should adopt a "zero tolerance" policy to dealing on their premises.

2.3:2
Figures made available from the Youth Offending Team indicate that during the first quarter of this year 59 young people were dealt with for either possessing or supplying illicit substances. There is no hard data available on where young people get their drugs but it is reasonable to assume that at least some of the drugs used by young people are given or sold to them by other young people. In such instances where young people are supplying drugs to others the seriousness of this situation means that the individuals concerned are likely to require comprehensive support and removal from school to another facility where issues can be addressed without endangering the safety of others.

2.3:3
The Committee was told that although the LEA supports the programme some schools do not like to acknowledge that drugs are an issue and do not refer young people to the DISP. As further evidence of the ambivalent attitude of some schools towards drugs Kent Police used the example of the Kent Invicta Disk. The disk includes guidance on developing a schools drugs policy and was sent out by the LEA to all schools in Kent. Not all schools use or access the disk and not all schools have drugs policies; the Mapping and Needs Assessment identified only 59%. The Committee feel strongly that governors, head-teachers and parents at primary and secondary schools across the County have a responsibility to engage with the support that is available and develop, or adopt, a coherent drugs policy. This recommendation applies to all schools regardless of whether or not the school perceives it has a drug problem.

2.3:4

[31] DISP information leaflet. Kent Police

The DISP has widespread strategic support as a constructive early response to drug use and an alternative to exclusion. Kent Police expressed another concern about the demands that are made on their resources to run the scheme. The Police are seen by some as *the* drugs educators but would prefer another agency to lead on managing the DISP and suggested that the programme needs a County Co-ordinator. Currently the management and co-ordination programme makes significant demands on Youth Crime Reduction Officers (YCROs) at an area level.

2.4
Operation Caddy

2.4:1
The role of Kent Police in tier 1 or 2 raising awareness of drug use and the law should be seen as a part of a range of possible inputs into drugs prevention in schools. Members of the Committee met with officers at Tonbridge police station and received a briefing on Operation Caddy: "a schools based drug enforcement strategy." West Kent Police area and the three district authorities they cover have used "Communities Against Drugs" funding to pilot a series of anti-drug initiatives. This funding comes from the Government Office and is used to fund additional work in the community to combat drugs. In West Kent the three district authorities agreed to use the money to fund a Drugs Co-ordinator this helped to provide the link to a range of agencies and facilitated innovative projects in the area. Further details of work in West Kent will be discussed below.

2.4:2
Operation Caddy was piloted in ten schools across West Kent. The project aimed to educate young people about drug misuse and demonstrate the role of the Police in tackling drug-related crime. The project has received some attention in the press because of the use of "passive dogs". The dogs were used as part of a structured educational session. The dogs demonstrated their abilities to detect illegal substances in staged searches before going on to do "live" searches as the students left their assembly room. This was then followed by a parent's evening intended to respond to parents concerns and queries.

2.4:3
Overall 3080 students received the demonstration leading to a 50% reduction in drug incidents 2001/02 - 2002/3. Eleven referrals were made to the DISP programme. The Committee was aware of potential concerns about how the use of such tactics would be perceived by parents and students. Findings from the pilot project indicated that there were significant levels of satisfaction with the way such a sensitive issue was handled: Kent Police's evaluation of the project revealed that 96% of parents wished the initiative to be continuous and 60% of pupils graded the demonstrations as excellent.

2.4:4
The Committee welcomed the pro-active approach being taken by the Police in West Kent - the project is now being rolled out across Kent and 14 other

police forces in the UK are using the package - but recognised that the full burden of drugs education should not fall to the Police. Schools should seek to establish and maintain constructive links with their local YCRO and include the police in drug education initiatives however this should form part of a balanced drugs education programme that not only considers criminal justice but also health and social and personal responsibilities.

2.5
Support for schools

2.5:1
Schools can receive support and advice from a range of agencies and organisations. School staff are unlikely to possess in depth knowledge about drug prevention issues; schools need support in preparing or accessing drug education and preparing drugs policies.

Kent Schools are supported in developing drug education programmes and drugs policies by the National Healthy School Standard (NHSS) Co-ordinators. These are based within the 3 health promotions services that cover the County. The NHSS Co-ordinators have a broader health remit but drugs education is a major theme. Their role includes

> "the development of drugs education policies; advice on appropriate schemes of work on drug use and misuse; effective and appropriate resources; supporting parents; signposting to specialists agencies/organisations."[32]

2.5:2
In addition to these there are two School Drug Advisers who can support schools in working in partnerships with other agencies. Both the LEA School Drug Advisers and NHSS Co-ordinators recognise that their own resources are spread quite thinly across the schools in the County. However their role is to advise, support and facilitate rather than to deliver drugs education. This may involve greater support for some schools than others, but the support is available for all.

2.5:3
It is clear that the role of designated Drugs Education Co-ordinators in each school is essential to carry forward drugs education on a school by school basis. This has serious implications for staff training. The schools mapping assessment found that 44% of schools have at least one trained member of staff, and said that training is "variable in quality and availability." The Mapping and Needs Assessment report goes on to recommend a whole county strategy on training and recognises that training opportunities should be more widely available.

[32] NHSS Co-ordinators evidence 080503

2.5:4
Following the Mapping and Needs Assessment the LEA has been extremely pro-active in developing a range of initiatives to support schools. These include:

- LEA Drug Education Co-ordination Group
- Drug Education Practitioner Networks/Meetings
- Development of Drug Education resources available county wide
- Development of a multi-agency drug education database
- Development of referral and tracking processes
- Revision of drug policy within the LEA Invicta Manual and provision of exemplar model in line with anticipated DfES guidelines
- Development of special educational needs pack
- Risk assessment guidance on use of passive dogs[33]

2.6
Drug Awareness in Teacher Training

2.6:1
There is a wider concern about drug awareness amongst all teachers and the lack of preparation for dealing with drugs issues in Initial Teacher Training (ITT). The Under Secretary of State for Education said in a recent House of Commons debate that "unprecedented resources are going in to focusing on the issue [of drug awareness] at the Initial Teacher Training Stage". [34] The DfES has been asked to comment on this issue and outline what is being done; no confirmation has been received.

2.6:2
The Head Teacher of Abbey School told the Committee that ITT included very little drug awareness training. The current guidance in the Qualified Teacher Status handbook says only that teachers should be aware of the PSHCE curriculum. A representative of Canterbury Christchurch College[35] told the Committee that PSHCE, in line with each of the National Curriculum areas, is taught for one day of the one year Postgraduate Certificate in Education. She went on to add that the QTS Standards are "deficient because they do not recognise the pastoral role."

2.6:3
Teacher's pastoral responsibilities make many complex demands on their time and abilities. The Committee acknowledged that in the context of an already onerous syllabus for ITT it might be difficult to increase the drug awareness content. An issue, which the Committee felt needed further investigation, is: *what do (non-specialist) teachers need to know about drug prevention?*

[33] LEA evidence 050503
[34] Ivan Lewis MP Hansard 22 May 2003
[35] Gill Watson, Senior Lecturer in Education at Canterbury Christchurch College

2.6:4
The type of knowledge and degree of awareness necessary for a drugs education co-ordinator will inevitably be more specialised than that for a teacher without specific drug prevention responsibilities. School drug policies and effective induction processes will be a necessary complement to pre-qualification training and this increases the need for all schools to develop drugs policies. The Committee would support further dialogue between the DAAT, KCC Education Directorate, ITT providers, and the Teacher Training Agency to consider strategies to raise awareness of drug prevention issues among qualifying teachers.

2.6:5
The evidence that the representative from Kent Youth Council gave to the Committee supported the findings of the Mapping and Needs Assessment.

> "Currently PSHE lessons are run by teachers who are not specifically trained to teach [drugs education] and present facts from information sheets that are already known to pupils"[36]

While this view is not necessarily representative of wider experiences it does highlight a general concern that teachers may lack credibility if they are not adequately prepared. The KYC representative went on to add that the Police and the Health Service were better informed about drugs issues and therefore better placed to deliver drugs education. Though this was qualified by the recognition that some young people did not trust the Police and perceived them to be a part of the problem. In informal discussions with Kent Police it was apparent that such a view was not surprising but the partnership work carried out with schools and other agencies and their profile in drugs prevention is working to break down this barrier.

2.6:6
Having seen the success of Operation Caddy, which was constructively assertive in identifying and dealing with drug use, members of the Committee were keen to find out whether or not random drug testing would be appropriate in schools. This raised inevitable concerns about human rights and the practicality of such an approach. While witnesses recognised that such a tactic was motivated by the desire to protect young people from the dangers of drug use, the suggestion received little support and the Committee concluded that random drug testing in schools would be inappropriate.

2.7
Outreach Services

2.7:1
In addition to the formal drugs education and prevention work being carried out in schools there is also significant support available for young people outside of school. Much of this work is again in tier 1 and tier 2. The Youth Service told the Committee that substance misuse training is a very high

[36] Steven Ferguson Member Kent Youth Council 050503

priority, in the last three years over 90 staff have taken part in training. The Youth Service has a comprehensive network that is sometimes able to reach young people who either do not attend school or are less likely to engage with formal delivery methods.

> "Last year the Youth Service worked with over 10000 pupils in approximately 40 schools including Pupil Referral Units and Alternative Curriculum Provision for permanently excluded young people therefore contributing to work with the hardest to help disaffected young people."[37]

2.7:2
The Youth Service also work in partnership with initiatives such as the Grey Zebra project ("because nothing is black and white") operated by the Kenward Trust. During a visit to Kenward House the Committee were shown the bus used by the project to visit outlying areas, and housing estates. The project workers explained that staff from different disciplines go out with the bus, some from a generic youth work background, and other more specialist staff such as counsellors who are able to talk to young people informally before signposting, or referring them to more formal support when necessary. Currently the Grey Zebra project operates predominantly in Mid and West Kent but the Trust are considering increasing provision.

2.7:3
The work carried out by the Youth Service and the Grey Zebra project ranges from broadly accessible tier 1 work in open sessions to more targeted activities with vulnerable groups at tier 2. This kind of work may involve non-substance misuse specialists in identifying drug use issues and referring young people to specialists. To support this process the DAAT have developed the Drug Use Screening Tool (DUST). DUST is a screening checklist intended to help practitioners identify drug use and associated risk factors and can be used by non drug specialists to assist with referral to treatment providers.

2.8
Young person's treatment services

2.8:1
The main sources of substance misuse specialist support and advice for young people are the young people's treatment providers. KCA provide services in East Kent and West Kent NHS and Social Care Trust provide their own young peoples services in the West. KCA's Young Persons Drug and Alcohol Services Manager told the Committee that the governments drug strategy has provided an increase in funding for young people's services. In 1999 KCA had three Young Persons service Practitioners. There are now 14 full time posts. This has led to an increase in the "quality and diversity of services on offer". These include

[37] Youth Service evidence 080503

> "Specialist individual treatment and support for young people referred to the service, outreach workers taking services out to the hard to reach groups, training for professionals working with young people, awareness groups for parents and carers, education and harm reduction groups for targeted, vulnerable young people."[38]

2.8:2
Although KCA are involved in drugs prevention across all four tiers including treatment the service recognises that there are key differences in working young people rather than adults. The Young Person's Service has more of a preventative focus than adult-based services and there is recognition that young people are more likely to be experimenting with drug use than developing dependency.

> "Above all, the ethos is one of harm minimisation. If one accepts that realistically young people are going to experiment with substances then it is our role to prevent or minimise the harm that could be caused." [39]

2.8:3
Some young people will experience more serious problems and require treatment. It has been established that there are sound clinical reasons for delivering treatment and support to young people in discrete settings. The relatively lower numbers of young people requiring treatment, as compared to adults, makes the provision of specialist services less viable. Young persons treatment providers referred the lack of facilities, particularly for in-patient detox

> "The recent explosion in the use of crack cocaine has led to agencies needing to provide specific responses for those involved. There is an abject lack of young persons specific de-tox provision." [40]

2.8:4
The Committee recognises that diversity in provision is a positive factor but would like to see greater coherence in the approach to young people's services across the County. It is apparent that treatment agencies have developed expertise in the delivery of particular tiers of work with young people. The Grey Zebra project appears to be a particularly constructive response to the needs of vulnerable and hard to reach groups at tier 1 and 2. KCA has been innovative in the development of comprehensive community treatment services for young people. West Kent NHS and Social Care Trust have a strong background in the delivery of tier 3 and 4 treatment services. The review highlighted evidence of collaborative working and partnership between each of the treatment agencies; it is vital that there is equal access to information, support and treatment services in all areas.

[38] KCA Matt Scott Evidence 230503
[39] KCA Matt Scott Evidence 230503
[40] Chris Easton WKNHS evidence 230503

Current figures indicate that young people sevices at tier 3 and 4 in the west of the county do not appear to be reaching the numbers achieved in the east. This is a matter of some concern.

Activity 2002/2003 – Kent Tier 3 & 4 Young Peoples Drug Services

West Kent

Total No. New Referrals	Service Provided	
106	22	Assessed, not engaged with treatment
	49	Assessed and engaged in planned treatment

East Kent

Total No. New Referrals	Service Provided	
332	44	Assessed, not engaged with treatment
	161	Assessed and engaged in planned treatment

The development of effective delivery models must be applied across the county, where best practice has been developed treatment agencies and the DAAT should ensure that all young people have access to a comparable level of service.

2.8:5
KCA's experience in east Kent indicates that parents of drug using children are often placed under considerable stress. But their support and advice will be crucial if the young person is to engage successfully with treatment.

The KCA Chief Executive said that there is a need for a

> "dedicated services for parents who discover their children are using drugs would be a welcome development"[41]

The Committee recognises the overwhelming anxiety and confusion experienced by parents with children who use drugs. The Committee would like the DAAT to explore the potential for services/projects that promote parental support and involvement in all tiers of drug treatment and prevention.

2.9
Youth Offending

[41] Anton Derkacz Chief Executive KCA evidence 160503

In Kent the Youth Justice Board is responsible for co-ordinating the youth justice system. The Board has funded Youth Offending Teams (£152000 p.a.) to support local drugs services; this funding is part of the pooled budget. In addition to this the Youth Justice Board retains some funding to commission specialist treatment services for young offenders. The Youth Offending Service (YOS) is responsible for

- Educating young people known to YOS about the potential harm that the misuse of drugs can cause.
- Supervising young people and monitoring their behaviour
- Referring those young people involved in substance misuse to specialist agencies
- Where required instigating court proceedings for non-compliance where young people do not co-operate with an agreed plan.[42]

The Youth Offending Service gave the Committee further data about the scale of youth offending in Kent.

Number of young people (10 –17) dealt with by YOS annually: approx. 200

- Percentages of overall referrals to YOS for Drug Problems 2002 by district

Dover	23%
Thanet	21%
Swale	14 %
Canterbury	12%
Shepway	7%
Maidstone	6%
Other districts	20%

- 75% of referrals were male
- 50% of referrals were aged between 15 –16
- Less than 10% were under 13
- Over 50% of referrals related to alcohol misuse
- Cannabis was the most common illicit substance and accounted for 20% of referrals
- Crack/Heroin 4%
- Cocaine and amphetamines 4%[43]

[42] Kumar Mehta Youth Justice Manager evidence 080503
[43] All Figures Kumar Mehta YOS

The Youth Offending Service recognises that although the majority of young offenders will not be involved in substance misuse they will be at a higher risk of experimentation due to their involvement in youth crime. [44]

2.10
Diversionary Activities

2.10:1
The DAAT Chairman told the Committee that there is a range of activities in development across Kent to "enhance protective factors around young people's risk of experimentation" including sports based programmes. This is in line with the government's strategy to increase diversionary activities, particularly in communities where the need is greatest. This approach has been adopted and was supported by treatment providers working with young people[45]

> "Targeting vulnerable groups with a holistic programme could change lives and give young people a link into services that would give them a more positive future, e.g., programme such as "Sport for Energy" in Thanet"

2.10:2
The government has introduced projects such as the Positive Futures programme launched in 2000 which uses sport as a way of reaching and influencing young people most at risk of becoming involved in drugs. The Committee strongly supports the use of sport and other recreational activities as catalyst for engaging marginalised young people with positive and meaningful opportunities and raising their aspirations.

2.11
This section has considered the range of services in Kent to respond to the problems of drug use among young people and has considered how these services are organised around the four-tiered model. The Committee recognises the positive role that the DAAT has played in increasing the co-ordination of services and agencies. The Committee also recognises that the willingness of agencies to develop collaborative approaches has improved the network of support available to young people.

The recommendations from this section are:

1. All schools in the County must put in place a drug policy by March 2004 in line with the Governments drugs strategy. The Committee feel strongly that governors, head-teachers and parents at primary and secondary schools across the County have a responsibility to engage with the support that is available and develop, or adopt, a coherent drugs policy.

[44] Kumar Mehta YOS
[45] Matt Scott KCA evidence 230503

This recommendation applies to all schools regardless of whether or not the school perceives it has a drug problem. (2.3:3)

2. Drug education must be credible to young people; opportunities should be taken to share and learn from their experiences. (2.2:6)

3. There are effective and proven strategies in place to respond to young people's drug related problems such as the Drug Intervention Support Programme. Fixed-term or permanent exclusion from school should only be considered as a last resort. (2.3:1) However, the Committee supports the recommendation made in the "Next Four Years" that dealing is not to be tolerated on school premises or youth centres. Young people guilty of supplying drugs to other young people should be removed from school in order to receive comprehensive support and for the protection of others. (2.3:2)

4. Operation Caddy, the drug awareness initiative developed by Kent Police, is welcomed, and the Committee would support its use in secondary schools across the County. There are two important qualifications to be added here

    - The project should be used as part of a wider programme of drug education.

    - The use of passive dogs is only an aspect of this initiative. Schools should only seek to implement the full programme including proper recognition of protocols established by the LEA, integration with the Drug Intervention Support Programme, and follow up activities with parents. (2.4:4)

5. Schools should seek to establish and maintain constructive links with their local Youth Crime Reduction Officer and include the police in drugs education initiatives, however this should form part of a balanced drugs education programme that not only considers criminal justice but also health, and social and personal responsibilities. (2.4:4) Schools have a responsibility to maintain an effective network of pastoral support. Schools should engage with the issue of drug, alcohol and substance misuse at the level of the newly created cluster groups across the community through partnerships with relevant agencies

6. The Committee would welcome dialogue between Kent Drug Action Team, LEA, Initial Teacher Training Providers and the Teacher Training Agency to raise awareness of drug prevention and **early identification** for newly qualified teachers and **support staff**. However, effective induction and coherent schools drug policies are fundamental if teachers are to understand local drug prevention issues. (2.6:4). Kent is establishing its own modular training for teachers leading to accreditation recognised by the Department for Education and Skills (DfES).

7. Young Persons Treatment Services across the county should be determined by common guiding principles of community based delivery, harm reduction and seamless transition between the tiers that structure service delivery. The introduction of a pooled budget for young people's treatment should support this transition (2.8:4)

8. The Committee strongly supports the use of sport and other recreational activities as catalyst for engaging marginalised young people with positive and meaningful opportunities and raising their aspirations. (2.10:2)

3.0

Treatment

3.1:1
The Drug Strategy places a strong emphasis on treatment

> "Treatment works. Getting drug misusers in to treatment and support is the best way of improving their health and increasing their ability to lead fulfilling lives. Treatment breaks the cycle of drug misuse and crime, and investing in treatment reduces the overall cost of drug misuse to society." [46]

[46] Updated Drugs Strategy Home Office 2002

The Strategy cites the innovation of the NTA (see above), the introduction of pooled treatment budgets and increasing numbers of people in treatment as evidence of their commitment. And, the strategy aims to continue the increase in those accessing treatment, targeting those at most risk using Class A drugs and improving access to treatment in deprived communities.

3.1:2
Harm-minimisation is an important complement to the treatment of addiction. Harm-minimisation can be used to describe a broad spectrum of activities; from making sure that users are aware of the health implications of their drug taking; ensuring access to primary healthcare; to needle exchanges.

> "Harm-minimisation will ensure that drug users receive good basic health care, helping to reduce the risks arising from drug misuse, including the risk of drug related death" [47]

This section will give an overview of what services are on offer in Kent and identify key issues for further consideration or action. The Committee has not sought to make investigations in to the complexities of clinical decision making; this is not in its remit.

3.1:3
The key issues that will be discussed in this section are:

- Treatment Modalities
- The Pooled Treatment Budget
- Shared Care
- data Collection
- Treatment Capacity

3.2:1
The KDAAT Commissioners are now the responsible body that determines which treatment services are available in the county. However, the system is new and the current configuration of services owes as much to the historical development of services as it does to current clinical priorities. Until the latest round of health service re-organisations the county was divided east/west between two health authorities. These developed different approaches to the treatment of addiction and some of these are still evident in current provision.

3.2:2
In broad terms Kent Council on Addiction provide treatment services in the east of the county and West Kent NHS & Social Care Trust provide services in the West. In addition to these the Kenward Trust provides residential rehabilitation programmes and structured day programmes that are situated in West Kent. People from outside of Kent as well as Kent residents access these services.

[47] Updated Drugs Strategy Home Office 2002

3.2:3
Drug users accessing treatment have complex and idiosyncratic needs; these may vary according to their drug(s) of choice, pattern of use, length of addiction and social circumstances. There is no single method of treatment that works for all drug users. The treatment modalities -

- In-patient detoxification,
- Community prescribing – Specialist,
- Community prescribing – GPs,
- Structured Care Planned Counselling
- Structured Day Programmes
- Residential Rehabilitation

- are not necessarily exclusive; indeed it is likely that a user undergoing a programme of treatment might access a number of these treatment modalities either simultaneously or consecutively.

So for example an individual might receive a daily methadone prescription from their GP, while at the same time attending a Structured Day Programme for 2 or 3 days per week. Or alternatively, an individual might undergo a period of In-Patient Detoxification before moving on to a Residential Rehabilitation programme and then progress from this to a Structured Day Programme as part of their final reintegration.

3.3
Treatment modalities

3.3:1
Substance-misuse specialists will help the individual user identify which mode of treatment is the most appropriate. As not all attempts at treatment are successful the choice might be partly determined by past experiences. It is important therefore that users accessing treatment have options

> "The key factors in successful treatment are
>
> - To have a range of treatment options, which includes those which reduce short term harm and those which will promote longer term abstinence, and
> - To be able to respond to the individual needs of each service user with an appropriately tailored package of treatment and support." [48]

3.3:2
There is an ongoing debate in clinical circles about which treatment modalities are the most effective. This has the potential at least to present the Commissioners with difficult issues: how are their resources best used; should safer and proven methods be favoured over newer approaches? How do the current configuration of services match with clinical priorities; and what

[48] Anton Derkacz Chief Executive KCA evidence 190503

basis is there for changing provider or for requiring a provider to change? The NTA has a clear role to lead this debate and the DAATs should provide an effective local focus for sharing and disseminating best practice. The Committee was assured by the Commissioning team that provision in Kent and Medway is based upon the best current understanding of clinical practice.

> "In Kent work has been done to ensure that all services are functioning to the existing evidence base, for example a prescribing review is underway to ensure consistent and best practice standards across the area."[49]

3.3:3
The NTA monitors performance at a regional level. In Kent and Medway there is still some way to go to before these targets are reached (see above). The consequences of delays in accessing care can be severe.

Number of clients accessing treatment services by treatment modality 2001/02

Treatment Modality	Frequency
1:1 Counselling	1201
Groupwork	433
Prescribing - Long Term	374
Prescribing - Short Term	257
Detox	162
Structured Day Care	93
Community Support	89
ISSP/DTTO	87
Rehab	42
Drug Free Day Care	42
Relapse Prevention Unit	39
Probation with Specialist PO	30
Probation without Specialist PO	19
Family Therapy/Work	9
2nd Stage	6
Total	**2883**

3.3:4
The Committee visited a number of treatment providers and spoke to service users. On one visit the Members talked to people on a day programme. The group talked about excessive waiting times for substitute prescribing. Many were positive about substitute prescribing and its effectiveness. However one member told the Committee that he had to wait 9 months before he could begin a substitute-prescribing programme. He and others explained how difficult it is for many users to make the decision to access treatment. To do

[49] KDAAT Commissioners 090503

so and then find that the treatment is unavailable is hard to cope with, and many are unable to wait and may be put off trying again.

3.3:5
The particular problems with substitute prescribing will be discussed in greater depth below. Another deficiency noted by some is the inadequacy of in-patient detox facilities

> "We do not have detox facilities in East Kent and the facilities in West Kent are not adequate. It's a big gap at the moment and people have to stay on methadone longer than they need to." [50]

3.3:6
The Committee was concerned to find that there are 8 in-patient detox beds in Dartford but this facility is due to close. In addition to these there are another 8 beds at the Medway Maritime Hospital that may be used for detox, however these are sited within a psychiatric ward. There are no detox beds for young people. As result the Commissioning Team carried out a review to consider the re-provisioning of detox facilities in 2002**.** Two of the options under consideration were the construction of a newly built or refurbished 16-bed facility in the centre of the county. Both of these options were costed at over £700000. Other options under consideration were to provide a service with fewer beds, or to not re-provision at all. The review also considered the possibility of joint commissioning detox facilities with a neighbouring authority.

3.3:8
In-patient detox is the most expensive treatment modality[51] and there is debate among practitioners about the value of such a facility compared to the potential investment in less costly alternatives.

3.3:9
The Committee can not contribute to the clinical aspects of this debate. The KDAAT report on this issue made it clear that budgetary constraints are a driving factor in the continued uncertainty surrounding detox provision. The costs of reprovisioning will need to be shared between funds from the pooled budget and PCTs. Evidence given to the Committee indicates that a decision has been taken to build new facilities at a site that is yet to be confirmed. The Committee welcomes this decision and expresses the hope that new facilities will be in place before the existing facilities are closed. There is a concern here that the competing priorities of the wider health economy can still have the potential undermine drugs provision despite the innovation of the pooled budget.

3.4
The Pooled Treatment Budget

[50] Anton Derkacz evidence to Select Committee 190503
[51] A review of in patient detoxification services in Kent/Medway and the reprovision of Stonehouse Addiction Service. KDAAT 2002

3.4:1
The Committee welcomed the positive comments from the NTA about Commissioning arrangements in Kent and sought further evidence from treatment providers about the impact of the new commissioning structures and the Pooled Treatment Budget.

3.4:2
The Chief Executive of West Kent NHS & Social Care Trust, recognised that previous commissioning arrangements lacked co-ordination and the introduction of a dedicated Commissioning team leads to informed decisions.

> "The impact of the Pooled treatment budget has been to simplify contracting of services. In previous years the Trust had separate main contacts with Health, Probation, Police and several smaller contracts each of which took no account of what other organisations might be commissioning. Now there is one contract with the Kent DAAT Commissioning and Performance Management Team. They are a dedicated team that allows them to devote sufficient time to contracting services based on informed decisions." [52]

3.4:3
However it was clear from discussions with treatment providers that the pace change meant that advances have been achieved at a cost. One said that their service would welcome a prolonged debate between the Commissioners and the providers. And, went on to say that there is a heavy agenda on changing the delivery of services; because of the change agenda there is now more money than there has ever been but there are also now more vacancies. Treatment numbers need to double by 2008, the NTA want services restructured, and there is a great debate about change. As a consequence, the Committee was told, staff are suffering "change fatigue".

3.4:4
Treatment providers do have an ongoing link in to the Commissioning Team via the Treatment Services sub-group. The point about prolonged dialogue may reflect frustration at a nationally/regionally directed agenda rather than the Commissioning Team itself but it highlights the pressures that treatment providers have been under to accommodate new structures and practices.

3.4:5
Generally the Committee found the Pooled Budget arrangements were welcomed.

> "it is likely when all the new arrangements are fully established they will represent a significant improvement on the previous fragmented and relatively arbitrary system." [53]

[52] John Wilkes Chief Executive West Kent Health & Social Care Trust evidence 190503
[53] Anton Derkacz Chief Executive KCA evidence 190503

3.5
Shared Care

3.5:1
Shared Care arrangements for substitute prescribing of methadone is intended to be a collaboration between a substance misuse specialist, pharmacists, treatment providers and GP's. An individual undergoing treatment will be stabilised on a dose of methadone that replaces their previous use of illegal drugs by a substance misuse specialist. A specialist typically at Consultant grade will oversee the process of stabilisation. Implicit in the stabilisation process is a contract between the user and those involved in their care that the user will cease their problematic behaviour. The GP is expected to provide general primary care services and prescriptions as agreed as part of a treatment plan. The treatment provider will have a nominated key worker who will monitor the prescribing regime including saliva/urine tests to ensure that prescribed doses are not being illegally "topped up".

3.5:2
In some cases where a user requires a higher level dose a specialist will carry out the prescribing. West Kent NHS & Social Care Trust plans to increase the number of specialists providing higher level prescribing across their area.

3.5:3
The Kent Local Medical Committee (LMC) told representatives of the Select Committee that Shared Care works well in Maidstone where a protocol was agreed that involved training for GPs, pharmacists, and surgery staff. In Maidstone GPs are confident that if a patient breaches the agreement they can be returned to the responsibility of the treatment provider.

3.5:4
The point was also made that, typically the doses prescribed in Maidstone were either to support a long-term reduction, or a maintenance dose (i.e. not reducing). GPs do not have the resources to support what are effectively short-term community based detoxification programmes; short-term programmes are likely to require specialist skills and require increased monitoring.

3.5:5
The LMC explained that there is a range of factors inhibiting more GP's becoming involved in shared care.

- Problematic Behaviour
- Workload
- Support from treatment providers

Members were extremely disappointed to find the unavailability of GP prescribing services, particularly in east Kent, an area that has the highest levels of drug use across the whole county. The Committee was particularly

concerned by this because although Shared Care methadone prescribing will not necessarily be managed by the users own GP, the lack of any GP's involved in Shared Care in and around Thanet implies a lack of rapport between GP's, treatment providers and users. Some users indicated that they had experienced difficulties in accessing the general range of primary care services because of concerns about erratic behaviour and HIV.

3.5:6
Some of the concerns that GP's have appear to be around getting the training to develop the necessary competencies. It seems that there are two models that could be adopted: generalist or generalist/specialist.

- The generalist model would imply that GPs received basic level training but do not develop their prescribing work load to any significant degree

- The specialist/generalist model implies that GPs who are interested might develop higher competencies in substance misuse and could become a focus for these activities in their area/surgery. Strategically it would be beneficial to ensure an even coverage of specialist-generalist GPs.

3.5:7
This second model appears to be supported by the DAAT who told the Committee

> "It is important to build a critical mass in every area of GP's prescribing under specialist interest contracts."[54]

The Audit Commission also prefers the specialist generalist model

> "Shared care arrangements that focus on those GPs who are willing to participate, build up their expertise, and ensure an effective balance between the roles of specialists and generalists are likely to be the most promising approach." [55]

3.5:8
Evidence from the DAAT indicates that only 14% of GPs are involved in Shared Care, the added factor of an uneven geographical spread worsens this scenario and East Kent in particular appears to be poorly served. The Committee would support continued efforts by the DAAT to engage with GPs and would hope that forums can be established where GPs, Pharmacists and treatment providers and service users can share concerns.

3.6
Data Collection

3.6:1
The Committee has received detailed data from the DAAT on patterns of drug use, and the effectiveness of services. It is clear that drug services in the

[54] KDAAT Commissioners 090503
[55] Changing Habits Audit Commission 2002 p.91

county have benefited greatly from the increased focus on evidence based provision. The Kent and Medway Effectiveness Monitoring Project, which collates anonymous service user data from all Kent providers enables, service planners to recognise success and identify difficulties. A data Analyst, monitoring data on availability now complements this work.

3.6:2
There is a concern however that the requirements to measure and monitor provision could interfere with delivery

> "Regulatory and reporting requirements are much more stringent than was previously the case. The increased requirements for Data in relation to outputs, waiting times, unit costs, and activities in particular geographical areas and by treatment modality have increased the administrative costs borne by treatment providers." [56]

3.6:3
This raises a familiar but nonetheless serious concern that too much time may be spent on measuring and proving outcomes. DAAT members will inevitably have their own organisational reporting requirements added to this are the regional bodies like the NTA and the Regional Drugs Team. This concern was highlighted in a recent Guardian article referred to above.

> "The government says that the DAATs must do the work; so the DAATs must prove they are working; and very quickly the proving becomes their work." [57]

3.6:4
Performance management structures were a key innovation of the drugs strategy, however the Committee urges funding bodies to consider the impact of outcome measurements on service delivery.

3.7
Increasing Treatment Capacity

3.7:1
The Drugs Strategy sets out to double treatment capacity by 2008.

> "An expansion of treatment provision will take time to build – there is no quick fix solution. However by 2008, we will have doubled the capacity so that 200000 problematic drug users can be treated per year in the community or in a residential setting." [58]

[56] Anton Derkacz Chief Executive KCA evidence 190503

[57] Nick Davies "How Britain is losing the drugs war" Guardian 22 May 2003

[58] Updated Drugs Strategy Home Office 2002 p.11

This will present all the agencies involved treating and supporting drug users with a serious challenge to increase the staffing and the capacity of facilities significantly over the next four years.

3.7:2
Kent and more particularly east Kent experiences the difficulties common to the rest of the south east in being accessible to key public sector workers because of high housing costs; in addition the peninsular location and poor transport links further complicate the recruitment of public sector workers. Increasing staff numbers could be a significant problem.

> "Survey data suggests that there are at least 250000 problem drug users in England and Wales. If Kent's population is typical then the county may have 7000 problem drug users. Current treatment capacity falls far short of this and the shortfall in capacity is reflected in the existence of waiting lists for most of the treatment modalities. There is therefore a need for an expansion of drug treatment capacity." [59]

The Committee recognised the constructive efforts being made by KCA to offer adults a voluntary route in to drugs work that could subsequently lead to paid opportunities.

3.7:3
The Committee visited a number of treatment provider facilities across the area. None were purpose built and most seemed to date from the Victorian era. It was apparent that the facilities could potentially compromise treatment and staff and user safety.

3.7:4
The Commissioners told the Committee that they have recently audited facilities across the county and established action plans but there is an inevitable trade off between increased capacity and investment in infrastructure and this is an issue that the team is struggling with. This appears to be a reprise of the earlier discussion regarding in patient detox facilities. Increases in capacity can not be achieved on the cheap and there should be a greater commitment to capital investment if the treatment targets are to be taken seriously.

The Committee recognises the contradictory pressures experienced by the Commissioning Team to increase treatment while needing to improve facilities. The Commissioning Team could require treatment providers to upgrade facilities using disability legislation, or the Team could identify funds from within the pooled budget for capital improvements. Either scenario detracts from the funding available for treatment with potentially damaging consequences for local relationships. Distinct capital funding would promote stability in forward planning and investment in facilities would improve access and safety. The Committee recognises the wider pressures on funding for

[59] Anton Derkacz Chief Executive KCA evidence 190503

health in Kent but would welcome dialogue between the NTA and the Commissioning Team to consider the need for both distinct and additional capital funding.

3.8
Parental Drug Use

3.8:1
In June 2003 the Advisory Council on the Misuse of Drugs published its report "Hidden Harm – Responding to the needs of children of problem drug users". This report estimated that there are between 250000 and 350000 children of problem drug users, about one for every problem drug user.[60] Using some estimates of the scale of problem drug use in Kent this could mean that there are 7000 or more children of problem drug using parents in Kent.

3.8:2
Problem drug users as parents present a health risk to the unborn child and in early life continued risks of damage and poor nutrition. As children grow older children may be exposed to more of the dangers and costs of their parents drug misuse. These include:

> "physical and emotional abuse or neglect, dangerously inadequate supervision; other inappropriate parenting practices; intermittent or permanent separation; inadequate accommodation and frequent changes in residence; toxic substances in the home; interrupted or otherwise unsatisfactory education and socialisation; exposure to criminal or other inappropriate adult behaviour; and social isolation." [61]

Kent is already piloting a project in Thanet for substance misusing parents that is jointly funded by the DAAT and the Children and Families team the service

> "offers rapid interagency response. Protecting small case loads for the staff involved is expensive and creates a trade off with overall capacity for DAAT"[62]

3.8:3
The ACMD report recommendation 35 says that DAATs "have a responsibility towards the dependent children of their clients"[63] There are additional cost implications here which may further compromise existing services. Parents may be reluctant to engage with treatment services if they feel there will be a focus on the children and the perceived risk of contact with statutory agencies.[64]

The recommendations from this section are:

[60] ACMD Hidden Harm June 2003
[61] ACMD Hidden Harm June 2003
[62] Diane French Commissioning Manager evidence 180603
[63] ACMD Hidden Harm June 2003 Recommendation 35
[64] Diane French Commissioning Manager evidence 180603

1. The Committee recognises the overwhelming anxiety and confusion experienced by parents with children who use drugs. The Committee would like the DAAT to explore the potential for services/projects that promote parental support and involvement in all tiers of drugs treatment and prevention.(2.8:5)

2. Capital investment must be increased if there is not to be a trade off between increasing capacity and improving treatment facilities. The Committee would welcome a distinction between funding for treatment and funding for capital investment and recommends that the NTA represents the concerns of the Committee to the Department of Health in order to seek mainstream capital funding for the improvement of treatment facilities. (3.7:3) (3.3:9)

3. The Committee supports continued efforts by the DAAT to engage with GP's and promote involvement in Shared Care. (3.5:9) Particular efforts should be devoted to increasing the GP participation in Shared Care in East Kent. (3.5:9)

4. The application of performance management measures by national and regional agencies should be moderated and funding bodies should ensure that data collection requirements complement rather than compromise service delivery. (3.6:4)

4.0

Availability

This section will refer to work carried out by enforcement agencies such as the police and Customs and Excise to prevent the supply of illegal drugs and the role of other agencies in the criminal justice system such as the prison service and the probation service, to deal with offenders. The key innovation in the reorganisation of drug strategies following the 1998 Act was the increased local level partnership working between all agencies holding responsibility for drug related issues. This has led to representation on KDAAT by the main criminal justice agencies and ongoing input from Kent Police and Kent Area Probation Service in the Commissioning of services. At a district level the police are also represented on the Crime and Disorder Reduction Partnerships.

4.1
Supply

4.1:1
The Committee made several visits to area police offices around the county to consider the responses being made to challenging issues. It is apparent that Kent Police are developing a range of innovative responses to drugs. Although overall levels of drug use and offending in Kent are not significantly different to other comparable areas there are specific factors that influence the supply of drugs. Kent's proximity to London is especially significant; the Committee received evidence that the supply of class A drugs in north and west Kent is linked to London based suppliers.

4.1:2
The Committee found that the issue of supply directly from the Channel ports/Tunnel in to Kent is not in itself a significant problem (although the Committee found that there are negative affects associated with the illegal trafficking of tobacco and alcohol). Typically drugs that do make it through the Kent ports/Tunnel go in to London before their secondary distribution to other areas.

4.1:3
Kent Police have identified that areas in Thanet, and in Medway have the highest levels of crack use in the county, experience indicates that crack use leads to violence and gun crime; preventing the growth of crack use has become a priority. The problem of heroin use is more widespread, there are 'hot spots across the county with a notable prevalence in areas that experience the highest levels of social and economic deprivation.

4.1:4
The problem of drugs supply from London coming in to Kent has been identified as a particular problem in the West Kent area where a number of initiatives have been developed to stifle supply with a particular focus on the movement of drugs.

4.2
Innovations in West Kent

4.2:1
The West Kent Area has been able to develop considerable expertise in tackling drug use because, together with the district councils, there has been an agreement to use Communities Against Drugs (CAD) funding to pay for a Drugs Co-ordinator for three years. This money comes to local partnerships from the regional team. The Drugs Co-ordinator is a dedicated police sergeant with the responsibility for developing innovative anti-drugs projects and co-ordination with other agencies; the funding has to be used to fund additional work, that is work which is over and above what could normally be paid for at a local level.

As a result of the potential created by this post 5 strategic objectives were identified at the beginning of the project in 2001. These are:

- Schools: Operation Caddy *"a schools based passive drugs dog enforcement and education package"*

- Cross Border: Operation Scallywag *"a strategic cross border multi-agency road check to disrupt drug supply routes in to the county utilising Automatic Number Plate Reader (ANPR), passive drugs dogs and Ion track testing machine."*

- Emerging Hotspots: Operation Wave *"target emerging hotspot areas of Class A dealing with plain clothed and uniform officers supported with drugs dogs"*

- Community: Operation Quest *"a high profile housing estate initiative focusing on drugs and crime links."*

- Night Time Economy: Operation Quibble *"targeting pubs, clubs, and rail stations at night to combat drug misuse within the night time economy utilising plain clothed and uniform officers supported with drugs dogs and Ion Track testing machine."*[65]

West Kent is the only area in Kent to have used CAD funding in this way and is demonstrating considerable success. Some of this success is explained by simply having more money to carry out more operations, but the success of the project can also be viewed as a vindication of the local Drugs Co-ordinator role. The approaches developed in West Kent are being rolled out across the county.

4.3
Operation Academy

4.3:1
The Committee visited Kent Police at Sittingbourne and was told about "Operation Academy" on Sheppey. Hard drug use had escalated in an area of the island. The police developed a response to this threat that built on their experiences in the Medway area. Conventional techniques had proven ineffectual in securing prosecutions for supply and the decision was taken to instigate a long term under cover operation. Perhaps the most significant aspect of Operation Academy occurred after all Class A drug users were removed from the island when 34 arrests were made. Experience from Medway indicated that supply would readily re-establish itself to meet the

[65] All details Sgt Howard Chandler Drugs Co-ordinator West Kent

demands of often desperate users, who have suddenly been deprived of their suppliers.

4.3:2
The approach was to draft in experienced Drug Liaison Officers from across the county to identify users seeking suppliers and direct them towards treatment agencies. The intention was to seize the opportunity to signpost users in to treatment and prevent supply networks re-establishing. The flaw in this plan however was the lack of notice given to treatment providers who were only informed once arrests had been made. KCA were able to set up a helpline and drop in centre at short notice. The Police indicated that this was necessary to maintain operational integrity. There is a general recognition that protocols need to be developed at a strategic level to govern the sharing of sensitive information between agencies to ensure that support is available when it is needed.

This highlighted a concern that although there is strong evidence of constructive partnerships between the police and other agencies at a strategic level (as evidenced by the police's role on the Commissioning team) co-operative working at a local level may be less developed in some areas.

4.4
Local Partnerships

4.4:1
Each of the police areas in Kent has a Drugs Liaison Officer. The Committee saw that these officers have embraced the ethos of partnership working and are conscious of the need to offer support to drug users who genuinely seek treatment as a means of resolving their addiction. Drugs Liaison Officers have a broader role than just enforcement. Intelligence about drug use in local communities means that the Drug Liaison Officers know who their local users are, this enables the officers to encourage identified users to seek treatment before they commit further offences that will make their situation worse. Although Kent Police were concerned to point out to the Committee that the police did not make decisions about whether to prosecute or refer to treatment where an offence has been committed. If an offence has been committed then there are sentencing options such as DTTO that enable offenders to access treatment.

4.4:2
Drug Liaison Officers are aware of the need to seize every opportunity to refer users to treatment if there is any indication that individual are willing to access it. Work is currently being done to consider non-arrest referral. The expertise and contacts that the Drugs Liaison Officers have developed in partnership with treatment agencies is working to change attitudes about the police and erode confrontational stereotypes.

4.4:3
The concern remains that local historical differences in the membership and approach CDRPs, and cultural differences between treatment agencies and

the police can lead to a mutual lack of understanding of priorities and processes. While the Committee recognises that there are local distinctions in the nature of the drug problem, inter-agency co-operation should be a priority at a local level across the county to complement the partnerships that already exist at the strategic level.

4.5
Arrest Referral

4.5:1
The provision of arrest referral services is a further area of concern regarding the relationship between the police and treatment providers. Until April 2002 offenders taken in to custody could be seen by a treatment agency worker who was able to advise and refer drug-using offenders to treatment for further assessment and support. Kent Police decided to change the system and provide Custody Nurses employed by the police who would have responsibility for offender's wider health needs including drug problems. There are currently 22 Custody Nurses across the county and five more will be employed in July 2003. Training in drug awareness has been provided by KCA.

4.5:2
The reason for the change appears to centre on a fundamental difference in approach between the treatment agencies and the police, an apparent lack of accountability and difficulties in providing adequate cover.

> "There was a philosophically different approach between the previous assessment of prisoners and the custody nurses. Whereas a worker from an agency tended to be more flexible in their assessments nurses tend to have a stricter approach and will only refer if they think a person will engage in treatment." [66]

The police are positive about the success of the change, nationally 4% of detainees are seen by arrest referral workers, in Kent the figure is 5.8%. Figures from the police indicate that referrals are increasing quarter by quarter.

4.5:3
The response to the change from the treatment agencies is less positive. KCA acknowledged that under the previous arrangements adequate cover was not always available. West Kent Health and Social Care Trust expressed a more fundamental concern when they said

> "The Trust had a contract with Kent Police to provide arrest referral schemes in Maidstone, Tonbridge and Medway. This contract required a Cell Intervention Worker and also a dedicated Drug Treatment Worker to receive these referrals. The uptake was good, there was a seamless transfer in to treatment and engagement was generally

[66] Superintendent Trevor Pankhurst evidence 160503

> effective. Kent Police subsequently revised the contract and the work in cells was passed to Custody Nurses. These nurses do not have specific experience in substance misuse and are there to attend to the broad spectrum of health needs of people in custody. Whilst some are able to identify and refer drug users many make inappropriate referrals and both the referral rate and the engagement rate have fallen." [67]

Both of the main treatment agencies said that they would welcome further discussion on this matter. The Committee is concerned at the apparently serious disagreement between key agencies on the provision of arrest referral services. The arrangements put in place by the police appears to offer better coverage and with effective and ongoing co-operation between agencies; the Custody Nurses will be able to increase their awareness of drug treatment issues. Although the Custody Nurses have broader role than drug awareness, and are therefore not funded from the pooled budget, the issue should be addressed by the DAAT who should ensure that the best clinical model is in place to promote harm minimisation among detainees.

4.6
Re-classification of cannabis

4.6:1
Although not explicitly part of the review's terms of reference the Committee found evidence that the government's plans to re-classify cannabis, from a class B to a class C is causing a concern because of the uncertainty that it has caused. Young people in particular are vulnerable in this context; some now believe that cannabis has been legalised. The debate about the "gateway affect" of cannabis as a precursor to the use of hard drugs is complex. The Committee received anecdotal evidence of the link between cannabis and subsequent problem drug use.

4.6:2
The debate about the reclassification of cannabis is based around maintaining the credibility of the message about the harmfulness of drug use. The Home Secretary's decision to propose the reclassification of Cannabis will mean that possession will no longer be an arrestable offence, however this is complemented by an increase in the penalty for supply, especially where a link can be proven to vulnerable groups such as young people. Following research by the Advisory Council on the Misuse of Drugs the Home Secretary said in the Commons in July 2002 that

> "Cannabis is a potentially harmful drug and should remain illegal. However it is not comparable with crack, heroin or ecstasy. The Council made it clear that greater differentiation between drugs that kill

[67] John Wilkes Chief Executive West Kent Health & Social Care Trust evidence 190503

> and drugs that cause harm would be both scientifically justified and educationally sensible."[68]

The Committee found that the popular, if erroneous, interpretation of this decision undermined the supposed educational benefits. The perception of many officers that the Committee spoke to is that the decision to re-classify sends a confused message that dilutes the strength of the governments overall focus on drugs.

4.6:3
In 2000 the Police Foundation published their Report on the Independent Inquiry in to the Misuse of Drugs Act (1971), this supported broader changes than those proposed by the Home Secretary. Their comment on the re-classification summarises much of the argument that supports reclassification

> "Our conclusion is that the present law on cannabis produces more harm than it prevents. It is very expensive of the time and resources of the criminal justice system and especially of the police … It criminalises large numbers of otherwise law-abiding, mainly young, people to the detriment of their futures. It has become a proxy for the control of public order; and it inhibits accurate education about the relative risks of different drugs including the risks of cannabis itself. Weighing these costs against the harms of cannabis, we are convinced that a better balance is needed"[69]

4.6:4
The government's approach to this issue draws on research in to the gateway function of cannabis. Home Office Research Study 253 looked at the role cannabis has in initiating young people in to hard drug use and offending and sought to identify the best policy approaches to prevent growing drug misuse.

> "If there is indeed a slippery slope from early minor offending through soft drugs to hard drugs and serious crime, then the question must be asked whether there are critical stages in this causal chain, against which policy is best directed."[70]

4.6:5
The study goes on to look at the relationship between the first use of drugs; subsequent use and offending career. It is apparent that the relationship is highly complex and that a range of social and psychological factors also contributes to an individual's progression to the use of hard drugs and participation in serious crime.

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[68] Secretary of State for the Home Department Mr David Blunkett Hansard10 July 2002
[69] Police Foundation 2000 Report on the Independent Inquiry in to the Misuse of Drugs Act (1971)
[70] Home Office Research Study 253 "The road to ruin? Sequences of initiation in to drug use and offending by young people in Britain. Home Office Research, Development and Statistics Directorate 2002

> "it may well be that most hard drug addicts started off as soft drug users, but one cannot conclude from that fact that hard drug use is caused by previous experience of soft drugs."[71]

4.6:6
Using data gathered in the 1998/99 Youth Lifestyle Study the Home Office paper identified a greater statistical link between sequences of offending behaviour that begin with truancy or crime than those beginning with soft drug use. The report questions the value of using any perceived gateway as the focus of policy as this belies the complexity of causal factors, but is clear that deprivation and family are disruption are key factors

> "Social, economic and family circumstances seem to be the dominant influences on young people's risk of becoming involved in crime and drug use. Indirect policies, aimed at problems of local deprivation and family breakdown may offer at least as much hope as more direct anti-crime policies."[72]

These findings indicate that although there may be a strong association between cannabis use and young offenders it would be wrong to assume a causal link. Policy would best directed at strategies that aim to address social exclusion, support families and provide meaningful opportunities for young people living in deprived communities.

4.6:7
Another Home Office study makes it clear however that there is an evident risk that some young people in deprived areas are vulnerable and likely to escalate their drug use from recreational to problematic.

> "There is compelling evidence that a small but significant minority of young people, particularly those with a variety of specific domestic and social disadvantages, are more likely to use drugs, to use them more often and to consume more. In this model they are therefore likely to form a specific sub-section of young recreational users at high risk of moving in to problematic drug use."[73]

This indicates that for specific groups of young people, who may already be experiencing personal and social problems, cannabis use can be an additional indicator of an escalating, and worsening situation. The Committee

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[71] Home Office Research Study 253 "The road to ruin? Sequences of initiation in to drug use and offending by young people in Britain. Home Office Research, Development and Statistics Directorate 2002

[72] Home Office Research Study 253 "The road to ruin? Sequences of initiation in to drug use and offending by young people in Britain. Home Office Research, Development and Statistics Directorate 2002

[73] Home Office Research Study 249 The Economic and Social Costs of Class A Drug Use in England and Wales, 2000. Home Office Research, Development and Statistics Directorate July 2002. P16

believes that the seriousness of such a situation should not be diminished by the re-classification of cannabis.

4.7
Intelligence Led Policing

4.7:1
Intelligence led policing is a key element of strategies to stifle the availability of drugs and Kent police and the DAAT are working together to gather and collate intelligence about the use and supply of drugs in Kent. Kent Police have seconded an intelligence analyst to the DAAT to analyse the available data gathered at a local level to complement the planning and delivery of policy. In a wider context Kent Police use the National Intelligence Model to gather and interpret data. This identifies 3 levels of criminality

1. Area level – offenders committing crimes in a solely local context
2. Organised crime across areas
3. Serious and organised crime

4.7:2
At a local level the police are able to gather detailed information about local users and dealers and this contributes to the build up of a county picture. Previously the information gathered by the police was intended to promote enforcement strategies. With the placement of an intelligence analyst in the DAAT there is now the possibility that police intelligence about new supply networks, or the presence of new substances, for example, can be used to complement the planning of treatment and education and prevention strategies. In this context the DAAT need to be able to identify what information should be gathered to meet their objectives.

4.7:3
A corollary of intelligence led policing within Kent is the sharing of information with other forces, including those that share a border with Kent and others. In the light of the emerging trend of London based supply, information sharing between the Metropolitan police is likely to be crucial. The Committee was told that the scale and nature of drug problems within the capital often mean that the Metropolitan Police have different priorities and different approaches to handling drug related crime.

4.7:4
Activities such as Operation Academy have proven to be extremely effective at hitting local supply networks and identifying dealers. However drug crime within London appears to be far more comprehensive than in Kent. Typically arrests made in Kent do not lead directly to repercussions further up the supply chain in London; dealers and carriers can be replaced. Except where specific intelligence does exist the approach, as evidenced in Operation Scallywag, is to inhibit the transportation of illegal substances into Kent.

4.8
HM Customs & Excise

4.8:1
Another integral part of the intelligence network is H.M. Customs and Excise and the police work closely with Customs to identify trends in supply and intelligence about trafficking activity through forums such as the Joint Intelligence Teams. Customs and Excise is a member of the DAAT Availability Group. The Kent ports, and most particularly Dover, the busiest passenger ferry port in the world and the UK's closest link with the continent, create considerable potential for illegal drug trafficking activities.

4.8:2
As has already been demonstrated there is no significant direct link between trafficking across the Channel and supply in Kent

> "the bulk of the drugs being consumed in the county [are] brought in from South East London and metropolitan boroughs with those drugs being transported down from as far as the north of England"[74]

Committee members visited Dover Docks and were shown how the Customs and Excise staff there make best use of intelligence (and experience) to respond to the challenge of through-putting huge volumes of freight and passengers while at the same time maintaining a significant threat to traffickers. Far more vehicles and people pass through the port than can be individually checked and the staff seek to complement intelligence about known trafficking activity with a close analysis of data about crossings, looking for unusual or suspicious patterns of activity.

4.8:3
It is clear that Customs and Excise offers intelligence support to Kent police and their work at the Kent ports is significant at a national level but their relation to drug problems in Kent in particular is indirect.

4.9
Prison Service

4.9:1
The Prison service works in partnership with other agencies in the DAAT to address drug problems while prisoners are in custody and to ensure that when they leave they will continue to receive support from treatment providers. The Committee was told that the "vast majority" of prisoners in Kent do not return to the county on release. However some do, and the evidence gathered about the policies of the prison service adds valuable information to wider picture of to address drug use and misuse.

4.9:2

[74] Martin Cobb Senior Manager Detection, South Brigade HM Customs & Excise evidence 230503

The Prison Service faces considerable challenges in dealing with drug using prisoners. Some prisoners continue to use illicitly while in prison and the Prison Service works closely with the police to address the problem of supply in to prison as well as mandatory and voluntary testing and the use of drugs dogs. Mandatory drug tests carried out in men's prisons in March 2002 revealed that 15% of inmates had used an illegal drug.

4.9:3
The treatment of offenders in prison is an important aspect of prison work. All prisons in Kent offer treatment and prevention services from tier one to three. In addition to this the prisons at Elmley and Swaleside have detoxification facilities. The provision of drug treatment services in prisons nationally is based on the CARAT model. The model identifies the principal features of tier 1 to 3 treatment that should be available to all prisoners; these are

- Counselling
- Assessment
- Referral
- Advice
- Throughcare

The aim of the model is:

- To identify drug misusers as soon as possible

- Provide ongoing support and advice to prisoners throughout their time in prison

- Work in conjunction with agencies inside and outside prison to ensure prisoners are properly assessed and directed to the most effective intervention to address their problem

- Link the various departments and agencies that deal with prisoners in order to provide continuity between treatment in prison and that available on release.

The development of the model reflects the increased focus on drug treatment in prisons.

4.9:4
Treatment provision in Kent prisons appears to be comprehensive. A recent study of prisons in Kent, Surrey and Sussex carried out by the Centre for Health Studies at the University of Kent indicated that the current arrangement and level of service meets prisoners treatment needs while they are in prison. But, nationally and locally there appear to be greater problems with resettlement. The Prison Service has good relations with the DAAT and but experiences greater problems in ensuring the effective resettlement of prisoners in other DAAT areas.

4.9:5

The Prison Service highlighted this problem and told the Committee that resettlement arrangements are "less effective than they should be". The Audit Commission also supports this view

> "High levels of Government investment in the CARATs programme have dramatically expanded prisoners' access to treatment, but inadequate follow-up remains a problem."[75]

The University of Kent study points out that prisons receive no direct funding for throughcare. The problem of throughcare is partly beyond the control of the Prison Service, it is particularly difficult to make arrangements for transition when the prisoner is being resettled in an area outside of the DAAT's area.[76]

4.9:6
The Committee was also made aware of the problems associated with supporting prisoners on release. Normally the Probation Service is not funded to support prisoners serving sentences of less than twelve months. Prisoners on short sentences may prove especially difficult to respond to; the length of their sentence may compromise the effectiveness of any treatment programme and without the support of the Probation Service on release there is an obvious danger of re-offending and continued drug misuse. This point has been acknowledged by the minister with direct responsibility for the Drugs Strategy,

> "One of our biggest problems is the huge numbers of drug offenders in prison who are serving short sentences. Due to the offences that they commit, such as shoplifting, they are released from prison quickly, although they are not out on licence."[77]

The Drugs Strategy said that the Prison Service would be reviewing the CARAT system and looking at "how best to cement links with the community agencies." It is apparent that more still needs to be done particularly where prisoners are returning to DAAT areas that are not local to their prison.

There have been constructive steps to address problems experienced by short-term prisoners in Kent. In a project that was piloted initially at Canterbury prison a wide range of agencies have worked together to improve resettlement arrangements for short term prisoners. This approach derived from work done with long term prisoners released on license and persistent offenders. The process that has been developed under the Kent and Medway Re-Settlement Programme now supports each of these categories of offenders including short-term prisoners. The agencies involved include

- Police
- Prisons

[75] Changing Habits Audit Commission 2002 p.48
[76] Mr G Cooke Area Drugs Strategy Co-ordinator Kent, Surrey and Sussex Area Office
[77] Mr. Bob Ainsworth MP Under Secretary of State for the Home Department Hansard 22 May 2003

- Probation
- Employment
- Benefits
- Treatment Providers
- Housing
- Mental Health Teams

These agencies have worked together to develop a pre-release inter-agency case conference process; the outcome of this process is a Release Plan that seeks to predict and prepare for the difficulties that individuals may experience on release. The programme has not been developed solely to support offenders with a history of drug use but typically drug use is at least an aspect of the difficulties experienced. Kent Police have funded 9 Community Support Officers to liase between the agencies and ensure the effectiveness of the process. The Probation Service run a mentoring scheme to provide individual ongoing support for the offender. Mentors are volunteers who, with training and within proper protocols, help the offenders to cope with the demands and challenges they face. This element is crucial to the success of the project.

Currently the Probation Service receives no funding for work with short term prisoners. Although mentors are volunteers, their training and support is not funded and this additional work has to be paid for from existing Probation Service resources. There have been efforts to secure support for the project at local levels. The Committee was told that in this context even small amounts of funding could make a significant impact. The cycle of addiction, re-offending, and short-term sentences is damaging for individuals and communities. The Resettlement Programme is an example of partnership working that should be supported. The Committee urges local Crime and Disorder Reduction Partnerships to consider the input necessary at a local level to promote the training and support of mentors through the Probation Service.

4.10

Drug Treatment and Testing Orders (DTTO)

4.10:1

The Committee also received evidence about the use of Drug Treatment and Testing Orders, these are non-custodial sentences that can be ordered by the courts where an offender has a drug habit and has committed crime to support it. The Probation Service supports the offender to address their attitude to offending with the aim of reducing offending. An offender on a DTTO must have 20 hours contact per week, typically this contact is split between the Probation Service and the treatment agency. 207 DTTOs have been made in Kent since the system was first introduced in 2000.

4.10:2

The Probation Service works closely with Drugs Liaison Officers and the treatment agencies in the operation of DTTOs. Treatment agencies are obligated to see people placed on a DTTO within two days of their sentence and then provide ongoing treatment as necessary. Drug Liaison Officers support the operation of the Orders by visiting the offenders at their homes to ensure that they were keeping to the conditions of the order (the ongoing presence of uniformed officers also has the affect of keeping other offenders away from the individual placed on the order).

4.10:3
The Probation Service's lead officer on DTTO in Kent told the Committee that resources for the support of DTTO need to be prioritised. Once the order has been made participation is mandatory but there is little point in making an Order if the offender will not participate in treatment. There are sanctions for non-participation but ultimately only the users themselves, with support from all the agencies involved, can take the decision to participate in treatment; the alternative will typically be a custodial sentence. A point made the Probation Service's lead officer which adds further complexity to the issue of short sentences, raised above, is that some people will view a short custodial sentence as preferable to submitting to the ongoing demands of a DTTO in the community.

4.10:4
When DTTOs were first introduced the main problem that the service experienced was the lack of suitable day care facilities. DTTO accessed discrete day care and other services with their treatment provider. This placed considerable burdens on the providers who had to offer duplicate services for DTTO clients. The growth in DTTOs has made this system impractical, there are negotiations between the DAAT Commissioners and the treatment providers to move DTTO clients in to the mainstream of service provision.

4.10:5
The system still places considerable demands on the Probation Service and treatment providers, typically neither have purpose built facilities capable of accommodating large groups of people with complex and various needs for significant periods of time per week. The movement towards integrating DTTO clients in to mainstream prevents the development of a two-tier system with offenders being fast-tracked to the detriment of others who may seek to access treatment independently.

4.10:6
The Home Office sets targets for the amount of DTTOs. Kent is exceeding these targets but there are imbalances across the county, which creates local capacity problems. The success of DTTOs as a sentencing option is dependent on the capacity of treatment providers to deliver services. The problems identified above with the delivery of certain treatment modalities (notably GP prescribing and in-patient detox) have the potential to compromise the effective of DTTOs. There is a concern that central government departments

> "do not appear to take account of the competing and sometimes conflicting targets they set for their own staff."[78]

4.10:7
This comment highlights a concern that the Committee identified: the top down style and the variety of departments and agencies at a national and regional level can make overwhelming demands at a local level without a full recognition of either local issues or other agencies input. There is evidence of co-ordination of activities at a regional level by the Regional Drugs Team but there is a sense in which fundamental problems with the delivery and capacity of services continue despite targeting. This concern persists despite the innovation of local structures to participate in the delivery and management of drugs policy.

The recommendations from this section are:

1. Further consideration should be given to promoting the role of the Drugs Co-ordinator developed in West Kent using CAD funding in other areas to focus the anti-drugs activities at a local level. The model developed in West Kent is an initiative that has been led by the Police.(4.2:1)

2. Inter-agency co-operation between enforcement agencies and treatment providers should be a priority at a local level across the county to complement the partnerships that already exist at the strategic level. (4.3:2)

3. Kent DAAT should have a role in deciding the best clinical model for arrest referral to promote harm minimisation among detainees. (4.5:3)

4. Treatment and enforcement need to be properly resourced, but drugs policy should not become too narrowly focused; policy is best directed at strategies that aim to address social exclusion, supports families and provides meaningful opportunities for young people living in deprived communities. (4.6:6)

5. The Committee believes that government's proposals for the re-classification of cannabis sends out the wrong message and only serves to add to confusion. Evidence to the Committee does not support the re-classification of cannabis. If cannabis is re-classified drug information, advice, and education programmes should continue to emphasise that cannabis is both illegal and harmful.

6. The lack of supervision for offenders serving sentences of less than twelve months is a dangerous anomaly and action needs to be taken to improve the arrangements for resettlement support generally and for this group of offenders in particular if cycles of re-offending are to be stopped. (4.9:6) The cycle of addiction, re-offending, and short term sentences is

[78] Pat Morss evidence 190503

damaging for individuals and communities. The Kent and Medway Resettlement Programme is an example of partnership working that should be supported and the work of all the agencies involved is recognised. The Committee urges local Crime and Disorder Reduction Partnerships to consider the input necessary at a local level to promote the training and support of mentors through the Probation Service.

5.0

Communities

5.1:0The final element of the Government's strategy on drugs that will be considered here is the work to strengthen communities. The strategy recognises that "local communities are vulnerable to the corrosive effects of drug misuse and the misery it causes"[79]. Clearly there is a two way relationship here local drug markets, drug related offending and the personal costs of drug use contribute to the erosion of communities; equally for many drug users social exclusion, economic deprivation and family disruption are likely to be causal factors in their drug use.

5.1:2

[79] Updated Drugs Strategy 2002

The strategy places the emphasis on the individual as the problem, improving (treatment) or removing them (criminal justice) as a remedy for social problems. Efforts to address social exclusion through regeneration, education, and economic development are not strictly within the remit of the strategy but will all have a longer-term impact on drug use. The drugs strategy includes a recognition that "action needs to be linked to and co-ordinated strategically with action to tackle poverty and deprivation"[80].

5.1:3
In Kent the Committee has seen that there is a correlation between areas experiencing high levels of deprivation, and drug use and crime. Notably parts of Thanet, Swale and in smaller pockets of deprivation in towns across the county. Kent has adopted an approach that aims to reduce class A and B drug use, as this is likely to have biggest affect on offending and anti-social behaviour.

> "There is a clear indication that areas in decline are most badly affected by large drugs markets ... Regeneration of areas of social deprivation is impossible unless sufficient support is provided to users, their families and friends."[81]

The Drug and Alcohol Action Team estimates the total economic costs of drug use in Kent as being somewhere between £90m and £160m.

5.1:4
Crime reduction is an integral part of the Government's strategy. In addition to the direct support given to the criminal justice agencies the Government introduced Communities Against Drugs funding in 2001; this funding is available to local Crime and Disorder Reduction Partnerships for additional activities to tackle drug related crime at a local level.

5.1:5
Initiatives to strengthen communities may often have a broader remit than the focus on drugs (Healthy Living Centres, SRB Projects, and Community Schools) but it is imperative that drug prevention and treatment initiatives are included in such strategies at a local and county level. Otherwise drug services could be marginalised. Inter-agency groups should maintain a rapport with other services involved in outreach and community work including adult and further education and housing.

[80] Updated Drugs Strategy 2002
[81] Kent Police evidence 160503

6.0
Conclusion

6.1:1
The Committee found much evidence of good practice in many fields, and was pleased to find instances of developments in Kent that have received recognition and support at a regional and national level. Most significant of all has been the overall level of integration between agencies that formerly may have remained removed from one another.

6.1:2
A major concern that has continually emerged as a recurrent theme throughout the review has been the scale of the related problems of cigarettes and alcohol, particularly for young people. The DAAT told the Committee that 10% of 11 – 15 year olds are regular smokers; 24% of pupils

had consumed alcohol in the last week at an average of 10.5 units. This increased drastically with age, at 15 - 47% of pupils had consumed alcohol in the last week. Alcohol and cannabis were jointly the highest cause of young person's referral to treatment agencies. The education panel told the Committee that the "booze-cruise" culture and the proximity to the Kent ports is a significant factor in young people's alcohol abuse in east Kent.

6.1:3
For adults too the problems of alcohol abuse in relation to offending and anti-social behaviour are a more pervasive social ill than drugs; causing harm and disruption to families and communities. The health costs of smoking and alcohol abuse are also significant. The damaging and costly effects of these legal substances does not receive enough attention and their role harming young people, families and communities should be recognised.

6.1:4
The Committee found that much still needs to be done to respond properly to the challenges of drug use and misuse. The budgetary pressures placed on treatment services appear incongruous when viewed alongside the expectations placed upon treatment in the drugs strategy. The lack of GP participation in Shared Care is a matter of particular concern. The comments of users in treatment in Ramsgate who had to wait many months to access treatment were particularly forceful in this context.

6.1:4
The Committee was disappointed by the inconsistencies of schools based drug education and prevention strategies, but the proactive efforts of members of the LEA panel to make a comprehensive support available is encouraging.

6.1:5
The Committee recognises the achievement of the DAAT team and partner services in establishing a credible and co-operative forum to manage the drugs strategy. The Committee would like to take the opportunity to thank the DAAT team for their co-operation during this review.

7.0 **Witnesses:**

Mrs Stephanie Stanwick	Chief Executive Dartford, Gravesham and Swanley Primary Care Trusts
Cathy Donelon	West Kent Health Promotion Service
Chris Easton	West Kent Young Peoples Service
Dr B Vasudaven	
Gordon Bernard	Chief Executive Kent Connexions Service
Grant Biddle	East Kent Health Promotion Team Manager Young People
Jim Connolly	Specialist Youth Work Programmes Officer
Liz Mcavan	North West Kent Health Promotion
Matt Scott	Young Peoples Service Co-ordinator Kent Council on Addiction
Mr A Derkacz	Chief Executive Kent Council on Addiction

Mr Alan Foster	PSHE Adviser Kent Advisory Services
Mr G Cooke	Area Drugs Strategy Co-ordinator Kent, Surrey and Sussex Area Office
Mr G Featherstone	Director Kenward Trust
Mr H Luck	Regional Manager National Treatment Agency
Mr Ian Kirk	Manager - Kent Drug Action Team
Mr Jon Wilkes	Chief Executive West Kent NHS and Social Care Trust
Mr Karl Love	Community Drug Education Co-ordinator Kent County Council
Mr Kumar Mehta	County Youth Justice Officer
Mr Martin Cobb	HM Customs & Excise
Mr P Gilroy	Strategic Director – Social Services and Chairman of Drug Action Team
Mr P Walker	Headteacher The Abbey School
Mr S Mccoy	Mental Health Commissioner Dartford, Gravesham and Swanley Primary Care Trusts
Mrs P Morss	Kent Probation Service Kent Probation Service Co-ordinator
Ms Anne Lord	Community Drug Education Co-ordinator Kent County Council
Ms Diane French	Commissioning Manager Kent Drug Action Team
Ms E Howe	Chief Crown Prosecutor for Kent Crown Prosecution Service
Ms G Weaver	GOSE Regional Drugs Team
Ms Jill Wiles	Policy Officer
Ms Lee-Anne Farach	District Development Officer – Ashford
Superintendent T Pankhurst	Kent County Constabulary HQ

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9.0 **Glossary**

ACMD – Advisory Council on the Misuse of Drugs

CAD – Communities Against Drugs

CARAT – Counselling, Assessment, Referral, Advice, Throughcare (HM Prisons)

CDRP – Crime and Disorder Reduction Partnership

DfES – Department for Education and Skills

DTTO – Drug Treatment and Testing Order

GOSE – Government Office South East

KCA – Kent Council on Addiction

KCC 16 Plus Service for Care Leavers (helping young people aged 16 and over who are living in foster care or residential care to reach their potential and maximise their options for their future)

KDAAT – Kent Drug and Alcohol Action Team

LEA – Local Education Authority

LMC – Local Medical Committee

NTA – National Treatment Agency

PCT – Primary Care Trust

PDU's – Problematic Drug Users

PSHCE – Personal, Social, Health and Citizenship Education