CONFIDENTIAL

CABINET OFFICE

THIS FILE MUST NOT GO OUTSIDE THE CABINET OFFICE

No 10

HOME AFFAIRS

FILE TITLE HOME AFFAIRS	PART NUMBER 2
DR 055	
FILE BEGINS 22/11/02 ENDS 10/2/03	FILE No.
27 INDEX HEADINGS	PART NUMBER

REFERRED TO	DATE	REFERRED TO	DATE	REFERRED TO	DATE

LABOUR ADMINISTRATION

CLOSED.

PREM 49/3107

CONFIDENTIAL

PART

CLOSED

DATE CLOSED	

Series : **HOME AFFAIRS**

File Title : **DRUGS**

Part : **3**

Date	From	To	Subject	Class	Secret
27/11/2002	PUS/DoH	DPM	Publication of the Government's Updated Drug Strategy	U	
28/11/2002	SS/DWP	HS	Updated draft drug strategy	U	
28/11/2002	AG	DPM	Publication of the Government's updated drug strategy	U	
28/11/2002	HO	PPS	Strategy Unit Study on Drugs	R	
29/11/2002	PD(JR)	PM	Drug Treatment and Testing Programme	R	
02/12/2002	DPM	HS	Publication of the Government's updated drug strategy	C	
03/12/2002	PPS	HO	Strategy unit project on drugs	C	
10/12/2002	MS/HO	PM	Heroin in Bassetlaw	C	
11/12/2002	DFES	PPS	Strategy Unit Project on Drugs	U	
18/12/2002	EST	PPS	Strategy Unit Project on Drugs	U	
20/12/2002	HO	PD(JR)	Drug Treatment and Testing Programme	C	
23/12/2002	PD(EM)	PM	Drug Treatment and Testing Programme	C	
09/01/2003	PD(EM)	PM	Drug Treatment and Testing Programme Spot Check Meeting, 13 Jan	R	
09/01/2003	HS	PM	Drug Treatment and Testing Programme spot check meeting	C	
13/01/2003	PPS	HO	Strategy Unit Report on Drugs	R	
27/01/2003			Drug Treatment Provision in Bassetlaw	U	
29/01/2003	Cab Off	HO	Drugs Socktake 11 Feb 2003	U	
31/01/2003	HS	CST	Communities Against Drugs	U	
07/02/2003	PD(JR)	PM	Drugs delivery issues	C	
10/02/2003	PM		TO John Healey - drug stocktake meeting	U	
10/02/2003	PM		Alan Milburn - Drug Stocktake	U	
10/02/2003	PM		David Blunkett - Drug Stock take	U	

File
cc SL
M Barber

10 DOWNING STREET
LONDON SW1A 2AA

10 February 2003

THE PRIME MINISTER

Dear David,

I am sorry that the drugs stock-take meeting we were due to have this week has had to be cancelled. I understand that Michael will be chairing an officials meeting to consider the excellent papers which had already been prepared and which I had a chance to consider over the weekend.

I was pleased to see the progress which has been made with the 30 BCU initiative and am glad that a team is now in place at the Home Office to drive this forward. As I hope I have made clear I regard successful delivery of this project as one of my top delivery priorities for the Department on a par with the Street Crime Initiative. As such, I would be grateful if you could put in hand the systems which will be needed to deliver regular progress reports from the beginning of April – ideally on a weekly basis – using the same sort of 'tracker' format as for the street crime initiative.

The 30 BCUs selected clearly cover a wide range of areas – some of them with a stronger infrastructure than others. I would be grateful for further advice on what the Home Office will be doing to raise standards in the weakest areas including the conditions which will be attached to new funding. As with the street crime initiative it may be helpful to have a sponsor minister for each BCU (perhaps building on the arrangements already established for the street crime

initiative) to send a clear signal of the importance we attach to delivery in this area. I would be grateful if you could put in hand the necessary arrangements.

I understand that you are planning to bring representatives from the 30 BCUs together on a regular basis. Diary engagements permitting I would be happy to drop in on one of these if that would be helpful.

Copies of this letter go to Alan Milburn, Paul Boateng and Derry.

yours ever,

Tony

The Right Honourable David Blunkett MP

Free
cc JR
MBarber

10 DOWNING STREET
LONDON SW1A 2AA

10 February 2003

THE PRIME MINISTER

Dear Alan,

Thank you for the note about drug treatment for the drug stocktake. As you know the meeting has had to be cancelled at short notice but I asked Michael Barber to read your note and he has raised a number of questions. I would be grateful if you could look into these issues and ask your officials to discuss with Michael Barber at a follow up meeting. I have also asked the Strategy Unit to examine how the impact of treatment can be maximised as part of their current study.

yours ever,

Tony

The Right Honourable Alan Milburn MP

Annex

Key questions raised by Michael Barber about the delivery of drug treatment:

- Can you give an unequivocal commitment that the 55% expansion in problem drug users in treatment by 2004 will be delivered?
- If not, what pre-emptive action do you plan to take to ensure that the expansion is delivered by every PCT and trust?
- Do you need to reinforce with NHS staff and managers the importance of delivering the expansion in drug treatment by a high profile Ministerial speech?
- Can you monitor separately the waiting times of problem drug users who are referred via the criminal justice system?
- When will all drug treatment service providers meet minimum quality standards? Will these standards include minimum expected outcomes including reduced drug use and crime or retention in treatment targets?
- What evidence is there that drug treatment providers are working closely with other agencies to re-build the lives of drug users after treatment?
- Can you give a commitment that comprehensive and accurate management information will be gathered from April onwards?
- Does any additional action necessary to achieve need to be taken now to ensure that accurate management information is gathered?
- Can you increase the frequency of monitoring of treatment expansion to monthly?

File
cc Barber
JR

10 DOWNING STREET
LONDON SW1A 2AA

10 February 2003

THE PRIME MINISTER

Dear John,

As you know the drug stocktake meeting of 11 February has had to be cancelled at short notice. Although the main purpose of this meeting was to focus on drug treatment and the planned criminal justice interventions I was hoping to be able to raise one particular issue with you. The delivery of the drugs strategy is a major priority for the government and reducing the availability of drugs is an important element of the strategy. Although the CIDA agencies have worked together well and succeeded in taking out large quantities of heroin and cocaine from the UK, I believe that even closer cross-government working is possible to stifle the availability of drugs on our streets. With this in mind I have asked Michael Barber to attend the next meeting of CIDA in order to discuss how this can best be taken forward.

yours ever,

Tony

Mr John Healey MP

PRIME MINISTER

From: Michael Barber
Justin Russell
Date: 7th February 2003

DRUGS DELIVERY ISSUES

Following the cancellation of this week's stocktake we are keen that there is no loss of momentum. This briefing sets out the current state of play and outcomes we believe necessary to ensure progress. There are specific questions for you on pages 2,6 and 7.

Action we recommend you seek:

A) Drug treatment

- An unequivocal commitment by Alan Milburn that the 55% expansion in problem drug users in treatment by 2004 will be delivered;
- If this cannot be given, pre-emptive action now to ensure that the expansion is delivered by every PCT and trust;
- A high profile public speech by Alan Milburn to NHS managers and staff to communicate the importance of delivering the expansion in drug treatment;
- A clear statement by the NTA about when minimum quality standards will be met by all drug treatment service providers;
- Further work by the Strategy Unit on maximising the impact of treatment services;
- Evidence that drug treatment providers are working closely with other agencies to re-build the lives of drug users after treatment; and

- A commitment that comprehensive and accurate management information is gathered from April onwards and any additional action necessary to achieve this is identified and taken now.

B) **Roll-out of CJS interventions** –

- Reassurance from the Home Office that they are giving this project the priority it requires and are treating it as seriously as the street crime initiative. In particular we would like to press for weekly reports on numbers of offenders being tested and referred to treatment along the lines of the reports you already receive on street crime.

C) Availability of drugs

- A commitment from CIDA agencies to think and work together to deliver a strategic and sustainable approach to reducing availability and improving intelligence sharing.

Can you confirm that you agree with the suggested actions?

Subject to your comments we would like to send the attached letters to David Blunkett, Alan Milburn and John Healey and seek a follow-through officials meeting chaired by Michael.

ITEM1: Delivery Overview

A set of slides is attached (annex A) summarising progress across the four areas of the drugs strategy. Key points:

- **Young people**: latest data shows that class A drug use among 16-24 year olds is falling but stable among 11-15 year olds. There is also a small increase in the use of crack;
- **Drug crime**: drug related convictions continue to rise but the real underlying trend in drug-related crime remains unclear;
- **Drug treatment**: the 7.5% increase in people entering treatment in 2001/02 throws into doubt target of a 10.1% pa increase in problem drug users receiving treatment over the years 2001/02 – 2003/04; and
- **Availability**: the amount of heroin and cocaine taken out of the market by HMCE and other agencies is currently ahead of trajectory but there is no evidence of any impact on the street or intermediate markets.

Departments have responded very positively to the recent drugs delivery report and have already taken action including improving the quality and timeliness of drugs data, reviewing how performance management of the delivery chain can be strengthened and sharpening the delivery focus of the cross-government drugs Strategic Programme Board and AIM groups (see attached extract from DA(D) report – annex B).

ITEM 2: Drug Treatment (main focus)

It is intended that from now on each drugs stocktake will examine in depth one area of the drugs strategy and give it proper detailed scrutiny. This meeting would have focused on drug treatment - the cornerstone of the drugs strategy.

There are four main delivery issues for treatment: capacity, waiting times, effectiveness and information (see attached DH paper – annex C.

1) Capacity:

- The data is not robust enough to tell whether the expansion in capacity is on track or not to deliver the target of 158,000 people in treatment by March 2004.
- We have asked whether any pre-emptive action is needed now to ensure delivery remains on track and been told no
- Yet we remain concerned about (a) the variable local capacity of PCTs and NHS trusts to deliver the expansion (b) whether drug treatment is given sufficient priority by NHS performance management and (c) whether drugs funding is being diverted elsewhere by PCTs and trusts.

2) Waiting times

- Waiting times for drug treatment are falling and the work with the Modernisation Agency to reduce waiting times in 33 DATs is encouraging.
- However the target of a maximum average wait of 4 weeks by end 2002/03 and 2/3 weeks by end 2003/04 is demanding and we need re-assurance they will deliver.
- It is also important that separate data on waiting times for criminal justice referrals is gathered to ensure they have prompt access to treatment.

3) Quality and effectiveness

- It is critical to resolve John Mann's concerns about the quality and effectiveness of drug treatment.

- The NTA has launched drug treatment models of care and will introduce quality standards by Mar 2003, assessed compliance with the standards by Mar 2004 and introduced accreditation for treatment providers by Mar 2005.
- Transforming the currently highly variable standard of drug treatment will be challenging and it is not clear if this is enough.
- Treatment is also unlikely to work if the underlying problems of drug users are not tackled ie housing, jobs, education, family breakdown etc.
- It is not clear how the NHS plans to work with other agencies to re-build the lives of drug users after completion of treatment

4) Information

- Information on treatment is currently very poor.
- The NTA plans to significantly improve data collection from April to provide quarterly information on numbers in treatment, completion rates, and waiting times.
- However it is likely that the information will be incomplete and further action is needed to ensure that the NHS provides the information required.
- More frequent data on treatment is also needed – at least monthly.

ITEM 3: Up-date on criminal justice interventions

Home Office have provided an update on the 30 BCU initiative (attached – annex D). £46m is being made available to these BCUs in 2003-04 to fund a range of interventions including:

- Drug testing of arrestees in police stations
- Arrest referral schemes
- More DTTOs

- Aftercare for those leaving prison

The National Treatment Agency are confident that each BCU now has sufficient DH treatment resources to deal with the extra criminal justice referrals and by now each should also have been told what other resources to expect from the £46m pot (eg for drug testing). Arrest referral schemes and DTTO expansion should kick in from April; prison aftercare and drug testing (including the provision of this information to the courts) is not expected to start until June – so there has been a three month slippage from our target start date. Representatives from each of the 30 BCUs are being brought together for an event in early March. **Would you be willing to drop in on this event to show the priority you attach to the initiative?**

You asked HO to ensure that each BCU had appointed a lead person responsible for ensuring local delivery. Sixteen out of the 30 have now appointed a 'local champion'. We should press for the remainder to be appointed as soon as possible. Robust action will also be needed to raise the quality of some of the poorer DATs about whom there are major concerns. (Seven of the 25 DATs which cover the 30 BCUs – eg Bristol, Lambeth, Salford, Bradford - are assessed as being very weak with "entrenched problems" needing substantial input). And we should build on the Ministerial sponsor arrangements we have already established for the street crime areas so that official level interventions are backed up by Ministerial pressure.

We have been assuming that in the initial stages of the project you will be after weekly progress reports (eg on number of arrestees testing positive, numbers referred to treatment, numbers refused bail or given DTTOs) similar to those

you already get for street crime. HO are resisting and prefer monthly data collection. We don't feel this is good enough. **Content for us to continue to press for weekly progress reports from April?**

ITEM 4: Drug availability

We will be meeting with the Concerted Inter-Agency Drug Action (CIDA) group on 14 February to reinforce the message that all CIDA agencies need to recognise the importance of the drugs strategy and give the time, commitment and resources needed to implement the delivery plan.

Can you confirm that you support this message?

DRUGS UPDATE

7 February 2003

PROGRESS ON DELIVERY

A critical moment for the drugs strategy

- clear policy and strategy established
- revised targets and delivery plan developed
- interdepartmental collaboration greatly strengthened
- some early signs of impact

...

…NOW WE NEED TO:

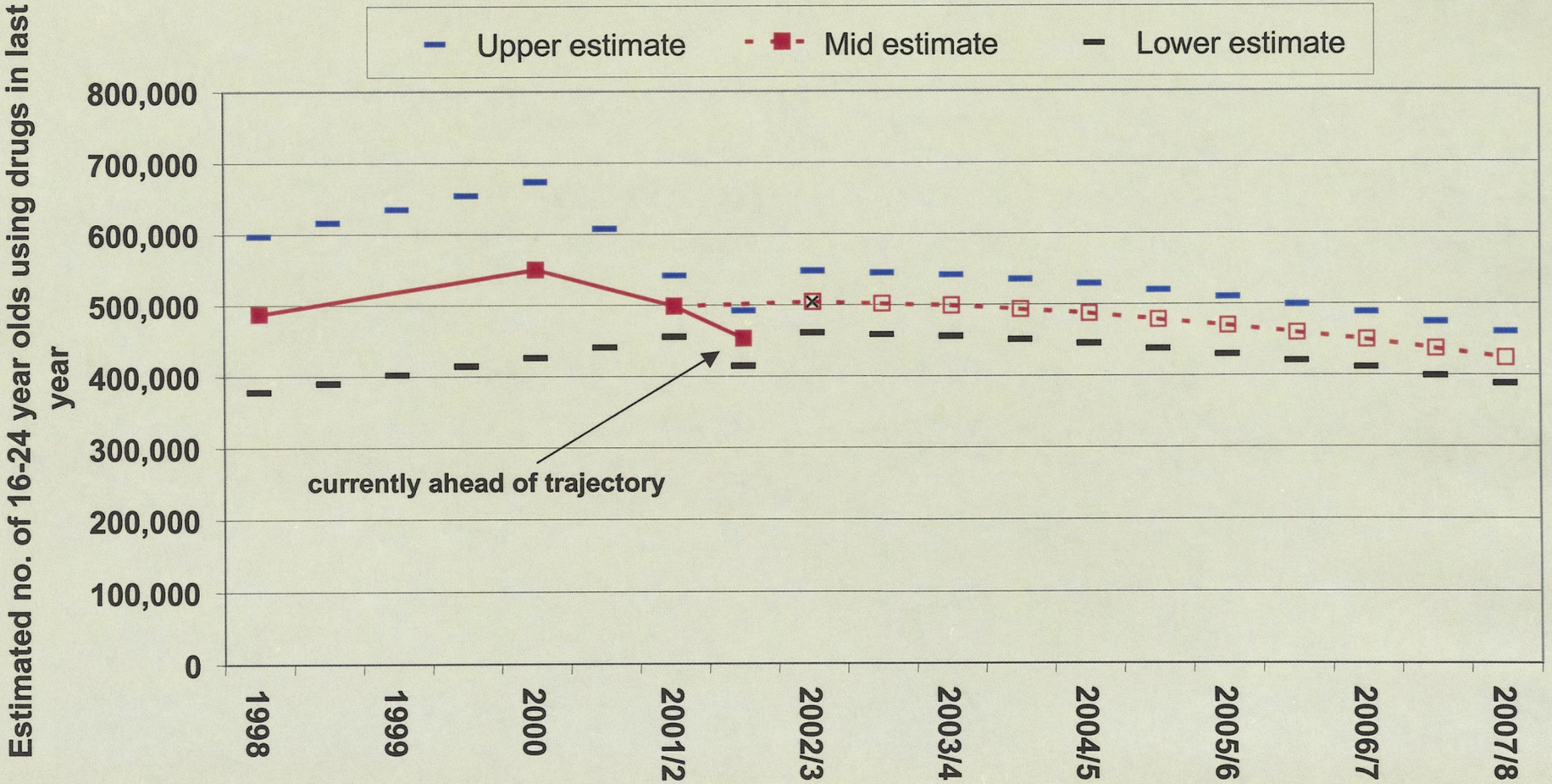
- strengthen capacity down the delivery chain
- target key localities
- develop effective performance management
- improve the collaboration between intelligence agencies
- greatly improve the quality and timeliness of data

IMPROVEMENTS IN DATA

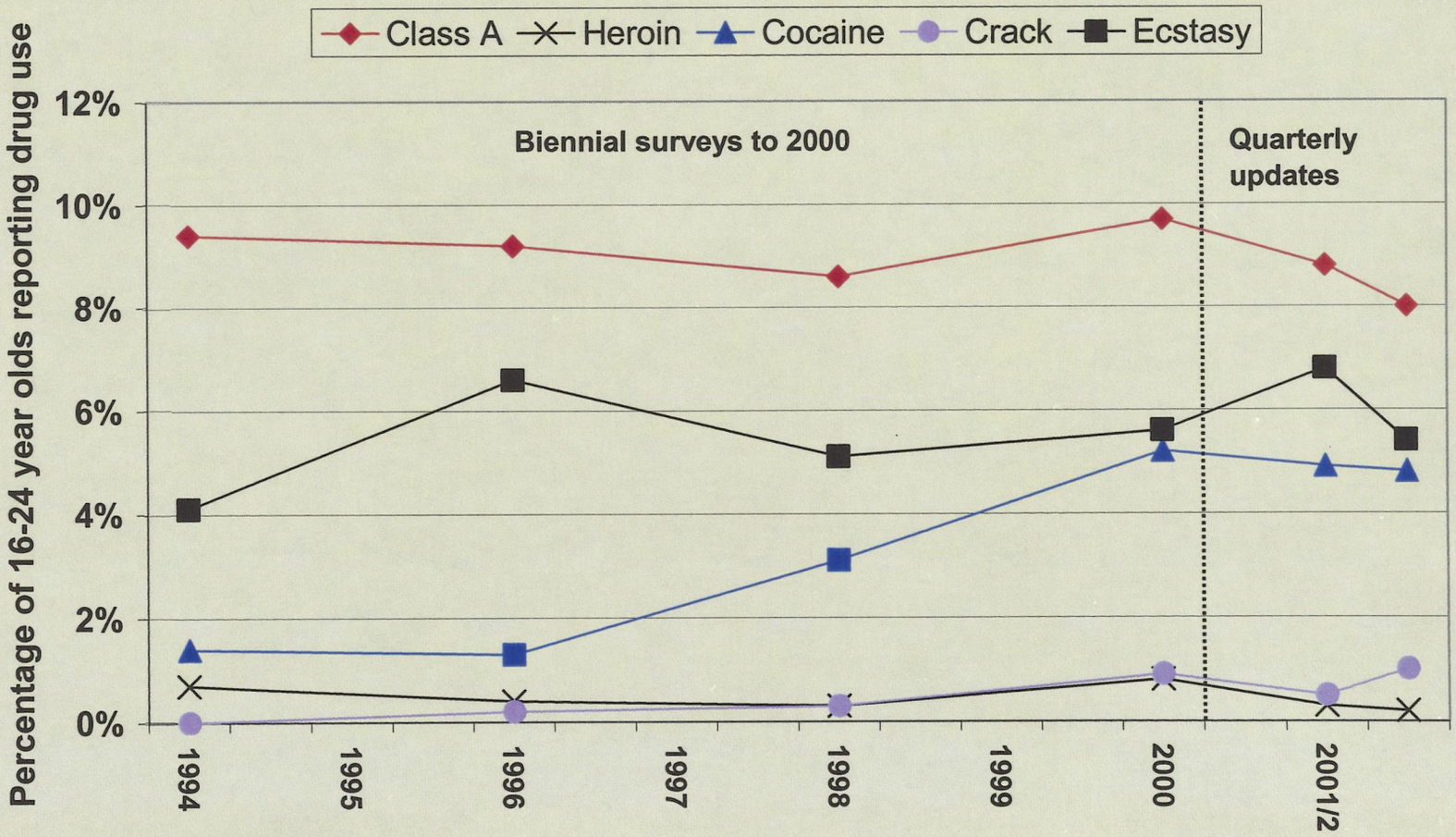
From April 2003:

- young people: expanded, more representative sample
- drug crime: survey of arrestees to start (July 2003)
- treatment much more frequent and timely data on numbers
- 30 BCUs: weekly or monthly data on key indicators

Number of 16 - 24 year olds reporting Class A drug use in the last year (British Crime Survey)

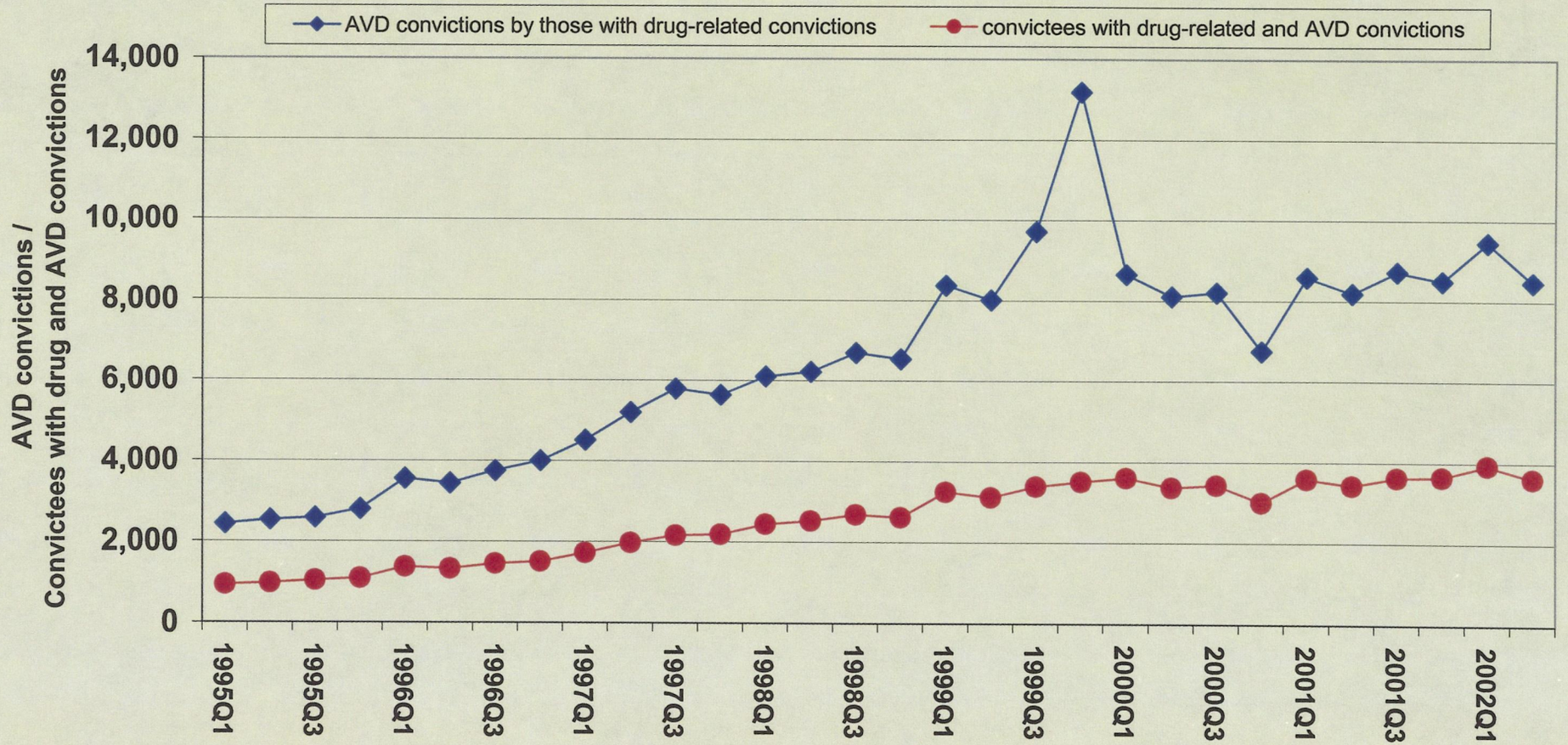


Percentage of 16-24 year olds reporting Class A drug use in the last year (British Crime Survey)

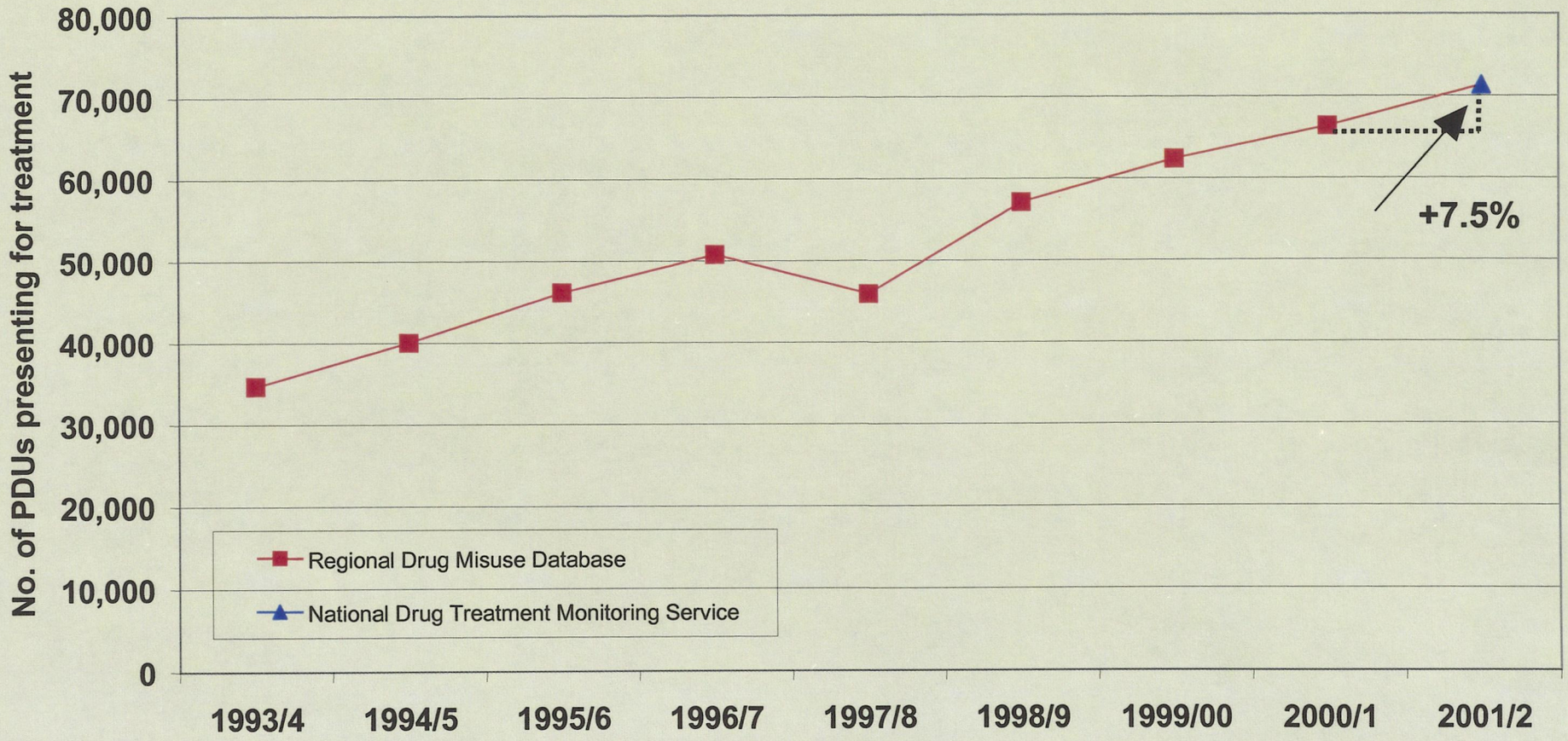


Class A drug use in the last year (11-15 year olds) : Department of Health Schools Survey

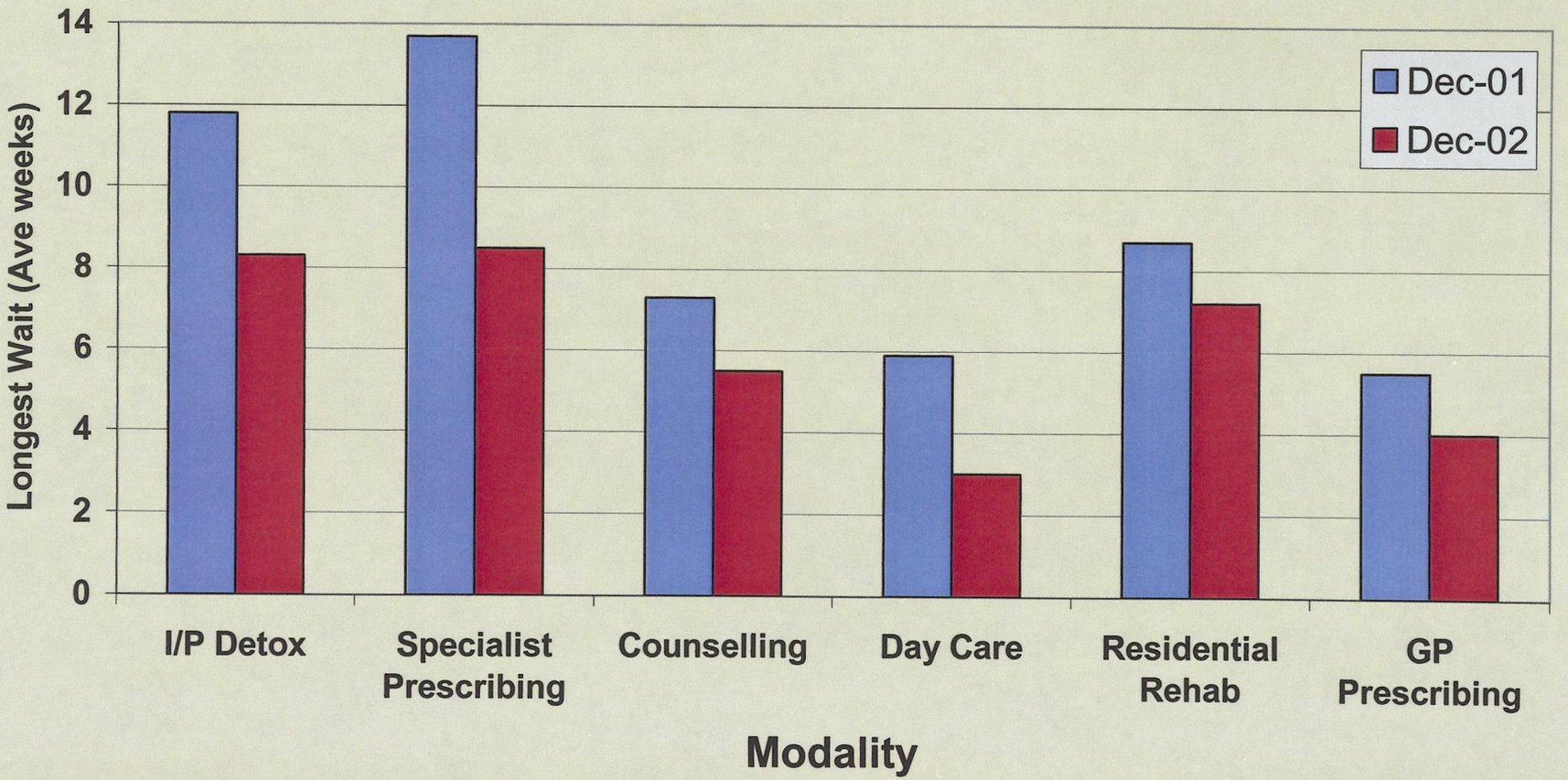
Convictions for AVD crime by those convicted of heroin, cocaine or crack offences (supply/possession)



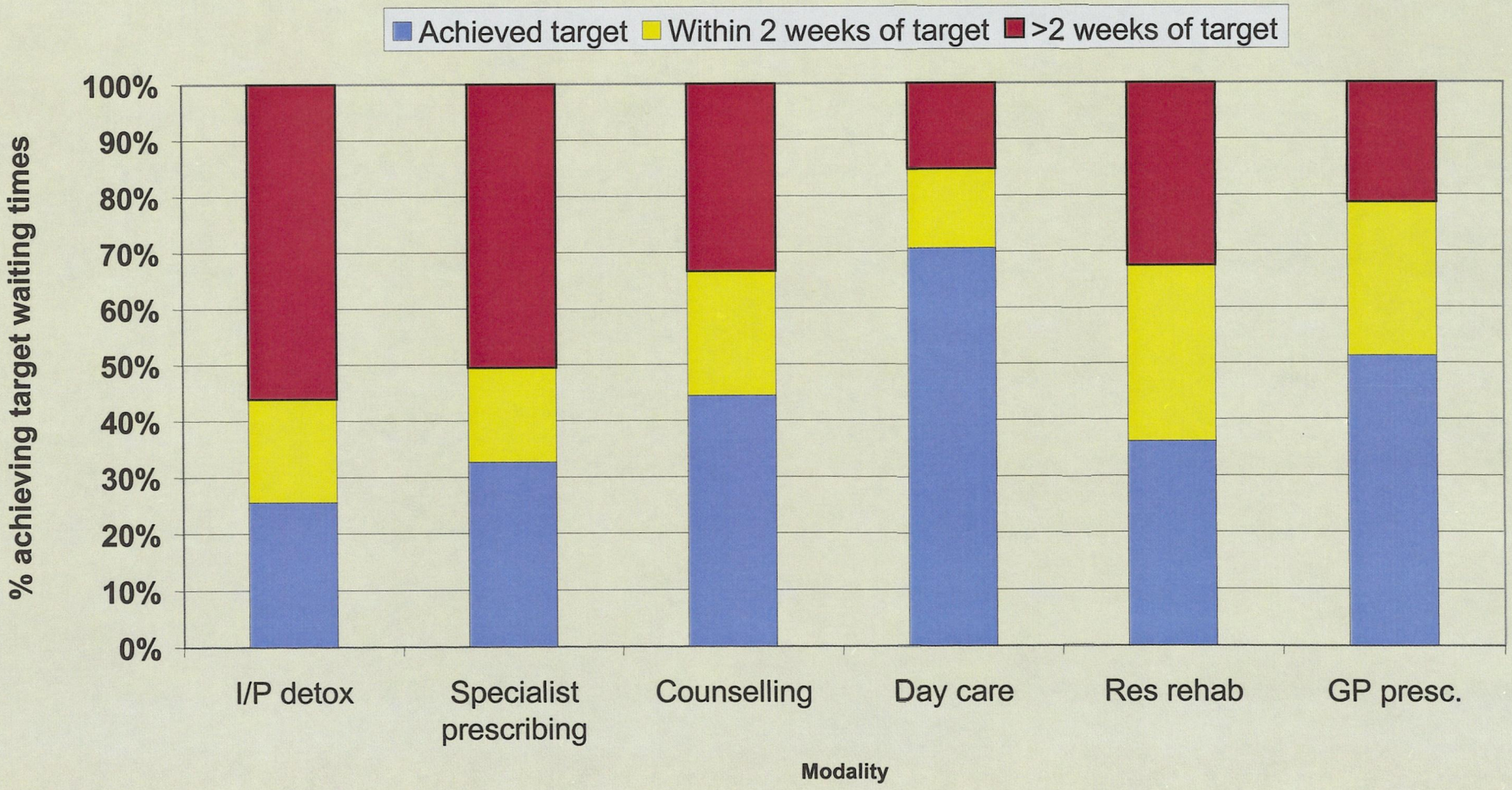
Problem drug users presenting for treatment



Waiting Times :
Provisional Results from 2003 DAT template

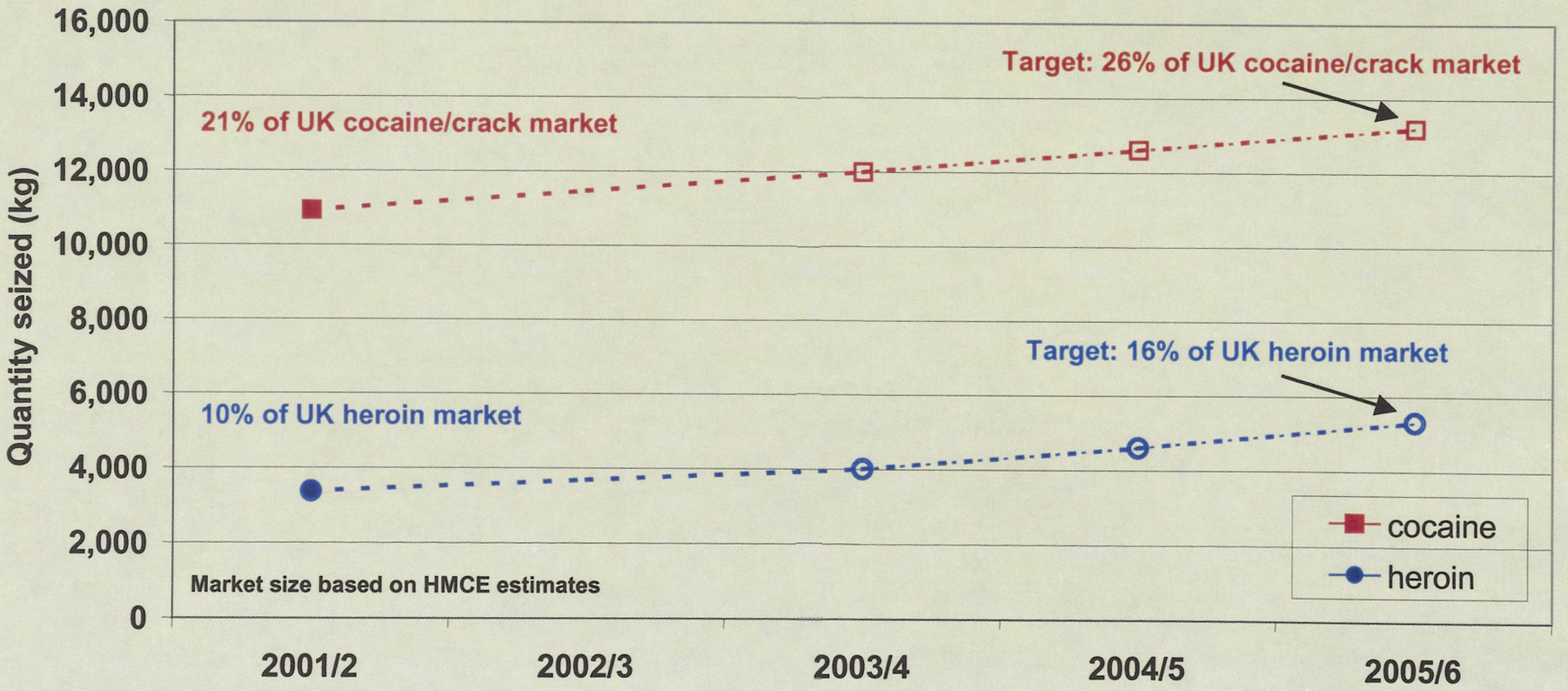


DATs achieving target waiting times as at Dec 2002

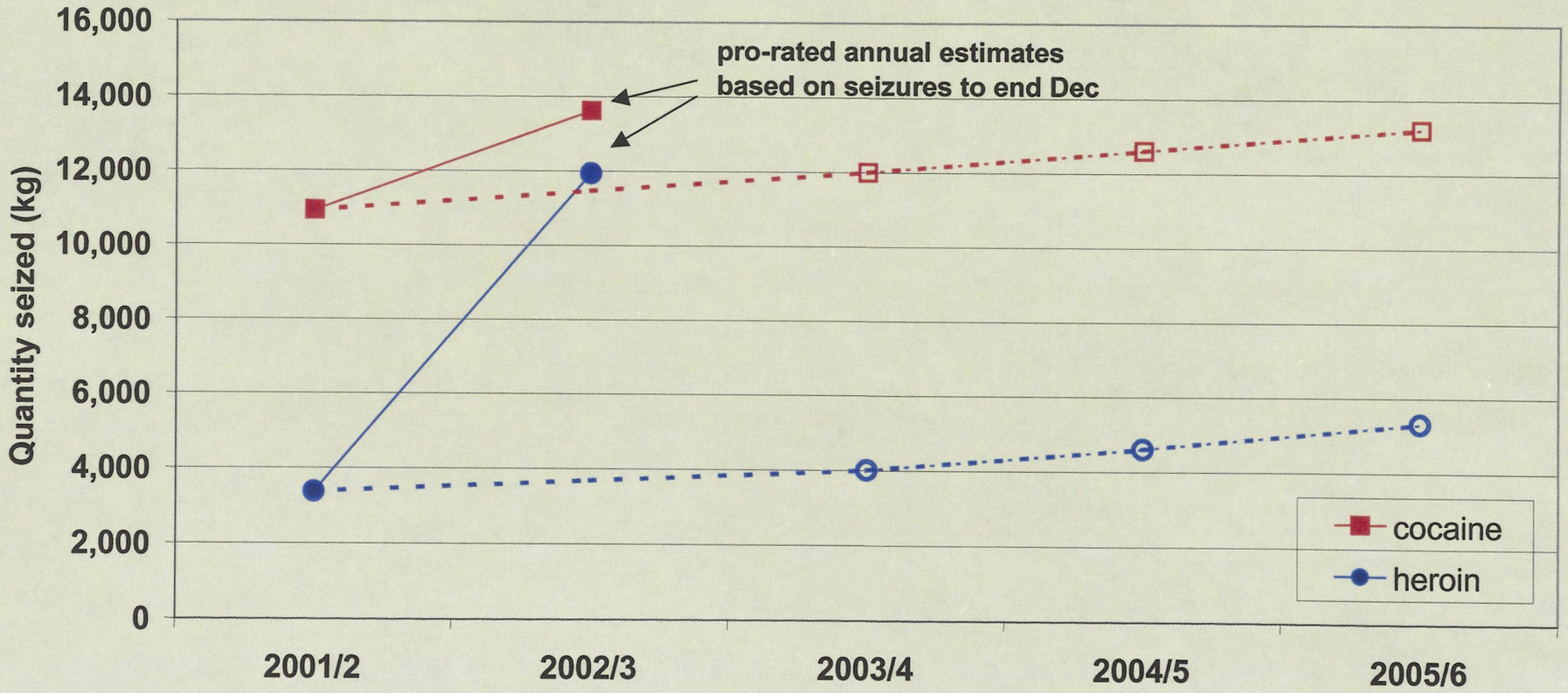


Target of maximum 4 week wait by March 2003

Heroin and cocaine taken out



Heroin and cocaine taken out



Extract from HO paper to DA(D) on progress with delivery report recommendations

ANNEX B: RECOMMENDATIONS FROM THE BARBER REPORT AND PROGRESS AGAINST THEM

Evidence of improvements for key outcomes	
Recommendation	**Progress**
Delivering expansion in treatment capacity	Subject of separate report from NTA. See Annex C for data on progress against PSA target.
Reductions in drug-related convictions	Data available suggest some reduction but more work needed to improve data. This is being addressed in the review of data.
Significant reductions in the availability of heroin & cocaine	Data suggest on track to meet reductions set in PSA target but size of market estimate is not robust. This is being addressed in the review of data.

Visible progress in areas that input to key PSAs	
Recommendation	**Progress**
Development of effective plans for the roll out of drug treatment & testing in the selected 30 BCUs from April 2003 and plans for further rollout in 2004/05 and 2005/06	See separate DA(D) paper
Improved evidence and focus on what works in preventing the use of Class A drugs by young people	Working to ensure that local services reflect the best available evidence of what works, and to extend and improve the evidence base. Guidance issued on needs assessment; guidance in development of screening young people for substance misuse problems and on commissioning services (both on time for February 2003). Activities aimed at improving the evidence base include Blueprint (September 2007), the HO vulnerable young people's research programme (February 2003), DH vulnerable young people pilots (initial results September 2003) and the Health Development Agency internal review of prevention evidence (February 2003). A detailed strategy wide Communications Plan is in place to drive a comprehensive range of projects based on what works, including with young people. Prior to the cannabis re-classification announcement, cards and factsheets to remind young people that cannabis is still harmful and illegal were distributed to a wide range of outlets such as youth clubs, GP surgeries, libraries etc. ACPO guidance on the policy of cannabis is expected to be agreed later this month, so that guidance for professionals working with young people can be finalised and issued. A three-year communications campaign will be launched in Spring 2003, jointly funded by HO and DH, working closely with DfES. The campaign will target parents and carers as well as young people, providing drugs advice and information. All materials have been pre-tested with target audience and stakeholders and the campaign will be fully evaluated.

Development of a delivery plan to tackle the Afghan poppy crop by April 2003	FCO is developing the plan. It will focus on a long-term strategy to provide sustainable alternative livelihoods for opium farmers and to build up Afghan law enforcement capacity. Planned activity by the CIDA agencies (and other Whitehall partners such as DfID), both in Afghanistan and the immediate surrounding countries, will make a direct contribution to achieving the target and have a direct impact on the supply of heroin to the UK.
Agreement of implementation plan for reducing availability of illegal drugs by the end of January 2003	HMCE and other CIDA members are working to have the plan in place by end January
The development of a strategy for tackling supply middle markets.	Three area-based middle market teams have been set up in England and Wales. The purpose of each team is to tackle level 2 drug related criminality and each is accountable to a regional tasking and coordination group, under the National Intelligence model. Two of the team have just started work but the West Midlands team has been in operation for 12 months and is being evaluated. The report on its first year is due March 2003. Evaluation for the other two teams is in development. Plans are in place to set up similar teams in other regions, as funding allows. Fuller report to next DA(D) and May PM Stocktake.

Improvements in underlying capacity in key areas	
Recommendation	**Progress**
Clear focus on tackling crack across all areas of the drugs strategy:	Working closely with other departments, especially DH, the Home Office has drawn up a Crack Plan, a summary which was published in the Strategy Update and on the drugs website to ensure Drug Action Teams integrate it into their plans for 2003-4. An initial list of the high crack areas has been announced to DATs, along with guidance for DATs, police and other key partners. The Crack Plan will be used and developed to drive progress. It will be reviewed after the first meeting of the interdepartmental crack programme management group, on 15 January. An oral update will be provided to DA(D) on 28 January with a fuller progress report to the next DA(D) meeting. **Diversity** awareness is one of the factors on which successful interventions on crack depend. As part of the strategy-wide diversity plan, a diversity toolkit is being drawn up for regional teams and DATs to use in developing their own diversity plans and communication strategies. The toolkit should be issued at the end of January and will be supported by training for regional diversity advisers who support DATs. Events to engage key organisations concerned with women and black and minority ethnic issues around drug misuse will be held in February. Progress will be included in the next delivery report to the next DA(D).

Improvements in the timeliness, frequency and quality of drugs performance data in all areas and in sharing it between the agencies involved:	Both DA(D) at its last meeting and the Barber report, highlighted the need for improvement in the timeliness, frequency and quality of drugs performance data. A review of the data underpinning the PSA targets is underway and will report to the next DA(D) meeting. It will be linked into two wider consultancy projects, both taking place in early 2003, one of which is looking at information management across the strategy and the other at strengthening local delivery. A summary of emerging options and proposals from the data review and how it links into the two consultancy projects is at Annex B.
Strengthening of the delivery chain and stronger performance management, particularly at local level	Covered in separate DA(D) paper
Sharpening the delivery focus of the Strategic Planning Board and Aim Delivery Groups	The Strategic Planning Board is sharpening its monitoring and delivery function, reviewing its role, remit and membership and that of the Aim Delivery Groups and ensuring that it has timely and relevant information. It will use a programme management tool developed from the overarching delivery plan, together with the data report at Annex A to this paper, to drive delivery of the Strategy.

ANNEX C

Paper for PM Drugs Stocktake – 11 February 2003
Update on Progress on Drug Treatment

1. INTRODUCTION

This paper outlines the current progress that is being made towards achieving the treatment target:

> *Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008, and increase year on year the proportion of users successfully sustaining or completing treatment programmes.*

It provides a summary, recommendation, details on current progress and key risks to delivery.

2. SUMMARY

- **The National Treatment Agency (NTA) are successfully leading a rapid and fundamental reform of the drug treatment sector.**

- **The Treatment Target is broadly on track but additional steps are being taken to ensure the numbers of drug users accessing treatment services continues to increase.**

- **The NTA has reduced waiting lists of drug treatment services nationally, and is targeting areas having difficulties in reducing their waiting lists to acceptable levels.**

- **The number of drug workers has increased but local problems in recruiting workers are expected. This is being addressed through the NTA's workforce strategy.**

- **Monitoring systems, data collection, and links between health and criminal justice data collection systems have been improved to ensure all those who receive treatment are recorded.**

- **DA(D) and the Treatment Aim Delivery Group are closely monitoring risks to delivery and measures are in place to address all risks, such as performance management systems for the NHS and Social Services.**

3. RECOMMENDATION

The PM notes the progress made and supports the SofS in getting the message across to that drug treatment is a priority for NHS and social care and it is critical that PCTs and social services sustain and increase mainstream funds as the pooled budget increases.

4. UPDATE ON PROGRESS

4.1 Access to Drug Treatment Services

4.1.1 The numbers presenting for treatment grew from 66,000 in 2000/1 to 71,000 in 2001/2. This represents a 7.5% increase over the previous year and is sufficient to meet the 2008 target.

4.1.2 This is below the estimated 10.1% needed to meet the 2004 target. To ensure this is achieved the planned increase of 7.1% in 2004/05 will need to be exceeded.

4.1.3 Yearly variations in growth are not unusual. Rapid expansion of drug treatment services, especially in the areas with the worst substance misuse problems, is taking place against a background of historic under-funding, limited workforce capacity. It is also likely that not everyone who receives treatment is being recorded.

4.1.4 Steps being taken to ensure the target is achieved include:

- Increasing the number of drug workers. Drug Action Teams (DATs) report an increase 1,088 additional posts 2002-2003 and are projecting a further 680 between 2003-2004. This is ahead of expectations. The NTA workforce strategy is seeking to address the lack of qualified/trained staff, which causes recruitment problems in some areas.

- Training GPs. DH has supported the Royal College of General Practitioner (RCGP) in training 400 GPs and 40 prison doctors to provide drug services and support strategic development in drug misuse services in their local area. The RGCP now has over 100 GPs waiting for this course, and DH has committed £1.2m to fund this for another year.

- Ensuring all those who receive treatment are recorded. DH have commissioned a programme to computerise the collection of the National Drug Treatment Monitoring System (NDTMS), the NTA who will take responsibility for data collection from April 2003 and key trend data should be available from July 2003

- Targeting services which have not recorded treatment provision in the past: Arrest Referral data is now being included with NDTMS and discussions are underway to include prison data increasing the total number of treatment episodes being recorded. NTA Regional Manager will be targeted areas or services which they believe are failing to report data.

- Expanding the provision of injectable methadone and heroin: New guidance on heroin prescribing and the use of other injectable drugs has been prepared by the NTA and is now out to final consultation prior to publication. The guidance estimates that a significant minority of opiate dependant patients (estimated at 5%-10% of the total) may benefit from the prescription of injectable heroin or methadone. Around 3%, or 2,500 methadone and 450 heroin users, currently receive this treatment.

4.2 Reduction in Waiting Times

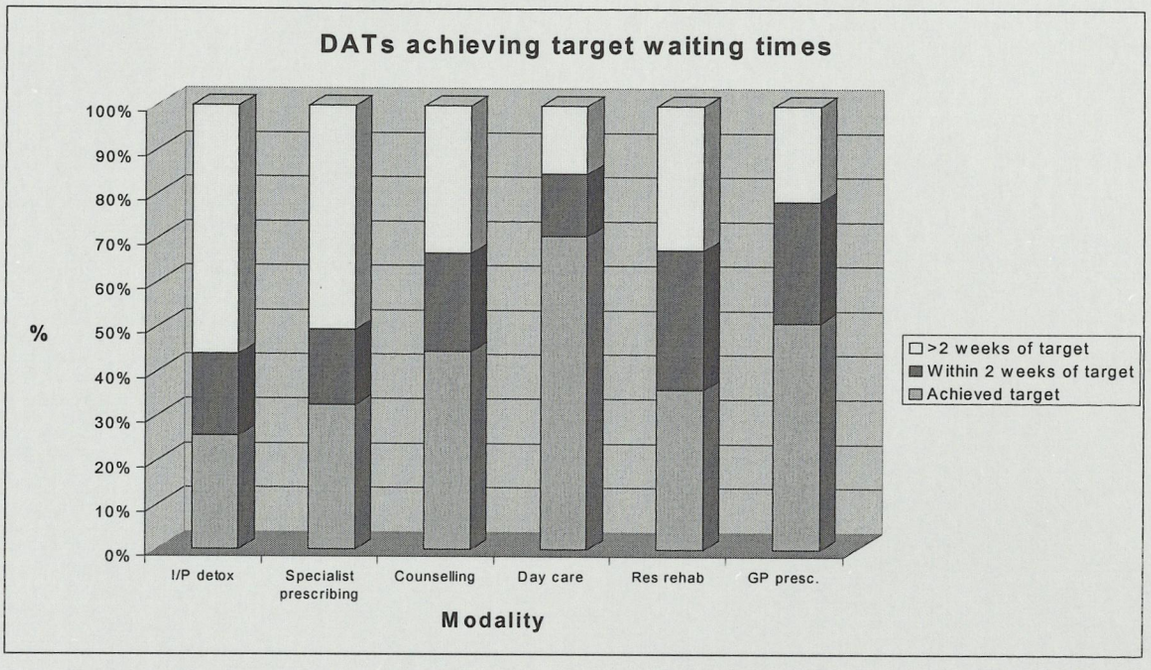
4.2.1 In December 2001, the NTA developed a programme to tackle the growing waiting times problem. They also set targets on the maximum acceptable lengths of waits:

	2002/03	2003/04
In patient detoxification	4 weeks	2 weeks
Specialist prescribing	6 weeks	3 weeks
GP prescribing	4 weeks	2 weeks
Structured counselling	4 weeks	2 weeks
Day Care	4 weeks	3 weeks
Residential rehab	4 weeks	3 weeks

4.2.2 The NTA's programme to reduce waiting times has successfully achieved falls in waiting lists across the country. Longest waiting times reported in DAT Treatment Plans are as follows:

	December 2001	December 2002
In patient detoxification	12 weeks	8 weeks
Specialist prescribing	14 weeks	8 weeks
GP prescribing	5 weeks	4 weeks
Structured counselling	7 weeks	5 weeks
Day Care	6 weeks	3 weeks
Residential rehab	9 weeks	7 weeks

4.2.3 The proportion of DATs which have achieved the targeted reduction in waiting times is as follows.



4.2.4 The target relates to reductions in average waiting times and data on this will be provided quarterly from April.

4.2.5 The NTA and the National Institute for Mental Health (NIHME), which is part of the Modernisation Agency, are providing training and advice to DATs. targeting 18 areas with higher than average waiting times. Examples of what has been achieved through this programme are:

- Shropshire: Specialist prescribing longest wait down from 52 weeks to 12 weeks.
- Darlington: Specialist prescribing longest wait down from 18 weeks to 10 weeks.
- Durham: Inpatient detox longest wait 12 weeks down to 3 weeks.
- S. Gloucs: Inpatient detox longest wait 76 weeks down to 2 weeks.

4.3 Improving Quality of Delivery and Accountability

4.3.1 The following mechanisms have been put in place to mitigate risks to the delivery of the strategy:

- Ministerial oversight of the treatment section of the national drug strategy is through DA(D), which is supported by the Treatment Aim Delivery Group at official level and chaired by DH. A detailed risk register has been developed, which informs the work of the Treatment Aim Delivery Group;

- Tight performance management by the NTA of the pooled budget and progress towards the targets, with a particular focus on improving service commissioning and addressing poor performing DATs;

- Implementation of NDTMS enhancements to enable effective performance management;

- Use of the NHS Performance Planning Framework, including oversight through the Regional Directors of Public Health and Strategic Health Authorities, to ensure that PCTs are engaged;

- Use of the treatment indicator in Social Services Best Value Performance Indicator set;

- Continued implementation and careful monitoring of the impact of the workforce strategy;

- Proactive DH involvement in the arrangements for CDRP/DAT merger.

4.4 Strategy Unit

4.4.1 The SU are assisting HO and DH with modelling the flows of problem drug users into treatment in the context of new criminal justice system interventions.

4.4.2 There has been an increased emphasis on treatment as a key mechanism for reducing the negative impacts of problem drug use over the last few years. New interventions to move problem drug users (PDUs) into treatment have centred on offenders and been tied into the criminal justice system.

4.4.3 However, there is currently uncertainty about whether new criminal justice interventions will increase the flows of PDUs into treatment above the current projected expansion in capacity; and, if they do:

- what the gaps in capacity would be, e.g. geographical, in types of treatment;
- what the barriers would be to further expansion, e.g. resources, workforce; and
- what the subsequent impact on other outcomes will be, e.g. crime and health.

4.4.4 It is crucial that analysis of these issues is rigorous and thorough in order to reach reliable conclusions. If not, there is a risk that roll out of criminal justice interventions will not effectively reduce problem drug use or associated crime and/or that costs will be driven excessively high.

4.4.5 Since there is currently no reliable model in existence for predicting flows of problematic drug users into treatment, SU, in collaboration with HO and DH, need to build one from scratch.

4.4.6 This work will last until the beginning of May and will put SU in a position to make preliminary conclusions about treatment capacity. Departments and the unit will then discuss what further work needs to take place and what SU involvement in it should be. These initial conclusions will be available for discussion at the PM Stocktake in May.

ANNEX D

UPDATE ON CRIMINAL JUSTICE INTERVENTIONS AND STRENGTHENING LOCAL DELIVERY

Summary

This paper reports progress on the major expansion of criminal justice interventions, aimed at getting drug misusing offenders out of crime and into effective treatment. Overall the programme is on track with progress in developing capacity for delivery on the ground, in establishing a central team, and securing the active engagement of stakeholders.

The key developments include:

- recruitment of the programme leader and team members;
- establishment and first meeting of the Ministerial steering committee;
- announcements to stakeholders;
- progressing drug-related provisions of the Criminal Justice and Sentencing Bill;
- calculating early resource allocations and notifying amounts to forces for arrest referral
- steps to strengthen local delivery particularly:
  - the development of a performance management framework for all DATs
  - identifying the strengths and weaknesses of DATs
  - putting in place support and remedial action strategies for the weaker DATs.

The paper also provides an outline of what will be implemented and when in the early months of 2003/04.

Progress to date - detail

Project management

2. The creation of a strong, dedicated programme team at the centre is vital to the success of this programme. Work is now progressing quickly to build such a team:

- a suitably qualified leader is in place
- the secondment of a senior DH official from 1 March has been agreed
- 4 further appointments have recently been agreed. These complement the one-third of the new team drawn from existing DSD staff resources who are already engaged on CJS interventions project work.
- consultancy support for the programme leader from PA Consulting is in place, working specifically on detailed worksteam and risk analysis.

Recruitment of the remainder of the team should be completed by March. A cross-departmental programme group has been set up in the meantime, under the chairmanship of the Director, Drug Strategy Directorate, to drive the initial planning requirements forward.

Ministerial Committee

3. Following agreement with No 10, a Ministerial Steering Committee has been set up, under Bob Ainsworth's chairmanship, to give Ministerial direction to the programme. The membership of the Committee comprises Hazel Blears, Hilary Benn and Yvette Cooper, in addition to the chairman. A first meeting of the Steering Committee took place on 21 January at which it was agreed that

- the Committee will take a close involvement with the programme including assuming the role of individual local and regional champions
- options would be explored to replicate for the interventions programme the London CJS "Reality Group"
- there was a need for robust monthly data including baselines.

Urgent work is continuing on assessing what data is available in the short term pending the delivery of more robust and sophisticated systems – which are being introduced but will take time to become fully effective.

Stakeholder Management/Announcements

4. Local commitment to delivery will be key to successful interventions, so stakeholder management is crucial. To raise awareness and push forward planning, officials have:

- alerted those in the areas containing the 30 high crime BCUs
- explained the criteria for choosing the initial BCUs
- set in train discussions on plans for capacity development and roll out
- allocated funding for all BCUs for arrest referral and notified police forces accordingly

A number of events and workshops (set out at Annex A) at both strategic and working practitioner levels have been organised to engage key local and regional stakeholders.

Treatment Capacity and Effectiveness

5. In overall terms, NTA are confident that there will be sufficient treatment capacity to meet the needs of those referred via the Criminal Justice System. As mentioned below, in some areas this will be more challenging than others but work with the NTA and DATs will address short-comings, for example by:

- tackling waiting times;
- introducing new treatment capacity;
- ensuring appropriate services are available; and
- Improving monitoring systems.

6. Effective treatment outcomes require personal commitment by the problematic drug user and those referred within the CJS will be some of the most difficult to engage and retain. The introduction of more structured aftercare and throughcare should secure higher success rates in completing treatment and minimising recidivism. These are new

and innovative interventions that have not been introduced nationally anywhere else in the world. Barriers and problems are bound to arise; ways to address them will need to be found. We will be pilot these interventions and evaluate them carefully to ensure we can deliver the best results. In doing so, we will need to address issues around partnership working and data sharing between local agencies in enable us to track individuals through the system. Monitoring and evaluation of treatment provision will also ensure the appropriate use of resources.

7. Looking further forward, the Strategy Unit, working with HO and DH are developing a model to help predict the flows of problematic drug users into treatment. This project, involving an appraisal of existing information, modelling options, literature analysis and some local studies, is now under way. The work is due to report in May, which should put us in a position to reach preliminary conclusions about treatment capacity and its implications for further extension of the Criminal Justice Interventions beyond the 30 BCUs.

Criminal Justice and Sentencing Bill

8. Clauses that relate to the CJ interventions programme are currently being considered in Standing Committee. Key ones that have been passed from Committee to report (following very useful debates) are drug testing under 18s and presumption against bail. Others are in train and Committee stage is due to finish in early March.

Resource Allocations

9. £46.2m is being made available to resource CJS interventions in the 30 BCUs. Further resources are being made available to strengthen services in the remaining DAT areas, eg for enhanced arrest referral and for DTTOs. These funds will support drug testing, enhanced arrest referral, increased availability of DTTOs, throughcare and aftercare and pre-arrest initiatives. DATs have now been informed of their allocations. Allocations for following years will be informed by further assessment of local need and ability to deliver. The £46.2m is complemented by the £94m drawn into a single national pot to help local groups tackle crime and drugs in their communities, £19m nationally for enhanced arrest referral and the £50m being allocated to BCUs to combat crime problems including those related to drugs. Further details of resources can be found in Annex B.

Future work programme

10. The Communities Aim Delivery Plan and the Overarching Delivery Plan are being updated to incorporate the programme changes which have been agreed since it went to the PMDU in November, including the focus on the 30 BCUs. Meanwhile, an outline of the implementation element has been constructed as follows:-

- Pilot of pre-arrest initiatives: pilot areas identified by April and established on a phased basis commencing in July
- Enhanced arrest referral: funding available to all force areas to commence delivery from April

• Drug testing:	Procurement issues in hand; dedicated stakeholder event to be organised and necessary secondary legislation prepared to enable implementation from June
• Courts made aware of drug test results:	from June in line with extension of drug testing
• Additional DTTOs	Progressively from April
• Integrated throughcare:	Progressively from June
• Aftercare:	system design and recruitment issues agreed with stakeholders to enable piloting from June
• Provisions requiring primary legislation (eg presumption against bail):	Contained in Criminal Justice and Sentencing Bill now in Committee stage: all provisions on track
• Longer term roll-out of initiatives:	Strategy Unit work on track.

Enhancing DAT Performance to Deliver

11. The Home Office, Department of Health and the NTA are currently taking forward work to improve performance management of delivery of the Drug Strategy generally; and also focusing on the 25 DATs which contain the 30 BCUs to identify how to overcome obstacles to delivery. More details of this work are set out at Annex C; and a table summarising the assessment of capacity in the 25 DATs is at Annex D.

12. The key issues identified in the plans agreed with the 25 DATs are :

- treatment capacity – in particular meeting the needs of people coming through the CJS interventions;
- the effectiveness of partnerships to deliver, and the availability at local level of robust management information;
- problems of workforce capacity; and the extent to which the DATs are meeting the needs of black and minority ethnic communities and other under-served groups
- restrictive use of planning regulations hampering expansion of treatment facilities.

By March there will be in place an implementation team, available to work with the Government Offices and partnerships as well as at national level to help overcome these obstacles to delivery."

Drug Treatment and Testing Orders – Increasing the Likelihood of a Successful Outcome

13. In addition to the above, Yvette Cooper has commissioned work by the Court

Service, in partnership with other agencies, to establish pilots in three areas to identify how the courts' contribution to effective Drug Treatment and Testing Orders (DTTO's) can be improved. The Court Service is committed to establishing pilots in some shape or form in Nottingham, The Wirral and Bristol in the first half of 2003, although this timing has not been confirmed nor agreed.

Home Office/Department of Health
February 2003

Annex A

STAKEHOLDER EVENTS (February to April 2003)

DAT Co-ordinators conference	18/19 February
Presumption against bail seminar	25 March
Drug testing seminar for additional BCUs	Late Feb/early March
Drug testing seminar for additional BCUs (South East)	Late Feb/early March
Strategic Stakeholder event	Early March
National Group meeting	28 March
DAT Chairs meeting	10 April

Annex B

Resource Allocations

DAT treatment allocations through the pooled budget arrangements were announced in December by the National Treatment Agency (i.e. detailed allocations for 2003/04, and minimum levels for the following 2 years). In addition to the treatment allocations already announced, each DAT will receive capacity building funds and a proportion of the funding which has been made available in 2003/04 under SR 2002 for a national system of managed aftercare for those leaving prison and/or treatment. The initial allocation of arrest referral funds agreed under SR 2002 reflects the existing formula for allocating such monies across police force areas. It is proposed to mainstream this funding from 2004/05 by marrying it to the pooled budget arrangements for treatment services to which the arrest referral function is closely aligned. Remaining funding will be spent centrally as initiatives are rolled out.

2. In seeking to allocate the capacity building and aftercare resources in a way which best reflects the likely needs (which will vary significantly from one area to another), the most equitable formula is one which brings together the York formula (used for the allocation of the Pooled Treatment Budget) and a crime formula, weighted 40:60. The element for capacity building could be available for each of the three years of the Spending Review, depending on local need and ability to deliver. As we introduce the interventions in other areas from year two onwards, we envisage needing to provide lower levels of resource for capacity building as we will be able to apply the lessons learned in year 1.

3. The Home Secretary announced on 21 January the new single pot crime reduction fund, the £50m BCU fund and the 30 high crime areas that will be a focus of the SR2002 drugs package.

4. Funding by intervention/workstream is summarised below:

Treatment: Pooled budget arrangements - the increase in 03/4 totals £12.65m and averages over £0.5m per DAT.

Local delivery capacity: HO is allocating capacity building funds to each of the 25 DATs covering the 30 BCUs in ¾; an average of £0.6m per DAT, total for all: £15m

Aftercare: a proportion of the funding for a national system of managed aftercare will be allocated to the 25 DATs covering 30 BCUs,; an average £0.2m per DAT in ¾.

Arrest referral: allocated to the 9 Police Forces containing the 30 BCUs under the existing formula for allocating monies across police force areas; (total £5.3m in 03/04)

Drug testing funds are controlled centrally to ensure consistency and propriety in procurement, but each BCU will receive testing equipment and admin support averaging £336k in value (total for 30 High Crime BCUs is £10.1m in O3/04.)

Young people community sentencing monies will go to 10 YOTs within the 30 BCUs ; (Total: £1.5m, average £0.15 per YOT in O3/04)

early prevention and intervention funding to the 25 local authorities covering the 30 BCUs (Total: £2m in O3/04;ave £0.08m per LA)

Positive Futures Programme funding to Positive Futures Partnerships Total for 30 BCUs: £2.5m in 03/04; average £0.083m per BCU)

5. The Communities Against Drugs Fund (CAD) is currently being reviewed by the Treasury and Home Office. One of the aims of the review is to make CAD more flexible, including in terms of the types of drug projects and supporting services to which the funding can be applied. The review will be completed shortly, and recommendations submitted to Treasury and Home Office Ministers for approval.

Annex C

Enhancing DAT Performance to Deliver

The Home Office, Department of Health and the NTA are currently taking forward two areas of work in parallel to raise standards of local delivery, which will support other strands of work - namely bringing together the partnerships delivering the drug and crime agendas; and engaging the Inspectorates more directly in assessing partnerships' performance.

Performance Management Generally

2. Following an initial consultancy review, we are now taking forward work to develop by the end of March a clear and agreed performance management framework which will

- increase the clarity and focus on delivery at local level through better use of key performance indicators and less burdensome requirements for information
- provide a better basis for involving the Inspectorates and the Audit Commission in holding key agencies to account for delivery as well as monitoring performance
- allow a clearer focus on local targets and performance management at regional and local level .

Focusing on the 30 BCUs

3. A separate exercise is focusing on the DATs containing the 30 BCUs where the key priority is to address obstacles to delivery to ensure that CJS interventions make a real difference on the ground. Building on work done before Christmas, teams in the Government Offices with the NTA and other key partners, have agreed with the DATs action plans which identify issues such as lack of qualified staff; problems of disengagement by some agencies; and ineffective mechanisms in place to ensure delivery. A dedicated implementation team will be available to work with the GOs and partnerships to tackle these problems Each DAT has identified a named individual in each area to be in charge of leading the programme locally and pulling together all the key strands.

4. There will be additional support for implementation of these action plans at national, regional and local levels. This will include in each area support to the local leader to ensure delivery. The implementation team will comprise:

- additional post(s) to strengthen support at Regional level in the Government Offices in the North West, Yorkshire and Humberside, and London (which have the majority of the high crime areas), to enhance the capacity of the Drug Teams and the NTA in performance management;
- consultants and, possibly, secondees from across and outside Government available to support individual partnerships and the other affected regions (South

West, North East, East Midlands and South East – each of which have one affected area.

Delivery of the action plans will be project managed by a strengthened Local Delivery Unit in the Drug Strategy Directorate.

ANNEX D

DSD DAT/BCU assessment

Region and DAT Area	DSD Assessment (see note)	NTA Assessment	CPA Assessment (Local Govt)	High Crack Area	SCI	10 BCU pilot areas for YP	Local Champion	Key Issues (see note)
East Midlands								
Nottingham City	B		Weak	✓	✓	✓	Drugs Strategy Manager (interim)	Partnership, Information, Treatment, CJS, Diversity (homelessness and YPs)
London								
Camden	B	Amber/ Green	Excellent	✓	✓	✓	Tbc	Treatment/Workforce
Ealing	A	Amber	Weak	X	✓	X	Joint Commissioning Manager	Treatment
Hackney	A	Amber/ Green	Poor	✓	✓	✓	Tbc	
Haringey	B	Green	Weak	✓	✓	X	Tbc	Workforce, BME, Partnership
Islington	C	Amber	Poor	✓	✓	X	Tbc	Partnership, Finance, Workforce
Lambeth	C	Red	Poor	✓	✓	✓	Head of Community Safety	Partnership, Info, Diversity, Workforce
Newham	B	Amber	Fair	✓	✓	✓	Tbc	Information
Southwark	A	Amber	Weak	✓	✓	X	Tbc	Finance, Workforce
Tower Hamlets	B	Amber	Good	✓	✓	X	Head of Community Safety Unit	Partnership, Information, Diversity
Waltham Forest	B	Amber/ Green	Poor	✓	✓	X	Tbc	Finance, CJS, No Action Plan
Wandsworth	B	Amber	Excellent	✓	✓	X	Joint Commissioning Manager	Treatment, Finance, CJS Interventions
Westminster	B	Amber	Excellent	✓	✓	X	Tbc	CJS Interventions, Diversity
North East								
Middlesbrough	C		Good	✓	X	✓	Chief Exec	Partnership, Information, Finance, Diversity, CJS

Region and DAT Area	DSD Assessment (see note)	NTA Assessment	CPA Assessment (Local Govt)	High Crack Area	SCI	10 BCU pilot areas for YP	Local Champion	Key Issues (see note)
North West								
Bolton	**B**	**Amber**	**Good**	✓	✓	X	**DAT Chr & Chief Exec**	Treatment, Finance
Liverpool	**B**	**Amber**	**Fair**	✓	✓	✓	**DAT Chr**	Partnership, Treatment, Workforce, Diversity
Manchester	**A**	**Green**	**Good**	✓	✓	✓	**DAT Chr & Dep Ch Ex**	Information
Rochdale	**A**	**Green**	**Fair**	✓	✓	X	**DAT Chr & Chief Exec**	Workforce
Salford	**C**	**Red**	**Weak**	✓	✓	X	**DAT Chr & Dir C&SS**	Treatment, Finance, Diversity, No Action Plan
South East								
Reading	**C**	**Amber**	**Good**	✓	✓	X	**Chief Exec**	Partnership, Treatment, Information, Finance, Workforce, Diversity
South West								
Bristol	**C**	**Red**	**Weak**	✓	✓	X	**Dir SS & H**	Partnership, Treatment, Information, Finance, Workforce, Diversity
Yorkshire & Humber								
Bradford	**C**	**Hot Red**	**Good**	✓	✓	X	**Snr Man. Pol & Dev** (temp)	Partnership, Treatment, Finance, Workforce, Diversity
Calderdale	**B**	**Amber**	**Fair**	✓	✓	✓	**Tbc**	Partnership
Kingston upon Hull	**B**	**Red**	**Poor**	X	X	✓	**DAT Chr & Asst Ch. PO**	Treatment, CJS, Diversity, Workforce
Leeds	**A**	**Hot Red**	**Good**	✓	✓	X	**Community Safety Officer (interim)**	Finance

Notes:

DSD Assessment Explanation:

A - partnerships in a position to deliver interventions with minimal additional work - perform well on partnership process, treatment plans and cjs interventions;
B - relatively few problems eg with partnership issues, treatment plans etc: need some additional support;
C - entrenched problems needing substantial input to get partnership on track to deliver.

Key Issues Explanation:

Partnership: Ability of Partnership to deliver the new range of services at a strategic & operational level
Information: Clarity of Baseline and degrees to which information is used to inform commissioning decisions
Treatment: Issues flagged up in treatment plan review focussing on the needs of CJS clients, Crack users, BME and other under served groups.

Finance: Significant underspends in existing funding streams
Workforce: Existing vacancies and plans for capacity and workforce expansion
CJS/CJS Interventions: Performance of current CJS Interventions
Diversity: The degree to which the needs of BME communities and other under – served groups have been assesses and action taken to address

Home Office

Home Secretary
50 Queen Anne's Gate, London SW1H 9AT

cc: GM
NA
AMcG

The Rt Hon Paul Boateng MP
Chief Secretary to the Treasury
HM Treasury
1 Horse Guards Road
LONDON
SW1A 2HQ

31 JAN 2003

Dear Paul

COMMUNITIES AGAINST DRUGS

Thank you for your letter of 20 January.

I am keen to enhance the delivery focus of local partnerships. A single funding stream for local crime reduction and drugs spend enables them to focus on the problems in their area and how best to tackle them, rather than giving priority to problems that fit neatly into one or the other funding stream. I am therefore persuaded of the value of moving to a single funding stream, provided that partnerships say this will indeed be helpful for them in improving their delivery focus, and that they demonstrate they will take effective responsibility for ensuring that spend on tackling drugs related crime continues to meet the CAD objectives and does not diminish.

I am therefore undertaking a quick consultation of those at the sharp end, including the local community groups that have to grapple with the complex government funding system, before reaching final view. The CAD review is, in fact, well down the track and the evidence obtained via the consultation process should allow it to be brought to a successful conclusion. There is no reason of principle why funding for crime and drugs spend should be dealt with in any different way from the clear policy, under the Area Based Initiatives review, of removing overlapping funding streams, provided we are satisfied it will help, not hinder, our efforts to tackle class A drugs.

I am copying this letter to the Prime Minister, Gordon Brown and Barbara Roche.

Best wishes,

David

DAVID BLUNKETT

5449DB

CABINET
OFFICE

The Prime Minister's
DELIVERY
UNIT

53 Parliament Street
London
SW1A 2NG
T: 020 7276 3520
F: 020 7276 3511
E: nicholas.ville@cabinet-office.x.gsi.gov.uk

29 January 2003

Dear Kevin

DRUGS STOCKTAKE, 11 FEBRUARY 2003

As you know, the Prime Minister is chairing the next Drugs Stocktake on 11 February. I expect the agenda will be as follows:

1. Update on delivery. Bob Ainsworth to introduce Michael Barber's presentation.
2. Drug treatment (Hazel Blears)
3. Update on criminal justice interventions, including roll out of drug treatment and testing programme to 30 highest crime BCUs, and strengthening local delivery (Bob Ainsworth)

I would be grateful if final versions of the papers supporting these agenda items could be with Emily Miles at No. 10 by Thursday 6 February. Officials will be meeting to discuss drafts on 4 February at 11am, at 53 Parliament Street and it would be helpful to have draft papers circulated in advance of the officials meeting.

I expect the cast list for the meeting to be Home Secretary, Secretary of State for Health, Chief Secretary, Bob Ainsworth, Hazel Blears, Ivan Lewis, John Healey, Michael Barber, Sue Killen, Paul Hayes, and Cathy Hamlyn. I would be grateful if you could also invite to the meeting Steve Haymer, Chief Executive of Compass. If you have any problems with attendance, please let Emily Miles know.

Looking ahead to the rest of the year I anticipate that the agenda for the Drugs Stocktake scheduled for 13 May will focus on drugs availability. In particular it would be helpful at this meeting to look at progress with tackling 'middle markets', the Strategy Unit findings on the relative cost-effectiveness of Government interventions in the drugs market and the delivery plan for reducing opium production in Afghanistan.

For the PM stocktake on September 16 it is currently planned to focus on helping young people resist drug use. The specific issues that might be covered by this will be discussed and agreed with officials closer to the meeting.

I am copying this letter to the private secretaries to Alan Milburn, Paul Boateng, Charles Clarke, Hazel Blears, Bob Ainsworth, Ivan Lewis, John Healey, and to Sir Andrew Turnbull, Justin Russell (No. 10 Policy Directorate) and Paul Hayes (National Treatment Agency).

Yours ever

Signed : Nick Ville
29/01/2003

NICK VILLE

Kevin O'Connor
PS/Home Secretary

DRUG TREATMENT PROVISION IN BASSETLAW

The Good
Health centres we are building 3 new health centres this year
Jobs other than addicts we have virtually full employment
DARE : teaching primary school children about the dangers of drugs and alcohol

The Bad
Last weeks home office drugs announcement will reduce drugs treatment in Bassetlaw.
The crime statistics mislead:
heroin addicts do few car crimes (included) they do lots of shop-lifting (excluded)
the BCU is for Worksop police station, plus Newark and Retford

The Ugly

For Worksop	66.9 crimes per 1000 people
	50 addicts through Worksop custody suite weekly
	95 % of probation clients are addicts (<10% in Retford)
	67 % of all reported crime from addicts
	95 % of all Worksop crime
	700 drug heroin addicts
	1 in 3 families heroin crime hit or family member addicted
	burglary up 34.4% (2001/02)

Nottinghamshire DAAT assert they wrote the Government response to my report.
Seven PQs on what treatment works answered: don't know

What I am doing

1. **Leading** : I intend merging the CDP, DRG and LSP community safety cttee
2. **Private sector leisure contracts** : two private sector companies brought in to build leisure facilities
3. **Engaging schools** : I am insisting all secondary schools develop effective drug prevention strategies
4. **New school bid** : the current PFI bid for Worksop will provide the community with new schools and raise educational aspirations and is backed by my 10,000 people petition demanding PFI
5. **Visiting Holland/France/Sweden** : With a local GP, I am visiting Amsterdam this week, and then other countries, to discuss how they deal with the problem.

What we need

1. Mandatory drug testing in Worksop custody suite
2. Drug Courts (as part of the first pilot phase)
3. Research, evaluating what treatment and interventions work, within a geographically stable population
4. DARE expanded

CAD
Communities Against Drugs
CDRP
Crime and Disorder Reduction Partnerships
CDT
The Community Drug Team which officers a service to families and groups affected.
CRIMINAL JUSTICE ALCOHOL AND DRUG TEAM
Provides information and advice to clients within the criminal justice system.
CRP
Crime Reduction Programme
DARE
Drug Abuse Resistance Education.
DAAT
Drug and Alcohol Action Team
DPAS
Drug Prevention Advisory Service
DRG
Drug Reference Group
DTTO
Drug Treatment and Testing Order
FACEIT
The Young Persons Drug Service for users under 18 years of age.
FRAMEWORK
Supported tenancies provider
GOEM
Government Office of the East Midlands
HETTYS
A support service for addicts and their families in Bassetlaw.
HOPE FOR THE HOMELESS
A shelter for the homeless. Many of their residents are addicts.
LSP
Local Strategic Partnership
MALTINGS
A service based in Mansfield which provides the drugs services commissioned
NTA
National Treatment Agency
NNCDT
North Nottinghamshire Community Drug Team
NNDAS
North Nottinghamshire Drug and Alcohol Service
NPS
National Probation Service
PCT
Primary Care Trust
SORTED
Non prescribing support service for current and ex users.
WAM
What About Me. A support service for the friends and families
WOMEN'S DRUG SERVICE
Offers advice and support to current and ex female addicts.
YOT Youth Offending Team

RESTRICTED

file. LA131.

E-MAILED

10 DOWNING STREET
LONDON SW1A 2AA

From the Principal Private Secretary

13 January 2003

Dear Jonathan,

STRATEGY UNIT PROJECT ON DRUGS

Following my letter of 3 December, I thought it would be useful to set out the overall governance arrangements for the Strategy Unit's project on drugs.

The Strategy Unit will report to both the Home Secretary and Prime Minister on this work. Both strands of the project will be led and project managed by the Strategy Unit, supported by a single Advisory Group which will be chaired by Sir Andrew Turnbull (please see Annex 1 for further membership of the group).

It is expected that the Advisory Group will meet three times during the lifetime of the project: at the end of January to discuss the project timetable and scope of work; again at the end of February to discuss the content from the first phase of the project; and finally towards the end of May to discuss the emerging package of recommendations.

The role of the Advisory Group will be to advise the project and act as critical friend. It will not hold a power of veto over advice from the Strategy Unit team to the Prime Minister and Home Secretary. The Strategy Unit will provide the secretariat to the Advisory Group.

I am copying this letter to Ian Fletcher, Justin Russell and Geoff Mulgan.

Yours,

JEREMY HEYWOOD

Jonathan Sedgwick
HO

RESTRICTED

ANNEX 1: Membership of Advisory Group

Sir Andrew Turnbull (Chair)
John Gieve (HO)
Sue Killen (HO)
Kate Collins (HO)
Cathy Hamlyn (DH)
Chris Smith (HMT)
Paul Evans or Terry Byrne (HMCE)
Michael Ryder (FCO)
Nick Ville (PMDU)
Justin Russell (No 10)
Geoff Mulgan (SU)
Lord Birt (SU)
Patricia Greer (SU)
Charlie Massey (SU[1])

[1] Plus other SU team members on an ad hoc basis

10 DOWNING STREET

FM

DB is cutting up rough about coming over to report on the BCA drugs programme - the first of our new "spot check" delivery meetings. I've been pretty robust about this - though willing to accommodate DB's diary. If we are to make real progress on your 10 priority issues we do need to have the right to call Ministers over for 20 minute meetings. GZ

From: **Emily Miles**
Date: **9 January 2003**

PRIME MINISTER

cc: **AA, JJH, JR, MB, SM, AC, SS, DH, Nick Ville, Ben Wilson, NA**

DRUG TREATMENT AND TESTING PROGRAMME – SPOT CHECK MEETING, w/c 13 JANUARY

You are scheduled to have a brief "spot check" meeting with Alan Milburn and David Blunkett next week, to chase progress on the drug treatment and testing programme in the 30 highest crime BCUs.

I suggest you ask for reassurance on
- **Getting the project team in place, and a start date for the project leader;**
- **An April start date for the programme;**
- **Clarity over how many other BCUs will be included in years 2 and 3.**

The **good news** is that on Thursday the HO finally appointed someone to head up the criminal justice interventions project team. **Peter Wheelhouse** has front line experience and is currently managing the Home Office side of the police IT project. We do not know when he will start. The HO is also likely to take up PMDU's suggestion of getting interim support from consultants. **The next challenge is sorting out his team.** HO has been slow on the uptake.

That said, the HO has set up the ministerial steering committee, and has got the ball rolling with stakeholders. They are on track to finalise resource allocations to DATs by the middle of the month. By the end of January they will have identified a local leader in each of the areas covering the 30 BCUs. Consultants, who are assessing the capacity of drug action teams and reviewing the delivery chain, will give an interim report next week.

The **bad news** is that officials have been **pessimistic about an April start date**, because the project team has been so long in materialising. The most recent read-out is that treatment roll out will happen in April, and the CJS programme in June. This needs probing. **If they persist with their "delayed until the Summer" line, you should make it clear that this is unacceptable.**

Justin has asked for an indication of **how far the programme will be extended in years 2 and 3**, by February. Sue Killen wants to wait for the Strategy Unit to finish

their rough modelling work on offenders going through treatment (unclear when this will be done, but I imagine 6-8 weeks at earliest). Less promising is the National Treatment Agency, who have hinted they want to "suck it and see" before considering how to extend the programme (i.e. no views on roll out for years 2 and 3 til Autumn).

NB: This is the first of your "spot checks" and there has been resistance to the concept. David is concerned we are in danger of spending too much time reviewing progress and not enough on delivery, given other meetings which will look at drugs in Jan and Feb (the drugs sub-committee of DA meets on 28/1 and your drugs stocktake is on 11/2). We will do our best here to be sensitive to the pressures a meeting with you puts on departments, and simultaneously to balance the need to reassure you that action is happening. **David may mention this in the meeting, and wrote to you accordingly today to suggest cancelling (attached).**

Background on the "rolls royce" treatment and testing programme

Each of the 30 BCU areas would get the following package:

- **pre-arrest** initiatives which target the most persistent offenders before they are arrested and steer them into treatment
- enhanced **arrest referral** (including the immediate provision of low level interventions such as advice and counselling);
- **drug testing in custody suites** so that every offender charged with a trigger offence is tested and if positive referred to an arrest referral worker;
- **courts** made aware of every offender testing positive at every **bail hearing** and each one offered treatment. (Within the framework of the current bail Act until the CJ Bill measures on presumption of treatment or remand receive Royal Assent);
- a 50% increase in the availability of **DTTOs**;
- the phased implementation of a lower intensity DTTO;
- improved quality and coverage of **prison-based treatment programmes**;
- an **aftercare system** for those leaving prison to ensure they receive the support/treatment they need to stop them returning to drug abuse and offending, and starting out on the whole system again.

In November, the HO estimated the cost of rolling out drug testing to 60 BCUs in year 1, rising to 100 in year 3, at £20.1/20.1/33.6m. The introduction of generic Community Sentences for drugs, including doubling the number of DTTOs by year 2 would add £17.7/40/52m. Increasing the local piloting of presumption against bail for drug-using offenders to 42 court areas by year 3

would cost £0.6/7.3/27.6m. **Total: £219m over 3 years.** We have not had any revised figures since the number of BCUs with the programme was revised down to 30.

Emily Miles

EMILY MILES

Top: PPS
cc PD(AA)
PD(SR)
PD(EM)
PD(NA)

PERSONAL

Prime Minister

Your office have been setting up two additional delivery meetings as part of a new series of spot checks in a number of key areas. I thought that I would let you know my concerns about this.

2 As you would expect, I will always make whatever changes to my diary are needed to accommodate any meetings at short notice that you might want to hold – as we did earlier this week to discuss sentencing. However, I am concerned at the impact on my diary if we need to hold over a regular weekly spot check slot. To mitigate this, your office has suggested that junior Ministers and officials might attend in my place but I would, of course, always want to attend such meetings myself.

3 But more generally, I wonder whether we are not in danger here of spending too much time reviewing progress and distracting ourselves and key senior officials from the important job of getting on with delivery.

4 Two additional meetings in particular are being arranged – on drugs and asset recovery. On drugs, I attach a note which sets out the latest progress. Given this, I am not sure how much we could usefully add at the proposed meeting next week. Officials will produce progress reports for the CJS Ministerial Group on the 20th, DA(D) on the 28th and our Stocktake on the 11th of February. But my preference would be for PMDU, Justin Russell and my Drugs team to talk next week about how we could streamline the monitoring and reporting process.

5 On asset recovery we are making progress both on the launch of the agency next month and with the Task Force. This comprises a mixture of 23 staff from CPS, Customs and the police and has already successfully realised an outstanding confiscation order in the sum of £44,000. A scoping exercise is underway involving nine key magistrates' court areas and in the next month or so we should begin to get a much clearer idea of major sums outstanding and how best to prioritise the backlog.

6 There is also the outstanding question of funding for the new Act and the incentivisation scheme on which we are working urgently with the Treasury and proposals should be with you very shortly. Again, given that we have a stocktake scheduled for 11th February, I am not convinced that there is a great deal usefully to be covered in an additional meeting.

7 But of course, as always, I am very happy to adjust my time to your requirements.

Best wishes.

David

9 January 2003

SKP 10/1/03

Annex

Drugs

Jonathan Sedgwick's letter to Justin Russell on 20th December outlined progress on the drugs CJS Interventions Project. This report updates that picture.

Project Team

Peter Wheelhouse is joining Drugs Strategy Directorate later this month to head up the new project team. He has extensive operational experience of front line services and project delivery.

Ministerial Committee

The first meeting of the Ministerial Steering Committee has been arranged for the 20th of January. We are hoping that Justin Russell will attend.

Local capacity and Resource Allocation

We are on track to finalise resource allocations by the middle of the month. These will be circulated in the draft DA(D) papers next week. By the end January we will have identified a local leader in each of the areas covering the 30 BCUs, along with an initial assessment of obstacles to delivery and action plans to address these.

Stakeholder Management

A letter was sent to core stakeholders on 20 December. (DAT chairs and co-ordinators, ACPO, NTA, LGA, Regional Directors and Managers). We are also arranging a national event for them (probably the last week of February) and are currently consulting them on the format and issues they would like addressed.

Strategy Unit

The Strategy Unit work on modelling flows into treatment and capacity issues is underway with a further progress meeting this week. As you know this work is critical to decisions on the further roll-out of the project in 2004/5 and 2005/6

02072733965 1. PR HA: Drugs PT 3

Top: PPS
cc PS(AA)
PS(JR)
PS(EM)
PS(NA)

MATRIX

PFQ

PERSONAL

Prime Minister

Your office have been setting up two additional delivery meetings as part of a new series of spot checks in a number of key areas. I thought that I would let you know my concerns about this.

2 As you would expect, I will always make whatever changes to my diary are needed to accommodate any meetings at short notice that you might want to hold – as we did earlier this week to discuss sentencing. However, I am concerned at the impact on my diary if we need to hold over a regular weekly spot check slot. To mitigate this, your office has suggested that junior Ministers and officials might attend in my place but I would, of course, always want to attend such meetings myself.

3 But more generally, I wonder whether we are not in danger here of spending too much time reviewing progress and distracting ourselves and key senior officials from the important job of getting on with delivery.

4 Two additional meetings in particular are being arranged – on drugs and asset recovery. On drugs, I attach a note which sets out the latest progress. Given this, I am not sure how much we could usefully add at the proposed meeting next week. Officials will produce progress reports for the CJS Ministerial Group on the 20th, DA(D) on the 28th and our Stocktake on the 11th of February. But my preference would be for PMDU, Justin Russell and my Drugs team to talk next week about how we could streamline the monitoring and reporting process.

5 On asset recovery we are making progress both on the launch of the agency next month and with the Task Force. This comprises a mixture of 23 staff from CPS, Customs and the police and has already successfully realised an outstanding confiscation order in the sum of £44,000. A scoping exercise is underway involving nine key magistrates' court areas and in the next month or so we should begin to get a much clearer idea of major sums outstanding and how best to prioritise the backlog.

6 There is also the outstanding question of funding for the new Act and the incentivisation scheme on which we are working urgently with the Treasury and proposals should be with you very shortly. Again, given that we have a stocktake scheduled for 11th February, I am not convinced that there is a great deal usefully to be covered in an additional meeting.

7 But of course, as always, I am very happy to adjust my time to your requirements.

Best wishes.

9 January 2003

02072733965

Annex

Drugs

Jonathan Sedgwick's letter to Justin Russell on 20th December outlined progress on the drugs CJS Interventions Project. This report updates that picture.

Project Team

Peter Wheelhouse is joining Drugs Strategy Directorate later this month to head up the new project team. He has extensive operational experience of front line services and project delivery.

Ministerial Committee

The first meeting of the Ministerial Steering Committee has been arranged for the 20th of January. We are hoping that Justin Russell will attend.

Local capacity and Resource Allocation

We are on track to finalise resource allocations by the middle of the month. These will be circulated in the draft DA(D) papers next week. By the end January we will have identified a local leader in each of the areas covering the 30 BCUs, along with an initial assessment of obstacles to delivery and action plans to address these.

Stakeholder Management

A letter was sent to core stakeholders on 20 December. (DAT chairs and co-ordinators, ACPO, NTA, LGA, Regional Directors and Managers). We are also arranging a national event for them (probably the last week of February) and are currently consulting them on the format and issues they would like addressed.

Strategy Unit

The Strategy Unit work on modelling flows into treatment and capacity issues is underway with a further progress meeting this week. As you know this work is critical to decisions on the further roll-out of the project in 2004/5 and 2005/6

file
Added to DCO In Box

From: **Emily Miles**
Date: **23 December 2002**

PRIME MINISTER

JJH, AA, JP, JR, NA, AC, SM, MB, Paul Brittan (Cab Office), Ben Wilson

DRUG TREATMENT AND TESTING PROGRAMME

The Home Office has written to update you on the comprehensive drug treatment and testing programme that you asked for. They report that the programme will be announced in January, and that work is underway to identify those Drug Action Teams (DAT) whose capacity to deliver gives cause for concern. (A number, e.g. Liverpool, Bradford, Waltham Forest, Leeds, Calderdale, Hackney, Bolton and Reading, are already known to be poor performers who will need considerable support and intervention to get them up to scratch). Officials are alerting those in the 30 high crime BCUs to what is on the cards – though until they are told their specific funding allocations it is unlikely they will be able to recruit staff and purchase equipment. A 1 April start date is looking increasingly unlikely.

Disappointingly, **HO have still not appointed a team with a Louise Casey head of unit equivalent to take this forward.** Nor have they told the 30 high crime BCUs what their funding allocation will be, or provided us with an assessment of the delivery capacity of each DAT. They promise us these in January, though we have been pressing them for clarity since October. You are meeting Ministers to talk about the BCU drugs strategy on 22 January. You may need to give them a loud wake up call.

Emily

EMILY MILES

02072733965

Fc

Home Office

The Private Secretary to the Home Secretary

20 December 2002

Justin Russell
10 Downing Street
London SW1

cc: EM
NA

Dear Justin

DRUG TREATMENT AND TESTING PROGRAMME

Thank you for your letter of 10 December, confirming that the Prime Minister is content with the proposals set out in the note which Bob Ainsworth and Hazel Blears submitted on 29 November.

We are now gearing up to deliver the comprehensive programme described, and we will provide progress reports through the Prime Minister's quarterly stocktakes on delivery of the drug strategy targets. The first such report will be prepared for the next stocktake on 11 February, but in the meantime I thought it might be helpful to give you a brief update on where we are at present, picking up on the key points in your letter.

Project Team

We are building up a project team to take this work forward as quickly as possible. In the meantime we have set up a cross-departmental project group which Sue Killen is chairing and you and/or Emily might find it helpful to attend meetings of this group in future.

Ministerial Committee

Bob Ainsworth's office is currently setting up the first meeting of the Ministerial committee which will have oversight of the drug treatment and testing programme. They are currently aiming for a meeting in mid-January, with invitations going to Hilary Benn, Hazel Blears and Yvette Cooper. The committee will work closely with other Ministerial groups which exist within the Home Office to ensure that the necessary links are made on crime reduction, policing, and criminal justice issues, without creating duplication of effort. Again you would be very welcome to attend meetings of this committee.

Taking this project forward in advance of a full team being in place presents a significant challenge. However, steady progress is being made within existing resources.

Local Capacity and Resource Allocation

Work is underway to identify those DATs whose capacity to deliver gives cause for concern and to ensure that the necessary assistance and guidance is provided speedily and effectively. We will be setting up an "improvement team" to put resources where they are needed at regional or local level. Some of the key obstacles to delivery which the team will need to address include: problems with commissioning; inadequate treatment capacity; and lack of robust information for proper local monitoring and management of people going into treatment. We are also using consultants to identify ways in which we can improve the way we performance manage delivery and they will come up with proposals in mid January.

We will also identify named individuals in each of the areas containing the BCUs to lead the programme locally.

We expect by mid-January to have the precise allocations which will go to each of the 30 BCUs from year 1 of the SR 2002 drugs allocation. This will include a small percentage of the overall pot to facilitate capacity building in the areas containing the BCUs.

Stakeholder Management/Announcements

Local commitment to delivery will be a key to the successful implementation of these interventions, so stakeholder management is key. In parallel with this letter, therefore, officials are writing round to key stakeholders alerting those in the areas containing the 30 high crime BCUs what we are proposing (including the fact that there will be additional resources as described above); explaining the criteria for choosing the initial BCUs; and to set in train discussions on plans for capacity development and roll out of the various initiatives. Equally, we need to explain the position to those not affected in the first year, especially those whose areas are recognised as having a significant problem with Crack under the emerging Crack Plan, but not in the highest areas for acquisitive crime. (I enclose a copy to this letter.)

As the plans take shape we will announce the programme in January and hold a more formal launch at an event involving key local and regional players.

I am copying this letter to recipients of yours.

Yours ever

Jonathan

JONATHAN SEDGWICK

DRAFT LETTER TO ALL STAKEHOLDERS

As you will have seen in the Updated Drug Strategy published earlier this month, we plan to break the link between drugs and crime by introducing or extending a range of interventions aimed at getting offenders with drug problems into drug treatment. In particular this will involve taking forward the work we have already done on Arrest Referral and Drug Treatment and Testing Orders, building on the pilot Drug Testing projects by extending this approach more widely, and developing better systems for throughcare and aftercare.

We have an ambitious programme for the next three years from April 2003 and will be making significant new resources available. We plan to start by focusing on the areas containing the basic command units with the highest levels of acquisitive crime as set out in the attached list (with new interventions for young people being piloted on 10 of these BCUs). We have identified these areas using national figures for recorded crimes – namely burglary, robbery and theft of and from vehicles. These are known to have a strong link with high levels of drug misuse.

This list omits many areas also known to suffer significant problems with drug misuse including crack. But many such areas will have seen their allocations to the Pooled Treatment Budget increased; and some of the proposed interventions we are funding from April 2003 will apply across the whole country. The programmes for 2004/05 and for 2005/06 will extend the interventions to the areas ranked lower for acquisitive crime.

For those in the areas containing the top 30 BCUs, we will need to begin discussions with you and your colleagues as a matter of urgency on the

possible implications for your area – in particular to ensure that there is or will be the treatment capacity available to deal with offenders being referred as a result of these new interventions. We recognise that there will be obstacles to delivery everywhere – though some will be more challenging than others - and there will be resources available to help overcome these obstacles.

Colleagues from the Government Offices will be in touch early in the New Year to explore in more detail the key issues for your area to ensure delivery. One of the key issues for discussion with you will be to identify a named individual in each of the areas containing the 30 BCUs to be in charge of leading the programme locally and pulling together all the key strands.

By mid January we will be able to determine exact financial allocations for each area. In overall terms we envisage each area containing the top 30 BCUs, receiving funding to introduce the range of interventions and some resource in 2003/4 to develop the necessary capacity to support delivery. This will be in addition to the increased allocations for drug treatment through the pooled treatment budget announced recently by the NTA.

Rec'd 20 Dec
file

Home Office

The Private Secretary to the Home Secretary

20 December 2002

Justin Russell
10 Downing Street
London SW1

Dear Justin

DRUG TREATMENT AND TESTING PROGRAMME

Thank you for your letter of 10 December, confirming that the Prime Minister is content with the proposals set out in the note which Bob Ainsworth and Hazel Blears submitted on 29 November.

We are now gearing up to deliver the comprehensive programme described, and we will provide progress reports through the Prime Minister's quarterly stocktakes on delivery of the drug strategy targets. The first such report will be prepared for the next stocktake on 11 February, but in the meantime I thought it might be helpful to give you a brief update on where we are at present, picking up on the key points in your letter.

Project Team

We are building up a project team to take this work forward as quickly as possible. In the meantime we have set up a cross-departmental project group which Sue Killen is chairing and you and/or Emily might find it helpful to attend meetings of this group in future.

Ministerial Committee

Bob Ainsworth's office is currently setting up the first meeting of the Ministerial committee which will have oversight of the drug treatment and testing programme. They are currently aiming for a meeting in mid-January, with invitations going to Hilary Benn, Hazel Blears and Yvette Cooper. The committee will work closely with other Ministerial groups which exist within the Home Office to ensure that the necessary links are made on crime reduction, policing, and criminal justice issues, without creating duplication of effort. Again you would be very welcome to attend meetings of this committee.

Taking this project forward in advance of a full team being in place presents a significant challenge. However, steady progress is being made within existing resources.

Local Capacity and Resource Allocation

Work is underway to identify those DATs whose capacity to deliver gives cause for concern and to ensure that the necessary assistance and guidance is provided speedily and effectively. We will be setting up an "improvement team" to put resources where they are needed at regional or local level. Some of the key obstacles to delivery which the team will need to address include: problems with commissioning; inadequate treatment capacity; and lack of robust information for proper local monitoring and management of people going into treatment. We are also using consultants to identify ways in which we can improve the way we performance manage delivery and they will come up with proposals in mid January.

We will also identify named individuals in each of the areas containing the BCUs to lead the programme locally.

We expect by mid-January to have the precise allocations which will go to each of the 30 BCUs from year 1 of the SR 2002 drugs allocation. This will include a small percentage of the overall pot to facilitate capacity building in the areas containing the BCUs.

Stakeholder Management/Announcements

Local commitment to delivery will be a key to the successful implementation of these interventions, so stakeholder management is key. In parallel with this letter, therefore, officials are writing round to key stakeholders alerting those in the areas containing the 30 high crime BCUs what we are proposing (including the fact that there will be additional resources as described above); explaining the criteria for choosing the initial BCUs; and to set in train discussions on plans for capacity development and roll out of the various initiatives. Equally, we need to explain the position to those not affected in the first year, especially those whose areas are recognised as having a significant problem with Crack under the emerging Crack Plan, but not in the highest areas for acquisitive crime. (I enclose a copy to this letter.)

As the plans take shape we will announce the programme in January and hold a more formal launch at an event involving key local and regional players.

I am copying this letter to recipients of yours.

Yours ever

JONATHAN SEDGWICK

DRAFT LETTER TO ALL STAKEHOLDERS

As you will have seen in the Updated Drug Strategy published earlier this month, we plan to break the link between drugs and crime by introducing or extending a range of interventions aimed at getting offenders with drug problems into drug treatment. In particular this will involve taking forward the work we have already done on Arrest Referral and Drug Treatment and Testing Orders, building on the pilot Drug Testing projects by extending this approach more widely, and developing better systems for throughcare and aftercare.

We have an ambitious programme for the next three years from April 2003 and will be making significant new resources available. We plan to start by focusing on the areas containing the basic command units with the highest levels of acquisitive crime as set out in the attached list (with new interventions for young people being piloted on 10 of these BCUs). We have identified these areas using national figures for recorded crimes – namely burglary, robbery and theft of and from vehicles. These are known to have a strong link with high levels of drug misuse.

This list omits many areas also known to suffer significant problems with drug misuse including crack. But many such areas will have seen their allocations to the Pooled Treatment Budget increased; and some of the proposed interventions we are funding from April 2003 will apply across the whole country. The programmes for 2004/05 and for 2005/06 will extend the interventions to the areas ranked lower for acquisitive crime.

For those in the areas containing the top 30 BCUs, we will need to begin discussions with you and your colleagues as a matter of urgency on the

possible implications for your area – in particular to ensure that there is or will be the treatment capacity available to deal with offenders being referred as a result of these new interventions. We recognise that there will be obstacles to delivery everywhere – though some will be more challenging than others - and there will be resources available to help overcome these obstacles.

Colleagues from the Government Offices will be in touch early in the New Year to explore in more detail the key issues for your area to ensure delivery. One of the key issues for discussion with you will be to identify a named individual in each of the areas containing the 30 BCUs to be in charge of leading the programme locally and pulling together all the key strands.

By mid January we will be able to determine exact financial allocations for each area. In overall terms we envisage each area containing the top 30 BCUs, receiving funding to introduce the range of interventions and some resource in 2003/4 to develop the necessary capacity to support delivery. This will be in addition to the increased allocations for drug treatment through the pooled treatment budget announced recently by the NTA.

HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

Jeremy Heywood
Principal Private Secretary
10 Downing Street
London
SW1A 2AA

December 2002

STRATEGY UNIT PROJECT ON DRUGS

The Economic Secretary has seen your letter of 3 December to Jonathan Sedgwick about the Strategy Unit project to assess the relative cost effectiveness of the interventions in the drugs market.

The Economic Secretary, as Minister with responsibility for Customs, is the lead Minister for the supply side of the Government's drug strategy. Customs co-ordinates the multi-agency effort against drug supply and related criminal finances. The Economic Secretary and Customs would have welcomed being involved earlier, prior to the public announcement of the Strategy Unit review in the Updated Drug Strategy on 3 December.

That said, the Economic Secretary very much welcomes the review. Customs officials have already met with Charlie Massey and his Strategy Unit team to discuss how the work will be taken forward and what help Customs can offer.

SAM WOODS

Sanctuary Buildings Great Smith Street Westminster London SW1P 3BT
tel: 0870 0012345 dfes.ministers@dfes.gsi.gov.uk
Rt Hon Charles Clarke MP

(F)

c JR
EM
NA
AA
PD

Jeremy Heywood
Principal Private Secretary
10 Downing Street
London
SW1A 2AA

11 December 2002

Dear Jeremy

STRATEGY UNIT PROJECT ON DRUGS

Thank you for your recent letter of 3rd December to Jonathan Sedgwick concerning the Strategy Unit and its potential to take forward a project on drugs.

This is an important area and one which Charles Clarke is keen that the DfES should support. Officials have been working closely on the Drugs Strategy, delivery plans and communication of the key messages to ensure vulnerable young people are referred to the treatment programmes they need. I would be grateful if DfES officials could be involved in the Strategy Unit's work on the project.

I am copying this letter to Private Secretaries to Cabinet Ministers and the first Ministers for Scotland, Wales and Northern Ireland, Andrew Allberry, Paul Britton (EDS) and Geoff Mulgan (SU).

Yours sincerely

Claire Carroll

CLAIRE CARROLL
PRIVATE SECRETARY

R 11/12

JR
cc GM
- file

Home Office

Bob Ainsworth MP
PARLIAMENTARY UNDER SECRETARY OF STATE
50 Queen Anne's Gate, London SW1H 9AT

10 December 2002

Prime Minister

As you are aware, I undertook to co-ordinate the response to John Mann's public inquiry report into heroin use in Bassetlaw.

As part of this undertaking, I commissioned replies to the recommendations from the local Drug and Alcohol Action Team (DAAT) and other Government departments.

Although inquiries such as these can raise difficult issues, I am pleased with the response of the local DAAT and other local officials. They have considered the report seriously and have genuinely taken on board many of the recommendations as part of their on going work programme.

I also understand that John Mann and the DAAT have recently met to establish a regular dialogue and explore how the action plan of the local DAAT can be kept on track and communicated to local people.

This has been a positive experience in that it has challenged and tested local working practices and demanded greater accountability for the delivery of services.

I enclose a suggested reply to John Mann for your consideration.

BOB AINSWORTH

DRAFT COVERING LETTER OF REPLY.

John Mann MP

I am pleased to enclose the response to the report of your public inquiry on heroin in Bassetlaw.

I am encouraged that many of the recommendations contained in your report are being addressed by the local Drug and Alcohol Action Team, which shows a genuine willingness to listen to the local community and deliver better services.

Drugs misuse is a major problem for all of our communities and the solution must lie with all the agencies, communities, officials and elected members, pulling together to ensure that allocated resources reach those communities most at risk. I applaud your efforts in holding the inquiry and producing its recommendations. It is clear that there is still much to do, but I am assured that there is genuine commitment to get it right.

I hope that the developing partnership between you and the Nottinghamshire DAAT continues to identify local needs and develop local solutions.

TONY

Government response to the recommendations in John Mann's report into heroin in Bassetlaw

Recommendation 1 – We recommend that urgent research be carried out in coalfield communities to quantify the scale of the problem of heroin use, access to facilities and resources to fight it.

Research has been commissioned by the Home Office research unit to look at rural drug markets. The contract has been awarded to Southbank University and Nottinghamshire is being considered as a potential pilot site. If chosen the study may include Bassetlaw.

It is key that the local DAAT keeps track of local drug trends. Over the last three years the DAAT has commissioned research which has included:

- Research into the criminal justice arrest and referral work with Bournemouth University;
- Research into the pilot Youth Justice Board 'Face It' Young Peoples Criminal Justice Workers within Youth Offending Teams by Bournemouth University;
- Research into the Sorted 24 hour project by Professor Harold Parker, Manchester University
- Research on the development and need of women substance misusers by Sheila Henderson & Jackie Goode.

Recommendation 2 – We recommend that the DAAT set annual targets for Bassetlaw, with regular reviews to assess successes and failures.

For the last 7 years, Notts County Drug and Alcohol Action Team (DAAT), alongside the Bassetlaw Drug Reference Group, has set annual targets alongside the DAAT annual plan on a yearly basis, but also, separately for the Bassetlaw Drug Reference Groups, (as it has done for all of the 7 drug reference groups in Notts County).

Regular reviews through the DAAT and the commissioning structure take place of the DAAT county annual targets alongside the Regional Government template and NTA treatment reviews. The Bassetlaw Drug Reference Group targets are also reviewed on a yearly basis and, through constitutional and yearly target setting, through the Bassetlaw Chair.

The Bassetlaw Drug Reference Group should continue to set robust annual targets on a local basis and include targets which will be agreed in partnership with the lead strategic partners of the Primary Care Trust and the local strategic partnership/crime and disorder partnerships.

The Notts County DAAT Joint Commissioning Group (JCG) has been seen as an example of good practice by the NTA for its robust commissioning and performance management procedure. This includes performance management and quarterly, six monthly and yearly reviews of all service providers, with target setting for individual

service providers including waiting list targets, sustainability of clients, access from new clients and in the future, unit cost.

Recommendation 3 – We recommend that a pilot in Bassetlaw should be funded to develop and effective approach to parental education about drugs.

Notts County DAAT, alongside the LEA, the (PSDI) personal and social development initiative and primary/secondary special schools in Bassetlaw continue to ensure that the target is reached of 100% of effective education regarding substance misuse in schools. This includes the target of 100% of parental advice and information around substance misuse. The LEA will continue to work actively with all schools in Bassetlaw to enhance their substance misuse curriculum and out of curriculum involvement with pupils, parents, head teachers, staff and governors. Parents Evening Education events are being extended in Secondary School settings.

Recommendation 4 – We recommend that the lack of a local provision of drugs education be addressed immediately by secondary heads and governors, with quantified changes by the year-end.

See answer to Recommendation 3. Notts County DAAT, alongside the Chair of the DAAT, John Berridge, Assistant Director for Education and Inspectorate for Schools, will continue to give high priority to the provision of drug education to be addressed by secondary heads and governors, enhancing secondary education, both in and out of curriculum. This includes partnership work with the Youth Service, Connections, Youth Offending Team, Pupil Referral Units and opportunities through the school setting. This includes the recent commissioning of Education Link Workers with Young People and Substance Misuse Providers, alongside improved training and support around policies and implementation through the Personal and Social Development Initiative (PSDI) for secondary schools in Bassetlaw. PSDI provide 'Heroin Worksops' and a Nottingham Programme of Interventions, including a partnership project for 'Children affected by someone else's drug use'.

Recommendation 5 - We recommend changes in the guidelines to the national curriculum, to give drugs education a higher and more clearly defined priority and that follows good practice.

DfES has recently begun the process of revising and consolidating their guidance to schools on drug, alcohol and tobacco education with a series of pre-drafting consultation events. This will be an important opportunity to both raise the profile of drug education in school and reinforce key messages to schools in relation to their responsibilities and what constitutes good practice. The revised guidance will be subject to a three-month consultation period in spring 2003 with a view to publication in the 2003/4 academic year.

Recommendations 6-12:

The service must have a base in the Worksop area immediately. We find the excuses from the many agencies involved quite unacceptable. To be unable to find premises in three years is in itself a symptom of a deeper problem in partnership working. No one accepts responsibility for this farce. We believe that suitable premises can be found.

A Worksop based service must have a new name and identify to help rebuild confidence in it.

The service must have a 7-day, 24-hour on-duty support available for telephone advice and counselling. We have no view on whether this service could be a shared service with other providers

There must be a quantified standard set and maintained for the answering, logging and returning of telephone calls.

The service needs to honestly quantify its waiting list time to partners, funders and users.

There must be an agreed care plan for all patients arranged in co-operation with other agencies.

Users need to get into treatment without delay.

The Notts County Joint Commissioning Group (JCG) has commissioned two facilities based in Bassetlaw in relation to substance mis-use, a) a partnership with Bassetlaw PCT for a new build of a community drugs team alongside a generic health centre – this has been developed over the last 18 months, although there has been at times, slow progress in relation to planning permission and applications, community involvement, valuations and District Valuer Reports. This has now reached the stage of going to the final planning committee on 8 January and the build will take place immediately after this date with a target date for opening at the end of 2003.

The second premises has been commissioned for a one-stop shop for service providers to meet clients with a base identified for refurbishment within Worksop town centre. This is following a model used very successfully in other disbursed communities in Newark and Sherwood. This has a target date of opening of February 2003. The premises will then be named appropriately with consultation of community clients, providers and commissioners.

It is important to recognise that although the DAAT has moved forward for premises based within Bassetlaw, clients have always had the provision to be seen within the Bassetlaw district, with 98% of Bassetlaw clients being seen in their district in the quarter of June-September 2002 - this includes home visits, surgeries within the Probation Offices homelessness sector venues, and also a clinic which takes place on a weekly basis through the Bassetlaw Hospital.

Services have been commissioned for the last 2 years with a 24-hour help-line system and this has also provided a separate service on a 7-day per week for families and carers. Provider services work out of hours in order to cater for men and women who work or require additional time or support, this includes week-end and out of hours cover within the arrest and referral custody suites, outreach and pm. work for young people's services. At present there is no evidence to state that a 24-hour drop in service would be appropriate or best value, but there is a commitment to ensure that the 24-hour telephone line is available through the *Sorted* provider service and available 365 days of the year.

All services are required to maintain an appropriate system of assessment, screening and referral, including telephone enquiries. The Maltings services, and particularly the Community Drug Service have been tasked with improving the access for administration, support and immediate referral for telephone enquiries and this is being monitored on a quarterly basis.

The Maltings service, as part of the Commissioning and NTA performance management with the Notts County DAAT provide a monthly report on their waiting times and the waiting times have been reduced in a year period from 21 weeks to 8 weeks, with the longest wait currently standing at 8 weeks. This of course needs to be improved to meet the national NTA targets for April 2003.

The Maltings and all service providers are working with the NTA Models of Care to ensure integrated pathways and care plans for all patients and this is now being moved forward through the provider services and Notts County DAAT is an ETO Enhanced Treatment Option pilot for the Models of Care to ensure NTA support for integrated care pathways with all agencies.

Notts County DAAT provider services, endeavouring that users get into treatment without delay/or with minimum delay, hence a range of services have been commissioned to ensure that users needs are met in relation to diversity, including women, young people, outreach, criminal justice, DTTO probation and community drug team services and have recently increased the capacity of workers within The Maltings Community Drug Team Service and the clinical time from GP's and consultants. This will be monitored on a regular basis to ensure it is at the appropriate capacity, accessibility and quality.

Recommendation 13 – We recommend that the new clinic and health centre proceed without delay.

The development of a new Community Drug Service, adjacent to the Bassetlaw Generic Health Clinic and Centre is proceeding and has had the support through the DAAT and Bassetlaw Drug Reference Group and Local Strategic Partnership to ensure progress and District Council and Community Involvement to this point.

Recommendation 14 – We recommend that residential rehabilitation should be part of a menu of treatment options available within Bassetlaw.

Over the past two years, the DAAT in partnership with the Social Services department has increased the funding for residential rehabilitation placements for Drug and Alcohol users by £125,000 bringing the total available to in excess of £325,000.

Discussions are currently taking place with residential providers including Framework Housing Association, Phoenix and RAPT to provide a menu of residential rehabilitation options for communities in Bassetlaw and surrounding districts. Additional support for the commissioning and development of residential services in the East Midlands is being sought from the Government Office Drug teams and the NTA.

Recommendation 15 – We recommend that the DAAT and the NTA give a high priority to evaluating the effectiveness of implants and providing guidance to local people.

The expert group that produced the Department of Health guidelines **Drug misuse and *dependence – guidelines on clinical management*** (1999) reviewed the evidence for the use of oral naltrexone in drug treatment programmes for heroin addicts. The group concluded that because of the uncomfortable or severe opiate withdrawal symptoms if taken by an individual dependent on an opiate, naltrexone-assisted relapse prevention should only be initiated by specialists and specialised generalists experienced in this technique.

The National Treatment Agency (NTA) for drug misuse treatment, is currently reviewing research priorities in the drug treatment field. The NTA will continue to monitor the evidence for the wide range of potential treatments in consultation with experts and the research field. This is in accordance with its broad role in monitoring and developing the research base for the treatment of addiction and in disseminating relevant findings to the field.

Naltrexone in implant form is not currently licensed for use in the treatment of addiction in the UK. It is not generally used by specialists and research evidence is limited to support its use. Methods for obtaining a product licence apply equally to naltrexone implants as to any other drug, This is subject to satisfying standards of evidence on effectiveness and safety to ensure proper protection of the public. We are considering whether there is more that needs to be done on this.

Recommendation 16 - We recommend that consideration needs to be given, by Health Trusts and national government, to better integration of GP services into drugs treatment and whether Primary Care Trust management of drug treatment budgets would be preferable.

Shared Care is where GPs are expected to treat people with drug dependency (particularly opiate) problems alongside specialist treatment agencies, usually prescribing methadone. The Department of Health are currently reviewing progress in GP provision of shared care and in increasing access to GP general medical services for all problem drug users, irrespective of prescribing needs.

Recommendation 17 - We recommend that every GP practice be required to have a fully trained partner who is a specialist on drug treatment.

The National Treatment Agency is implementing a Workforce Strategy to support the rapid expansion of drug treatment services and improvement in quality. The Royal College of General Practitioners are providing training for health care professionals. A

target of getting 1,300 extra health care professionals trained by 2004, including 500 GPs based within the community and Prison Service has been set.

The Department of Health encourages GP practices to have a drugs specialist with practices but cannot enforce this. The reasons behind this are that it is not practical for small practices to have a drug specialist and most services have to reflect the needs of their community. They do insist that GPs provide general medical services to drug users, but cannot enforce that every GP practices substitute prescribing.

Recommendation 18 – We recommend that more needle exchanges be introduced, with a clear requirement to safely dispose of used needles.

Local pharmacies are being encouraged to provide additional pharmacy provision for needle and syringe exchanges but this is an area where development is still required. Additional needle and syringe exchange provision through a homelessness sector provider has been commissioned and it is hoped that this will be enhanced in the next year through outreach and other premises and pharmacy provision. The Joint Commissioning Group has commissioned a Primary Care Trust support post for pharmacy supervised consumption and the development of pharmacy NSE schemes with additional funding and payments available. As a result, 13 new pharmacies across Nottinghamshire County including pharmacies in Bassetlaw have now been commissioned and set up for supervised consumption and there is every confidence that needle and syringe exchanges will follow. In addition, a project "At The Sharp End" regarding the development of advice and information around the disposal of used needles and syringes has been commissioned and is seen as an example of national good practice, not only through the DAAT's but also the Tidy Britain campaign. This continues to work closely with the District Council for in and out of hours disposal for environmental services.

Recommendation 19 – We recommend that the council needle collection and disposal service be guaranteed, particularly at evenings and weekends and be far better publicised.

As Recommendation 18, there is continued closer with the District Council to ensure an improved service in out of hours for the disposal of used needles and syringes.

Recommendation 20 - We recommend to government and the Health Trusts that drugs treatment workers be mainstream funded, with permanent contracts and local working conditions suitable for the 21st Century not the late 19th Century.

Providing security of funding, good in-service training and conditions of employment are important to recruiting and retaining enough well qualified drugs workers to allow treatment services to expand sufficiently to meet the national drugs strategy target.

Much drugs treatment provision is already supported by mainstream funding with drugs workers being employed on permanent or fixed term contracts of several years in length. Increasing the security of funding for services would promote long term growth in the field. However, this needs to be balanced with provision to review contracts at regular intervals in order to ensure services perform effectively and continue to meet changing needs at local level.

Ensuring that existing funding for services is protected and that DATs receive an indication of the level of Pooled treatment budget funding that will be available to them over the whole SR2002 period is a key national priority. The National Treatment Agency is implementing a programme to recruit and train new drugs workers and to support the professional development of those already in post.

Drugs workers are employed by provider agencies, which may be statutory or non-statutory services. Provider agencies generally operate under contract to the commissioner of services, such as a primary care trust or drug action team. These contracts are usually awarded for a period of one or more years. Funding for drug services is provided from mainstream budgets or specific funding streams, such as the pooled treatment budget. Most mainstream funding comes from local and health authorities and to a lesser extent from probation and police services together with some additional funds from other bodies and charitable trusts.

Recommendation 21 - We recommend that every school in Bassetlaw have a compulsory uniform.

The schools in Nottinghamshire have a range of policies with regard to the school dress code, from a full and traditional uniform, through colour co-ordinated uniform sweatshirts, to no formal uniform in the sense of uniformity. All schools, however, do have a policy involving rules about a school dress code.

A sense of belonging and identity with the school as an organisation, is clearly a sensible objective. However, there is more to enhancing pride, achievement, worth and self-esteem than uniformity. A focus on pupils as individual learners with individual preferred learning styles requiring appropriate pedagogies in order to experience personal success; the prioritisation of the development of personal and social skills alongside other basic skills in the context of PSHE programmes; a pastoral system which values pupils and supports them with a view to promoting their inclusion, enabling them to feel wanted. These approaches will make the contribution to education which enable young people to fell good about themselves and resist the perhaps inevitable temptations which adolescence may bring.

Although there is no evidence to suggest that school uniform alone can enhance school improvement, raise achievement or reduce drug misuse, many schools value school uniform as an outward sign on their determination to raise standards; as such it has importance but should not be taken to be a panacea.

Recommendation 22 – We recommend that each school set a target of at least 50 per cent of the local community entering the school door each year.

This recommendation is consistent with the government's ambition to create extended schools. These will provide not only statutory education within a formal and constrained timetable but also a range of activities, services and opportunities for a client group beyond the school age population and will in addition extend the opening time of the school infrastructure.

Two secondary school and some of their feeder primary schools in Bassetlaw have recently made a bid to become pathfinder extended schools. This project will develop the means for recommendation 22 to be achieved widely across Bassetlaw in due course.

Recommendation 23 - We recommend that DATs and Local Education Authorities be charged with quantifying the level of domestic heroin use affecting children in primary schools.

Local Education Authorities and primary and secondary schools are not required to collect information about the drug use of their pupils' parents. There are inherent difficulties in collecting information about drug use; because of its often illegal nature, drug users are often reluctant to identify themselves to statutory bodies.

The Home Office is responsible for collecting information on the scale of drug misuse in England and Wales. The report of the Advisory Council on the Misuse of Drugs – 'The Children of Problem Drug Users' is due to be published next year and will contain estimates of the numbers of children affected by parental drug misuse. The report is also expected to make recommendations to address the problem.

When parents use drugs – especially problematic and illegal drugs like heroin – their children may be exposed to a range of emotional and physical hazards. Children may respond in a variety of ways, including: disturbed or anti-social behaviour; becoming withdrawn or introverted; turning to drink or drugs to escape unpleasant home situations; running away from home; losing concentration in class; and reluctance to form or develop friendships with schoolmates. The child may also be the subject of bullying if schoolmates perceive him or her to be 'different' or 'not fitting in' with the peer group. Schooling is likely to be interrupted if the child is depended upon to care for drug using parents.

The government recognises that the children of drug using parents are a vulnerable group. They should therefore benefit from the new requirement for every top tier or unitary local authority to prepare from April 2003 a local preventive strategy to improve outcomes for children aged 0-19 who are at risk of social exclusion. This was announced by the Minister for Young People on 6 September. On 30 October the Prime Minister announced to the House the government's intention to publish a Green Paper on Children at Risk in the New Year. The DFES is playing a full part in helping to make sure that vulnerable children and young people are identified as soon as possible, and that their needs are met with a coherent and effective response from the relevant statutory and voluntary agencies.

Recommendation 24 – We recommend that the Progress 2 Work pathfinder project be expanded in Worksop.

The progress2work pathfinder project is currently already working in Worksop and has a high level of referrals from the Bassetlaw area. The DAAT supports the progress2work project and ensuring care pathways and referrals from service providers and service users in Bassetlaw.

Recommendation 25 – We recommend that the business community take the lead in creating positive images of the world at work, including in primary schools.

The DAAT has been proactive in working with the business community in providing training opportunities in drug awareness but also working with policy guidelines and protocols with the business community, this has already taken place through the largest

employment providers in Bassetlaw, Wilkinsons Distribution Centre. Further opportunities and guidance in working with the role of the business community for regional and national policy would be welcome.

Recommendation 26 - We recommend that the churches develop policy and action plans to assist in tackling drug use.

The Government recognises the value of religious organisations and their potential for community development and the education of young people; and in the provision of welfare services. There is clearly a role at the local level in helping with activity to tackle drug problems and churches can of course obtain local funding for such work through CAD other funding. However as matter of their national policy it is surely a matter for the governing bodies of the respective churches and faith groups to explore the degree to which they assist with such work.

Recommendation 27 - We recommend that the government looks at additional community service orders for public figures glorifying drugs, including work in our communities with those most at risk.

The Government recognises the damaging effect that the apparent glamorisation of drugs by some celebrities may have on impressionable young people, and the need to give young people positive role models to help them make informed choices about drug use and to fulfil their potential.

The Government has put in place Positive Future Initiatives, which use sport and art to engage the most vulnerable people by developing skills to help them resist drugs and re-enter education and training, and is setting up a multi-agency advice and support service for 13-19 year olds, Connexions Partnerships, across England and Wales, which will help link young people into positive, stimulating activities and divert them from drug misuse.

The sentence of a convicted offender is a matter for the courts alone to determine within the statutory limits set by Parliament and in the light of all the circumstances of the offence and the offender. Community Service Orders, which were renamed Community Punishment Orders under the Criminal Justice and Court Services Act 2000, are a community sentence appropriate for those who have committed an offence punishable by imprisonment. They are made for a set number of hours, which can range from between 40-240, with the emphasis on punishment through unpaid work. A range of sentencing options is available to the courts for drug misusing offenders. The Community Punishment Order may not be the most appropriate option, but where it is imposed, it will be for the probation area to determine the work package based upon local need.

Recommendation 28 - We recommend the option of using current and ex-heroin addicts to explain the reality of addiction inside our secondary schools to complement drug education strategy.

The use of ex addicts for drug education in schools, is a discretionary decision for each local school and its Governors. General guidance is that it can be effective as long as it is part of an overall PHSE programme

Recommendation 29 - We recommend that the government explore options of national community service for those excluding themselves from work and education.

The issues raised by this recommendation are broad. The Home Office is consulting with other Government departments and will reply to this recommendation when these consultations are complete.

Recommendation 30 – We recommend that the District and the County Council give the highest priority, in partnership as necessary, to provide these facilities in our communities.

Recommendation 31 - We recommend this as the top priority for capital spending by both Councils, with a cinema and new Leisure Centre as immediate priorities.

Both the County and District Council are currently working on projects (both separately and in partnership), which will aim to bring new facilities to the residents of Bassetlaw. There is no doubt that facilities can provide a useful diversion from the dangers of drugs. Whilst agreeing with the reports comment stating that new facilities are not the answer in itself, the importance of raising aspirations and pride in the local area is recognised.

Both organisations will continue to strive to provide these facilities. Popularity of the Skate Board park in Worksop, provided by the District Council, is proof that facilities will be used if provided and plans are currently being developed to improve the facilities in both towns over the next 2-5 years.

Recommendation 32 – We recommend that the development of supported tenancies be quantified with clear targets, monitoring and reviews.

The District Council has just announced a commitment to provide financial support to a proposal to provide a further Supported Tenancy Project within the Worksop area. This is indicative of the District Councils recognition of the need for these facilities and the District Council will continue to work with partner agencies to improve this type of facility. Equally it will strive to ensure that the facilities, when provided, are operated professionally and have clear targets with regards to their effectiveness and are monitored and reviewed regularly.

Recommendation 33 – We recommend that future Government Funding for CISWO and the Coalfield Regeneration Trust require that the needs of young people be encompassed in all aspects of their work.

The District Council, whilst clearly being unable to affect directly funding distribution from the Government, have, through Local Strategic Partnership, recognised that the needs of young people are of the highest priority and future Local Strategic Partnership working will involve a focus on the needs of young people within the District.

Recommendation 34 – We recommend that the local Strategic Plan puts anti-drugs work at the heart of its priorities, specifically to develop recreation facilities and programmes for healthy living.

In re-profiling its priorities The Local Strategic Partnership has attempted to address the problem of drugs at several levels. The majority of the new priorities contain some objectives that relate to addressing aspects of the drug problem.

Here are just a few of the examples of the cross linkage between the Local Strategic Partnership and the Drugs Agencies and are provided in order to indicate the level of interconnection between the two arenas.

Within the Social and Community strand of the LSP there is a commitment to 'minimise the impact of drug and alcohol abuse'. A number of the initiatives implemented through the Joint Commissioning Structure of the DAAT are aimed at addressing this type of project. Similarly, within the Education and Life Long Learning strand, one of the aims is to 'raised aspirations and attainment in young people'. Again this tied into work with the Drug & Alcohol Action Team and Drug Reference Group, in particular through the Job Centre Plus Pilot Programme of Progress 2 work within North Nottinghamshire currently being operated in co-ordination with the DAAT. The quarterly digest September 2002 indicates that his is experiencing some success in that the majority of participants through this programme in the North Nottinghamshire area are actually within the Bassetlaw district.

Within the Health strand, the Healthy Living Centre bid for Bassetlaw will be providing health information and education to hundreds of young people within the District through a co-ordinated approach involving the County and District Councils as well as the voluntary sector.

Within the Community Safety Strand of the Partnership there is a target involving the reduction in offences by young people. This brings into play the Youth Offending Teams who are active members of the Drug and Alcohol Action Team as well as the Criminal Justice Referral Project operating from within the Police Stations in Bassetlaw aimed at reducing the number of repeat offenders with drug problems.

Recommendation 35 - We recommend the early introduction of Drug Courts into Bassetlaw

There are no "drug courts" in England and Wales but the court review process of the Drug Treatment and Testing Order (DTTO) shares with drug courts in other jurisdictions review by sentencers of the progress of offenders.

Recommendation 36 - We recommend that the government make Drug Treatment and Testing Orders much more available to the courts, so that they can be used with many more offenders.

The Government believes that getting drug misusing offenders into treatment through court based interventions can be effective in reducing drug misuse and crime, and officials are developing proposals for piloting drug courts drawing upon the good practice of dedicated DTTO review courts.

The favourable comments about the use and popularity of DTTOs in Bassetlaw is welcomed. This is being mirrored in other parts of the country. Up to 31st October 2002, the latest month for which complete figures are available, 9,510 orders had been made since roll-out, 3,400 of which have been made 1 April 2002 (102% of the profiled target for the period). Encouragingly, the number of orders terminated for failure to comply with requirements is considerably lower (at 29% of starts) than experience from the pilots (45.71%) would have suggested.

As far the availability of the order is concerned, the DTTO is already available to all courts in England and Wales. There is a settled baseline to fund the present Service Delivery Agreement target of approximately 6,000 commencements per year and this number will double by March 2005.

The DTTO is a high intensity sentence targeted at the most serious drug misusing offenders. Experience of the DTTO suggests that the intensive nature of supervision/treatment set out in probation National Standards may have resulted in a gap developing in the provision for offenders whose drug misuse and offending behaviour is of a less serious nature. Further consideration are looking at what steps can be taken to cover that potential gap by providing for a lower intensity order linked to treatment.

The Criminal Justice Bill contains measures for the introduction of a single generic community sentence made up of specific elements, to replace all existing community sentences, including the DTTO. Courts will have the option of making a drug rehabilitation requirement part of this sentence for all those aged 16 or over with a drug dependency or propensity to misuse drugs who have been convicted of an offence sufficiently serious to merit a community sentence. Like the DTTO, the requirement will have a treatment, testing, and court review component. The main difference will be that as well as having available the classic DTTO-type order, courts will be able to impose less extensive requirements on those, who, whilst needing some treatment, do not require the intensity of the DTTO. This change will have the effect of widening the range of those receiving treatment as part of a community sentence from the most serious drug misusing offenders, currently catered for by the DTTO, to those with less severe drug misuse and offending.

Recommendation 37 - We recommend that the names and faces of convicted drug dealers should be made available to the community and the media.

The positive remarks made in the report about the use of CAD funding and initiatives to recover drug dealers assets is welcomed. There are constant efforts to improve police handling of public intelligence and to recommend community consultation systems. Nottinghamshire Police will receive advice on how they can improve their handling of information passed from the public.

It is currently possible for anyone who is convicted of any offence to be publicly identified and at point of conviction this may be desirable. However, there is no evidence that drug dealers are necessarily inevitable recidivists and as such it would not assist their re-absorption into normal society by their identities being continually made openly available to the general public..

Recommendation 38 – We recommend a public campaign, led by the police, to highlight the consequences of buying stolen goods.

Nottinghamshire Police recently commenced in the Mansfield/Ashfield Division "Operation Amber", one key element of which is the education of the public, via the media, in relation to the issue of buying stolen goods. The evaluation of the learning points from that operation will be considered as it progresses and then, through the established force tasking and co-ordination systems chaired by the Assistant Chief Constable, consider extending such in the same, or amended form, to other Police Divisions.

Recommendation 39 - We recommend that there should be national minimum standards on the treatment of drugs in prison and the aftercare treatment of drug addicted offenders.

There are already national minimum standards for interventions in prisons:

Prison Service Order (PSO) 3550 - Clinical Services for Substance Misusers;

PSO 3630 - Counselling, Assessment, Reeferral, Advice & Throughcare services;

independent accreditation of interim treatment programmes by the Correctional Services Accreditation Panel (formerly the Joint Accreditation Panel).

These are also separately audited by Standards Audit Unit in accordance with PSO 0200 - Performance Standards Manual.

In addition, national minimum standards for the treatment of drug misusers are being addressed by the National Treatment Agency (NTA). The Service is working closely with colleagues in the NTA to ensure that its generic Models of Care, treatment standards and standards for drug workers are - where appropriate - being applied to prison-based interventions. Further consistency in treatment provision is also being achieved through the use - both by the Service and the NTA (through the local Drug Action Teams (DATs) - of the same external drug services providers.

-PRIME MINISTERS QUESTIONS

On Wednesday 23rd October 2002 I took the opportunity to ask the Prime Minister what he int to do to raise aspirations in coalfield communities and regarding the Heroin Inquiry report.

Not only can you read a transcript of my questions and the Prime Ministers replies below but y can also take a listen or download the audio MP3's.

A full list of these and other speeches I have made and questions I have asked in the House of Commons, including to the Prime Minister, can be found on my Parliamentary Work page.

AUDIO

You can either download the mp3's or listen to streamed audio of my questions to the Prim Minister.

Raising aspirations in coalfield communities.

LISTEN

Download the mp3 (112KB)

The recommendations of my Heroin Inquiry and the desire for Drugs Courts.

LISTEN

Download the mp3 (331KB)

To download mp3's Windows/PC users right-click link & select "Save Target As", Mac users option-click on the link.

TRANSCRIPT

John Mann : *What plans have you to raise aspirations in coalfield communities?*
The Prime Minister : *We are firmly committed to regeneration in coalfield communities throu education and job creation. We have already made substantial provision to support this commitment: £385 million for the English Partnerships' national coalfield programme, more t £90 million in funding for the coalfields regeneration trust, and £10 million for the coalfield enterprise fund. I hope that this is an indication of how we desire to make the investment neces to raise aspirations in coalfield communities.*
John Mann : *At the public inquiry into heroin that I conducted recently, former miners were i tears when they talked about the lives of their sons, daughters, grandsons and granddaughters being destroyed by heroin addiction. Will the Prime Minister reflect on the recommendations f action in the report that I have delivered to him? Will he note that, if drug courts are to be introduced, my community wants to be one of the first to have them?*
The Prime Minister : *I am sure that my hon. Friend speaks for many hon. Members from up a down the country. I have received his report, and I will study it carefully and come back to him with some decisions and recommendations on it. The point that he makes is right. What we are trying to do-obviously, this involves the up-coming criminal justice legislation-is to make sure we have proper drug treatment in local communities, and proper orders that the courts can gi An example is the drug treatment and testing orders, which are being very successfully implemented in many parts of the country. We must also make sure that we do not have a situa in which people who genuinely want help to get off their drug addiction do not have the chanc do so. We are increasing investment in drug abuse programmes, and in addition, we need to u the measures outlined in the proceeds of crime legislation to try to attack the assets of the drug dealers who have caused such misery in our local communities. However, I hear what my hon. Friend says about drug courts, and I shall certainly bear it in mind.*

-DOWNLOAD MY REPORT

The report into my Heroin Inquiry has now been published. I called it to investigate the grow problem of heroin misuse in Bassetlaw and the measures being taken on all levels by the crim justice system, treatment providers, and community schemes to deal with the epidemic. It establishes that a pattern of heroin abuse peculiar to coalfield areas creates problems that curi

Heroin Inquiry Page I

-CONTENTS

You can also read more about the Inquiry in my Parliamentary Work, In the Press and Mann of the People sections.

-WESTMINSTER HALL DEBATE

On Tuesday 26th November I secured a Westminster Hall debate on heroin addiction. The Minister present was the Parliamentary Under-Secretary of State for Health, David Lammy, a the large number of MP's who were in attendance shows the level of interest in this issue in Parliament at the moment.

The debate lasted an hour and a half and to read a transcript beginning with my opening spee then please visit
26/11/02 Westminster Hall Debate : Heroin Addicts.

This is just one of the many occasions I have raised the issue of Heroin in Parliament. A full li the issues I have raised and the questions I have asked is available on my Parliamentary Wo page.

-PUBLIC MEETING

I spoke about the report and the Inquiry in general at a Public Meeting of the North Nottinghamshire Fabian Society last Thursday 31st October 2002 at Worksops Town Hall I want to thank all those who attended and the Fabians Society for hosting a meeting that allo anyone who wanted to come along.

The event was, I thought, a tremendous success. Not just because of the number of people w attended but also because of the range and quality of the points they raised and the questions t asked. In the next few days a transcript of the evening will be available to download from th pages.

FOREWARD

We would like to thank the local community for the support that you have given us in our inquiry into heroin use. We have been deeply affected by the number of letters, phone calls and discussions we have had from all over the community.

Many of you have told us about the crime you have suffered. Pensioners burgled, shopkeepers put out of business, staff threatened and property stolen.

We have heard from many families; mothers whose sons have died from overdoses, fathers who are having to buy heroin to keep their daughters away from dealers, and even heroin users who have had to give their children up for adoption.

We have heard from the police, members of the health and prison services and also from many other sectors of the community.

We have heard incessant cries for help; from heroin users, from pensioners too scared to leave their homes, and from the families of heroin addicts.

We were aware of the attempts by some, even as we met, to sweep the issue of heroin addiction under the carpet. We cannot do this.

We were struck by the brilliance of some of the professionals working on our behalf in the police and health services. Given the resources and facilities to do their job properly, they would be far more effective.

This document is put out for consultation but it is also a call for action. We will continue to seek answers, but we will not wait in vain for action.

The situation in Bassetlaw is a shambles. We spend a fortune dealing with the costs of heroin related crime, of policing and imprisoning, yet we have no coherent treatment service to get people off this evil drug. If smallpox were rampant in our area there would be a national emergency until it was brought under control. Heroin use in our community needs a similar response.

There will always be criminals and there will continue to be heroin addicts. But we believe that the problem here can be brought under control. In this report we outline our recommendations for action.

People growing up in the coalfields lack the sense of identity afforded to their parents and grandparents who were part of a stable and prosperous mining industry. The strongest substance used in these communities was beer, and stable employment allowed most a good standard of living.

In these communities, with their low educational and employment aspirations, there is a need to escape. Heroin is a drug associated with the need to "get away from it all". In the 1990s, the use

of heroin by those who felt alienated in society was presented as a mainstream view in the British film *Trainspotting*. Mining villages are *Trainspotting* without the glamour.

Heroin addiction is a national problem, but it is particularly acute in the coalfields. Low aspirations and a desire to escape, without having the means or confidence to do so leads to a life of addiction to a drug that offers a way out. These experiences never appear in national statistics, and the abuse of heroin and its resulting crime is something that is not being addressed, but brushed under the carpet.

This is going to change.

Our public inquiry was held between 16th and 18th of September in Bassetlaw, and the scale of the problem in the coalfields was confronted for the first time. In this document we recommendations about the best way to deal with it.

The voice of the coalfields has not been heard. Now it must be.

HEROIN IN BASSETLAW

Report of the inquiry convened by John Mann MP

16th – 18th September 2002

CONTENTS

1. STRENGTHENING COMMUNITIES

The community in Bassetlaw is determined to beat the plague of heroin and drug use that is hitting hard at its heart. We estimate that one in three households have been directly affected - the majority through burglaries - but many through the heroin addiction of a family member. In terms of the wasted opportunities, costs of criminal justice and healthcare the closure of shops and through the overall loss in confidence in personal safety and security, we are all directly affected.

Since the closure of the pits, parts of our community has developed inner-city scale problems yet we do not have city resources to deal with them. Many of our oldest communities, the former mining villages, were traditionally our strongest and most closely-knit. These communities have been fractured by the pit closures. From these wounds, the scourge of heroin has emerged.

Having heard from every sector of society and each corner of the community, we believe that only a policy of zero tolerance of drugs and crime will overcome this blight.

We believe that a series of obvious changes would immediately have an impact in stopping the spread of heroin through our community. These proposals are detailed in our report.

We do not believe that drugs can ever be eliminated from our society, but we believe that this area has the resolve to make drugs use a small and manageable problem - as it used to be.

In this report we make recommendations to national government for local delivery, which we believe will make a major difference. Some of these are easy to implement; others challenge current policy and practice at its very heart. Some challenge the attitude and approach within our own community.

We are confident that the resolve of our community will win through. Few other communities would have had the courage to look at the problem as honestly as ours has done in recent weeks. We are a strong and proud community and we will restore that pride and confidence amongst our young people.

2. CHALLENGING ATTITUDES

Quantifying the problem

Quantifying the scale of the problem of heroin use in Bassetlaw is difficult for two reasons. Firstly, national statistics and studies have been conducted into heroin misuse in the cities, but no one has conducted similar reports into the problem in more remote communities. We have been astonished to find that there are no statistics on the scale of the problem in coalfield communities. Secondly, such statistics do not take into account all the costs of heroin abuse; cost of lives lost, families broken apart, costs to shopkeepers, to criminal justice and most of all the cost of crime.

From evidence presented to us at the inquiry, we were able to conclude that the problem here is as great as in any inner city, yet we do not have the infrastructure or resources available to cities to tackle the problem. Our situation, in terms of the scale of the problem and the means by which to deal with it, is far worse than in the cities.

We would not be surprised to find other communities - such as fishing and steel communities – are facing similar problems. There may also be intense localised problems in some agricultural communities.

We do not accept the argument that heroin addiction is hard to quantify and we do not, even after our inquiry, understand the reluctance of some to do so.

We recommend that urgent research be carried out in coalfield communities to quantify the scale of the problem of heroin use, access to facilities and resources to fight it (recommendation 1).

Accountability

The drugs service should be no less accountable to its client group and the local community than any other sector of the health service or the criminal justice service. However, the *ad hoc* development of drugs services presents difficulties in terms of how service provision can be audited and held to account.

There are Government targets that have been adopted by the Drug and Alcohol Action Team (DAAT). However, the base line assumptions of the problem are supplied upwards by the DAAT. Without independent research, the problem can be easily understated.

One avenue worth exploring is a study combining treatment statistics with criminal justice statistics. Significant numbers of heroin users commit crimes and more often than not will pass through the criminal justice system. A cross analysis of these two will offer a valuable source of data.

Target setting, reviews and inter-agency coherence need to be local as well as national obligations.

We recommend that the DAAT set annual targets for Bassetlaw, with regular reviews to assess successes and failures (2).

Openness

We are struck by the extraordinary number of professionals in the field prepared to speak out in private about the weaknesses of local drugs provision, but are reluctant to do so in public. There is a culture of consensual agreement being built, which at its best is excellent, at its worst dangerous and prohibitive to best practice.

This culture allows organisations or individuals not delivering to find shelter in partnership working. The plethora of funding sources and the inter-dependence on funding streams makes this problem more acute.

Put bluntly, some would not speak out because they feared their future funding might be affected.

Partnership working

There is a balance to be reached between effective partnership working and detrimentally consensual relationships.

We are stunned at some of the agenda items for decision on the part of the Drugs Reference Group (DRG), allocating £100 or £200 for minor matters. To put this in context, this is below the average cost in crime of one heroin user in a single day.

Many of those giving evidence stressed how well this partnership is working; yet neither the Manton clinic, nor a base for other drugs agencies has materialised. We do not accept that this is good partnership practice.

Specifically, we believe that representatives of some influential bodies do not have the authority to speak and act on behalf of their sponsoring body. This is often masked by their personal drive, enthusiasm and commitment. Without genuine delegated authority, the Drugs Reference Group and to some extent the DAAT, becomes a discussion forum not a strategic decision-maker.

Given the remit and funding of the DAAT, this issue does not appear to be surfacing. This is a criticism of the internal strategic decision making of external bodies, notably local government.

Those on the DAAT and the DRG must have sufficient authority delegated to them.

We also note that many drugs workers attend the Drugs Reference Group and presumably their own internal team meetings. This does not appear to us to be a model of highly efficient working. A horse designed by committee can end up as a camel.

We believe that a seamless multi-agency approach is crucial in tackling the problems that we face.

Drug education

We find DARE to be effective in primary schools. We see an important priority for the funding of parental education through the current DARE approach for primary school parents.

We recommend that a pilot in Bassetlaw should be funded to develop an effective approach to parental education about drugs (3).

We are aware of other education policies and initiatives used in our area, but in order to be effective these require consistency and continuity of delivery. Drugs education needs to be seen as a specialist role, not a soft option taught by a variety of teachers.

We were shocked by the view of most secondary school sixth-formers that they had received no recognisable anti-drugs education. It is clear that the local provision differs significantly.

We recommend that the lack of a local provision of drugs education be addressed immediately by secondary heads and governors, with quantified changes by the year-end (4).

We recommend changes in the guidelines to the national curriculum, to give drugs education a higher and more clearly defined priority and that follows good practice (5).

3. TREATMENT SERVICES

The treatment service offered to heroin users is inconsistent. The recommended model of a seamless treatment service is not being provided in our community. We find strong evidence of differing philosophies between the drug treatment service and other professionals.

The menu of treatment services provided is illusory. There is a strong preference for community-based treatment. We cannot comment on which treatments are most effective, but we note that both the Drugs Prevention Advisory Service (DPAS) and the National Treatment Agency (NTA) stated that residential rehabilitation is successful for some individuals. Despite claims to the contrary, we found a strong bias against residential rehabilitation by those involved in treatment service provision.

Either this position should be the official stated policy, in which case users and their families should be informed, or there should be far more opportunity for this form of treatment to be an available option.

We were concerned at the lack of transparency in the decision-making process surrounding the assessment of heroin users for treatment, and the absence of any real appeal process to challenge such decisions. Patient rights are important and an open assessment procedure is essential to maintain confidence in the service.

The concept of heroin addicts presenting themselves for treatment sits uncomfortably with the perceived wisdom that they must show consistent determination of their intent to stop using. We have received no satisfactory benchmark for how this intent is determined and our evidence suggests it can be somewhat arbitrarily applied.

The Maltings

The Maltings is a package of six treatment and support services commissioned by the DAAT. The Maltings works from a base in Mansfield, some 17 miles from Worksop. Most heroin users and their families equate the name Maltings with the drug treatment service based from there.

The Maltings received sustained and often vitriolic complaints from users and their families. The voluntary sector and others echoed these complaints. We accept the validity of the complaints made, but many of them should in fact be directed elsewhere.

Users, their families, and the voluntary sector were highly critical of the Maltings waiting times. More worryingly, we found that the Maltings has lost the confidence of its current service users and potential users. Heroin users from our community are not contacting the Maltings because of its reputation for delay and poor responsiveness.

The Maltings suffers from being perceived as distant. The five non-treatment services received plaudits, not criticism.

Incredibly, at the end of the inquiry we had a young woman whose case demonstrates the situation of which we were repeatedly told. In no other part of the NHS would such an unresponsive approach be acceptable today. The very worst practices of aloof hospital consultants and unapproachable GPs are mirrored by the way in which many clients see the Maltings.

We have no doubt that the staff are highly dedicated, but their work is impaired by an acute lack of resources and by the culture of the service delivery that they work within.

We outline our concerns about treatment elsewhere. As a provider, we do not believe these criticisms are the sole responsibility of the Maltings. Indeed, we recommend additional staff resources for the treatment services as a top priority.

We have seven specific recommendations for the drugs treatment service:

a) **The service must have a base in the Worksop area immediately. We find the excuses from the many agencies involved quite unacceptable. To be unable to find premises in three years is in itself a symptom of a deeper problem in partnership working. No one accepts responsibility for this farce. We believe that suitable premises can be found (6).**

b) **A Worksop based service must have a new name and identity to help rebuild confidence in it (7).**

c) **The service must have a seven-day, 24-hour on-duty support available for telephone advice and counselling. We have no view on whether this service could be a shared service with other providers (8).**

d) **There must be a quantified standard set and maintained for the answering, logging and returning of telephone calls (9).**

e) **The service needs to honestly quantify its waiting list time to partners, funders and users (10).**

f) **There must be an agreed care plan for all patients arranged in co-operation with other agencies (11).**

g) **Users need to get into treatment without delay (12).**

Additional resources

In our view, the Maltings drug treatment service is under funded. To only have a part-time consultant and such a waiting list is quite unacceptable. We also find the funding streams irrational. Short fixed-term contracts will neither motivate nor attract the calibre of workers required in this difficult field. Locally and nationally, this *ad hoc* approach must change quickly.

We believe that a properly resourced drug treatment service which responds immediately to client needs, will make a considerable difference to the heroin problem in Bassetlaw.

Assessment procedures

We heard conflicting evidence about whether one individual or a multi-agency team makes assessment decisions. This disparity is in itself a cause for concern. Good assessment procedures and access to a diverse range of treatments are essential. Each individual will have slightly different needs. To maintain motivation, rapid access to treatment and intervention at every stage is essential.

We believe that close inter-agency co-operation, rather than one individual assessor, is essential for a robust treatment service. Clients have a right to expect the best assessment procedures and care management. We reject any notion of a user having treatment options restricted by the narrow focus one individual assessor. The system must have safeguards built into it to ensure that this never happens.

We are concerned that there is a rigid focus on one model of community rehabilitation to the exclusion of other treatment options. This is an unacceptable practice.

We reject the concept that users have to prove their motivation in order to be treated. This, in our view, contradicts national best practice, and we are concerned at how many and examples of this we have received.

The new health clinic

The Newgate Health Centre's proposed clinic is part of a new health centre that would include a facility for drug treatment. The clinic is only one small part of the health centre and should be seen as the start of the process of integrating drugs treatment into mainstream NHS facilities in Bassetlaw. We believe that this model of shared working has the best likelihood of success in our community.

We recommend that the new clinic and health centre proceed without delay (13).

Residential rehabilitation

We have been surprised at the unwillingness to discuss residential rehabilitation. The National Treatment Agency told us that it works for some people, yet it is virtually unused in this area. Nobody has convinced us that this option is available to people here.

We recommend that residential rehabilitation should be part of a menu of treatment options available within Bassetlaw (14).

Implants

We profess no medical expertise. We were presented with evidence about the use of implants to act as blockers for addicts trying to come off heroin. Both privately, in Meden Vale, and in Sheffield through a GP, local provision is available.

Our evidence leads us to believe that many local heroin users will be tempted to use implants in the near future.

We recommend that the DAAT and the NTA give a high priority to evaluating the effectiveness of implants and providing guidance to local people (15).

Aftercare

One of the issues most frequently raised was the continuity and intensiveness of support to those coming off heroin. Whether from treatment, voluntary abstinence or forced abstinence in prison, users have repeatedly told us of the importance of after care. The popularity of Sorted is partly explained by its after care service. Yet the Maltings are not routinely referring clients to all partner agencies.

In our view, the option of planned individual and group after care and support is essential. The need for good mentoring, embracing churches and the voluntary sector, is obvious. Intervention in maintaining a drug free condition is a top priority of several other drugs treatment services in the country. It should be here.

We were given evidence of teamwork in shoplifting. As heroin users have a very limited circle of friends and associates, the role of teamwork in aftercare is very important. We applaud initiatives such as the Sorted football teams and wish to see them expanded.

General Practitioners

The number of GPs trained in specialist drugs treatment in Bassetlaw is below the county average of 20%, which is in turn below the national target of 30%. Local GP practices have a public and ethical duty to have a specialism in drug addiction.

We are shocked to find the variations in GP knowledge and expertise that exists locally. Drug awareness training is also vital for nursing staff and receptionists.

The lack of a localised drug treatment service begs the question of whether GPs should fill the vacuum. National government needs to look at whether a GP led treatment service is preferable in communities like ours.

We recommend that consideration needs to be given, by Health Trusts and national government, to better integration of GP services into drugs treatment and whether Primary Care Trust management of drug treatment budgets would be preferable (16).

We do not profess a view on whether GPs should prescribe methadone or other substances. What is crucial is that treatment services in Bassetlaw are comprehensive and seamless.

The Government needs to enforce its targets effectively and ensure that communities like ours are at the top of the list, not near the bottom.

We recommend that every GP practice be required to have a fully trained partner who is a specialist on drug treatment (17).

Needle exchanges

The two day per week needle exchange is the most successful and best used service provided to users. The more needles can be disposed of safely the better.

We are concerned that it requires the voluntary sector to offer a home to the exchange and that the outlying villages are not effectively covered.

Whilst clean needles are easily available, we are concerned that there is insufficient pressure placed on the safe disposal of used needles. Many users are clearly disposing of needles without care, including in areas where children play.

We recommend that more needle exchanges be introduced, with a clear requirement to safely dispose of used needles (18).

Bassetlaw District Council has a comprehensive policy in terms of collecting discarded needles safely.

We recommend that the council needle collection and disposal service be guaranteed, particularly at evenings and weekends and be far better publicised (19).

Specialist services

We approve of the development of specialist services, such as those for women drug users, which are essential to improving the local situation. This area of work has received notable positive praise from users and other support agencies. Sorted was equally popular, despite its poor resources. Hetty's was universally well respected amongst those who have used the service, which include a significant number of local families. We believe that the voice of these services needs to be heard more often when determining treatment priorities and systems.

We would like to see these services expanded.

Mainstream funding

Drugs treatment services are seen as an add-on extra to health provision, not as essential. There is no NHS national service framework for treating heroin addicts.

With a clear national shortage of qualified staff, which government must address immediately, the use of short-term contracts hardly encourages service development and staff morale.

We were struck by the lack of drugs training at Bassetlaw Hospital, the short term working accommodation of the Maltings and the need for a charity to provide a base for the needle exchange.

Bassetlaw needs to develop a coherent approach to tackling drug abuse in the community. It is clear from their evidence that the current approach is patchy and ad-hoc. The issue of drug addiction is undetectable in the new Annual Reports of both the Hospital and the Bassetlaw Primary Care Trust.

This is neither a serious nor a coherent way in which to treat this scourge of our community.

We recommend to government and the Health Trusts that drugs treatment workers be mainstream funded, with permanent contracts and local working conditions suitable for the 21st Century not the late 19th Century (20).

Confusion over services

There are more organisations, methods of funding, bidding rounds and acronyms than anyone could imagine. It has taken the panel substantial research and analysis to understand. This is not acceptable. There needs to be clearer communication, fewer organisations competing for publicity and far more mainstream funding.

With funding from so many sources and the various agencies not working well together, organisations are too easily able to avoid taking responsibility. The identifiable and enabling role of Macmillan nurses in the care of cancer patients contrasts starkly with the confusion over drug treatment services.

Schools and drugs

We were pleasantly surprised at the consistent view of school and college students that there were few drugs going into schools or the local college, and that tales of drug dealers outside the school gate is something of a myth. However, most students knew how to get drugs outside school, which demonstrates their easy availability. We note, with great concern, the extensive use of cannabis in this area by teenagers.

The debate on cannabis is irrelevant to our area, aside from the mixed message its reclassification has sent to the public.

Experimentation with cigarettes and alcohol, glue and gas, then with cannabis and other controlled drugs is a common path for heroin addicts.

We were repeatedly told that users who could control cannabis use believed that could also control heroin use. They realise now that they were wrong.

4. RAISING ASPIRATIONS

Schools as a beacon of excellence

The campaign to build eight new secondary schools across Bassetlaw is vital. This must happen and these new schools must be part of a new ethos of community schools that are open to the community on evenings and weekends throughout the year. The design of these new schools needs to be such that community access to facilities is easy and comprehensive.

We are convinced of the need for structure, boundaries and discipline in the lives of young people. One small but powerful message is for all schools to have a compulsory school uniform. School is a place of learning, not extended and free childcare for de-motivated parents, and needs to be seen as such.

Children within primary schools are learning to be citizens with rights and responsibilities. Pride in, and identity with, their school is part of this learning process.

We recommend that every school in Bassetlaw have a compulsory school uniform (21).

Community schools

Community regeneration money is spread thinly across communities with many 'projects' competing within these communities. Such projects are usually short term in nature. We don't want projects, we want changes.

Communities are encouraged to bid and compete for money, leading to reliance on external form fillers rather than the development of community leaders.

Schools must be the heart of the community, not 9-5, term time only facilities. In villages such as Langold, Manton, and Rhodesia the school should be the focal point of the village. New initiatives, new funding, Coalfield Regeneration money and community organisations should be based at the school. The school should become a 7-day, 24-hour resource and be the beating heart of its community.

We recommend that each school set a target of at least 50 per cent of the local community entering through the school door each year (22).

Children of heroin addicts

Nobody can quantify the number of children whose parents are heroin addicts. Some will be on the child protection register; others live with grandparents or are adopted. It is even harder to count the number of those who are living in a household with at least one heroin user. These children will tend to be living in particular villages and streets.

The impact on SureStart and primary schools is profound. But nobody is volunteering to label their nursery or school in this way.

We understand this dilemma, but there is a clear policy consequence.

A child living with a heroin addict parent will be more susceptible to social and educational problems. High aspirations and such lifestyles do not go together. Before we create a new generation of even younger heroin addicts, direct intervention is necessary.

We recommend that DATS and Local Education Authorities be charged with quantifying the level of domestic heroin use affecting children in primary schools (23).

Employment

For differing and understandable reasons, the largest employers are unwilling to take on heroin addicts or ex-addicts with a criminal record. This places additional, and usually difficult, pressures on the Employment Service and its Progress 2 Work initiative.

We believe that there is a role for experienced voluntary sector organisations including the Prince's Trust.

We believe that employment opportunities are critical to rehabilitation and to controlling and beating heroin. We welcome the introduction of Progress 2 Work in this area and would like to see its capacity develop further. Bassetlaw is the top priority for this programme, which has capacity for 125 people this year.

We recommend that the Progress 2 Work pathfinder project be expanded in Worksop (24).

We are frustrated with the slow progress over the development of the Manton pit site. This needs to become a major employment site. As a symbol of neglect, this contrasts with the success of Manton Wood.

We note however the negativity of comment about 'sandwich' factories, which must be addressed in schools. Many heroin users referred inaccurately to this as their potential job option. This contrasts with the likely previous work of many as miners or clothing workers. Young men were particularly dismissive.

This stereotype is wrong, as is the myth of high unemployment. However, we lack the range of major employers required to provide positive images of employment opportunities.

We recommend that the business community take the lead in creating positive images of the world at work, including in primary schools (25).

Churches

Alongside schools, the church is a permanent feature of all communities. We believe that the stronger the church the more empowered the community. Yet for many the church has become separated from the mainstream community rather than its heartbeat. Church schools and other church activities should involve themselves at the very centre of their local community, taking the church into the community, rather than taking the community out to the church.

The church has a vital mentoring role, both aspiring young people and directly assisting families fighting heroin addiction. The 24/7 support so frequently requested by addicts creates a challenge for any living church. It also creates opportunity for the church to re-engage the community.

The prison chaplaincy provides a direct link between prisons and their local communities, creating the opportunity for the support in the aftercare of prisoners returning into the local community.

At a national level the Bishops in the House of Lords have a responsibility to inform debate, drawing on their extensive network of community leaders.

We recommend that the Churches develop policy and action plans to assist in tackling drug use (26).

Role models

We received several pieces of evidence suggesting that drug dealing was seen by a few young teenagers as a role model of wealth and success. As we conducted the public inquiry, television celebrity Michael Barrymore was telling the nation about his use of cocaine. Many actors and musicians have done likewise - glamorising the use of drugs, including heroin.

This coincides with an increasing shortage of fathers as role models, as one parent and other non-nuclear families continue to proliferate. For second generation heroin addicts, the role model can now be a heroin user.

We recommend that the government looks at additional community service orders for public figures glorifying drugs, including work in our communities with those most at risk (27).

We recommend the option of using current and ex-heroin addicts to explain the reality of addiction inside our secondary schools to complement drug education strategy(28).

Sport and healthy living

The Sporting Chance programme, run by Bassetlaw Council, shows what is possible through sport. This initiative needs to be funded both locally and nationally to become a permanent part of an alternative to the lifestyle choices that often lead to heroin.

Sport and healthy living are vital to all our communities and it is strange that sport does not feature more highly on the agenda of all the agencies working in the drugs arena. A programme of sport and healthy living built into the core activities of all our schools will help prevent the lifestyle choices which are more prone to drug use.

National community service

The lack of structure and discipline that deteriorates into the chaotic lifestyle of most heroin addicts begins at a young age. The movement of the individual into hard drugs rarely begins before age 16, although some young people and addicts we spoke to suggested 13/14 is a critical time in moving into more serious drug experimentation.

It is at precisely this time that educational and social exclusion bite.

We believe that 14 year olds need a range of options to take them to full adulthood at 18, including work and school education. What we find unacceptable and destructive is the self-exclusion from these options. Young people failing to attend school, anticipating a crime and/or benefit 'career' and getting hooked on drugs should not be an available option.

We applaud moves to strengthen vocational options for 14-18 year old at school and with employers, in traditional areas such as plumbing and woodworking as well as newer areas such as nursing.

There will however, still be some who resist the options offered. Before they fall into a permanently chaotic lifestyle of self-exclusion or expulsion from school, we believe that a new positive choice should be available. A society that allows self-exclusion at such an early age will inevitably see rising chaos and crime caused by such individuals.

Whilst we do not believe that the army needs burdening with people affected in this way, and is a career option in itself, some form of national community service needs to be seriously considered. Breaking the chaotic lifestyle of young drug users should be at the beginning not the end of the cycle of social exclusion.

We recommend that the government explore options of national community service for those excluding themselves from work and education (29).

5. INNER CITY PROBLEMS WITHOUT INNER CITY FACILITIES

Facilities

We do not believe that simply building new facilities for young people is the answer in itself. However, we do believe that this is vital to aspiration levels and pride in the local area. Poor shopping opportunities, a run-down cinema, leisure centres dying on their feet, and sub-standard youth clubs and youth drop-in facilities contribute greatly to a loss of pride and aspiration. This area urgently needs facilities of the very highest standard for the community.

We recommend that the District and County Councils give the highest priority, in partnership as necessary, to provide these facilities in our community (30).

We recommend this as the top priority for capital spending by both councils, with a cinema and new leisure centre as immediate priorities (31).

Housing

Housing provision is essential to healthy living and to stabilising and breaking heroin addiction. We find the housing policies of Bassetlaw Council, much maligned previously, to be increasingly advanced. The dilemmas over housing heroin users are now carefully thought through.

The one weakness is a lack flexibility in allowing ex-users to re-integrate into the community. However, we believe that the expansion of supported tenancies will do much to fill this gap and it is essential that council policy be delivered into sustained action.

We recommend that the development of supported tenancies be quantified with clear targets, monitoring and reviews (32).

Mobility

Inability to access support services for users and their families has been highlighted a number of times. The problem is runs deeper than is immediately apparent. Success and leaving the area are equated as the same by many young people. The lack of mobility of the remaining younger community is a factor in heroin treatment plans.

Shopping

The loss of pride in Worksop Town Centre and some of our village shopping parades is an important issue for the well being of all the community. There are still very good shops available, but the costs of shoplifting, insurance and security hits their viability.

The shopping experience in Worksop needs to be far more pleasant. Young people in particular are being hassled for 'bus fare' from heroin addicts.

Shopkeepers faced with repeated shoplifting and the ever-increasing number of charity shops need support. Why can charity shops get rate relief but small business shops not? The Chancellor of the Exchequer needs to consider this in the next budget.

Miners' Welfares

Miners Welfares can play a vital role in these communities if they choose to do so. Government, through the Coalfield Regeneration Trust and the Coal Industry Social Welfare Organisation (CISWO) still support such work. This must directly relate to the young in these communities. Miners Welfares have a defined responsibility to the younger generation as part of their charitable status.

We recommend that future government funding for CISWO and the Coalfield Regeneration Trust require that the needs of young people be encompassed in all aspects of their work (33).

Health and mining communities

Heroin users we spoke to were often dropping out of society's normal activities at a young age. We believe that healthy living is an important aspect of defeating heroin. We are pleased that the Coalfield Communities Campaign is at last looking at this as a priority.

As with other initiatives, any funding for healthy living must be channelled through the permanent institutions of villages and estates, notably primary schools, rather than be distant and temporary fads.

We recommend that the local strategic plan puts anti drugs work at the heart of its priorities, specifically to develop recreation facilities and programmes for healthy living (34).

6. THE CRIMINAL JUSTICE SYSTEM

The biggest section of our community blighted by heroin are those individuals whose houses and cars have been broken into. Pensioners are particularly vulnerable, especially those in council bungalows.

Many older people feel under siege through their experiences of crime and the perceived threat of crime. The level of theft and break-ins on private property is directly correlated to the scale of heroin addiction.

Many people wrote to the inquiry demanding stronger action by the courts, particularly on dealers. We agree.

Ironically, we had a number of heroin users who were demanding longer prison sentences for themselves. This was specifically to assist in breaking their addiction.

Sentencing policy

Justices of the Peace, probation and police all pointed to the futility of fining heroin-addicted criminals who had stolen to feed their habit. The fine will immediately lead to more theft.

Prison is used regularly, but it is an expensive option compared to other forms of treatment. However, the panel does not believe that the problem can be cured by accepting theft and all acquisitive crimes as inevitable. Neither do we believe such crimes should be ignored or downplayed.

The sense of invasion and loss of freedom of the pensioner who has been burgled is no less because the crime is committed by an addict feeding their habit.

Drugs Courts, with magistrates trained in drug treatment issues, would allow heroin addicted offenders to choose between custody or supervised treatment. Our evidence is that the level of intervention needed in such supervision is high. The courts supervising treatment orders, delivered by the health service, seems to us a much better relationship than currently exists between the criminal justice and health services.

We were impressed by the use of Drug Treatment and Testing Orders (DTTOs). In particular we were struck by how popular they are with heroin addicts. This support is due to the high level of intervention of the drug treatment services with the offender. We recognise that the popularity of Drug Treatment and Testing Orders exists due to the near impossibility of an addict being able to embark upon a treatment course which involves a similar level of intervention.

These orders are only available for a handful of offenders - only 10 currently in this area. This is because stringent requirements have to be met before one can be ordered.

We recommend the early introduction of Drugs Courts into Bassetlaw (35).

We recommend that the government make Drug Treatment and Testing Orders much more available to the courts, so that they can be used with many more offenders (36).

Drug dealers

A majority of submissions from the general public call for drug dealers to be routed out and imprisoned. The panel believes that the identity of local dealers ought to be quite easily established and action taken.

We applaud the additional resources from Communities Against Drugs to assist intelligence policing which targeting dealers. The general public clearly has a role to play in alerting police to the presence of local dealers.

We support the new legislation to seize drug dealers' assets and want to see the Inland Revenue and VAT inspectors investigating suspected dealers.

The police need a better system of handling information on drugs received from the general public. People giving evidence to the panel have often been unclear who to approach with information and Worksop Police Station has been inconsistent in terms of how it deals with such information. The public needs to see the police responding to information provided on drug dealing and provided with clear results from the Communities Against Drugs initiative.

We recommend that the names and faces of convicted drug dealers should be made available to the community and the media (37).

Stolen goods

The level of theft reported by the police is £70-80,000 per heroin addict per year. Some are funded through work, parents and dealing, but this still leaves an incredible amount who fund their habit through the proceeds of crime.

With each crime comes additional stress, inconvenience, loss and fear for the victim of crime. We have received evidence of shops being forced out of business and out of the town centre because of shoplifting.

The goods stolen are sold on, at a police estimate of one-fifth their value. Nobody buying stolen goods can be unaware by what means they have been procured. If heroin is to start disappearing from our streets, it will only do so when the community is prepared to stop buying stolen goods, and is prepared to report the salesmen.

We recommend a public campaign, led by the police, to highlight the consequences of buying stolen goods (38).

Crack cocaine

Crack cocaine has been rarely used in this area. The evidence we received indicated that the result of an increase in crack cocaine addiction would be a corresponding increase in violent crime. As crack spreads through the inner cities, this makes us even more determined to get on top of the drugs situation here.

Cannabis

The inquiry didn't set out to look at cannabis use. However, heroin addict after addict raised it with us. Virtually every heroin user who we spoke to, had used cannabis at an earlier stage. We were astonished at the consistent message from addicts that cannabis is a danger to our community. The comparison often made was that the experience of taking heroin was like taking cannabis but with much more strength. Many users told us that they had felt that they could control heroin use because they could control cannabis use.

This was not a message any of us expected.

The group of young people most at risk from drugs, in our community, is being sent a mixed message. We believe that the dangers of cannabis use need to be strongly restated.

Prison

The treatment of heroin addicts in prisons is clearly improving, but varies between institutions. We heard of many different experiences from users who had served sentences.

Some prisons are relatively drug free. Users indicate that this varies between institutions, as does the systems of treatment.

After care of offenders on leaving prison is a high priority. The treatment gap here is obvious yet ignored. Most of the heroin deaths that we have been informed of are due to an overdose administered immediately after leaving prison.

Significantly, the success of drug treatment in prison, which is highly regarded by some offenders, is negated by the lack of an aftercare service in the community, and also the temptations and peer pressure consequent upon being re-united with friends still using drugs.

Everybody who gave evidence about this recognised the likelihood of re-addiction, re-offending, and possible re-imprisonment.

No situation demonstrates better the vicious circle of heroin addiction and crime.

We recommend that there should be national minimum standards on the treatment of drugs in prison and the aftercare treatment of drug addicted offenders (39).

7. THE REAL COSTS OF HEROIN

This year nearly £4,000 million will be spent on fighting drugs. An extra £300 million is going on Communities Against Drugs. Incredibly, the drugs service in our area remains poorly funded with major gaps in provision.

We applaud the strong action taken by the government on drugs. Our recommendations will help deliver this message on the ground within our community.

We have highlighted changes needed to get better value for money out of the current system. However, re-allocating small amounts of money to critical gaps in provision would make a major difference.

The Audit Commission states that £738 million goes on drug user social security benefits; £177 million goes on legal aid for drug addicted criminals; £1,923 million goes on the policing and imprisoning of drug addicted offenders.

Our estimate, from the police evidence given, is that at a very minimum £20 million of goods are being stolen from our community every year by heroin addicts. The actual amount is almost certainly much higher. None of this includes the emotional and economic cost of families torn apart, and of the victims of crime.

In our own community, we are all major victims of heroin, through the resources that should be better spent elsewhere, the decline of our shopping centres, and the fear of crime. The £100 million spent on treatment nationally shrinks into insignificance when compared with this.

The evidence is clear, from the government itself. Treatment can work. Research suggests a £3 saving for every £1 spent. In this area the saving will be many times greater. The reductions in crime, predicted by the Audit Commission, of a 67 per cent reduction in shoplifting and a 77 per cent reduction in burglary would transform the local situation.

Our highest priority is a seamless service with no treatment gaps.

We demand immediate action on many of our recommendations and considered thought followed by action on the rest.

We demand zero tolerance of heroin and all other illicit drugs.

8. THE NEXT STEPS

This report will be sent to every MP and presented to appropriate Government Ministers.

A copy will be sent to all organisations and individuals that submitted verbal or written evidence to the inquiry.

A meeting will be sought with all local organisations commented on in the report.

A review will be held within six months to review progress on each of the 39 recommendations

9. EVIDENCE AND REFERENCES

A full document of the panel's evidence is available in each Bassetlaw library and from John Mann MP. This document also has a detailed reference guide to other documentation looked at as part of this enquiry.

This document also contains detail of the three day public inquiry held on 16-18 September 2002 at Worksop Town Hall. Many case studies are included in this documentation.

Those serving on the inquiry panel were:

John Mann	Member of Parliament for Bassetlaw
Josie Potts	Grandmother from Manton village
Shirley Hoyland	Town Centre businesswoman
Tracy Powell	Deputy Editor of the Worksop Guardian
Roy Bennett	Chaplain of Bassetlaw Hospital
Simon Greaves	Youngest District councillor

The inquiry team, in publishing its findings has agreed to continue maintaining confidence where requested.

The researchers for this report are Sadie Smith and Craig MacDonald.

Whilst the report is the agreed conclusions of the panel, any errors and omissions are solely the responsibility of John Mann MP.

The report and appendices are available on the web at www.johnmannmp.co.uk

Any correspondence should be sent to:

John Mann MP
House of Commons
London
SW1A 0AA

Telephone numbers
0207 219 8345 (Westminster)
01909 506200 (Worksop)

Fax numbers
020 7219 5965 (Westminster)
01909 532447 (Worksop)

10. ACKNOWLEDGEMENTS

The inquiry team would like to thank:

The 2000 plus people who wrote or phoned in with their views and personal experiences.

The heroin users, both former and current, who attended the inquiry to give evidence in public and in private.

The Drug and Alcohol Action Team and all other bodies who provided background information and gave evidence to the inquiry.

Bassetlaw Council for the use of the Town Hall and their facilities.

Betty Harvey and her intrepid team of volunteers.

John White for internet advice and technical support.

file
Copy in DCO
Inbox

10 DOWNING STREET
LONDON SW1A 2AA

From the Principal Private Secretary

3 December 2002

Dear Jonathan,

STRATEGY UNIT PROJECT ON DRUGS

The Prime Minister has discussed with the Home Secretary the potential for some work for the Strategy Unit to take forward on drugs.

The Prime Minister and the Home Secretary are keen to make progress in this area, building on the work that the Home Office and other Departments have already done. The project will involve an initial analytical study of the supply chain from international production to distribution within the UK, assessing the relative cost effectiveness of Government interventions in the drugs market. Following on from discussions at the Drugs Stocktake meeting on 14 November, the project will also include work on the assessment of flows of problematic drug users into treatment.

The Strategy Unit will lead this work, reporting to both the Home Secretary and the Prime Minister. Given the cross-cutting nature of this work, the Prime Minister would be grateful for close co-operation and support from all key Departments, in particular DH, HMCE, DfID, FCO, MoD, DWP and the Intelligence agencies.

I am copying this letter to Private Secretaries to Cabinet Ministers and the First Ministers for Scotland, Wales and Northern Ireland, Andrew Allberry, Paul Britton (EDS) and Geoff Mulgan (SU).

Yours, Jeremy

JEREMY HEYWOOD

Jonathan Sedgwick
HO

JM

DEPUTY PRIME MINISTER

OFFICE OF THE
DEPUTY PRIME MINISTER
26 Whitehall
London
SW1A 2WH

Tel: 020 7944 8623
Fax: 020 7944 8621

The Rt Hon David Blunkett MP
Home Secretary
50 Queen Anne's Gate
London
SW1 9AT

JR
E.EH
NA

2 December 2002

PUBLICATION OF THE GOVERNMENT'S UPDATED DRUG STARTEGY

You sought policy agreement in your letter to me of 19 November to publish the Government's Updated Drug Strategy. This letter gives you DA clearance to proceed, subject to the views of colleagues recorded below.

Replies were received from Peter Goldsmith, Andrew Smith, Hazel Blears and Stephen Twigg.

Peter said that the proposal for extending drug-testing to youths would have a resource impact for the Crown Prosecution Service (CPS). Once this could be quantified he would expect you to provide the necessary funding if appropriate. He also said the increased number of bail hearings which would result from the piloting of the rebuttable presumption against bail could lead to more court sittings. If this were the case further funding would have to be allocated to the CPS.

Stephen said that if the Strategy was to be successful it was essential to continue effective joined up working across Government.

Andrew welcomed the approaches suggested in the strategy, he said that the work of Jobcentre Plus would help support and reinforce the aim of strengthening communities by helping recovering drugs misusers into work.

Website: www.odpm.gov.uk
Email: john.prescott@odpm.gsi.gov.uk

Hazel said she was content with the document subject to some small drafting amendments.

I am copying this letter to the Prime Minister, members of DA Committee and Sir Andrew Turnbull.

JOHN PRESCOTT

HA Drugs pt3 01-05

From: Justin Russell
Date: 29 November 2002

PRIME MINISTER

cc: Jeremy Heywood
Andrew Adonis
Emily Miles
Natalie Acton
Michael Barber
Nick Ville
Sally Morgan
Ben Wilson
Jonathan Powell
Alastair Campbell
Godric Smith
Simon Stevens
Dominic Hardy

DRUG TREATMENT AND TESTING PROGRAMME

Bob Ainsworth and Hazel Blears have written offering to roll out the drug treatment and testing of offenders package to 30 high-crime BCUs from next year. Coverage for years 2 and 3 has still to be agreed – more work is needed to assess likely treatment demand. Home Office are pressing for 60 BCUs from April 2004.

Background

At your drugs stocktake meeting with Alan and David on 14 November it became clear there was still no agreement between HO and DH about the speed with which your drug testing and treatment package can be rolled out. I invited Bob and Hazel to No10 last week to find a way through this and they have provided the attached paper (annex 1).

This offers to roll out a comprehensive package of testing and treatment at each stage of the CJS to the 30 highest crime BCUs from April 2003. This is significantly less than the 60 agreed to by DB last month – but an improvement on the 13 BCUs originally agreed by DH. DB feels that DH should be funding more and is not happy with 30 – but in the absence of any firm data on the treatment flows resulting from increased testing at arrest this is the highest DH will go at present. (HO have agreed a joint modelling exercise with the Strategy Unit to provide a more complete picture by next Spring).

Annex A of Bob and Hazel's paper lists the 30 high crime BCUs to be included in year 1. These cover 57 police custody suites in 7 of the 10 street crime areas and account for about 25% of all acquisitive crime in England. They include 11 London boroughs, 3 BCUs in Bristol plus key divisions in Liverpool, Leeds and

anchester. None of the West Midlands BCUs has enough crime to make it into the top 30.

Each of these areas would get the following package:

- pre-arrest initiatives which target the most persistent offenders before they are arrested and steer them into treatment

- enhanced arrest referral (including the immediate provision of low level interventions such as advice and counselling);

- drug testing in custody suites so that every offender charged with a trigger offence is tested and if positive referred to an arrest referral worker;

- courts made aware of every offender testing positive at every bail hearing and each one offered treatment. (Within the framework of the current bail Act until the CJ Bill measures on presumption of treatment or remand receive Royal Assent);

- a 50% increase in the availability of DTTOs;

- the phased implementation of a lower intensity DTTO;

- improved quality and coverage of prison-based treatment programmes;

- an aftercare system for those leaving prison to ensure they receive the support/treatment they need to stop them returning to drug abuse and offending, and starting out on the whole system again.

Arrangements for managing this package and for driving up the performance of DATs in the target areas remain vague (though it has been agreed that DATs and CDRPs will be amalgamated in the 30 BCUs). DH have agreed that they will announce their treatment allocations for all DATs alongside the revised drugs strategy next Tuesday which will enable local areas to start recruiting drugs workers for the longer term. Average uplift in treatment spend will be 23% next year – rising to 35% in some of the 30 high crime BCUs.

Now that Louise Casey has been appointed to run the ASB initiative we should press HO to appoint an equally strong lead official for this drugs and crime programme. You should press DB on this when you meet him to discuss HO modernisation on Tuesday (3/12).

Content for HO and DH to roll this programme out to 30 rather than 60 BCUs in 2003-04? (If not you will need to press Alan directly on Monday).

We will press DB and AM for final proposals for years 2 and 3 by the time of your next drugs stocktake on 11 February.

No final decision has been taken on whether to announce the 30 BCUs on Tuesday when the drugs strategy is re-launched. **Would you prefer to announce them yourself on your regional tour to the South West next Friday (Bristol will be a key beneficiary of the package)?**

I agree with the package but two things are vital:
(a) a dedicated team at the centre
(b) locally one key person in charge but it all together: the problem at present is as much disorganisation as it is resources.
Also so does well is better than 60 done average

JUSTIN RUSSELL

PRIME MINISTER

DRUG TREATMENT AND TESTING PROGRAMME

Following last week's meeting at No.10 and the stocktake meeting on Drugs, we are writing to set out our plans over the SR2002 period for the extension of drug treatment and testing in the areas which contain BCUs with the highest levels of acquisitive crime and the provision of associated treatment. This note covers: selection of the areas; handling of the announcement of Drug Action Teams pooled treatment budget allocations; the use of CAD funding; the programme to enhance the performance of our local partnerships to ensure they deliver; and a description of the services that would be available both in the high crime areas and across the rest of the country over the SR2002 period for both adults and young people.

30 BCUs

Attached at Annex A is a list of the 30 BCUs with the highest levels of acquisitive crime and the 26 partnership areas that contain them. The list includes a number of London boroughs along with key cities like Bristol, Bradford, Leeds and Manchester. Also included are the next 10 BCUs we would wish to extend the interventions to if treatment capacity were available.

The 30 BCUs cover 57 custody suites, 4 of which are already piloting drug testing. There is a high correlation between the BCUs, the top 88 deprived areas, and the areas with the worst crack problems.

Announcement of DAT Treatment Allocations

We can confirm that we will be in a position to announce 3 year allocations to Drug Action Teams in parallel with publication of the updated drug strategy on the 3rd of December. This will involve detailed allocations for 2003/4 and minimum levels for years 2 and 3. The allocations represent a minimum increase of 10% with much higher increases of up to 35% being directed to the most deprived areas: the average increase Is 23%. The full list of allocations is set out in Annex C. We believe this provides a sound basis both for DATs and treatment providers to plan for growth.

CAD Funding

From April DATs and Crime and Disorder Reduction Partnerships (CRDPs) will be bought together in all the areas containing the 30 BCUs, and CAD will be part of their funding. This will reinforce the focus of the crime reduction elements of the drug programme. As you know CAD can already be used flexibly in support of the drug strategy as determined by local partnerships. It

makes up over 50% of the funding they have available to spend on crime reduction, and is therefore an essential part of crime reduction and drugs spend. Much of it has also already been committed to ongoing drugs projects. Given the limited nature of the funding it has proved most effective in providing innovative local services which support mainstream treatment, and in helping to develop the capacity to deliver at local level. For example it supported the Blackpool 'Tower' project which identifies prolific drug related offenders and offers them access to treatment before they have been arrested for a specific offence. It has also been used to develop new and more effective co-ordination arrangements in areas like Bristol, which have suffered from major drugs problems and ineffective co-ordination between key agencies at local level.

CAD is currently being jointly reviewed by the Home Office and the Treasury and proposals will be put to Ministers shortly. In communicating the results of the review to partnerships we would propose giving specific examples of how CAD funds can be used to support the CJS package as part of its key objective of tackling drug related crime. It would not be appropriate however for CAD to replace mainstream treatment spend either through the pooled treatment budget or mainstream NHS resources.

Enhancing DAT Performance

We are taking forward two areas of work in parallel. This will support work already in hand to bring together the partnerships delivering the drug and crime agendas:

- a joint review with the NTA of local delivery across the whole country to identify ways of improving agencies' and partnerships' performance, to raise standards of delivery over the SR2002 period;

- a separate exercise focusing on the areas containing the 30 BCUs. Working with Regional Directors, the NTA and other key partners, we will identify specific problems and obstacles to delivery in each area – eg lack of qualified staff; failure by an agency to deliver – and, using a dedicated project team take whatever steps are needed to tackle the problem and ensure that the planned interventions make a real difference on the ground.

It is important to remember that where there are problems with partnerships it is often because of failures or lack of commitment on the part of individual agencies. We will need to tackle this at both local and national level. Partnerships are only as good as the performance of their local PCTs, social services, police etc.

The proposed enhanced Package

Attached at Annex B(i) is a table outlining what services will be available both nationally and in the 30 BCUs in 2003/4. The table at B(ii) shows the position

in 2005/6 reflecting further roll out and implementation of the drug provisions of the Criminal Justice and Sentencing Bill. Adult and young people's services are outlined separately given that they will be managed separately and there are differences in the nature of the interventions offered.

In summary a partnership area covering a high crime BCU will deliver the following services:

- pilot of pre-arrest initiatives which target the most persistent offenders before they are arrested and steer them into treatment (subject to assessment of local need and funding);

- enhanced arrest referral (including the immediate provision of low level interventions such as advice and counselling);

- drug testing in custody suites so that every offender charged with a trigger offence is tested and if positive is again referred to an arrest referral worker;

- courts made aware of every offender testing positive at every bail hearing and offered treatment if not yet taken up within the framework of the current bail Act;

- a 50% increase in the availability of DTTOs;

- the phased implementation of a lower intensive DTTO;

- integrated throughcare for those who are processed through the whole system, with improvements in the quality and coverage of prison-based treatment programmes;

- an aftercare system for those leaving prison and treatment to ensure they receive the support/treatment they need to stop them returning to drug abuse and offending, and starting out on the whole system again.

This outlines the package in year one. As indicated above once the new powers of the Criminal Justice and Sentencing Bill have been commenced we will be able to extend the services available. For example this will include a piloted presumption against bail and the introduction of a generic community sentence which may include a drug rehabilitation requirement.

Our proposals include a broadly similar package for young people within the CJS – eg support within juvenile custodial facilities – combined with additional measures to ensure that vulnerable young people get the support they need through outreach, training or specialist early intervention and treatment.

Summary

We believe that this package will provide a fully integrated programme of interventions which will move drug misusing offenders and vulnerable young people into the right treatment and support both within the community and at every stage of the criminal justice process. Working with the NTA we will:

- expand the capacity of drug treatment services to increase the number of people (both from the CJS and other sources of referral) receiving treatment;

- improve the effectiveness of services;

- and reduce waiting times with the aim of ensuring that people receive the support and interventions they need, when they need them. Resources to complement the HO SR2002 allocation will be focussed in particular on areas of high deprivation, which align closely with the areas containing the 30 BCUs.

Many of the services described above are being introduced across the whole country and not just in the 30 BCUs. Further implementation of those extra services currently restricted to the 30 BCUs will be dependent on the increases in treatment capacity. We therefore propose reviewing the scope for implementation in years two and three once the modelling work with the Strategy Unit is complete.

Copies of this letter go to Alan Milburn, David Blunkett, Paul Boateng, Charles Clarke and Michael Barber.

ANNEX A

1. THE TOP 30 BCUs FOR ACQUISITIVE CRIME (WITH CORRESPONDING DAT AREA) ARE:

1. **Lambeth** (Lambeth)
2. **North Liverpool** (Liverpool)
3. **Central Bristol** (Bristol)
4. **Camden** (Camden)
5. **Southwark** (Southwark)
6. **Haringey** (Haringey)
7. **Middlesbrough** (Middlesbrough)
8. **Bradford South** (Bradford)
9. **North Bristol** (Bristol)
10. **Waltham Forest** (Waltham Forest)
11. **Bradford North** (Bradford)
12. **South Bristol** (Bristol)
13. **Millgarth** (Leeds)
14. **Calderdale** (Calderdale)
15. **Killingbeck** (Leeds)

16. **Nottingham** (Nottingham)
17. **South Manchester** (Manchester)
18. **Kingston Upon Hull** (Kingston Upon Hull)
19. **Newham** (Newham)
20. **Hackney** (Hackney)
21. **Salford** (Salford)
22. **Bolton** (Bolton)
23. **Ealing** (Ealing)
24. **Reading and Wokingham** (Reading and Wokingham separately)
25. **North Manchester** (Manchester)
26. **City of Westminster** (Westminster)
27. **Islington** (Islington)
28. **Tower Hamlets** (Tower Hamlets)
29. **Wandsworth** (Wandsworth)
30. **Rochdale** (Rochdale)

They cover:

- 26 DAT areas

- 53 <u>new</u> custody suites, plus 4 already covered under existing initiatives (pilots, extension to pilots, and the Street Crime Initiative).

- 21 of the highest 35 crack areas identified, with a further 3 included in the next 10 BCUs after the top 30 (Brent, Hammersmith & Fulham, and Trafford). The remaining 6 top BCU areas for acquisitive crime do not appear to overlap with the highest 35 crack areas, but 4 are likely to be

included in the top 60 - 70 BCUs (Croydon, Kensington and Chelsea, Lewisham, and Sheffield Central) for further roll out.

And:

- With the exception of Millgarth, Calderdale, Killingbeck, and Reading and Wokingham, all BCUs are in the top 88 deprived areas.

- The top 30 BCUs fall within 7 of the top 10 Police Force Areas covered by the Street Crime Initiative. The three areas that fall outside are West Midlands, South Yorkshire and Lancashire.

2. THE NEXT 10 BCUs AFTER THE TOP 30

Cover:

31. **Oldham** (Oldham)
32. **Weetwood** (Leeds)
33. **Hammersmith & Fulham** (Hammersmith & Fulham)
34. **Tameside** (Tameside)
35. **Trafford** (Trafford)
36. **Stockport** (Stockport)
37. **Slough and District** (Slough)
38. **Brent** (Brent)
39. **Redbridge** (Redbridge)
40. **Mansfield / Ashfield** (Nottinghamshire)

- These 10 BCUs fall within the same 7 Police Force Areas as the top 30.

- Brent, Hammersmith & Fulham, and Trafford are in the highest 35 crack areas identified.

- Weetwood, Trafford, Stockport, Slough and District, and Redbridge are <u>not</u> in the top 88 deprived areas.

Definitive lists ranking all 280 BCUs for individual crime criteria are available. Further work to identify additional BCU areas for roll out of drug testing in Years 2 and 3 of SR2002 using all crime criteria combined will be completed shortly following the final commitment to Year 1 allocations.

3. SELECTION CRITERIA

- The top 30 BCUs for acquisitive crime are identified using national figures for recorded crimes, namely burglary, robbery, theft of and from vehicles.

- Crime criteria used to select the top BCUs cover:

- Total number of acquisitive crimes committed (the main measure)
- Acquisitive crimes committed per head of the population
- Burglary and robbery crimes only

- Increase in acquisitive crimes during 00/01 to 01/02

  - The first 15 BCUs are in the top 60 out of a total of 280 overall for **all** crime criteria, and then ranked according to volume of crime. The next 15 BCUs meet the **first 3** crime criteria and ranked according to volume of crimes. BCUs ranked between 31 – 35 also meet the first 3 crime conditions, with those ranked between 36-40 close to the first 3 crime conditions.

  - Finally, ranking acquisitive crime at the BCU level places a sharper focus on the drugs and crime problem compared with analysis of acquisitive crime at the higher Police Force Area level.

ANNEX B1

COMPREHENSIVE INTEGRATED CRIMINAL JUSTICE PACKAGE

A comprehensive range of criminal justice interventions funded through SR2002, will deliver a fully integrated end to end system, which will use every opportunity within the criminal justice system to identify and help move drug-misusing offenders into treatment. The interventions set out below will be in the first year of the spending review (ie 2003/04). The annex at B2 sets out what will be delivered progressively by 2005/06 subject to the further work on modelling.

Some elements of the interventions outlined below will be delivered nationally across England and Wales whilst a more enhanced integrated package will be delivered within the BCUs in high crime and partnership areas.

Details 2003/04

The following package will be delivered nationally and within 30 BCUs

Interventions	**National England & Wales**	**BCU focused**
The piloting of pre-arrest initiatives which target the most persistent offenders before they are arrested and accesses them into treatment (subject to local partnership assessment of need and funding).		✓
Implementation of enhanced arrest referral across all Police Forces in England & Wales, which will include caseload management. Within the 30 BCUs adopt enhancements to develop an integrated end to end criminal justice team.	✓	✓ (30)
Arrest Referral for juveniles.		✓ (10)
Extending drug testing in police custody to 30 BCUs with the highest levels of drug-related crime. Every offender will be offered the opportunity to see an arrest referral worker before charge, and again after being charged with a trigger offence and testing positive.		✓ (30)
Courts made aware of every offender testing positive at every bail hearing – and offered treatment if not yet taken up within the legal framework of the Bail Act.		✓ (30)
Increase by 50% the number Drug Treatment and Testing Orders to provide for all those who will benefit from them.	✓	✓ (30)
Phased implementation of the less intensive version of the Drug Treatment and Testing Order, whilst awaiting full implementation of the single generic community sentence. (Subject to availability of treatment)		✓
Community Sentencing for Juveniles.		✓ (10)

Interventions	National England & Wales	BCU focused
Providing throughcare and improving the quality and coverage of prison-based treatment programmes. Improving the quality and coverage of prison-based treatment programmes across England & Wales with a focus on improving the throughcare links with the 30 BCUs/25 DATs.	✓	✓ (30)
Build on the existing criminal justice work force including arrest referral to develop an integrated criminal justice team, which can provide an end to end system including a comprehensive throughcare and aftercare service. This may also include testing as a condition of on license for specific offenders (i.e. trigger offences) (Subject to availability of treatment and local partnerships).		✓
Drugs workers and the provision of prevention treatment and aftercare programmes within all juvenile custodial facilities.	✓	✓ (30)
All DATs in England &Wales to undertake an analysis of need to inform the planning and delivery of a co-ordinated system of aftercare provision from 04/05.	✓	✓ (30)
Outreach training or specialist early intervention and treatment within mainstream services.	✓	✓ (30)
Diversionary programmes – eg sport part – for young people (Positive Futures).	✓	✓ (30)

ANNEX B2

COMPREHENSIVE INTEGRATED CRIMINAL JUSTICE PACKAGE

Details 2005/06

The following interventions will be delivered as indicated nationally/BCU focused. The extension of BCUs will be reviewed once the modelling work on treatment capacity is completed

Interventions	**National England & Wales**	**BCU focused**
The piloting of pre-arrest initiatives which targets the most persistent offenders before they are arrested and accesses them into treatment(subject to local partnerships assessment of need and funding).		✓
Implementation of enhanced arrest referral across all Police Forces in England & Wales, which will include caseload management. Within the high crime areas adopt enhancements to develop an integrated end to end criminal justice team.	✓	✓ (30+)
Arrest Referral for juveniles.	✓	✓ (30+)
Extending drug testing in police custody to BCUs with the highest levels of drug-related crime. Every offender will be offered the opportunity to see an arrest referral worker before charge, and again after being charged with a trigger offence and testing positive.		✓ (30+)
Drug Testing of Juveniles.		✓ (30)
Pilot the introduction of a rebuttable presumption against bail for those arrested for and charged with a trigger offence, which test positive for a Class A drug, and refuse assessment by a suitably qualified practitioner as to their suitability for treatment or, having been assessed as suitable, refuse to undergo treatment (Subject to agreement with petty sessional areas and local partnerships).		✓ (+)
In all areas where drug testing is being undertaken courts not part of the presumption against bail pilot made aware of every offender testing positive at every bail hearing – and offered treatment if not yet taken up within the legal framework of the Bail Act.		✓ (30+)
Double the number of Drug Treatment and Testing Orders by March 2005 to provide for all those who will benefit from them (until they are replaced by the new generic community sentence and specific drug rehabilitation requirements).	✓	✓ (30+)
Continued phased implementation of the less intensive version of the Drug Treatment and Testing Order, whilst		✓

Interventions	National England & Wales	BCU focused
awaiting full implementation of the single generic community sentence. (Subject to availability of treatment and local partnerships).		
Community Sentencing for Juveniles.	✓	✓ (30+)
Providing throughcare and improving the quality and coverage of prison-based treatment programmes. Improving the quality and coverage of prison-based treatment programmes across England & Wales with a focus on improving the throughcare links with the high crime areas.	✓	✓ (30+)
Drugs workers and the provision of prevention treatment and aftercare programmes within all juvenile custodial facilities.	✓	✓ (30+)
Build on the existing criminal justice work force including arrest referral to develop an integrated criminal justice team, which can provide an end to end system including a comprehensive throughcare and aftercare service. This will also include probation officer discretion to include drug testing as an on licence condition, post release for those not convicted of a trigger offence.		✓ (30+)
All DATs in England & Wales to deliver a co-ordinated system of aftercare for those leaving prison and or treatment planned/unplanned, in line with good practice.	✓	✓ (30+)
Outreach training or specialist early intervention and treatment within mainstream services.	✓	✓ (30+)
Positive Futures.	✓	✓ (30+)

Drug misuse treatment allocations by DAT 2003/04 to 2005/06

DAT	Opening position Drugs misuse baseline	2003/04			2004/05			2005/06		
		Increase		Allocation	Increase		Allocation	Increase		Allocation
	£000s	£000s	%	£000s	£000s	%	£000s	£000s	%	£000s
Darlington	436	105	24.04	541	38	6.96	578	107	18.46	685
Durham	1,895	466	24.60	2,361	175	7.43	2,537	481	18.98	3,018
Gateshead	800	197	24.60	997	74	7.43	1,071	203	18.98	1,274
Newcastle City	1,639	394	24.02	2,033	141	6.94	2,174	401	18.45	2,575
Northumberland	1,175	237	20.16	1,412	50	3.54	1,462	213	14.59	1,675
South Tyneside	980	260	26.55	1,240	112	9.05	1,352	280	20.72	1,633
Sunderland	1,470	392	26.67	1,862	171	9.16	2,033	423	20.83	2,456
North Tyneside	848	210	24.77	1,058	80	7.58	1,138	218	19.14	1,356
Hartlepool	392	136	34.79	528	81	15.39	610	165	27.05	775
Redcar & Cleveland	555	210	37.81	765	134	17.52	899	261	29.02	1,160
Middlesborough	823	290	35.28	1,113	175	15.75	1,289	353	27.38	1,642
Stockton	702	262	37.34	964	166	17.20	1,130	325	28.73	1,455
Liverpool	2,838	1,052	37.08	3,890	662	17.02	4,552	1,300	28.56	5,852
Manchester	3,596	898	24.98	4,494	348	7.75	4,842	936	19.32	5,778
Bury	440	111	25.27	551	44	7.99	595	117	19.59	712
Salford	1,201	218	18.18	1,419	24	1.71	1,444	179	12.40	1,622
Trafford	776	133	17.13	909	6	0.71	915	102	11.18	1,018
Stockport	697	156	22.45	853	48	5.58	901	153	16.93	1,054
Bolton	903	249	27.53	1,152	113	9.85	1,265	273	21.55	1,538
Rochdale	817	206	25.16	1,023	81	7.90	1,103	215	19.49	1,318
Blackburn With Darwen	609	165	27.09	774	73	9.49	847	180	21.18	1,027
Blackpool	600	140	23.38	740	47	6.39	788	140	17.83	928
Lancashire	3,061	829	27.08	3,890	369	9.49	4,259	902	21.18	5,161
Cumbria	1,499	353	23.52	1,852	121	6.51	1,972	354	17.97	2,327
Warrington	494	133	26.85	627	58	9.30	685	144	20.98	829
Halton	593	161	27.22	754	72	9.60	827	176	21.29	1,003
South Cheshire	1,762	337	19.10	2,099	54	2.57	2,152	289	13.43	2,442
Sefton	1,030	306	29.68	1,336	154	11.56	1,490	347	23.31	1,837
St Helens	628	212	33.73	840	123	14.62	963	253	26.32	1,216
Knowsley	827	348	42.13	1,175	240	20.42	1,415	447	31.59	1,863
Wirral	1,060	395	37.26	1,455	249	17.14	1,704	489	28.68	2,193
Wigan	911	253	27.77	1,164	117	10.04	1,281	279	21.75	1,559
Tameside	750	171	22.85	921	55	5.94	976	169	17.33	1,145
Oldham	807	209	25.86	1,016	86	8.48	1,102	222	20.11	1,323

Drug misuse treatment allocations by DAT 2003/04 to 2005/06

DAT	Opening position Drugs misuse baseline	2003/04 Increase		Allocation	2004/05 Increase		Allocation	2005/06 Increase		Allocation
	£000s	£000s	%	£000s	£000s	%	£000s	£000s	%	£000s
Barnsley	923	209	22.64	1,132	65	5.75	1,197	205	17.12	1,402
Bradford	1,804	605	33.55	2,409	349	14.49	2,758	722	26.19	3,480
Doncaster	1,060	316	29.84	1,376	161	11.68	1,537	360	23.43	1,897
Kingston upon Hull	1,600	467	29.19	2,067	231	11.18	2,298	527	22.92	2,825
East Riding	701	223	31.76	924	122	13.16	1,045	260	24.90	1,305
Calderdale	665	175	26.35	840	75	8.89	915	188	20.55	1,103
Kirklees	1,324	350	26.45	1,674	150	8.97	1,824	376	20.63	2,201
Leeds	3,437	713	20.73	4,150	168	4.06	4,318	656	15.19	4,974
North Yorkshire	1,532	271	17.69	1,803	23	1.25	1,826	216	11.84	2,042
City of York	585	123	21.04	708	31	4.33	739	115	15.51	853
Rotherham	1,048	253	24.13	1,301	92	7.04	1,392	258	18.55	1,651
Sheffield	2,485	633	25.47	3,118	255	8.17	3,373	667	19.77	4,040
North Lincolnshire	491	137	27.87	628	64	10.13	691	151	21.84	842
North East Lincolnshire	534	261	48.90	795	196	24.62	991	348	35.11	1,339
Wakefield	1,380	261	18.88	1,641	39	2.37	1,679	222	13.20	1,901
Birmingham	5,002	1,875	37.49	6,877	1,190	17.30	8,067	2,325	28.82	10,392
Coventry	1,101	385	34.98	1,486	231	15.53	1,717	467	27.18	2,183
Dudley	1,059	298	28.13	1,357	140	10.34	1,497	330	22.06	1,827
Herefordshire	507	80	15.75	587	0	0.00	587	54	9.18	641
Sandwell	1,415	416	29.41	1,831	208	11.35	2,039	471	23.10	2,510
Shropshire	713	146	20.47	859	33	3.82	892	133	14.92	1,025
Telford & Wrekin	640	132	20.68	772	31	4.01	803	122	15.13	925
Solihull	554	124	22.41	678	38	5.55	716	121	16.89	837
Staffordshire	2,083	503	24.13	2,586	182	7.03	2,767	513	18.54	3,281
Stoke on Trent	1,086	256	23.55	1,342	88	6.54	1,430	257	18.00	1,687
Walsall	1,097	281	25.58	1,378	114	8.26	1,491	296	19.87	1,788
Warwickshire	1,358	251	18.46	1,609	32	1.97	1,640	209	12.72	1,849
Wolverhampton	1,110	377	33.93	1,487	220	14.77	1,706	451	26.46	2,158
Worcestershire	1,475	291	19.74	1,766	56	3.16	1,822	258	14.14	2,080

Drug misuse treatment allocations by DAT 2003/04 to 2005/06

DAT	Opening position Drugs misuse baseline	2003/04			2004/05			2005/06		
		Increase		Allocation	Increase		Allocation	Increase		Allocation
	£000s	£000s	%	£000s	£000s	%	£000s	£000s	%	£000s
Leicestershire	1,177	332	28.23	1,509	157	10.42	1,667	369	22.14	2,036
Leicester City	1,645	419	25.48	2,064	169	8.17	2,233	441	19.77	2,674
Rutland	35	7	20.24	42	2	3.62	44	6	14.68	50
Lincolnshire	1,883	364	19.33	2,247	63	2.78	2,310	316	13.69	2,626
Northamptonshire	1,897	395	20.82	2,292	95	4.14	2,387	365	15.28	2,751
Derbyshire	1,849	545	29.49	2,395	273	11.41	2,668	618	23.15	3,286
Derby City	1,008	255	25.35	1,263	102	8.06	1,365	268	19.66	1,633
Nottinghamshire	1,811	614	33.90	2,425	358	14.74	2,782	736	26.43	3,518
City of Nottingham	1,650	537	32.54	2,187	301	13.74	2,487	634	25.47	3,121
Bracknell Forest	297	35	11.63	332	0	0.00	332	17	5.00	348
Reading	787	103	13.05	890	0	0.00	890	44	5.00	934
Slough	767	110	14.37	877	0	0.00	877	59	6.77	937
West Berkshire	310	35	11.27	345	0	0.00	345	17	5.00	362
Windsor & Maidenhead	373	43	11.43	416	0	0.00	416	21	5.00	436
Wokingham	273	33	12.27	306	0	0.00	306	15	5.00	322
Buckinghamshire	1,266	144	11.41	1,410	0	0.00	1,410	71	5.00	1,481
Milton Keynes	914	102	11.15	1,016	0	0.00	1,016	51	5.00	1,067
Brighton & Hove	1,235	305	24.66	1,540	115	7.48	1,655	315	19.04	1,970
East Sussex	1,104	259	23.47	1,363	88	6.47	1,451	260	17.92	1,711
Isle of Wight	507	114	22.55	621	35	5.67	657	112	17.03	768
Kent	3,948	832	21.07	4,780	209	4.37	4,989	775	15.54	5,764
Medway Towns	905	210	23.16	1,115	69	6.20	1,184	209	17.62	1,392
Hampshire	3,661	366	10.00	4,027	0	0.00	4,027	201	5.00	4,228
Portsmouth	924	171	18.49	1,095	22	2.00	1,117	142	12.75	1,259
Southampton	1,189	222	18.66	1,411	30	2.16	1,441	187	12.94	1,628
Oxfordshire	2,428	243	10.00	2,671	0	0.00	2,671	134	5.00	2,804
Surrey	2,576	258	10.00	2,834	0	0.00	2,834	142	5.00	2,975
West Sussex	1,980	202	10.22	2,182	0	0.00	2,182	109	5.00	2,291

Drug misuse treatment allocations by DAT 2003/04 to 2005/06

DAT	Opening position Drugs misuse baseline	2003/04 Increase		Allocation	2004/05 Increase		Allocation	2005/06 Increase		Allocation
	£000s	£000s	%	£000s	£000s	%	£000s	£000s	%	£000s
Bath & North East Somerset	375	78	20.72	453	18	4.05	471	72	15.18	543
Bristol	1,941	405	20.87	2,346	98	4.19	2,444	375	15.34	2,819
South Gloucester	451	94	20.78	545	22	4.11	567	86	15.24	654
North Somerset	390	74	18.94	464	11	2.43	475	63	13.26	538
Cornwall & Isles of Scilly	1,534	363	23.64	1,897	126	6.62	2,022	366	18.09	2,388
Dorset	863	114	13.26	977	0	0.00	977	49	5.00	1,026
Bournemouth	737	131	17.79	868	12	1.35	880	105	11.96	985
Poole	360	50	13.80	410	0	0.00	410	24	5.75	433
Gloucestershire	1,727	311	18.01	2,038	32	1.56	2,070	253	12.21	2,322
Devon	1,965	352	17.92	2,317	34	1.46	2,351	284	12.10	2,635
Plymouth	1,191	202	16.99	1,393	8	0.58	1,401	154	11.02	1,556
Torbay	555	110	19.75	665	21	3.17	686	97	14.15	783
Swindon	790	92	11.63	882	0	0.00	882	44	5.00	926
Wiltshire	1,208	127	10.48	1,335	0	0.00	1,335	67	5.00	1,401
Somerset	1,378	227	16.46	1,605	1	0.07	1,606	167	10.38	1,773
Bedfordshire	986	210	21.32	1,196	55	4.59	1,251	198	15.80	1,449
Luton	835	204	24.46	1,039	76	7.31	1,115	210	18.85	1,326
Cambridgeshire	1,822	199	10.95	2,021	0	0.00	2,021	101	5.00	2,122
Peterborough	939	115	12.24	1,054	0	0.00	1,054	53	5.00	1,107
Essex	3,085	708	22.94	3,793	228	6.01	4,021	700	17.42	4,721
Southend	758	128	16.89	886	4	0.49	890	97	10.90	987
Thurrock	507	120	23.64	627	41	6.62	668	121	18.09	789
Hertfordshire	3,567	357	10.00	3,924	0	0.00	3,924	196	5.00	4,120
Norfolk	2,517	514	20.42	3,031	115	3.78	3,146	467	14.86	3,613
Suffolk	2,138	360	16.84	2,498	11	0.44	2,509	272	10.84	2,781

Drug misuse treatment allocations by DAT 2003/04 to 2005/06

DAT	Opening position Drugs misuse baseline	2003/04			2004/05			2005/06		
		Increase		Allocation	Increase		Allocation	Increase		Allocation
	£000s	£000s	%	£000s	£000s	%	£000s	£000s	%	£000s
Barking	777	242	31.19	1,019	130	12.73	1,149	281	24.47	1,430
Havering	566	145	25.66	711	59	8.32	770	154	19.94	924
Barnet	955	249	26.11	1,205	105	8.69	1,309	266	20.34	1,576
Bexley	600	159	26.44	759	68	8.97	827	171	20.63	997
Brent	1,417	492	34.70	1,909	293	15.33	2,201	594	26.99	2,795
Bromley	716	185	25.89	901	77	8.51	978	197	20.15	1,175
Camden	2,017	449	22.24	2,466	133	5.40	2,599	435	16.73	3,033
Islington	2,451	498	20.33	2,950	109	3.70	3,059	452	14.77	3,511
City of London	14	9	66.41	23	8	33.89	31	13	42.09	44
Hackney	2,112	637	30.17	2,749	328	11.94	3,077	729	23.69	3,806
Croydon	1,212	353	29.09	1,565	174	11.09	1,738	397	22.84	2,135
Ealing	1,794	341	19.02	2,135	53	2.49	2,188	292	13.34	2,480
Enfield	1,093	366	33.45	1,458	210	14.41	1,669	436	26.12	2,104
Haringey	1,547	549	35.51	2,096	333	15.91	2,430	669	27.53	3,099
Greenwich	1,449	418	28.83	1,867	203	10.89	2,070	468	22.63	2,538
Hammersmith & Fulham	1,340	276	20.58	1,616	63	3.92	1,679	252	15.03	1,931
Harrow	542	147	27.11	689	66	9.51	754	160	21.20	914
Hillingdon	888	150	16.91	1,038	5	0.51	1,043	114	10.92	1,157
Hounslow	861	179	20.84	1,041	43	4.15	1,084	166	15.30	1,250
Kensington & Chelsea	1,817	182	10.00	1,999	0	0.00	1,999	100	5.00	2,099
Kingston upon Thames	658	67	10.16	725	0	0.00	725	36	5.00	761
Lambeth	2,439	827	33.91	3,266	482	14.75	3,748	991	26.44	4,739
Lewisham	2,023	563	27.83	2,586	261	10.09	2,847	621	21.80	3,468
Southwark	2,274	778	34.23	3,052	457	14.99	3,510	936	26.66	4,446
Merton	804	145	17.99	949	15	1.53	964	117	12.18	1,081
Newham	2,164	820	37.89	2,984	525	17.58	3,509	1,020	29.08	4,529
Redbridge	678	251	37.07	929	158	17.01	1,087	310	28.55	1,398
Waltham Forest	958	399	41.67	1,357	273	20.12	1,630	511	31.33	2,141
Richmond upon Thames	687	69	10.00	756	0	0.00	756	38	5.00	793
Sutton	568	94	16.59	662	1	0.20	664	70	10.54	733
Tower Hamlets	1,988	743	37.40	2,731	471	17.24	3,202	921	28.77	4,124
Wandsworth	1,663	337	20.28	2,000	73	3.65	2,073	305	14.72	2,378
Westminster	2,729	273	10.00	3,002	0	0.00	3,002	150	5.00	3,152
England total	191,202	44,898	23.48	236,100	17,300	7.33	253,400	46,000	18.15	299,400

DCO Top: PD(EM)
" PD(NA)
PD(GR)

The Rt Hon The Lord Goldsmith QC

9 BUCKINGHAM GATE
LONDON SW1E 6JP

020-7271 2460

The Rt Hon John Prescott MP
Office of the Deputy Prime Minister
Dover House
Whitehall
London
SW1A 2AU

27 November 2002

Dear John

PUBLICATION OF THE GOVERNMENT'S UPDATED DRUG STRATEGY

I was copied into David's letter to you of the 19 November 2002 enclosing the draft of the updated drug strategy for comments.

I welcome the various elements of the drug strategy. The strategy reinforces the need for a more joined-up approach by the various agencies and bodies if progress is to be made in reducing drug offending and the related offences caused by drug users. David's foreword rightly emphasises the priority to be attached to the problems of drugs.

I have in a letter dated June 2002 to Bob made some observations in relation to the proposed extension of the drug-testing pilot scheme to youths. I have also made observations, in a letter dated 9th May 2002, sent by one of my officials to the Home Office, in relation to the piloting of the rebuttal presumption against bail where an offender has tested positive for the presence of class A drugs, which is worth repeating.

Extension of the drug-testing proposal to youths is welcomed in principle. The pilot is currently operating in 10 Areas for adults only. Our White Paper proposals will result in an increase in the 'trigger' offences coupled with the extension of the scheme to cover some youth offenders. This is likely to have some impact on the resources needed by the Crown Prosecution Service to deal with the pilots. It is difficult to provide figures at this stage as the results of the interim evaluation are not expected until Spring 2003. I shall look to the Home Secretary to provide the necessary funding for this proposal if appropriate. Perhaps his and my officials can liase to finalise this matter in due course.

SKP 2/12/02

ATTORNEY GENERAL

The piloting of the rebuttable presumption against bail may also have some cost implications for the CPS. An increase in the number of bail applications can be anticipated to follow as a natural consequence. This will require more time in court and thus fewer cases can be listed. If this were to lead to more court sittings, there will be a need to consider if further funding will need to be allocated to the CPS to reflect this.

The other proposals on preventing young people from using drugs, reducing the prevalence of drugs on the streets, reducing drug related crime and reducing the demand for drugs are matters that officials have previously discussed and are welcomed.

I am copying this letter to the Prime Minister, members of the DA Committee and to Sir Andrew Turnbull.

From the Secretary of State
for Work and Pensions

DWP Department for Work and Pensions

Richmond House
Room 205
79 Whitehall
London
SW1A 2NS

Telephone
020 7238 0800

Facsimile
020 7238 0661

Email
ministers@dwp.gsi.gov.uk
www.dwp.gov.uk

JJH
c: JR
NA
SM

SOS/02/1340

Rt Hon David Blunkett MP
Home Secretary
Home Office
50 Queen Anne's Gate
London
SW1H 9AT

28 November 2002

Dear David,

Thank you for copying me your letter of 19 November enclosing the updated draft drug strategy.

I warmly welcome the approaches suggested, particularly the emphasis placed upon strengthening communities. I am confident that the work of Jobcentre Plus will support and reinforce this element of the strategy, particularly, through the 'Progress2Work' (p2w) initiative to help recovering drugs misusers into work and therefore more stable and constructive lives. Contracts are currently being awarded for phase 2 of the roll-out which will mean p2w activity in 61 Jobcentre Plus districts. We envisage the process of contracting for the remaining areas will begin in April 03.

I am copying this letter to the Prime Minister, members of DA committee and to Sir Andrew Turnbull.

Best wishes,

ANDREW SMITH

ls2701

RESTRICTED

Home Office

The Private Secretary to the Home Secretary

28 November 2002

Jeremy Heywood
Principal Private Secretary
10 Downing Street
London SW1

Dear Jeremy

STRATEGY UNIT STUDY ON DRUGS POLICY

I am replying both to your letter of 19th November and your email of the following day.

The Home Secretary is content with the proposals attached to your email for the scope of some analytical work on drugs and he is content for the an FSU team lead by Geoff Mulgan to work closely with Drugs Unit in the Home Office and with other departments on this. For the sake of clarity, I should say that he regards the review of the effectiveness of existing interventions to be confined to the supply side part of this work. He proposes to include a brief reference to this work in the Drugs Strategy which is due to be published next week.

You mentioned that the Prime Minister will want to discuss with the Home Secretary the role that advisors outside the immediate FSU team might play in the analysis as it develops. I agree that this would be helpful but that we should not now hold up work by the team until this conversation has taken place.

In relation to further work beyond this first phase, the Home Secretary will obviously want to look very carefully with colleagues at the analysis when it is available. He is, however, very concerned to register that in terms of delivery, it is vital that in any further phase of work we do not give the impression that the Drugs Strategy - about to be re-launched - is being reviewed or re-considered before it has had chance to work. The Home Secretary believes this can be avoided provided we stick closely to the scope now agreed.

Yours ever

JONATHAN SEDGWICK

RESTRICTED

From the Parliamentary Under Secretary of State for Public Health
Hazel Blears MP

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS
Tel: 020 7210 3000

IMC 24814

The Rt Hon John Prescott MP
Deputy Prime Minister and
First Secretary of State
26 Whitehall
London
SW1A 2WH

27 November 2002

Dear John,

PUBLICATION OF THE GOVERNMENT'S UPDATED DRUG STRATEGY

I have seen David Blunkett's letter of 19 November to you seeking comments on the updated draft drug strategy, which is to be launched on 3rd December 2002.

My officials and I are broadly content with the current version of the document, subject to one or two drafting amendments.

As you know I am currently directing significant resources towards an improvement in the availability and quality of drug treatment. The National Treatment Agency is working closely with providers across the country. I firmly believe that the emphasis on working at a local level is the right approach. With significant government funding and support we are on track to get more drug misusers into treatment.

I welcome the revised strategy which will help us to continue to focus on this very important issue.

I am copying this letter to the Prime Minister, members of DA Committee and to Sir Andrew Turnbull.

Yours,

HAZEL BLEARS

SV251103

CONFIDENTIAL

CONFIDENTIAL