2010 Drug Strategy Consultation – Stockton DAAT/Safer Stockton Partnership Response

Aims:

Greater ambition for individual recovery whilst ensuring the crime reduction impact of treatment. (Priority)
Actions to tackle drugs being part of building the 'Big Society.'
A more holistic approach with drugs issues being assessed and tackled alongside other issues such as alcohol abuse, child protection, mental health, employment and housing. (Priority)
Budgets and responsibility devolved wherever possible, with commissioning of services at a local level. (Priority)
Budgets and funding streams simplified and outcome based.
The financial cost of drug misuse reduced.

QA1 Are there other key aspects of reducing drug use that you feel should be addressed?

Yes

The structure of the consultation is departmental, there needs to be assurance that the drug and alcohol strategy is co-ordinated across all Government departments.
There needs to be more clarity on what the 'Big Society' means relating to drugs?
When mental health is referenced it should also include Learning Disabilities.
Recognition that drugs other than Class A, including alcohol, contribute significant harm to individuals and society. Greater involvement of families with a holistic approach and safeguarding the needs of children and young people prior to reaching crisis point, ie, in need of protection.

QA2 Which areas would you like to see prioritised? See above

QA3 What do you think has worked well in previous approaches to tackling drug misuse?

Partnership work at a local level between Drug & Alcohol Action Teams, Police, Probation, Prison Service, Housing, Voluntary Sector, etc.
Partnership working is essential where yp drug services need to be part of an integrated system of working with young people as is working with the whole family, Providing education and awareness of impact of drugs and alcohol on a young person in services to parents/carers/family members;
Quick and easy access to treatment, including prescribing and psychosocial/wraparound support.
Therapeutic Communities in prison settings.
Integrated Offender Management approach
Enforcement and treatment as part of police operations, ie, dealers arrested, identified users referred directly into treatment.

Movement towards looking at outcomes, eg, improved mental health, improved general health, improved housing circumstances, improved relationships, reduced offending, etc. On the recovery journey outcomes are more than being drug free and should not solely be based on being drug free.

QA4 What do you think has not worked so well in previous approaches to tackling drug misuse?

More evidence base is needed around all four Tiers of treatment.
More boundaries are needed in treatment – prescribing along is insufficient.
Behaviour change needs to be worked on from the commencement of treatment.
More robust enforcement of holistic treatment as part of criminal sentencing.
There needs to be very clear guidelines on information sharing, especially relating to health/treatment services.
There has been too much focus on numbers/outputs relating to funding.
There is a lack of co-operation within the system from the courts and Crown Prosecution Service. Designated drug and alcohol courts would be positive in terms of understanding addiction and ensuring robust treatment as part of sentencing.
Within the prison setting, Voluntary Drug Testing has not worked and the benefits of Mandatory Drug Testing are questionable.
A medical model of delivering "treatment" to young people has not been very effective previously– young people need to be catered for in young people's services with substance misuse as an element of their overall care package. The whole approach needs to be holistic, reducing harm and a move to abstinence.

PREVENTING DRUG USE

QB1 What are the most effective ways of preventing drug or alcohol misuse?

Ensuring young people have positive re-enforcement messages re self-esteem – should be part of the national curriculum.
Promoting positive social norms.
Minimum pricing for alcohol to reduce accessibility and affordability for young people and harmful drinkers
Social inclusion relating to positive values.
Trying to move away from the cultural acceptance and expectations regarding harm, eg, it being generally accepted that individuals will consume alcohol and fight/end up in hospital/engage in risk taking behaviours
Education of parents in a generic way, but also very specific education and parenting programmes for adult substance misusers who are parents;
Education within schools, colleges and pupil referral unit, this needs to be statutory so that there is a consistent delivery to all young people in order that they can make safer and informed choices about their lifestyle; this education needs to be factual not negative in its delivery

QB2 Who (which agencies, organisations and individuals) are best able to prevent drug or alcohol misuse?

Parents and family – ensuring self-esteem and enabling coping mechanisms/life skills.
Older teenage peers to provide positive role models/education
Partnership approach at community level
Narcotics Anonymous/Alcoholics Anonymous
Voluntary/third sector
Young people's youth workers and targeted youth support need to be skilled up and identify early and problems relating to drug/alcohol use and able to provide a brief intervention
Parents schools advisors are best to deliver to parents as a joined up approach developing resources with young people drug/alcohol services
Specialist teams in schools to deliver to specific leads which will then deliver to young people in classes or experts in field to deliver;

QB3 Which groups (in terms of age, location or vulnerability) should prevention programmes particularly focus on?

For younger children parents need to be engaged as well as the child. Vulnerable families need to be targeted where addiction and other social problems are occurring and being repeated in subsequent generations, eg, Family Intervention Project activities.
Social marketing to be expanded.
Alcohol and drugs are different in that it is more likely that alcohol harm will be experienced within all stages of the lifespan – therefore, prevention should be throughout the lifespan.
Funding towards prevention should not be prescriptive and decided centrally how to be spent. There should be autonomy for the local area to identify and target priorities.
Prevention should always include an element of early intervention especially in services where the most vulnerable groups of young people exist, Looked after Children, Youth Offending, Pupil referral units, prevention programmes in youth services. Prevention needs to be defined are we preventing drug & alcohol use in young people or preventing problematic use in adulthood?
Locations should always be where the young person feels most comfortable (dependant upon risk) but at school, at home – then discussions with parents could take place, in other agencies as a joint session – as long as the young person feels safe and the surroundings are comfortable and are easily accessible and flexible, in the substance misuse services
Age – overall prevention needs to start from a very early age in primary schools and as per national and local research drugs as medicines and personal safety right through to education around available services up to college students

QB4 Which drugs (including alcohol) should prevention programmes focus on?

Those that cause the most harm
Those that are most widely used
All drugs

All drugs – prevention should not just be focussed on young people. Misuse, particularly of alcohol, can occur at any age in the lifespan.
There needs to be comparisons given about what the effects are of all drugs so that informed choices can be made. If there is too much focus on illicit drugs then most young people will ignore the messages as it doesn't relate to them whereby if prevention consisted of drugs both illicit and legal and alcohol young people would possibly feel that it was more relevant to them

QB5 How can parents best be supported to prevent young people from misusing drugs or alcohol?

Giving parents more information on facts and skills to deliver information to children – consider options that involve parent evenings.
Address the issue of parents acknowledging their own behaviours and the impact of their behaviour on the children.
More promotion of services offering support rather than punishment, eg, prevention teams within the youth offending service.

QB6 How can communities play a more effective role in preventing drug or alcohol misuse?

Encourage more reporting of drug and alcohol related activity and ensure reporting of problems is made as easy as possible.
Encourage aspirations relating to more positive role models.
Change in culture re approach to 'recreational' substance intake – both alcohol and drugs.

QB7 Are there any particular examples of prevention activity that you would like to see used more widely?

Social norms/marketing
Hard hitting impact education
Diversion activities – natural highs
More use of parenting orders
Prevention teams within Youth Offending Service

QB8 What barriers are there to improving drug and alcohol prevention?

Apathy of communities to take action
Society demonization of someone with a drug addiction
Mainstream services need to be more focussed on prevention and more aware of addiction.
Individual understanding and acceptance of harm, eg, especially relating to alcohol.
Information sharing, particularly relating to health and social care sharing information with other agencies to prevent harm.
Current licensing laws
Alcohol has a major role in recreation
PHse in schools not being a statutory subject
Ownership of the agendas in other children and young people's arenas

STRENGTHEN ENFORCEMENT

QC1 When does drug use become problematic?

When an individual cannot do what would be expected of them without having taken the drug or alcohol, eg, socialise, work, parenting, employment, be healthy.

QC2 Do you think the criminal justice system should do anything differently when dealing with drug-misusing offenders?

Yes – a dedicated drugs/alcohol enforcement pathway that includes the courts/probation/prison services and treatment. Sentencing should be about the individual and should respond to their circumstances. Sometimes individuals are repeatedly in and out of the court system in short periods of time and sentencing relating to the individual crime rather than the individual person does not address the underlying issues. Needs to be clear co-ordination of care throughout.

Treatment should be more forcibly included and robust in community sentencing.

There are Tier 4 facilities already in prisons (therapeutic communities) – these could form part of sentencing.

Needs to be more focus on building life skills and emotional development.

Early releases need to be reconsidered as they make effective linkage with the community very difficult.

QC3 Do you have a view on what factors the government should take into consideration when deciding to invoke a temporary band on a new substance?

Yes – the potential to cause physical or psychological harm. Ease of obtain substances.

QC4 – What forms of community based accommodation do you think should be considered to rehabilitate drug offenders?

The consultation statement above this question reads ‘We will explore alternative forms of secure, treatment-based accommodation for mentally ill and drug-misusing offenders.’ The statement and subsequent question refer to two different client groups; one is dual diagnosis and one is offenders.

Any effective treatment should take into account someone’s offending behaviour regardless of the setting. If an individual is not willing to change enforcement alone will not work.

The need for improved housing and housing support appears frequently in needs assessments. Changing levels of support accommodation is positive, eg, Supporting People funding for accommodation enables more dedicated support for life-skills

relating to daily living. Needs to be a definite move away from hostel based accommodation on release from prison.

QC5 Where do you think we most need to target enforcement efforts to reduce the supply of drugs?

Street level dealing – gives respite to communities
Asset recovery – supported by the general public
Organised crime

QC6 What else do you think we can do to keep one step ahead of the changing drugs markets?

Community consultation amongst the drug using population to identify trends and drugs used.
More enforcement activity relating to the internet.
DAATs at a local level sharing intelligence from hospital admissions/treatment information/police intelligence.

QC7 Which partners – in the public, voluntary and community sectors – would you like to see work together to reduce drug related offending in your local area?

Health/Housing/Education/training/employment services/community safety/specialist treatment services/residents groups.

Offender management models work well with a seconded prison officer within them – simplifies links/sharing information between prison and community.

QC8 What results should be paid for or funded?

Funded to move clients into education/training/employment
Funded to reduce re-offending
Improved health and well-being should be funded (not just drug free). There are no short-term fixes for addiction.
Improvement in social behaviour
Aftercare support to be funded to assist with preventing potential relapse and someone to contact who understands addiction.

QC9 What measures do you think should be taken to reduce drug supply in prison?

Use of x-ray machines on entering prison (prisoners).
Disable mobile phone signals in and around prison environment/location.
Use of sniffer dogs on wings more.
Visitor recognition – if a visitor has been banned from one prison there is not way of stopping them entering another prison as they often use false ID. Need fingerprint or other form of undisputable recognition in such instances.
When an individual is caught dealing in prison this can often result in a concurrent sentence being given which is no deterrent. Consecutive sentencing for drug activity/trafficking in prison should take place.

QC10 What impact would the measures suggested have on:

Offenders
Your local community

Less pressure on people in the community to take drugs into prison
Less opportunity for offenders to engage in illicit drug use and more opportunity to engage in treatment
Improve confidence of the local community
Reduction in violence, bullying and control issues in prisons.

REBALANCE TREATMENT TO SUPPORT DRUG FREE OUTCOMES

QD1 Thinking about the current treatment system, what works well and should be retained?

Partnership working on addressing community harm and opportunity to link prevention, treatment and enforcement.
Treatment choice
Clear service specification and monitoring
Commissioning of services to remain with DAATs/public health – majority of generalist GPs are not interested in this client group

QD2 Thinking about the current treatment system, what is in need of improvement and how might it need to change to promote recovery?

Rehab needs to be used for treatment and not as respite
More information on outcomes from rehab is needed – more evidence base
Local autonomy as to how to use funding
Need to be clear about the definition of recovery
Improved links between community and prison – prison services are too centrally commissioned to allow local variation and response to communities

QD3 Are there situations in which drug and alcohol services might be more usefully brought together or are there situations where is it more useful for them to be operated separately?

Brought together – responding to dual diagnosis needs (led my Mental Health services), polydrug use that includes alcohol and arrest referral services in custody suites

Separate – some alcohol clients would not engage in treatment where Class A drug users are attending. Can be very differing ages and social circumstances and some experiencing alcohol misuse would not engage with a service (even on an outreach basis) that resulted in the possibility of them being linked with the social stigma of drug misuse.

QD4 Should there be a greater focus on treating people who use substances other than heroin or crack cocaine, such as powder cocaine and so called legal highs?

Yes – Funding has previously been heavily weighted towards crack and heroin use. Alcohol treatment needs more focus and funding.

QD5 Should treating addiction to legal substances, such as prescribed and over the counter medicines, be a higher priority?

Yes – higher than it currently is. GPs should be take more responsibility for prescribing to the general public. Prescribed drugs can be diverted and have been a contributory factor in drug related deaths.

QD6 What role should the public health service have in preventing people using drugs in the first place and how can this link in to other preventative work?

Public health to take responsibility for needs assessments, education to the general public and awareness of risk. Needs to work closely with other statutory and non-statutory bodies to work together to prevent wider community harm.

QD7 We want to ensure that we continue to build the skills of the drug treatment and rehabilitation sector to ensure that they are able to meet the needs of those seeking treatment, what more can we do to support this?

Mainstream medical and nursing training needs to include more around addiction and encouraging behaviour change.
National core competencies for the addiction workforce should include training regarding domestic violence and mental health.
Needs to be more awareness in mainstream services regarding understanding the nature of addiction.
In specialist treatment services, the fact that recurrent funding has been available for such services has enabled the production of service specification that outline service and training requirements and has enabled providers to respond to training needs in a workforce planning way.

QD8 Treatment is only one aspect contributing to abstinence and recovery, what actions can be taken to better link treatment services into wider support such as housing, employment and supporting offenders?

As departmental budgets are reduced there is a concern that this will adversely affect those with an addiction who require more specific input.
Enabling life skills to be developed and supported when placed in housing.
Community in-reach into prison. Too much prison commissioning is undertaken centrally, eg, CARATS, which does not facilitate maximising local opportunities.
Ensure any payment mechanism does not result in division, eg, rewarding one organisation for reducing offending may result in other organisations not contributing to the agenda. Specifically commissioned services for this client group, eg, champions within treatment services to mainstream services – eg housing/prison service.
Outreach from mainstream services into drug treatment services. Improving care co-ordination between the prison to the community – this happens effectively within some CARAT/CJIT services already but needs to be more ‘mainstreamed.’

QD9 How do you believe that commissioners should be held to account for ensuring that outcomes of community based treatments, for the promotion of reintegration and recovery, as well as reduced health harms, are delivered?

Transparency in process, budget and reporting.
Community consultation – you said – we did
Audit and performance management
Remove the link between numbers into treatment as being one definition of success and the formula for funding

SUPPORT RECEOVERY TO BREAK THE CYCLE OF ADDICTION

QE1 What interventions can be provided to better support the recovery and reintegration of drug and alcohol dependent offenders returning to communities from prison?

Improved housing and improved planning on discharge. Community staff to go into the prison whenever possible for a prison/customer and community handover – robust mechanism to transfer into about what customer has been doing in prison re training and education from prison to community. Effective psycho-social interventions in prisons – CARAT time has been reduced through benchmarking. IT systems need to be better integrated to enable 'tracking' between community and prison.

QE2 What interventions could be provided to address any issues commonly facing people dependent on drugs or alcohol in relation to housing?

Education for housing providers relating to addiction. Move away from communal 'hostels' where people are often sent on release from prison. Provide floating support relating to supporting the development of home owner/occupier skills with clients and to help with issues such as debt management. Either specific champions in housing services or specific funded assistance for this client group into mainstream services.

QE3 How might drug, alcohol and mental health services be more effective in working together to meet the needs of drug or alcohol dependent service users with mental health conditions?

Mental health services to not see addiction as a barrier to receiving mental health support. Clients can fall through the gap between addiction and mental health. There should be clear dual diagnosis policies that are effectively implemented in organisations and appointments for this client group should be in one location, they should not be 'referred on,' need to be less 'hand-offs' and more focus around addressing the individual's needs rather than the individual fitting in with the service. More effective outreach is needed from mental health services, written appointment cards and telephone calls do not suffice for such a complex client group. Service specs for addiction and mental health need to have clear links. Sharing of assessment tools and language, assessment of staff skills and early identification of mental health and learning disability.

QE4 Do appropriate opportunities exist for the acquisition of skills and training for this group?

Yes they do exist but a number of problems:

1 Sometimes funding is a postcode lottery so funding needs to be uniform
2 JCP need to promote opportunities for skills and training more
3 Work for JCP and Skills Funding Agency to re-educate training providers in how they can engage with this customer group
4 More work to be done around how key workers can help service users to access mainstream education and training services

QE5 Should we be making more of the potential to use the benefit system to offer claimants a choice between:

A – some form of financial benefit sanction, if they do not take action to address their drug or alcohol dependency;
B – additional support to take such steps, by tailoring the requirements placed upon them as a condition of benefit to assist their recovery.

B – Benefit sanction will increase criminality. If clients are in treatment and claiming benefits tailor their conditionality for benefit in line with discussions between JCP and treatment services as to what is realistic to expect from that customer at the point in their treatment.

QE6 What if anything could jobcentre plus do differently in engaging with this client group to better support recovery?

Have specialist advisors in JCP (Drugs Co-ordinator role works). Bigger scope to do more outreach by JCP staff into treatment services. JCP within prison settings and in the community need to be working more closely to facilitate recovery, prison JCP staff currently only seem to focus on benefit entitlement rather than recovery and reintegration. JCP drugs strategy to become more mainstream business for JCP. Greater understanding of client needs when applying conditionality.

QE7 In your experience, what interventions are most effective in helping this group find employment?

One to one interventions with well-trained (in relation to drug misuse) specialist JCP advisors. Need to work closely with customer and treatment key worker in relation to the reality of the current labour market at an appropriate stage in treatment, with funding for training and employer incentives to employ this customer group.

Educating employers around CRB and appropriate response to criminal record. Many recovered addicts find difficulty gaining employment in areas where CRBs are conducted.

QE8 What particular barriers do this group face when working or looking for employment and what could be done to address these?

Stigma, confidence, lack of experience and training and CRB.
Approach to address – work to be done with JCP/others re aftercare once the client group is taken into employment. Financial incentives to employers to mitigate the perceived risk in employing the customer group.

QE9 Based on your experience, how effective are whole family interventions as a way of tackling the harms of substance misuse?

This can very much depend upon the family dynamics, clients want families to be involved when they are doing well and progressing but they often withdraw consent when they are not doing well and this can cause conflict. Whole family interventions are successful when issues in addition to addiction are addressed.

QE10 Is enough done to harness the recovery capital of families, partners and friends of people addicted to drugs or alcohol?

No – but the main issue here is the consent of the client to others being involved in their care.

QE11 Do drug and alcohol services adequately take into account the needs of those clients who have children?

More could be done in this regard but the Common Assessment Framework is applied and Safeguarding training is implemented. Mainstream services need to be more closely involved with addiction services, eg, SureStart.
Routes into children's services still need defining, one area is child protection but the other area is identifying additional needs of the child and family that doesn't need referral to social care. There needs to be more skilling up of the adult workforce and more integration with children and young people's services including possible adult/children's practitioners on one team. The emphasis is moving towards a family focus but more family work needed.

QE12 What problems do agencies working with drug or alcohol dependent parents face in trying to protect their children from harm and what might be done to address any such barriers?

Clients are fearful of social care – they believe social services will take their children away. This may result in disengagement from addiction treatment.
There could be more robust testing of drug misuse where there are concerns re children.
Focus should also be on those who live with children, they may not necessarily be a parent.
Information on parental/guardian status is not recorded on hospital/GP/police systems so the identification of potential harm can be missed if individuals are not accessing specialist treatment where questions re children are asked. There are many individuals experiencing alcohol misuse who do not access specialist treatment.
Clients may not declare they have children or access to children – more information sharing from social care/schools etc with treatment services.
Links between prisons and community re parenting do not exist in any coherent or robust form.