

Making it Local

A report on the London Drug Policy Forum strategic drug partnership delivery project for the Home Office



October 2009

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This project was conceived by the London Drug Policy Forum following its work on the 2006 – 2008 Guides to the National Drug Strategy and has been financially supported by the Home Office.

The purpose of the project was to explore the challenges facing local partnerships seeking to deliver the National Drug Strategy – Drugs: Protecting Families and Communities.

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Making it Local

Executive Summary

Drugs weave through the interlocking issues that all local areas constantly strive to resolve. Problems associated with substance use complicate, or are complicated by, problems with housing, unemployment, young people's outcomes, social care and mental health. Against a background of increased government emphasis on localism, mainstreaming and personalisation/recovery, the challenge for local drug partnerships is to demonstrate to all local agencies that tackling drugs serves the community and has a positive impact on everyone's quality of life. This will ensure that drugs are mainstreamed effectively as a local issue.

The purpose of this project was to explore the opportunities and constraints facing all local partnerships seeking to deliver the National Drug Strategy Drugs: Protecting Families and Communities and to answer these questions:

- ❖ How robust are local partnerships?
- ❖ How far are they able to deliver the new national drug strategy through a combination of mainstream and specific work streams?
- ❖ How can Government best support local partnerships in doing this?
- ❖ Can local scrutiny work as an effective part of implementation and performance management?
- ❖ What are the support needs of local partnerships including elected members and chief officers?

The London Drug Policy Forum's approach was to consult local partnerships faced with meeting the demands of a strategy that places new emphasis on broadening the target group beyond drug users themselves – considering the needs of families and involving communities in identifying and resolving their specific issues with drugs.

The Forum used a simulation workshop and, on the briefing of a specialist reference group, a survey followed up with site visits and targeted interviews. Two events were held, for elected members and the London Scrutiny Board.

Principal findings

A range of challenges face local partnerships:

1 Structure and positioning

Where the drugs agenda is subsumed into the work of the Crime and Disorder Reduction Partnership – as it is in the majority of cases – most emphasis is laid on the crime elements of the strategy. Where drugs are the preserve of the Joint Commissioning Group, usually led by the Primary Care Trust, the principal focus is treatment. In either event, issues such as housing and social support are squeezed out – and the Local Authority, which frequently chairs local partnerships, seems rarely able to establish its own position and make space for these other critical areas of concern.

2 Local influence and linkages to the Local Strategic Partnership

Local partnerships need to be close to the Local Strategic Partnership in order to get drugs issues embedded within over-arching local strategy, and to compete for a fair share of local interest and resource. However, we found no drug-specific partnerships had direct links to the Local Strategic Partnership, and only a very small number appeared to be trying to use it to promote drugs as a cross-cutting theme of relevance to all local partners.

3 Relationships with stakeholders and key partners

Many of those whose contributions are needed to deliver the drug strategy effectively are rarely or never involved in drugs partnerships – for example, City Strategy Partnerships, Criminal Justice Boards, Local Involvement Networks, Housing Services, Local Inspectorates, Local Employment Partnerships, Private Sector Care providers, Regeneration Partnerships, Acute Trusts, Registered Social Landlords/Arms Length Management Organisations. Others are engaged only to a limited extent: Local Strategic Partnerships, Children's Trusts, Children's Services, Adult Social Services, Jobcentre Plus, Safeguarding Children Boards, Connexions, Health and Wellbeing

Partnerships, Child and Adolescent Mental Health Services, Supporting People, Regional Skills Organisations, Fire Services, Voluntary Sector Organisations, hospitals, elected members, schools, clinicians, users and carers, social workers and care staff, teachers, young people. The under-representation of mainstream children's services and the widespread absence of any links with local social inclusion and regeneration programmes present a particular threat to successful delivery of the emphasis within the drug strategy.

4 Relationship with communities and residents

Community perceptions are increasingly being used as a measure of progress in combating drugs issues, and our survey suggested that working with communities to reduce their fears, as well as helping them deploy resources to meet local needs, can save partnerships both time and money. It also enables individual partners to fulfil their obligation to consult and engage the public. However, partnerships rarely have dedicated resources for community development work and only a quarter said they had "fully integrated" the community perspective into their work.

5 Relationship with elected members

Elected members could have a key role in delivering the drug strategy, as community leaders, policy leads or in an overview or scrutiny role. However, many feel ill-informed and uncertain of what their remit might be, given the apparent strength of central direction on the drug strategy and the effective ring-fencing of the bulk of local investment in drugs. Many felt alcohol issues to be more pressing, and complained of the lack of adequate funding or an integrated policy on substance use.

6 Relationship with central/regional government

Many partnerships suggested that support from central government was too narrowly focused on treatment and the Drug Interventions Programme, and frequently confusing, with conflicting advice coming from different central

government agencies. They regretted the lack of a Drug Action Team newsletter or up-to-date website. The lack of adequate regional support was seen as a serious barrier to successful localism.

7 Local strategy

Only a small minority of partnerships have developed clear local strategies around social inclusion, communities, housing and reintegration. Most confine themselves to the needs assessments they are required to produce for the Crime and Disorder Reduction Partnership or The National Treatment Agency for Substance Misuse planning processes.

8 Resources

The fact that drugs funding in recent years – for the strategy’s core objectives of treatment and the Drug Interventions Programme – has been both relatively generous and set beyond local control is now making it harder to establish the shared objectives with local partners which are the route to mainstream funding for drugs via the Local Area Agreement. Delivering those parts of the new strategy not funded by Drug Interventions Programme or Pooled Treatment Budget monies is highly problematic (and in most localities any undesignated resources available tend to be directed towards alcohol rather than drugs work).

9 Performance management

The strategy looks towards the use of the National Indicator Set to move toward a more localised and outcome-driven system of service delivery, more effective local engagement and local identification of need. In their final iteration, the National Indicators have become the cornerstone of a performance management framework that also includes the Comprehensive Area Assessment. The Comprehensive Area Assessment’s potential for holding local areas to account for their performance on drugs even where they have not included all the drug-specific indicators in their Local Area Agreements could be a powerful lever to encourage local work. However, neither the Comprehensive Area Assessment process

nor the National Indicators actually reflect the objectives and activities laid out in the National Drug Strategy. Because the indicator set does not include outcome targets relating to the new areas of community development, working around families, employment, children and young people or personalisation/recovery, local partnerships have to work hard to generate local performance management frameworks by extending some of the other indicators in the national set.

10 Scrutiny

Elected members and scrutiny committees could, if adequately informed and persuaded of the local relevance, usefully support local activity around drugs. However, while some local authorities have a well-resourced secretariat which could support scrutiny activity in complex areas, others do not, and it is also clear that elected members’ interest in and commitment to scrutiny functions varies from area to area.

Recommendations

On the basis of these findings, our recommendations are as follows:

Recommendations for local areas

1 Local partnerships need to identify and clearly understand their local drug issues and use this understanding to produce a strategy of relevance to local partners. This should clearly iterate contributions that drugs work can make in a whole host of areas and should be built through an open consultative inclusive process. Local strategies increase local accountability, improve transparency and help deliver against local and national priorities.

2 Embedding approaches to drugs within the broader families and communities agenda locally and nationally has scope to improve service delivery. Government needs to explicitly acknowledge that substance misuse problems do not just affect the individuals who consume the substances, and that solutions and responses need to be targeted at whole communities as well as individuals. Better coordination of drugs responses across policy areas would lead to the development of a broader focus than that which currently limits itself to “problematic drug users”. This broader approach would make it harder for mainstream agencies to see “drugs” as a marginal area of little relevance to them.

3 Areas need to establish dedicated resources to respond to community concerns and to work proactively with those communities most vulnerable to experiencing problems related to substance use.

4 Local areas should make use of the universal significance of alcohol for local partnerships to develop and promote coherent holistic substance use policies. Developing local understanding, via best practice examples and support materials, of the linkages between alcohol and drug issues would help facilitate this.

5 Broadening the target group to include families and others affected by substance use problems, identifying economic impact etc. would help areas influence local strategic planning. Support to help local partnerships assess need across the “new” areas of the strategy would be welcomed.

6 Local areas may want to consider developing multi area or sub regional strategies to take advantage of economies of scale but should be cautious about moving too far away from the communities they serve.

7 Partnerships can communicate better about drugs by linking into existing communications initiatives and building a local communications strategy targeted at vulnerable people and areas and providing universal messages for the whole community.

8 Local communications activity, possibly supported by central resources (such as FRANK), can play an important part in helping make the case for the relevancy of a range of activities to reduce drug-related harm (eg around truancy, school exclusions, general health, employment etc.) and can protect and support mainstream investment in drugs interventions.

9 All local agencies have a role to play in tackling drugs and their communications with communities need to reflect this more effectively.

10 Local partnerships need to improve efforts to engage with local residents and communities using existing local structures (eg Community Forums) and increasing the reach of drug specific initiatives (Frank and Tackling Drugs Week). Areas should consider the use of targeted approaches that bring together a range of interventions in partnership with the community to tackle localised problems. These programmes should be focused on building sustainable citizen-led capacity in communities.

11 Building stronger relationships between drugs agencies, initiatives and professional groups working with vulnerable people and families could help support mainstreaming.

12 Partnerships are sustained by strong relationships between individuals and need to have appropriate senior level representation with the remit to look across the breadth of the drugs agenda. There is a role for these senior officers to champion drugs related work across other policy agendas. Efforts need to be made to ensure that attendance at partnership events and meetings is consistent, regular and at a sufficiently high level to enable progress to be made in mainstreaming drugs as a local issue.

13 Local partnerships should improve links with agencies addressing social inclusion/ community cohesion and in particular should seek to feed into the Local Area Agreement block tackling inclusion.

14 Representation of some agencies at partnerships remains problematic and in particular efforts need to be redoubled to engage effectively with Children's Services at a strategic level.

Recommendations for Government

15 While recognising that localism is critical and that reorienting the strategy to optimise local control is the appropriate medium and long term ambition, in the short term, Government needs to establish an explicit managed programme to make this change successfully without jeopardising recent gains.

16 Improving the sophistication and reach of the national Public Service Agreements, the National Indicator set and its underpinning matrices would help improve the ability of partnerships to work to the broader agenda identified by the new drug strategy. While retaining the light touch to which local partnerships and government are committed, greater attention needs to be given to the congruence between strategic ambitions and aspirations and the actual performance framework that monitors and guides local implementation.

17 Government should make a renewed effort to promote the relevance of substance misuse work to work-streams across Whitehall Departments – for example, making explicit how housing, mental health, employment and young people's outcomes can be supported and complemented by substance use work. The Home Office needs to consider how it can help deliver the broader ambitions of the National Drug Strategy. Communications across Whitehall should play an important part here.

18 Consideration might also be given to increasing central leverage on local agencies with whom partnerships find it harder to engage – such as those involved in regeneration or sustainable communities. The Comprehensive Area Assessment process could provide a vehicle for this.

19 A stronger linking of alcohol and drugs work nationally, demonstrating the overlaps and areas of common working (eg presentations to services; reducing problems in the night-time economy) would strengthen Local Partnerships working in this area.

20 Government should improve the co-ordination of initiatives and drive improvement in communication around the drug strategy. This might include working with external bodies around specific areas of partnership support (eg materials for elected members similar to the “Must Knows” produced by the Improvement and Development Agency).

21 The Home Office should look at developing a “gate-keeping” function so that it is better able to manage the flows of information to partners and understand its own work in the context of the rounded partnership experience.

22 Central communications around substance use directed at partnerships should be up to date and relevant. To achieve this there is a clear need to improve contacts and networks, ensuring that local partnership contact details are accurate and updated, as it appears no central database of partnerships exists. Similarly the www.drugs.gov.uk website should be a useful tool to communicate with and support local partnerships.

23 Greater emphasis could be placed on incentivising partnership performance. Consideration of the potential uses of challenge funding would be valuable in promoting the development of local outcome targets to encourage working outside the crime and treatment silos, thus delivering the broader ambitions of the strategy.

24 The Home Office, Whitehall partners and Government Offices have an important role in highlighting the promotion of best practice, which includes strengthening the role of Local Partnerships. Key to this should be encouraging the preparation of a clear local drug strategy, which is of relevance to local partners and promoting the establishment, or reinforcement, of adequately resourced Local Partnerships involving the full range of partners including elected members.

Local areas will have greater autonomy and flexibility to respond to the local needs and to the priorities of local communities

Drugs: Protecting Families and Communities

Our Approach

This work was begun in Autumn 2008 and concluded in Summer 2009 and used a three-stage qualitative process.

Stage 1 – Preparation, scoping and initial strategic analysis

We established an expert reference panel from across the field with whom we could share findings and the approach to the work and developed a brief analysis of the partnership requirements of the new strategy. From this we built a survey tool to get an overview of the national picture across the 149 partnership areas. The majority of responses came from London, closely followed by Yorkshire and the Humber, the North and the North West. All regions were represented with the lowest return being from West Midlands.

From this we conducted 24 follow up phone interviews and then from that second group, selected a further seven areas to undertake full day study visits.

Stage 2 – Site visits and local analysis

For each of the seven areas selected we requested and then analysed local plans across mainstream and drug/crime partnerships. This we then used to inform a structure for the day and identify key individuals to interview one to one and in small focus groups. During these visits we looked for:

- ❖ Strategic coherence – in particular linkages between specific activity to tackle drugs and local mainstream
- ❖ Partnership structure
- ❖ Relationships with stakeholders and key partners
- ❖ Relationships with central and regional government
- ❖ Understanding of local need
- ❖ Resource issues
- ❖ Performance management

To help further explore the way in which local priorities are determined and delivered, a simulation workshop was run. This brought together practitioners and policy makers to look at the issues in a “typical” urban area. This two-day event highlighted the challenges in translating national priorities into local action where there is competition from a range of agendas and for resources. Participants were engaged in responding to challenges typically faced in many partnerships and had to negotiate issues relating to both partnerships and resource allocation. Specific

focus was given to seeking to create a stronger relationship between practice on the ground and local strategy across a range of mainstream stakeholders.

Stage 3 – Dissemination, reality checking, thematic analysis

In stage three we set out to test the findings of our research through interviews with regional and local stakeholders. These included: Local Drug Specific Partnerships and Crime and Disorder Reduction Partnership Co-ordinators, local police leads and the Association of Chief Police Officers Portfolio Holder on Partnerships, a senior civil servant, Regional Government leads, Service Users, General Practitioners, elected members with portfolio or scrutiny responsibilities, social service directors, Local Authority Chief Executives, Young People's leads, service managers, officers responsible for negotiating Local Area Agreements and Drug Interventions Programme Managers.

We held two events for elected members – one an in-depth half-day focus group and another to present back our findings to The London Scrutiny Board in cooperation with London Councils.

The draft report was circulated to individuals in central and local government, key drug policy organisations and other stakeholders. Comments and feedback received informed this final report.

The authors are very grateful for the support and time of those who responded to the survey and especially those who agreed to host visits and take part in interviews. Their contribution was invaluable. We would also like to acknowledge and thank all those involved in the Goodenough 2 Think Tank event whose experience and understanding contributed to this work. To encourage frank and full contributions from individuals and partnerships the survey, site visits and interviews were anonymised.

Context

A brief history of local partnerships

Since the first Drug Action Teams and Community Safety Partnerships began to appear across the country in the mid 1990's, local partnerships have been at the heart of delivering responses to drug problems. The 1998 Crime and Disorder Act reinforced the statutory responsibilities around crime prevention by creating the Crime and Disorder Reduction Partnerships.

By the time the 1998 Drug Strategy was published, as well as a Crime and Disorder Reduction Partnership most areas had an active Drug Action Team. These early partnerships were comprised of senior officers, often chief executives, from across a range of local agencies – Local Authority, Probation, Police, Health Authorities, Provider Agencies and often Customs and Excise – and demonstrated a clear recognition that substance use could not effectively be tackled by any one agency. The Drug Action Team Partnership Standard (Home Office 2002) identified a number of key functions for partnerships, that included:

- ❖ Needs assessment across young people, communities, enforcement and treatment
- ❖ Local Action Planning
- ❖ Commissioning of Services
- ❖ Development of partnership initiatives
- ❖ Communication and “knitting partnerships together”

Core to the Drug Action Teams' work was driving the drugs agenda across the full range of local public services to deliver improvements in treatment, communities, enforcement and young people's work.

In 2002, an update to the drugs strategy was published which prioritised the provision of effective treatment and crime reduction. It was also announced in early 2002 by the Home Office that Drug Action Teams and Crime and Disorder Reduction Partnerships should merge and that accordingly Crime and Disorder Reduction Partnerships would be given an additional statutory responsibility for auditing and planning to reduce the impact of local drug problems. This was viewed as problematic by many in local partnerships. Firstly, many Crime and Disorder Reduction Partnerships lacked the experience in commissioning and health needs assessment that was core to delivering the new treatment focused updated Drug Strategy. Crime and Disorder Reduction Partnerships themselves were struggling with the timetable for audit and reporting which was subject to considerable amendments throughout 2002 – 2004. Some stakeholders felt that the location of drug strategy as a function of crime and disorder planning would put at risk the engagement of agencies such as young people's services, housing and regeneration. In two tier authorities, merging the Drug Action Team and Crime and Disorder Reduction Partnership functions was close to impossible. Crime and Disorder Reduction Partnerships were a statutory responsibility of district councils with police and health partners.

Drug Action Teams were located at county level and treatment spend still largely aggregated up to enable more effective commissioning.

In late 2002 the Home Office announced that Drug Action Teams and Crime and Disorder Reduction Partnerships would not have to merge, but that much closer working would be expected. Nevertheless, the majority of areas, faced with a proliferation of new partnerships and responsibilities, did merge their Drug Action Teams and Crime and Disorder Reduction Partnerships. In some areas this was very effective. In particular, where an area was running one of the new enhanced Criminal Justice Interventions Programmes (later Drug Interventions Programmes), the opportunities afforded by transferring drugs strategy to the Crime and Disorder Reduction Partnership were useful.

Over the next 6 years, Drug Action Teams in one configuration or another remained a part of many local structures. Subject to intense performance management by the National Treatment Agency for Substance Misuse against targets for treatment and crime reduction, their work became largely concerned with:

- ❖ Commissioning treatment against identified or specified need
- ❖ Managing treatment
- ❖ Reporting progress on treatment and crime reduction

This resulted in major improvements to treatment provision across the country including:

- ❖ Reduction in waiting times from an average of over 12 weeks to under three weeks
- ❖ Doubling of the numbers in treatment
- ❖ Improved flows of substance misusing offenders through the criminal justice system.

New strategy – new challenges?

The 2008 Strategy – Drugs: Protecting Families and Communities recognised these achievements and set an aspirational agenda to make further improvements. While the targets from the previous strategy were to remain in force (and central to delivery of Public Service Agreements 23 and 25) the new strategy would require greater efforts on the part of local partnerships to:

- ❖ Develop stronger responses to the challenge of reintegration
- ❖ Join up responses across specialist and mainstream services
- ❖ Provide a broader range of interventions for families
- ❖ Ensure greater community consultation and involvement
- ❖ Build a stronger understanding amongst all stakeholders of work to tackle the harms associated with drug use.

The economic downturn and rising unemployment levels of 2008/09 increases the likelihood of individuals, families and communities directly experiencing problems associated with drug use. A recent consultation (Both Sides of the Coin 2009) suggests that more than 1 in 10 of the UK population are directly affected by substance misuse – either their own or that of a family member or friend. If current economic conditions are sustained, the likelihood is that both individuals and communities affected by drug use will experience greater problems. This has been reinforced by a recent DrugScope ICM Poll which suggested that 19% of the population were affected by substance misuse (Druglink, July 2009). When viewed in this context, this new focus on communities, families and the “regeneration of individuals” begins to look not only desirable, but critical.

The ambitions of the strategy are set against the background of the recent localism, mainstreaming and personalisation/recovery

agendas (see below) which represent a fundamental shift in the relationship between central government and local partners, and between services and individuals.

The development of an alcohol strategy has also created fresh challenges. While at a national level alcohol and drugs are discrete policy agendas, at the level of local delivery the two are often intricately entwined. This presents many partnerships with both obstacles and opportunities. For example in a number of areas chief officers and elected members told us that engagement around alcohol and drug issues was considerably easier with partners than simply approaching drugs in isolation. However, it was also widely reported that the limitations of the resources to respond to alcohol issues created a tricky imbalance to manage locally. While the strategy acknowledges this issue, it does not clearly resolve it:

“Although the Pooled Treatment Budget for adults will remain beyond use for the provision of primary alcohol misuse treatment, it may be right in some communities for plans to tackle drug use to be developed alongside action to tackle harmful drinking.”

Drugs Protecting Families and Communities (Home Office 2008)

The important role of communities, elected members and senior officers in developing and supporting local responses was also recognised within the strategy. The part they can play in extending the work of Local Drug Partnerships through the Local Strategic Partnership and into other mainstream partnerships is pivotal. Elected members in particular can provide the main linkage between local delivery and the communities they serve.

The engagement with the Local Strategic Partnership is increasingly important not only in linking the drugs agenda across policy areas (eg reintegration, young people) but also in obtaining funding for activity from the Area Based Grant and other local funding streams.

This will require the adoption of joint outcome targets currently lying outside the architecture of Local Area Agreements and so will make additional demands on partnership working.

However, it is clear that this desired effective working faces a barrier in that, to many of those working outside the immediate world of local drug partnerships, it is seen as a dense, confusing and impenetrable policy area, often of little apparent relevance to the broader range of public service delivery. Maintaining and developing mainstream engagement and resources to tackle drug related problems is a major challenge locally as well as nationally and it is essential this hurdle is tackled.

This report examines the issues around engaging communities and other stakeholders in the preparation and development of local strategies to meet identified need. It explores the impact of the National Indicators that lie under the relevant Public Service Agreements. It considers the importance of central understanding and support in achieving local targets and the strategic actions needed to support a transition to a responsive and flexible local model.

For the purposes of this report we have referred to two distinct partnership configurations. Those areas which have a specific partnership dealing solely with drug and/or alcohol misuse (Local Drug Specific Partnership) and those that deal with drug and/or alcohol issues within a larger partnership focused on Crime and Disorder. During this project we found no other configurations.

Localism, mainstreaming, and personalisation/recovery

In recent years three new ways of looking at public service delivery have begun to have a big impact on the drugs field.

Critically these three approaches – Localism, Mainstreaming, and Personalisation share a single basic belief – that it is those who experience need and receive services who are best placed to decide what services they need, inform new developments and interventions and evaluate their effectiveness. Thus Central Government decision making is devolved to local partnerships, local government and Primary Care Trust decision making devolves to communities and localities and decisions about service provision devolve to the individual in receipt of the service. Similarly the “false boundaries” between different kinds of public services dissolve and people experience a holistic mainstreamed service package over which they – either at a community or individual level – have real control over. These approaches drive efficiencies by reducing duplication and unnecessary state intervention and also improve quality by endeavouring to better tailor strategic – and practical – ‘fit’.

Localism

Localism suggests that more decisions about service provision and strategy should be taken locally not just by local government and local partnerships but also by communities. This will require approaches that meet the training and development needs of staff.

The 2007 Concordat between the Local Government Association and the Department for Communities and Local Government, sets out a new relationship for public service governance. The Local Government National Indicators are the framework developed to monitor key areas of activity. The critical aspect of the Concordat is that the indicators will be the sole performance management framework for Local Government and its partnerships,

leaving this tier of government free to respond with more flexibility to community need.

This new relationship was described by the Communities Secretary as

“No more of Whitehall assuming it has all the answers. No more of Local Government relying on central guidance as a crutch, always waiting to be told what to do, seeing the statutory minimum as the extent of its ambitions. No more of the public’s views being overlooked or requested as a mere afterthought.”

Mainstreaming

From the perspective of the drug strategy, developing a mainstreamed approach means the systematic consideration of the particular needs of a community in relation to drug use in all areas of policy and social provision rather than simply looking at drugs in isolation and delivering services in a silo.

In practice this means that mainstream services, such as primary care, housing services, education and social care would be expected to take account of drug use and the needs of people and communities affected by drug use in all their work. This will need approaches that provide the training and development needs of staff working across this broad range of services.

Mainstreaming is an underpinning principle of the Local Area Agreement process and has led to the creation of the Area Based Grant, pooling resources against agreed shared local objectives and measured via the Local Indicator Set. Initial steps towards mainstreaming are outlined in the Drug Strategy which suggests **“allowing the Pooled Treatment Budget to be used alongside other funding streams to provide ... re-integration support”** although given the difficulties of identifying universally acceptable targets for reintegration etc, these steps are not elaborated. The current work being undertaken as part of the Systems Change Pilots will provide valuable learning for taking this process forward.

“This mainstreaming process is essential to establish and maintain a long term and sustainable response to drug misuse, and the process is supported by the new local government performance framework.”

Drugs: Protecting Families and Communities, 2008

Personalisation/recovery

“Over time, we need to ensure the drug treatment system and these services work more closely together and become more focused on improving outcomes, which could include a more personalised and innovative service.”

Drugs: Protecting Families and Communities 2008

Personalisation relates to the reworking of social care and other public service interventions to place the service user in control of what services they receive, how they receive them and who provides them. Personalisation is well developed in other fields – for example services for people with learning disabilities – and is now beginning to have an impact in drug use.

The concept of recovery – meaning the individually identified optimised path through treatment to improved quality of life and social functioning – has become a widely used term in drugs policy. It is closely linked to personalisation, as without truly personal individualised services, recovery becomes simply a label over the door rather than a new way of experiencing care. Mainstreaming is a critical part of building service responses that meet the recovery agenda, as is an equity-first approach to localism.

New performance culture

One of the challenges identified within the new strategy is that of local areas working together with communities on shared problems across institutional boundaries – setting and evaluating strategy from the community and individual perspective rather than that of government – local or national.

As identified above, the strategy looks towards the use of the National Indicator Set and the Assessments of Policing and Community Safety (APACS) framework to move toward a more localised and outcome driven system of service delivery, more effective local engagement and local identification of need.

Just prior to the publication of the new strategy, a new set of Public Service Agreements and linked Local Government Indicators was published. This is set out in the following Public Service Agreements.

PSA 14 – Increase the number of children and young people on the path to success

NI 115 – Substance misuse by young people

PSA 25 – Reduce the harm caused by alcohol and drugs

NI 17 – Perceptions of anti-social behaviour
NI 38 – Drug related class A offending rate

NI 40 – Drug users in effective treatment

NI 42 – Perceptions of drug use or drug dealing as a problem

This framework presents challenges in terms of performance managing the new strategy, as it does not include outcome targets relating to the new areas of community development working around families, employment, children and young people or personalisation/recovery. Again, this requires greater efforts on the part of local partnerships to generate local performance management frameworks extending some of the other indicators in the national set. Some of these are suggested

in the strategy including Public Service Agreements –

PSA 23 Make communities safer

PSA 18 Promote better health and wellbeing for all

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

PSA 8 Maximise employment opportunity for all

Resources

For the last decade the drugs field has experienced substantial increases in funding. In recent years the scale of new investment has slowed and it is likely future funding will be more modest. Both central and local government is having to face the possibility of reductions in resources including staff. It is clear that many local structures and those involved in local service delivery are largely unprepared for these changing circumstances. For local commissioners who are likely to face increased targets alongside diminishing budgets, the pressure will be on to squeeze every bit of value out of their resources. There is also heavily competing demand for resources across the public mainstream, for example within Primary Care Trusts or Social Service Departments.

Current financial pressures across the public sector make gaining investment from mainstream budgets for drug misuse interventions more difficult. Without agreed shared local outcomes it is very easy for current investments in drug provision from outside the Pooled Treatment Budget or Drug Interventions Programme monies to appear “poachable” by policy areas with greater ‘pull’. Recent accounts of levels of mainstream funding indicate huge variation across the country. Far from gaining more resources in this way, local areas may be pushed to retain the investment they already have.

This will have a significant impact on providers. Already cutbacks are evident in contracts where local services are asked to deliver enhancements and increased capacity for no additional funding. While this sits well in terms of driving efficiency there is also evidence locally of job cuts, reduced investment in training and development and a retreat back to basic services. This could see a narrow focus on traditional approaches to treatment rather than development of the newer, more ambitious, services envisaged within the new strategy. Ironically it is these areas of activity that may provide the greatest long-term gain for the investment available.

Discussions are beginning to take place, often led by Primary Care Trusts, suggesting a shift to sectoral or multi-area commissioning in order to take advantage of greater economies of scale. While this can seem a pragmatic and appropriate way to deal with the challenges of increasing demand and reducing resources, there are also risks. Firstly, any shift in commissioning away from a local area to a sub regional focus risks weakening links between services, commissioners and communities. Secondly, organisations which we know play an invaluable role in supporting these links and providing truly localised and personalised care may lack the infrastructure to deliver across wider areas. One potential assurance against this is to deploy market management techniques to support the development of new consortia of providers, able to provide choice and locally responsive services across wider areas. This too will require strong local partnerships for its delivery.

There is therefore a growing tension between strategy delivery, commissioning and provision of services. This situation needs to be managed to allow the benefits of genuine partnership working to deliver real economies and improve quality.

Underpinning Partnership Requirements of the Drug Strategy

“We know that this is long term work and will mean dealing not just with drug problems, but with the problems in societies, communities and families that can make people susceptible to drug use and can act as barriers to recovery”

2008 Drugs: Protecting families & communities

As can be seen from the quote above, the 2008 Drug Strategy sets out an ambitious agenda. How challenging this proves to be depends on the ability nationally, regionally and locally to create and sustain effective joint strategic approaches.

Partnership working is essential not only to deliver many aspects of the new strategy but also to allow the strategy to operate successfully within the local environment. Rather than simply relying on the current drug focused partnership work, areas are charged with deploying resources in such a way as to ensure all relevant local agencies, stakeholders and partnerships take account of drug misuse issues when planning and delivering their work. The strategy, and indeed Government policy in this area is clear. These relationships must be two way – with all agencies and stakeholders involved in the process of planning and, where appropriate, delivery, and in providing a dynamic feedback loop to ensure quality and ‘fit’ for all activity.

Looking at the critical actions identified within the strategy and the three-year action plan, we can see that a wide range of partners will be required to deliver them.

On our visits to partnerships we looked for examples of where this is already happening and how people imagine this may develop in the future. We also asked them to explore with us the barriers to these partnerships. The results of this part of the discussion are included in our findings section.

“We must now ensure that action to tackle substance misuse is at the core of national, regional and local planning and delivery processes in all departments and agencies that have a role to play in delivering the drug strategy.”

2008 Drugs: Protecting families & communities

The table overleaf explores some examples of the new and existing partnerships that will be required to deliver significant elements of the strategy. Some relevant key actions from the national 3 year action plan are included to enable central government partnerships – and their associated outcomes in terms of the strategy - to be mapped to local areas. If a partnership is required centrally to join up key actions of the strategy, then it is reasonable to assume that a similar partnership will be required locally to deliver against it. Please note however that this table is illustrative rather than definitive.

Key actions from the strategy

Making drugs a higher priority for police forces (Key Action 26)

Potential Partners - Crime and Disorder Reduction Partnership, Criminal Justice Boards, Police, Treatment Providers, Local Authorities, Elected Members

Local Partnerships are required to use every opportunity presented by the new Assessments of Policing and Community Safety and local government performance management frameworks to ‘**incentivise enforcement and supply reduction**’. While the departmental owners of this action are the Home Office and the Association of Chief Police Officers – there is a clear role and benefit for local drug specific partnerships/Crime and Disorder Reduction Partnerships to build an understanding between agencies at a local level. A number of partnerships have undertaken work to improve understanding at a strategic and practitioner level. This has included job shadowing, open days and newsletters emphasising the benefits of treatment.

Prioritising the most ‘harmful’ offenders (eg: Key Actions 1-6)

Probation, Police, HM Prison Service, Social Services, Crime and Disorder Reduction Partnerships, Local Authorities, Arms Length Management Organisations, Criminal Justice Boards

Local Partnerships understand that the police need help in identifying those Priority and Prolific Offenders who have drug problems. The local drug specific partnership/Crime and Disorder Reduction Partnership has a key role either in coordinating this or acting as conduit for information. In one area surveyed, regular meetings had been scheduled, chaired by a senior officer from across the partnership (probation, police or local authority) on a rotating basis to look at barriers and blockages to this on the ground. This ensured that information exchange was given an appropriate priority. On the basis of this work existing protocols were amended and updated.

Reducing public perceptions of drug use as a problem utilising Neighbourhood Policing (Key Action 20) and Community Call for Action (Key Action 21)

Local Authorities, Crime and Disorder Reduction Partnerships, Local Strategic Partnerships, Communities, Arms Length Management Organisations, Regeneration Partnerships, Police, Elected Members, Local Media

Activity here brings into play a wide range of local partners. While the police have a central role, public perception is influenced from many sources. This is acknowledged implicitly within the associated key actions. In one area, local surveys were conducted in partnership with the Arms Length Management Organisation to review residents’ perceptions. These were undertaken at a super-output level to enable targeted actions from a range of partners to follow. The residents were then re-surveyed and action amended according to impact.

Training the workforce (eg: Key Action 17)

Social Services; Youth Justice Boards and other youth workers; Treatment Providers, local Skills for Care/ Skills for Health; local area workforce employer-led partnerships; Youth Offending Teams and other Youth Services

The strategy recognises the benefits of having both specialist and generic workers who are “appropriately skilled, competent and trained ... to meet local needs”. An effective programme of this kind requires engagement beyond the local drug specific partnership.

<p>Supporting Social Re-integration and helping people complete treatment (eg: Key Actions 66, 6)</p>	<p>In terms of specific strands of this agenda key partnerships will include: Employment, Training and Education: Jobcentre Plus; Social Exclusion Task Force; Regional Improvement and Efficiency Partnerships/City Strategy Partnerships/Local Employment Partnerships; Connexions partnerships Housing: Arms Length Management Organisations, Housing Services, private sector housing providers, social landlords, housing associations Sustainable independent living: Adult Education, local voluntary sector, Citizens Advice Bureau, Regeneration Partnership, Private Sector, Credit Unions, Local Authority. Recognising the need to move people on from treatment is a critical first step in meeting the new agenda. The key actions for this aim of the strategy will include, at a local level, tackling the barriers to service access across mainstream public services and this will require significant partnership work. This is a challenge involving a number of agencies. An approach proposed by one of the areas surveyed was for the Local Strategic Partnership to recognise drug misusers as a priority ‘group of people in vulnerable circumstances’. Another area identified the key to achieving good partnership as longstanding relationships between responsible officers and staff.</p>
<p>Delivering a new package for families (eg: Key Actions 40, 43, 44)</p>	<p>Adult Social Care, Children’s Services, Carers Support Services, Housing Services, Primary Health Care, Education and Training, Primary Care Trust, Mental Health Trust.</p> <p>There is a significant overlap with policies and programmes designed to deal with people with caring responsibilities, families with problems and social exclusion. To meet the drug strategy’s ambition to provide family members, children, parents, grandparents, other kin carers and drug users with more meaningful personalised support will require strong partnership working led by Children’s and Adult Services.</p> <p>In one area surveyed, this issue is tackled through an informal partnership task force comprising Adult’s Services, Children’s Services, a lead from the Safeguarding Children Board, and a voluntary sector body (Home Start). This task force seeks to establish local targets and deliver directly to families.</p>
<p>Preventing Harm to Children and Young People (eg: Key Actions 53, 54, 57)</p>	<p>Children’ Trusts, Safeguarding Children Boards; Child and Adolescent Mental Health Services; Youth Offending Teams; Youth Services; Children’s Services; Connexions; regional public health groups</p> <p>Children and Young People services are already expected to have in place the kind of partnership working required in order to deliver the drug strategy. Drug services for Children and Young People in terms of education, prevention, early intervention and treatment should be coordinated alongside other children’s services.</p>
<p>Reaching under-served groups (eg: Key Actions 85, 87)</p>	<p>Community organisations – representing Black Minority Ethnic groups, sex workers, new arrivals, refugees/asylum seekers</p> <p>Work with these groups will be ongoing across a number of agencies. Knitting the drugs agenda into other local activity by social services, Children and Young People services etc is the main priority. While drug related work is unlikely to be the key priority its impact will cut across nearly all activity areas.</p>

Findings from the Consultation Period

Local partnerships in 2009

To deliver the new drug strategy local areas need to have a cross cutting multi agency partnership approach to delivery that is supported by strong links to local decision making and planning bodies. The exact structure of these partnerships is less important than the fact that they can effectively:

- ❖ Ensure that drugs interventions and activity are prioritised and mainstreamed across other areas of local planning and public service delivery (i.e. that they are able to get drug issues on other people's agendas)
- ❖ Articulate and respond to local need across all themes of the strategy
- ❖ Ensure coordination of activity to maximise the benefits of investment
- ❖ Ensure senior level engagement from all relevant agencies – in particular those less involved in the previous strategy including Supporting People, Jobcentre Plus and other mainstream agencies
- ❖ Identify and allocate an appropriate degree of mainstream investment to fund those elements of the strategy that cannot be funded from the Pooled Treatment Budget or Drug Interventions Programme allocation
- ❖ Communicate with local residents and communities to facilitate improved perceptions of local problems and impact.

Structure and positioning

In the majority of the areas we surveyed and visited, the drugs agenda had been subsumed into the work of the Crime and Disorder Reduction Partnership. Either the Local Drug Specific Partnership had disappeared altogether, or it had become a subgroup of the Crime and Disorder Reduction Partnership. 32% of areas reported still having a Local Drug Specific Partnership – but in half of these, governance lines led directly to the Crime and Disorder Reduction Partnership. Of the remaining areas 58% identified the Crime and Disorder Reduction Partnership as the partnership group responsible for drugs, one area identified the Joint Commissioning Group and the other areas (6%) could not identify any local partnership with responsibility for drugs.

During the follow up interviews and site visits we discussed what the implications of this were locally. Where the Crime and Disorder Reduction Partnership is the lead body, the crime elements of the strategy predominated. This meant that at the Local Strategic Partnership table and in discussions with other agencies, activity and strategies to tackle drugs focused primarily – if not completely – on Crime Reduction outcomes. Crime became the main business of the partnership. This meant that other business – treatment, housing and social support for example – was discussed at subgroups with more junior staff. In some areas the number of these subgroups had proliferated to a degree where one would be

hard pressed to imagine how all the meetings could actually take place. One partnership had a structure of 18 different subgroups. We were told they all met regularly. When we asked what actions came out of these groups and how they were taken forward, officers were quite blunt in saying that the groups were very effective in improving practice on the ground, but rarely if ever influenced local strategy.

“The focus of the Crime and Disorder Reduction Partnership is enforcement and policing. Other subject areas are lucky to get a look in once in a blue moon. In some ways Crime and Disorder Reduction Partnerships have become just another silo”

Senior Partnership Lead, Police

In the area where the Joint Commissioning Group – most often led by the Primary Care Trust – was the more vigorous body, it generally took responsibility for all treatment commissioning but lacked “muscle” when it came to delivering the other areas of the drugs strategy. This raised similar but opposite challenges. The Primary Care Trust are concerned with health improvement, and while a focus on enforcement remained due to pre-existing targets, other areas were squeezed out.

“Adult treatment and enforcement dominates. It’s a disincentive to partnership working”

User and carer worker

We found when many areas referred to “the Drug Action Team” they meant not a senior level partnership group but the staff team who delivered the work on behalf of a range of partnership groups. However there was also a strong recognition that partnership working was critical to delivering improvements in terms of drug misuse for the whole community.

“As a small area we enjoy good relationships. The co-ordinators of the Themed Partnerships of the Local Strategic Partnership have regular formal meetings that allow for networking and sharing of cross cutting ideas. The size, depth and width of agendas is a challenge though”

Drug Action Team Manager

In the majority of areas surveyed (55%), the Chair of the local responsible partnership was held by the Local Authority, with 24% and 20% reporting that the Police and Primary Care Trust respectively held the chair. Of the two tier areas that we surveyed or interviewed, all the partnerships were chaired by the Local Authority. In theory this should bring balance and a space to discuss those matters not covered by either enforcement or treatment. However, in discussion it became clear that because the Local Authority is jointly responsible for the targets of both Health and the Crime and Disorder Reduction Partnership, again the enforcement and treatment agendas dominated. One Chief Executive observed that it was very hard to discern what the role of the local authority was in terms of drugs and that stronger guidance from central government on this would be helpful.

Local influence and linkages to the Local Strategic Partnership

“We all make valiant efforts to climb out of our silos, network, identify cross cutting themes but partnership work is in essence challenging”

Crime and Disorder Reduction Partnership Manager

The Sustainable Communities Plan and the Local Area Agreement are at the centre of all local planning and service delivery and are overseen by the Local Strategic Partnership though the Local Authority is the lead responsible

partner. Local Strategic Partnerships have a number of subgroups which take the lead in specific areas and report back up to the Local Strategic Partnership on need, delivery and outcomes to inform development. In most of the areas we surveyed and visited, Local Strategic Partnership subgroups would include:

- ❖ Community Safety
- ❖ Health and Wellbeing
- ❖ Children and Young People (directly linked to the Children's Trust)
- ❖ Regeneration/Employment/Economic Development
- ❖ Older People
- ❖ Environment

Generally the closer to the Local Strategic Partnership a partnership is, the more likely it is that that agenda will be listened to and incorporated into local overarching strategy. These areas are also likely to be the areas of service to which the largest "piece of the local cake" are allocated, as one respondent told us when referring to the system for apportioning the Area Based Grant and other local monies.

Where respondents specified Drug Action Team or Drug and Alcohol Action Team as the local partnership responsible for drugs, further investigation identified that most of these were sub partnerships of the Crime and Disorder Reduction Partnership or, on a County level, sub groups of a multi district County Council-led Community Safety Group. Ten areas (20%) had Local Drug Specific Partnerships which they say fed directly into the Local Strategic Partnership, however further examination identified that none of them actually did so, instead feeding in via either just the Community Safety block or, in 6 cases, through the healthier communities blocks. Out of all the areas we examined and visited, no Local Drug Specific Partnership had a direct structural link to the Local Strategic Partnership. In some areas the Joint Commissioning Group was cited as the main local partnership and in these cases was often also located as a sub group of the Crime and Disorder Reduction Partnership,

taking on the role of a Drugs subgroup but with a focus on treatment.

"We are 'in the process' of formalising our links with the Local Strategic Partnership. We have been for two and a half years now."

Drug Action Team Co-ordinator

In most areas we found that links to the Local Strategic Partnership were weak or distant and Drug Partnerships reported back though the Crime and Disorder Reduction Partnership or in a small number of cases through a Health Group. Only in two cases did the local partnership responsible for drugs report back through more than one sub group of the Local Strategic Partnership (Health and Community Safety). Only where the Drug Action Team and Crime and Disorder Reduction Partnership were merged did the Drug Action Team report directly into the Local Strategic Partnership.

"The Crime Strategy Group is a subgroup of the Local Strategic Partnership. The Substance Misuse Project Management Board is a subgroup of the Crime Strategy Group. All the other Drug Action Team groups fit in below that."

Drug Interventions Programme Manager

Where a merged Crime and Disorder Reduction Partnership and Drug and Alcohol Action Team linked directly to the Local Strategic Partnership, some found that keeping drugs as a live issue on a crowded and often political agenda was a struggle.

"The Crime, Disorder Reduction and Misuse of Drugs Partnership is a themed partnership of the Local Strategic Partnership. The relationship is functional but drugs is not the most appealing subject to them and it is often a struggle to get it on the agenda, although it has improved recently"

Drug Action Team Manager

The Local Strategic Partnership is not only important because it holds the purse strings. Drugs as an issue is cross cutting – as the strategy recognises. To make a reality of community wide reduction in harm drugs needs to be on the agenda of all local partners. The only obvious vehicle to deliver this approach is the Local Area Agreement/Local Strategic Partnership, but currently drugs are not recognised as a cross cutting theme within this structure.

“The Drug Action Team is at the very outside of deliberations around the Local Area Agreement. It’s hard to get anything not urgent or immediate onto the agenda”

Community Safety Strategy Manager

Only in one area did we see evidence of a Local Drug Specific Partnership trying to take advantage of their Local Strategic Partnership to promote drugs as a cross-cutting theme. In this instance, the Partnership Chair and Co-ordinator were seeking to establish drugs as a core component of the social inclusion block in their partnership, which they perceived as the most cross cutting and appropriate.

Relationships with stakeholders and key partners

In order to effectively plan, deliver and monitor local activity, local partnerships need to build strong and focused relationships with agencies and stakeholders across the local public service delivery agencies and with local communities and service users. These relationships need to be articulated to deliver to local priorities in substance use and engaged across all areas of the new strategy.

“Partnership working is promoted, enabled and supported at the highest levels in (our area). The visible support of partnership working by senior officers allows the ‘working group’ activities to function well across organisational boundaries. There is a real sense of pulling together to achieve outcomes. The close integration and collaborative work of teams across Adult Social Care and our Primary Care Trust has set a good example of how pooling resources can bring big gains.”

Joint Commissioning Manager

All partnerships identified representation from the Primary Care Trust, Police, Local Authorities and the Probation service. Other representation varied across partnerships including:

- ❖ **Crime and Disorder Reduction Partnership**
- ❖ **Children and Young People’s Service**
- ❖ **Mental Health Trusts**
- ❖ **Drug and Alcohol Service Providers**
- ❖ **Community and Voluntary Sector**
- ❖ **HM Prison Service**
- ❖ **Connexions**
- ❖ **Child and Adolescent Mental Health Services**
- ❖ **Youth Offending Teams**
- ❖ **Crown Prosecution Service**
- ❖ **Churches Partnership**
- ❖ **General Practitioners**
- ❖ **Customs and Excise**
- ❖ **Housing Services**
- ❖ **Victim Support**
- ❖ **Service Users / Carers**

The range of partnerships, agencies and stakeholders who need to be engaged in the local delivery of the strategy is diverse. Through our consultation we have been able to identify key partners who are well integrated into local working, a second group whose engagement is less well developed and third group who seem rarely, if ever, engaged .

Well Integrated	Less well developed	Rarely if ever engaged
Crime and Disorder Reduction Partnership	Local Strategic Partnerships	Neighbourhood/locality/ward Forums
Youth Offending Team	Children's Trust	City Strategy Partnership
Treatment Providers	Hospitals	Criminal Justice Board
Probation/National Offender Management Service	Jobcentre Plus	Local Involvement Networks
Police	Voluntary Sector Organisations	Housing Services
Primary Care Trust	Elected members	Local Inspectorates
Adult Social Services	Children's Services	Local employment partnerships
Mental Health Trusts	Schools	Private Sector Care providers
Connexions	Safeguarding Children Boards	Regeneration Partnerships
Drugs Workers	Clinicians	Families
Regional Government/National Treatment Agency for Substance Misuse	Users and Carers	Acute Trusts
People working in Criminal Justice	Communities/residents	Registered Social Landlords/Arms Length Management Organisations
	Social Workers and care staff	
	Young People	
	Teachers	
	Health and Wellbeing Partnership	
	Child and Adolescent Mental Health Services	
	Black and Minority Ethnic Community and organisations	
	Regional Skills Organisations	
	Fire Service	
	Supporting People	

Many areas did not have any representation from mainstream children's services (66%), with many relying on the Youth Offending Team to provide the sole link into this critical area for the new strategy. Over 38% of areas reported only minimal contact with schools, youth services and young people themselves.

Over 60% of the partnerships we surveyed reported that elected members regularly attended their partnership group. However when asked to identify the members of the partnership only 10% actually named or identified elected members. This suggests that while elected members may attend as occasional or regular observers, they are not partnership members. This was borne out by interviews with elected members and work with London Councils.

Only 2% of our sample reported Jobcentre Plus attendance at partnership meetings and 6% Supporting People representation. Attendance by Housing Services or Arms Length Management Organisations was at 26% and Adult Social Services was represented on partnerships in 22% of areas. Of people directly affected by drug use, 12% of areas reported service users attending partnership board and only 4% reported any carer representation.

Local community involvement with partnerships was limited with most areas (80%) identifying that they had not much contact, met once or twice a year or communicated with local residents only through the media and leaflets. Improving community representation needs to extend beyond service users and carers (though as shown these are still in need of development) but families, teachers, those working in the generic housing and health sectors, local businesses and residents' associations all need to be considered and involved to give meaning to community involvement.

Most areas (90%) reported excellent links with Criminal Justice services. In particular, areas that had intensive Drug Interventions Programme schemes had very strong relationships with local partnerships having a dominant representation of Criminal Justice agencies, often being chaired by Police or Probation.

Only one area (out of 52) could demonstrate plans for establishing formal links with Social Inclusion and Regeneration Partnerships.

Relationship with communities and residents

“It’s an article of faith in drugs, isn’t it? That public investment in drug services is threatened when the general public control the purse strings. It’s not true, but you do have to tackle ignorance and work with people. No one wants to live next door to a crack house, no one wants to be frightened to walk down the street, but people also don’t want to step over dead bodies and see their kids and their neighbours’ kids come to harm because they can’t get help. It’s not hard to sell treatment and it’s not hard to sell policing. It just takes a bit of effort but people are interested and they do care”

Drug Action Team Co-ordinator

The Government’s vision for work with communities is clear. In the White Paper “Strong and Prosperous Communities” published in 2006, there was a clear commitment to developing a two-way relationship between local government and the residents and communities they serve. In this new relationship, communities would no longer be the passive recipients of services, but will:

- ❖ Set local priorities as a key partner in the Local Strategic Partnership
- ❖ Work with local government to define how responses are developed and rolled out locally
- ❖ Have their say on the effectiveness and value for money of local strategy.

This approach is still in its infancy but in areas across the country there is evidence of this new philosophy taking hold and, if not, of genuine local partnership, then of a reorientation of service provision to put the consumer at the centre.

The 1998 Drug Strategy specifically targeted communities as a focus for work and this emphasis, along with the Communities Against Drugs tranche of funding, brought some innovative – and some not so innovative – work with communities into the drugs field. Since Communities Against Drugs, work with communities has developed across a number of social policy areas and this has resulted in improvements in terms of sophistication and local infrastructures (for example in terms of asset transfer and budget participation). However, there is clearly benefit in supporting local stakeholders and partners in terms of identifying their concerns, ensuring they are well informed of local activity and working with them on how they can best deploy their resources to address substance use issues. However, local stakeholders and partners are likely to benefit from advice and support in terms of how best to deploy resources to address substance use issues.

The 2008 strategy reinforces the responsibility of local areas to meet the needs of all communities, emphasising responses to anti-social behaviour related to substance misuse, local drug markets and drug related crime. *Drugs: Protecting Families and Communities* also sets drugs activity within the broad diversity and equalities agenda, reminding local partners of their obligations to proactively ensure the needs of all groups are met. The strategy also added something new – a specific target measuring community perceptions of problems related to drug use (NI42). Thus far this measure has only been adopted by a small number of areas, however we identified that many others – particularly two tier areas - are using it informally to measure progress.

Community consultation and engagement is not new in the world of the Crime and Disorder Reduction Partnership, but the duty to respond and engage will soon be reinforced by specific measures to improve the responsiveness of the Police to public concerns (Policing and Crime Bill 2009). In addition to this, the introduction of “Face the Public” sessions for partnerships

and Community and Councillor Calls to Action, while yet to be fully understood, implemented or exploited, paves the way for greater involvement.

It is possible to define the role of Local Drug Specific Partnerships across four domains. Firstly, there is the need to address community concerns. Secondly, there is the need to ensure that decision makers are effectively engaging with communities and residents about future strategy. Partnerships also need to ensure that services that are established to meet need, are appropriate and accessible for all our diverse communities. The final domain is that of effective communications – addressing the need identified in the consultation for the strategy for government and partnerships to ensure that communities are informed and able to deal with problems related to drugs. Effective engagement with communities provides a strong basis to embed substance misuse work, making it relevant across the range of public services, and helps maintain local investment.

In one area we visited, the partnership had good links to Safer Neighbourhood Teams and had an active programme in target areas whereby the views and concerns of residents were sought and responded to. Local evidence showed that this had resulted in less fear around drug related issues but greater concern within the community about positive action. This highlights one of the clear tensions within indicator 41. While the objective of activity around community safety and drugs should be to lessen the fear of open drug markets and drug dealing, we must be careful to ensure that we do not extinguish proportionate concern as this is a key element of an active community. As one Community Safety manager expressed it to us, their role is to reduce the gap between actual crime and the fear of crime so that communities can be better prepared to deal with the real situations in which they live.

Another area had taken this one stage further. They identified their most vulnerable areas at Super Output Level and delivered a package of interventions over a period of 6 months to a

year. The first stage involved gaining residents' confidence and views through targeted outreach and a survey asking specifically about key drug issues. This informed Neighbourhood Policing activity but also resulted in a programme of events and open days in local community venues. Alongside this, outreach workers worked with both residents and influential local professionals to inform and support them to address community concerns. At the end of the period of engagement, a follow up survey was conducted which revealed that community confidence had significantly increased and perceptions of drug use as a problem had decreased. The partnership also identified that communities where this work had taken place were more willing to ask for help and significantly more engaged in other local activities (like carers groups and voluntary youth work). The survey was conducted a further 6 months later in some areas and the benefits were found to be sustained.

When we asked the partnership what had enabled them to develop and promote this approach, they said it was partly due to a strong commitment within the Local Strategic Partnership to targeted community development work. However they said what was more important was that they had continued their Communities Against Drugs work after the programme had ended, funding the work through neighbourhood renewal.

We also raised this issue with an inner city partnership facing a diverse range of serious problems. The team told us that it was difficult to engage with the communities' agenda in anything other than a "fire fighting" capacity. In this area, gang violence was a significant issue as were crack houses. The partnership had some limited success in supporting residents after closures and operations, but were required to move on quickly due to having no dedicated resources for community development work.

Other areas played a lower-key communities role – engaging in activities during National Tackling Drugs Week, and occasionally taking part in local community initiatives like Voluntary

Sector Fairs. A small proportion of areas also engaged with local community forums on an ad hoc basis – often when required to do so by the Crime and Disorder Reduction Partnership. A small proportion of areas had also been compelled to undertake wider consultation as part of gaining planning permission for new services. In places where this was undertaken prior to the first application going in, the planning process was reported as running more smoothly than areas where consultation was undertaken after the first objections had been tabled by the community. Proactivity was a valuable tool - truncating what could be time- and resource-hungry processes.

These findings are borne out by the survey results where only 25% of partnerships said they had "fully integrated" the community perspective into their work. The remaining 75% said they had "not much contact" (20%), "met once or twice a year" (29%) and sent out "leaflets and press releases" (26%).

Relationship with elected members

One of the areas this work specifically looked at was the relationship between local drug strategy and elected members. As has been mentioned, while many areas claim to work with elected members the reality is that relatively few can substantiate having an active or ongoing relationship with specific members. In terms of Cabinet responsibility, drugs were normally subsumed within the Community Safety brief.

However, it is clear, given the importance of community engagement and responsiveness, that elected members do have a potentially key role in helping deliver the drug strategy, whether that be via their community leadership role, an executive role (perhaps as a policy lead), or in an overview and scrutiny role.

During our work we interviewed and spoke to a number of elected members. A number of issues emerged. A key point, raised to some extent by every elected member we spoke to,

was the limitations and remit for their activity in this area. With central ring fenced funding providing the bulk of local investment and external models and targets imposed, they saw little point engaging in the subject area. One summed up his view that

“The more central involvement there is, the weaker local engagement. What can I meaningfully add when every time I ask I get told ‘we’re green’ ”

Scrutiny Committee Chair

Many saw drugs as primarily a health or police-led agenda and that the role and remit of local authorities was therefore limited.

When we explored the level of concern they experienced from their constituents relating to drugs and their associated problems, we received a very clear response, alcohol issues were what provided the bulk of letters and emails. There was a marked degree of frustration about the imbalance between drug and alcohol funding and the inflexibility of the resources even when local need for alcohol services was perceived as much higher.

Elected members often felt ill equipped to engage with the breadth of the drugs agenda. Even those who had a particular interest in drugs issues were often unaware of key aspects of the strategy and in some cases exhibited a strong degree of scepticism about national data, trends and the approaches being delivered or driven centrally. All indicated they would welcome suitable information and guidance targeted at elected members.

Relationship with central/ regional government

For appropriate governance of local activity, relationships between local partnerships and regional and central government should be characterised by:

- ❖ Freedom and flexibility – with sufficient local agency to make decisions about resource allocation and priorities
- ❖ Collaboration – where central and local partners can identify shared goals that meet the national and local strategic objectives and can share and learn from good practice
- ❖ Performance management – with clear outcome targets across all areas of the strategy and incentives for strong performance
- ❖ Central leadership capable of tackling the Whitehall blockages that impede local progress.

To inform this part of our work we asked local areas how they found the relationship with central and regional government. We also discussed the issue with people working in Regional Government Offices and in Central Departments. There was a surprising degree of congruence from these different perspectives.

In just one area, the government office was spoken of as being helpful – particularly in rationalising some of the performance management issues being faced locally. In this area officers were also highly complimentary about the support they received in relation to their communities work. This was an exception.

Most areas we spoke to did not feel that the regional government officers were offering them much in terms of help or support with the challenges they faced. The government office advisory teams – where they existed – were described as being “largely useless”. Many areas did not know that there was any support available other than the National Treatment Agency for Substance Misuse. In some partnerships, people commented that they missed the support that had been provided in

the past not just from regional teams but also from the Home Office itself. In particular people expressed disappointment that Drug Action Team families no longer met and that all central activities (from the National Treatment Agency for Substance Misuse) were focused on Joint Commissioners.

“There has been a flight from central control to localism without any support or road map to show how it can be achieved.”

Drug Action Team member

The National Treatment Agency for Substance Misuse were widely regarded as the central government support for local partnerships, but were seen as focusing entirely on performance managing treatment and Drug Interventions Programme. This is unsurprising as this is the role of the National Treatment Agency for Substance Misuse regional teams. Some areas said that the National Treatment Agency for Substance Misuse helped them better understand their work and plan appropriately. However, while some partnerships found National Treatment Agency for Substance Misuse support helpful, many others described the style as “aggressive and threatening” and damaging to their partnerships rather than supportive. Others criticised the National Treatment Agency for Substance Misuse for

“Lack of consistency and clear direction ... Overly critical engagement style. We have been repeatedly told we’re the worst Drug Action Team in the country. I don’t think we are, and even if we were it wouldn’t help to be told!”

One partnership chair told us that he felt the National Treatment Agency for Substance Misuse was always around for advice when it was needed and that at a time when there was no other support centrally for drugs, they did at least always show up.

One notable criticism of central government was that of confusing communication, inconsistency and contradictory guidance. The example given by one area was of a Youth Crime initiative where the guidance that was sent by the Home Office and the Ministry of Justice was significantly different in emphasis but arrived weeks apart, causing confusion and a waste of local resources in terms of planning. Another area talked about the difficulties caused locally by meeting central targets for first time entrants to the criminal justice system that conflicted with an existing, successful restorative justice scheme, resulting in funding loss. While these examples are not directly related to drug strategy we felt it important to include them as they demonstrate the difficulties for many partnerships in working across related agendas.

Many areas told us that they would like more direct support from central government. Specifically a number of officers regretted the loss of “a Drug Action Team monthly newsletter that contained more than spin” and a Drug Action Team section on the Home Office website. We did check this – while there is still a Drug Action Team section on www.drugs.gov.uk, the latest thing on it, is guidance from 2003, about the young people’s drugs specific grant.

Local strategy

“We should celebrate the breadth of our work more”

Drug Action Team carer representative

About half the areas we talked to had developed a local drugs strategy. These were highly variable in terms of content and quality. Some were essentially guides to local services, which also included the targets from the national drugs strategy. Others were more developed documents based on local consultation and needs assessment.

Most areas only undertook required needs assessment – eg those they had to deliver to the National Treatment Agency for Substance Misuse to inform treatment planning and those for the Crime and Disorder Reduction Partnership planning process. A small number of areas had begun to articulate clear joint plans around communities, housing and reintegration.

In the areas where local strategy was well-developed officers told us it was easier to get sign up from other local agencies. However some felt that having a written local strategy had actually impeded progress as it had become a “fossil” and actually reduced responsiveness to the community. This was particularly felt to be the case with the plan built on the drugs and crime audit by the Crime and Disorder Reduction Partnership.

Resources

“The Drug Action Team is not able to exercise strategic control of resources”

Drug Strategy Manager

“Basically we stretch drugs money to cover aspects of alcohol work and stretch the national definitions of Problematic Drug Users to fund those coming through the service door.”

Joint Commissioning Manager

Our work identified that resource allocations were variable but that in general Local Partnerships were resourced adequately to undertake the core activities which were central to the last strategy, namely treatment (in terms of Protocol Data Units) and Drug Interventions Programme. However, the fact that these monies (generous in comparison with other policy areas) were outside local control and unresponsive to local variation in need (particularly in relationship to drugs and alcohol) was problematic. Obtaining mainstream funding in these circumstances depends on objectives being shared, which in the realpolitik of local government means being part of the Local Area Agreement. This makes delivering those parts of the new strategy not funded by Drug Interventions Programme or Pooled Treatment Budget monies highly problematic. In most localities any undesignated resources available tend to be directed toward alcohol rather than drugs work.

Partnerships also reported difficulties in using the Pooled Treatment Budget for areas of work included in the new strategy. A number of areas wanted to commit investment from the pooled treatment budget to supporting the wider strategy - and in particular family support, housing and employment projects however they described this as difficult. This was not an issue of government monitoring of spend in most of the areas who raised this

issue, but of what was described as a “perverse incentive” in the Pooled Treatment Budget allocations where reductions of the numbers in treatment - regardless of the outcome for those individuals - could result in significant reductions in funding. Partnerships emphasised to us that simply because people were not in structured treatment it did not mean they no longer needed support, however moving people out of structured treatment meant a smaller allocation of Pooled Treatment Budget and consequently a lack of funding available to purchase lower level support. Similarly it was reported that the allocation formula which identifies a substantially smaller amount of funding being available for drug users who were not using crack cocaine or heroin meant that many people who could benefit from treatment and support were not engaged in treatment as to increase the overall proportion of these types of drug users being supported could also reduce funding available. One area specifically identified the difficulties of using Pooled Treatment Budget funding to support families.

“The Area Based Grant process doesn’t help us. Our money is outside the pot, their money is inside. We can’t get at it.”

Senior Police Officer

Performance management

“It’s not clear how we can bridge the gap between the ambitions of the strategy and the National Indicator Framework to which we work”

Civil Servant

“We have a huge number of national and local performance indicators in the Crime and Disorder Reduction Partnership. The relatively small number of drugs indicators is great. It means we do what matters, treatment and crime”

Crime and Disorder Reduction Partnership Manager

The issue of how to performance manage a disparate range of partnerships tackling a broad agenda is an ongoing challenge. Both light-touch and strongly directional approaches have been applied in the last ten years. With the changes in the relationship between central and local government, new approaches need to be developed.

For those involved in constructing it, the 2007 concordat was meant to be the end of all debate on this matter. The 198 indicators were to be “the only performance management framework in place” to measure the performance of local government. In their final iteration they have become the cornerstone of a performance management framework that also includes the Comprehensive Area Assessment.

The Comprehensive Area Assessment has been identified within the 2008 strategy as having potential to measure local performance. Its scope for holding local areas to account for their performance on drugs even where they have not included all the drug-specific indicators in their Local Area Agreements could be a powerful tool to encourage local work.

The use of inspectorates' assessments on the quality of engagement with local communities and the needs of people in vulnerable circumstances could also do much to promote effective partnerships. The priority here must be to ensure that all inspection regimes have a clear understanding of what should and can be achieved. This will require the Home Office to work closely with these bodies to raise awareness of what would constitute good practice.

The problem for local drugs partnerships and those who work within them is that currently neither the Comprehensive Area Assessment process nor the National Indicator set actually reflect the objectives and activities laid out in the National Drug Strategy. This means that the performance management framework for the new strategy is incomplete. As one Drug Action Team chair commented

“This is not something that can be remedied through good will and sealing wax.”

The most active element of current performance management is clearly that conducted by the National Treatment Agency for Substance Misuse on behalf of the Department of Health and the Home Office/ Ministry of Justice. With their resources and strong local presence they are the dominant national voice at the local table. While this may have contributed to some of the achievements around treatment targets, it has reportedly often led to a narrowing of local focus and a sense amongst many partners that there is little point in them engaging locally.

Scrutiny

Scrutiny is the process whereby non-executive elected members take a critical overview of an area of local policy and make recommendations for improvement or greater efficiency.

It has been described by central government as

“...potentially the most exciting and powerful element of the entire local government modernisation process. It places members at the heart of policy-making and at the heart of the way in which councils can achieve active community leadership”

Office of Deputy Prime Minister

and by one of the elected members we spoke to as:

“...low powered, full of well meaning amateurs with little resources seeking to come up with clever questions”

We would suggest the truth lies somewhere between these two descriptions. The scrutiny role of elected members is a relatively new and developing one, which will grow in importance.

Therefore as part of this work we looked at the capacity of scrutiny to help drive genuine and effective local partnership delivery around drugs. It became clear that scrutiny, and the resources supporting scrutiny, varied significantly from area to area. Some local authorities had a well-resourced secretariat which could support scrutiny activity to tackle complex areas; others did not. It was also clear that interest in and commitment to scrutiny functions varied amongst elected members from area to area.

It was also suggested to us that scrutiny committees were often composed of those who had been unable to secure cabinet positions or places on the more prestigious committees or indeed were full of opposition members (thus weakening their influence).

There is scope to help build the capacity of elected members and scrutiny committees to help support local activity around drugs. However, it is clear that considerable work needs to be undertaken to provide support in terms of relevant information to boost understanding of the issues and appropriate responses and also to strengthen the “local” aspects of drugs work.

For scrutiny to be effective, there needs to be scope for delivery or strategy to change to accommodate its recommendations. The competition for areas to be scrutinised is great – with elected members suggesting new “targets’ in much the same way MPs call for Select Committees. Accordingly, lines of scrutiny enquiry often follow the Local Area Agreement thematics. Interestingly, many areas reported that drugs had been a part of both health and crime scrutiny investigations and this may be a fruitful area for development as the scrutiny role grows.

We must now ensure that action to tackle substance misuse is at the core of national, regional and local planning and delivery processes in all departments and agencies that have a role to play in delivering the drug strategy

2008 Drugs: Protecting Families & Communities

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