



HM Government

An evaluation of the Government's Drug Strategy 2010



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Executive summary

Background

The National Audit Office (NAO, 2010) recommended that the Government develops an evaluation framework to assess the effectiveness and value for money of activity aimed at the tackling misuse of drugs. This was subsequently accepted by the Public Accounts Committee.¹ The Home Office, in collaboration with other relevant departments and agencies, led the response to the recommendation.

The *Drug Strategy 2010 Evaluation Framework* set out the initial approach (HM Government, 2013). This report builds on this approach and provides an assessment of the effectiveness and, where possible, value for money of activity delivered under the Drug Strategy 2010.

The Drug Strategy 2010

The Drug Strategy 2010 (HM Government, 2010) set out the Government's response to drugs misuse and drug addiction, encompassing activity across three themes: reducing demand; restricting supply; and building recovery in communities. Whilst the strategy did not contain targets or action plans, it had two overarching aims:

- reducing illicit and other harmful drug use; and
- increasing the numbers recovering from their dependence.

The strategy made clear its commitment to recovery and also recognised the importance of building on the recovery capital available to individuals in order for them to start and sustain recovery from dependence. It also marked a shift in power and accountability to the local level from top-down state intervention, to be delivered through the introduction of Police and Crime Commissioners, reform of the NHS, and the creation of Public Health England.

1 <http://www.parliament.uk/business/committees/committees-archive/committee-of-public-accounts/pacpn100407a/>

Approach to the evaluation

The evaluation of the Government's Drug Strategy 2010 contributes greatly to the evidence base for the Government's new [Drug Strategy](#). As such, this evaluation covers the strategy to the end of 2015 to provide sufficient time to feed into the development of the new strategy. However, a few 2016 and 2017 reports are also included for completeness.

The evaluation focusses on activities carried out in England only, and includes those activities that contribute to the aims of the strategy and receive, at least in some part, central government funding.

In the absence of the data and high quality evidence necessary to undertake a full impact evaluation of the strategy, the evaluation is based on a theory of change approach, following the stages below:

- identifying the **types of activity** that fall within the strategy;
- describing how the activities theoretically **contribute to the aims** of the strategy (using logic models);
- assessing the **effectiveness** of the activities, and where possible, **value for money**, using the best available evidence; and
- producing **estimates of government spend** on specified activities.

The Government made it clear that it would not be desirable or achievable to undertake a single evaluation encompassing the whole of the strategy, nor to provide a single value for money estimate (HM Government, 2013). Instead relevant programmes and interventions have been divided into five activity groups that incorporate the strategy's three themes.

- 1. Early interventions** (reducing demand).
- 2. Media and information approaches** (reducing demand).
- 3. Enforcement and enforcement-related activity** (restricting supply / building recovery).
- 4. Treatment** (building recovery / reducing demand).
- 5. Non-treatment rehabilitative activity** (building recovery / reducing demand).

Assessing these five components separately however, does not fully take into account the effectiveness of the strategy as a whole. It is recognised that all three themes, under which the activity groups sit, are important to build recovery and tackle drug-related harms and that each in isolation is likely to be less effective than the combined impact.

Estimating government spend and value for money

Due to the challenges listed below, value for money has not been estimated at a strategy or activity group level, with the exception of treatment. However, in order to update and improve (where possible) previously published figures (HM Government, 2013), new estimates of central government spend have been produced for each activity group. It is important to note that these estimates are, by necessity, based on large assumptions and therefore should be interpreted with caution.

Challenges in evaluating the Drug Strategy 2010

There are considerable challenges to carrying out an evaluation of a multi-faceted and complex national level strategy such as the Drug Strategy 2010, which have impacted on the approach to the evaluation. These include the following.

Increasing local control and accountability

Devolution of powers to local decision makers means that there is less certainty about how the strategy has been delivered at a local level than was the case with previous strategies. Furthermore, decentralisation of budgets makes it difficult to obtain accurate estimates of how much is spent on each activity and the population reach of each intervention.

Methodological constraints

Many of the activities under the strategy are delivered at a national level and therefore do not lend themselves to the robust experimental design necessary to evaluate effectiveness and estimate value for money.

Identifying drug misuse outcomes within multi-faceted programmes and the effect of time lags

Particularly for large programmes, drug misuse outcomes are often only part of what an intervention aims to achieve and it is invariably difficult to disentangle these from other outcomes such as health, education, employment, housing, and crime. Furthermore, when evidencing drug misuse outcomes there can be a considerable time lag before the effect is apparent, particularly in the early intervention and media and information activity groups. This often precludes evidence of long-term effectiveness.

Evidence gaps

The delivery of activity under the strategy has not been accompanied by a comprehensive programme of research and data collection. There are therefore some outstanding evidence gaps particularly around the impact and cost benefit of interventions.

Findings

Trends in indicators of the two overarching aims of the strategy are described first followed by a summary of key findings from each of the five activity groups that form the substantive chapters of this report.

Trends in drug use and related harm (Chapter 2)

Trends on the prevalence of drug use and recovery provide the context and a general indication of the direction of travel against the two main aims of the strategy. Further data are included in this section and within the relevant chapters in the main report.

Reducing illicit and other harmful drug use

- Since the beginning of the strategy drug use among adults (aged 16–59) and young adults (aged 16–24) in the general population in England and Wales has remained stable. The use of any illicit drug in the last year among all adults was 8.5 per cent in 2009/10 and 8.6 per cent in 2014/15 (Lader, 2015).
- The prevalence of last year drug use among school children aged 11 to 15 in England has shown a decline from 15 per cent in 2009 to 10 per cent in 2014 (Fuller, 2015).
- There were estimated to be around 294,000 opiate and/or crack cocaine users in England in 2011/12 (latest available data) compared with around 306,000 in 2009/10 (Hay *et al.*, 2014).

Increasing the numbers recovering from dependence

- Progress has been made in treatment outcomes, with an increase in the proportion of clients leaving treatment free of dependency from before the start of the strategy (12.2% in 2009/10) to 16.1 per cent in 2011/12, although this has subsequently fallen slightly (15.8% in 2014/15) (PHE, 2015).
- Successful completion of treatment differs substantially by drug type, with higher rates among non-opiate clients than among opiate clients: 39 per cent of non-opiate and 8 per cent of opiate clients in treatment left successfully in 2014/15. Both of these are rates are higher than before the start of the strategy (31% and 6% in 2009/10 respectively) (PHE, 2015).

Early intervention activity (Chapter 3)

Early intervention activities are central to achieving the strategy's aim of reducing demand for illicit drugs.

Evidence of effectiveness

- There is more evidence of effectiveness in relation to intermediate outcomes (e.g. tackling risk factors) than the central strategy outcome of interest: reduced drug use. This is largely due to a lack of evidence of the long-term impact of early intervention activities due to the time lag between intervention and effect.
- When implemented according to the evidence of what works, early intervention activity is effective in reducing risk factors associated with drug use and in turn drug use itself. Approaches most likely to be beneficial are targeted towards multiple risk behaviours, including substance misuse, as opposed to targeting drug use alone.
- Interventions most likely to be effective include pre-school and family-based programmes, such as those delivered via Children's Centres.
- There is promising evidence that interventions such as personal social health and economic education, Family Nurse Partnership programmes, Family Intervention Projects and MyPlace can positively impact on reducing risky behaviours and subsequently drug use. However, the stronger evidence is often from the USA which has different health and education structures.

Spend and value for money

- Estimates suggest that central government spend on early intervention activity under the Drug Strategy 2010 may have fallen from an estimated £269 million in 2010/11 to an estimated £215 million in 2014/15.
- Due to the absence of sufficient data on expenditure, reach of early interventions, and on drug use outcomes, it has not been possible to produce value for money estimates for early intervention activities.

Media and information activity (Chapter 4)

Media and information interventions fall under the reducing demand strand of the strategy.

Evidence of effectiveness

- Evidence suggests that well designed media and information interventions can provide reliable information to a large number of individuals, increasing knowledge and challenging misconceptions. However, there is evidence that these types of activities in isolation are unlikely to directly reduce drug use.
- The evidence of 'what works' is reflected in the design of recent government activity (FRANK and new psychoactive substance campaigns), which comprise carefully planned, targeted media campaigns alongside universal information programmes, rather than traditional mass media approaches. Other online activity (Rise Above) aims to build resilience and improve life skills in young people.
- These activities are also delivered as a component of the wider reducing demand strand that includes early interventions (chapter 3) and treatment (chapter 6), which may lead to wider synergies and increased impact. However, these combined impacts have not been assessed due to lack of evidence.
- Data show that government media and information activity has reached increasingly large numbers of people. However, there is insufficient evidence to assess whether such campaigns have led directly to behaviour change.

Spend and value for money

- Central government spend on media and information activity was £166,000 in 2014/15. Spend has varied substantially over the strategy dependent on whether FRANK marketing, in addition to routine web-based activity, was undertaken in a particular year.
- There is insufficient evidence to assess whether government media and information campaigns represent good value for money.

Enforcement and enforcement-related activity (Chapter 5)

Enforcement activities fall under the restricting supply theme of the strategy while enforcement-related activity can contribute to building recovery.

Evidence of effectiveness

- It is not possible to assess the overall impact of enforcement as the legal framework for the control of illicit drugs covers the whole of the UK. As such, establishing a robust counterfactual is not feasible as it is not possible to stop enforcing drug laws in a certain area to evaluate what happens in the absence of enforcement.
- The available evidence suggests that proportionate enforcement of the illegality of drugs raises prices, with drug misuse being inversely related to price.
- Illicit drug markets are resilient and can quickly adapt to even significant drug and asset seizures. Even though enforcement may cause wholesale prices to vary, street-level prices are generally maintained through variations in purity.
- There is evidence that some enforcement activities can contribute to the disruption of drug markets at all levels, thus reducing crime and improving health outcomes, but the effects tend to be short-lived. Activity solely to remove drugs from the market, for example, drug seizures, has little impact on availability.
- However, there are potential unintended consequences of enforcement activity such as violence related to drug markets and the negative impact of involvement with the criminal justice system.
- By diverting drug using offenders into treatment through the criminal justice system the benefits of treatment, including reductions in crime and improvements in health (see chapter 6) can be realised.

Spend and value for money

- Central government spend on enforcement and related activities was estimated to be £1.6 billion in 2014/15. Due to the complexities involved in estimation (the proportion of police and other law enforcement time spent on enforcing drug laws or implementing other drug-related activity is not routinely recorded) no attempt has been made to determine annual spend for each year of the strategy.
- Due to the absence of sufficient data on government spend or the direct impact of activities it has not been possible to produce value for money estimates for enforcement or enforcement-related activities.

Treatment activity (Chapter 6)

Drug treatment is an essential component of the building recovery in communities strand of the Drug Strategy 2010.

Evidence of effectiveness

- There is, to a large extent, robust evidence for the coverage and effectiveness of drug treatment in England and also evidence that, overall, treatment offers good value for money.
- The National Drug Treatment Monitoring System shows that progress has been made in treatment outcomes, with an increase in the proportion of adults who left treatment free of dependency at the start of the strategy, though this has since levelled off.

Spend and value for money

- The figures from 2014/15 show that estimated central government spend on adult drug misuse services was £541 million, of which £433 million was spent on structured treatment. A further £24 million was spent on substance misuse (including alcohol) services for those under 18. In 2013/14 £109 million was spent on treatment in prisons (spend in 2014/15 is not available).
- Overall, government spend on adult drug treatment remained stable for the first three years of the strategy. There are signs that spend may have fallen in 2013/14. The level of spend in 2014/15 was similar. The fall may in part be accounted for by the different method used to collect information on spend in 2013/14; however this also coincides with reports of disinvestment in treatment services
- The best available estimate shows that for every £1 spent on structured drug treatment £2.50 was saved to society. This leads to an estimated £1.1 billion in benefits from adult structured treatment spend in 2014/15 (excluding prison treatment spend).

Non-treatment rehabilitative activity (Chapter 7)

Non-treatment rehabilitative activity supports the strategy's theme of building recovery in communities.

Evidence of effectiveness

- There is a growing body of evidence that non-treatment rehabilitative initiatives aimed at improving aspects of a drug user's life to help them to reach and sustain recovery can be beneficial.
- There are some positive indications that non-treatment rehabilitative initiatives, such as Family Drug and Alcohol Courts and the Recovery Champions, may be improving outcomes for drug users.
- There is, however, a lack of robust evaluation evidence to assess the extent to which non-treatment rehabilitative initiatives under the strategy directly impact on outcomes.

Spend and value for money

- The best estimate of central government spend on non-treatment rehabilitative activity was £240 million in 2013/14, when the majority of non-treatment rehabilitative initiatives under the strategy were running.
- It is not reliable to comment on trends in government spend over time, as different programmes were available in different years and not all have associated spend estimates.
- Due to the absence of sufficient data on government spend, or the impact of initiatives on drug use outcomes, it has not been possible to produce value for money estimates for non-treatment rehabilitative activity.

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Chapter 1: Introduction

1.1 Background

The National Audit Office (NAO, 2010) review of the Drug Strategy 2008 recommended that the Government develop an evaluation framework to assess the effectiveness and value for money of activity aimed at tackling misuse of drugs. This was subsequently accepted by the Public Accounts Committee² and the Government's *Drug Strategy 2010 Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life* (HM Government, 2010) made a commitment to develop this.

The Home Office, in collaboration with other relevant departments and agencies, led the response to the recommendation. The initial approach to the evaluation was outlined in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013a). This report builds on the framework and provides an assessment of the effectiveness and, where possible, value for money of activity delivered under the strategy.

1.2 The Drug Strategy 2010

Illicit drug use and supply places a considerable cost burden on society. The social and economic costs of illicit drugs in the UK are estimated to be £10.7 billion a year, over half of which is attributed to drug-related crime, with the estimated scale of the illicit drugs market being around £3.3 billion (Mills *et al.*, 2013).

The Drug Strategy 2010 set out the Government's response to drugs misuse and drug addiction, encompassing activity across three themes, with two overarching aims (see Box 1.1). The strategy put recovery at the centre of its ambitions, and recognised the importance of building on the recovery capital available to individuals in order for them to start and sustain recovery from dependence. The 'reducing demand' theme was refreshed in 2014 to broaden prevention activity and respond to new challenges including new psychoactive substances (NPS).

² <http://www.parliament.uk/business/committees/committees-archive/committee-of-public-accounts/pacpn100407a/>

Box 1.1: Themes and aims of the Drug Strategy 2010

The Drug Strategy 2010 is structured around three themes:

- reducing demand;
- restricting supply; and
- building recovery in communities.

With two overarching aims:

- reducing illicit and other harmful drug use; and
- increasing the numbers recovering from their dependence.

The strategy also made clear the shift in power and accountability to the local level from top-down state intervention. This was to be delivered through the introduction of Police and Crime Commissioners, reform of the NHS, and the creation of Public Health England. There has, therefore, been a fundamental shift in the role of central government in delivering the strategy since the publication of the National Audit Office recommendations. This has presented challenges in both developing an evaluation framework and delivering the evaluation.

1.3 Approach to the evaluation

Evaluations of multi-faceted and complex strategies rely upon a detailed understanding of the implementation of each intervention and the interactions between them. The availability of robust evidence on effectiveness and value for money is also crucial. However, given the methodological, practical and resource constraints detailed in this chapter (see section 1.4), an evaluation of the Drug Strategy 2010 necessitates a more pragmatic method of assessment. The approach therefore has been based on a theory of change model, following the stages below:

- identifying the **types of activity** that fall within the strategy;
- describing how the activities theoretically **contribute to the aims** of the strategy (using logic models);
- assessing the **effectiveness** of the activities, and where possible, **value for money**, using the best available evidence; and
- producing **estimates of government spend** on specified activities.

In addition, the report includes national level survey, monitoring and operational data that provide information on trends in drug use, treatment, criminal justice system and enforcement activity. Chapter 2 presents key indicators and further data are included in the relevant chapters.

The evaluation of the Government's Drug Strategy 2010 contributes greatly to the evidence base for the Government's new [Drug Strategy](#). As such, this evaluation covers the strategy to the end of 2015 to provide sufficient time to feed into the development of the new strategy. However, a few 2016 and 2017 reports are also included for completeness. See [Additional Sources](#) (p. 21) for statistics published subsequently to this evaluation.

The evaluation mainly focusses on activities carried out in England only. Scotland (The Scottish Government, 2008), Wales (Welsh Government, 2008) and Northern Ireland (Department of Health, Social Services and Public Safety, 2011) have separate strategies for tackling drug misuse.

The activities included contribute to the aims of the strategy and receive, at least in some part, central government funding. A more detailed account of government activity that took place over the period of the strategy can be found in the annual reviews (HM Government, 2015; 2013b; 2012; and 2010).

The evaluation focusses solely on drug use and drug-related harms and does not cover other substances such as alcohol.

The following sections describe in more detail the key stages outlined above.

1.3.1 Types of activities

In accepting the recommendation from the National Audit Office, the Government's response made it clear that it would not be desirable or achievable to undertake a single evaluation encompassing the whole of the strategy, nor to provide a single value for money estimate. This is due to the complexity and overlapping nature of the various activities. Instead, relevant programmes and interventions have been divided into five activity groups that incorporate the strategy's three themes.

1. **Early intervention activity** (reducing demand): Interventions which aim to prevent future adverse outcomes including (but not only) drug use, by alleviating and countering known risk factors.
2. **Media and information activity** (reducing demand): Approaches to create awareness of the issues related to drug use and provide information and support, often aimed at young people but also useful for others.
3. **Enforcement and enforcement-related activity** (restricting supply / building recovery): Includes enforcement of the illegality of drugs, restricting the supply of drugs and diverting users into treatment.
4. **Treatment** (building recovery / reducing demand): Aims to enable individuals to become free from their drug of dependence as well as reducing drug-related harms.
5. **Non-treatment rehabilitative activity** (building recovery / reducing demand): Initiatives, other than treatment, aimed at improving aspects of a drug user's life to help them to reach and sustain recovery and reintegrate into society where necessary, for example, employment and housing programmes.

Assessing these five components separately does not fully take into account the effectiveness of the strategy as a whole. It is recognised that all three themes, under which the activity groups sit, are important to the Government's approach to building recovery and tackling the harms associated with drug use and that each in isolation is likely to be less effective than the combined impact.

The five activity groups form the five substantive chapters of this report. The chapters are designed to be standalone and whilst they largely follow a similar format there are differences in presentation and content dependent on the complexity of the activity group and the amount of evidence available for review. Broad conclusions are drawn within each chapter relating to effectiveness and value for money.

1.3.2 Logic models

The development of logic models is helpful at the beginning of any policy evaluation, and particularly so when evaluating a programme as complex as the Drug Strategy 2010. Logic models visually portray the theory, assumptions, and the evidence underlying the rationale for a policy, by linking the intended outcomes (both short- and long-term) with the policy inputs, activities, processes and theoretical assumptions (HM Treasury, 2011).

Logic models have been developed for each of the five activity groups to:

- present the **key activities** that are within scope of the evaluation;
- illustrate the theoretical **immediate, intermediate** and **long-term outcomes** which contribute to the aims of the strategy; and
- provide a **theory** or **hypothesis** for the effect of strategy activity, from which effectiveness can be assessed.

The activities within the logic models aim to reduce drug misuse and/or build recovery, either directly or indirectly, and in turn, are also hypothesised to reduce any associated health, crime, unemployment or other indirect harms (e.g. harms to family). Improving aspects such as health may positively impact on crime and employment prospects, and vice versa, and so potential overlapping, secondary and tertiary benefits are assessed where practical.

1.3.3 Assessing evidence

As described above, each logic model provides the framework to test the extent to which the theoretical assumptions are supported by evidence. Although not a systematic review of the literature, the assessments made are based on evidence from meta-analyses and systematic reviews, literature reviews, peer-reviewed articles and government research and statistical findings.³ Where available, evidence on the economic costs and benefits of an activity is included.

Not all of the evidence comes from the period of the strategy; earlier findings considered to be relevant to current practice have been included in the assessments. Also, a few 2016 and 2017 reports are included for completeness. Furthermore, where there is insufficient evidence on effectiveness from UK research, relevant international evidence has been included.

³ Trends in data are included in this evaluation to 2014/15 or 2015. Evidence referenced in this evaluation has largely been drawn from publications up to the end of December 2015, although a few 2016 and 2017 reports are included.

However, when applying international research evidence to the UK any cultural, social and economic differences must be taken into account.

Input from experts in all relevant fields has been sought to identify the most appropriate and robust research for use in this evaluation and to comment on its interpretation.

1.3.4 Estimating central government spend and value for money

For reasons described in section 1.4 below, value for money measures have not been produced at a strategy or activity group level, with the exception of treatment where existing information has been used to derive benefits under the strategy.

However, in order to increase knowledge of central government spend on each activity group further work has been undertaken to update and improve (where possible) the estimates published in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013a).

Indicative estimates of government spend have been derived by collating spend data on activities that:

- were funded by central government for example, through national programmes or grants distributed to local commissioners;
- feature reducing drug use, restricting supply or building recovery as an intended outcome; and
- were delivered under the strategy up to December 2015.

As the estimates are, by necessity, based on large assumptions they should therefore be interpreted with caution. Where possible spend estimates for each financial year of the strategy have been presented. Detailed information on spend for each activity group is included in an appendix in the relevant chapter.

It is not possible to ascertain whether any changes in spend over time are due to disinvestment in activity or other factors, for example, changes in third sector provision or how local areas allocate funding. The estimates do not take into account any non-government spend; no attempt has been made to estimate third sector or locally generated funding.

1.4 Challenges in evaluating the Drug Strategy 2010

There are considerable challenges to carrying out an evaluation of a complex national level strategy such as the Drug Strategy 2010, some of which were mentioned explicitly in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013a). Each of the five activity groups present their own specific challenges, and these are outlined within each chapter as appropriate. However, it is essential to consider overarching challenges and how they have impacted on the approach to the evaluation.

1.4.1 Increasing local control and accountability

Whilst the devolution of powers to local decision makers allows services to be tailored to local needs, a natural consequence is that the delivery of activity under many large programmes (e.g. Children's Centres and the Troubled Families Programme) and treatment provision is likely to differ across the country. A comprehensive audit of service provision and implementation of strategy activity has not been undertaken. It is acknowledged that even within the same activity there is likely to be differences in how it is delivered, which in turn is likely to impact on effectiveness.

Decentralisation of budgets also makes it difficult to obtain accurate estimates of how much is spent on each activity, and the population reach of each intervention. This applies across activity groups and, together with the other limitations stated, has prevented the production of value for money estimates. Estimates of the Government's spend on interventions delivered under each activity group have, however, been included.

1.4.2 Methodological constraints

Unlike previous strategies, the Drug Strategy 2010 did not include specific targets nor an accompanying action plan. This meant that an inbuilt framework to assess progress against the aims was unavailable, and so the approach to evaluation was developed during the delivery of the strategy.

At an intervention level, many of the activities delivered under the strategy do not lend themselves to the robust experimental design necessary to evaluate effectiveness and estimate value for money. This is particularly true of enforcement activity, where a robust counterfactual is not feasible – it is not possible to stop enforcing drug laws in a certain area to evaluate what happens in the absence of enforcement.

1.4.3 Identifying drug misuse outcomes within multi-faceted programmes and the effect of time lags

Particularly when evaluating larger programmes, drug misuse outcomes are often only part of what an intervention aims to achieve and it is invariably difficult to disentangle these from other outcomes such as improvements to health, education, employment, housing, and crime. In addition, there can be a considerable time lag between the intervention and the desired effect, particularly in the early intervention and media and information activity groups. This often precludes evidence of longer-term effectiveness.

In an attempt to tackle these challenges the available evidence on the effectiveness of activity types has been considered using a theory of change model. This allows us to frame the mechanisms by which each activity is intended to achieve drug use outcomes, testing these hypotheses where possible.

1.4.4 Evidence gaps

In delivering this evaluation the best available monitoring data held across government departments and agencies have been sought, and the most up-to-date evidence on centrally-funded activity that contributes towards the aims of the strategy has been collated. However, the delivery of activity under the strategy has not been accompanied by a comprehensive programme of research and data collection that would enable an assessment of value for money. Also, whilst some evaluations have been carried out at an intervention level, there is a lack of large-scale impact evaluations specifically with drug use outcomes or cost-benefit analysis.

Evaluations for some of the larger programmes delivered under the strategy remain works in progress and so the assessment of effectiveness based on interim findings is offered in advance of their final publication (including the pilots of payment by results for commissioning and delivering drug misuse treatment). Therefore findings may change. Some centrally-funded activities were delivered without evaluation built in, and others, whilst hypothesised to affect drug use and recovery, do not include drug use as a direct outcome measure (e.g. Children's Centres and the Work Programme).

Throughout the life-course of the strategy there have been constraints upon central government expenditure and the allocation of resources at a local level. These have meant that the resources necessary to fill all the identified evidence gaps have not been available, even if it was methodologically possible. This has limited the availability of data to support evaluation efforts.

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Additional sources

For the most recent publications on the key statistics in drug use and related harm, please see the following.

<https://www.gov.uk/government/collections/drug-misuse-declared>

<http://www.nta.nhs.uk/statistics.aspx>

<http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths>

<https://www.gov.uk/government/collections/seizures-of-drugs-in-england-and-wales>

<http://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/previousReleases>

<https://www.gov.uk/government/collections/criminal-justice-statistics-quarterly#criminal-justice-statistics-quarterly>

<https://www.gov.uk/government/statistics/statistics-on-drug-misuse-england-2017>

Chapter 2: Trends in drug use and related indicators

2.1 Introduction

This chapter provides an overview of national level survey, monitoring and operational data on trends in drug use, treatment, criminal justice system (CJS) and enforcement activity.⁴ These have been selected to provide context and an indication of the direction of travel against the two overarching aims of the Drug Strategy 2010:

- reducing illicit and other harmful drug use; and
- increasing the numbers recovering from their dependence.

However, for reasons of attribution, it is not possible to relate changes observed directly to the strategy. Further data are included within relevant chapters and within the referenced publications.

The strategy began in December 2010 so figures from the financial year 2009/10 or calendar year 2009 are used to measure change since the beginning of the strategy. Long-term trends are also presented where available.

⁴ The coverage of these data collections vary: some relate to England, some to England and Wales and some to the UK. These are specified when the figures are presented. The figures in this chapter are robust, although many have specific caveats, which are covered within the referenced reports.

2.2 Prevalence of drug use

Box 2.1 Measures of drug use prevalence

There are three main sources of data that provide a representative measure of the prevalence of drug use.

- The Crime Survey for England and Wales (CSEW), a survey of 16- to 59-year-olds resident in households in England and Wales;
- The School Survey of Smoking, Drinking and Drug Use Among Young People in England (SDD), a school based survey of 11- to 15-year-old secondary school pupils in England; and
- Bespoke estimates of the numbers of adult opiate and/or crack cocaine users in England.⁵

Since the beginning of the Drug Strategy 2010, **drug use among all adults (16–59)** and **young adults (16–24)** has remained stable (Lader, 2015). This is in the context of a longer-term decline in drug use since 1996 when measurement began and compared with ten years ago (Figure 2.1).

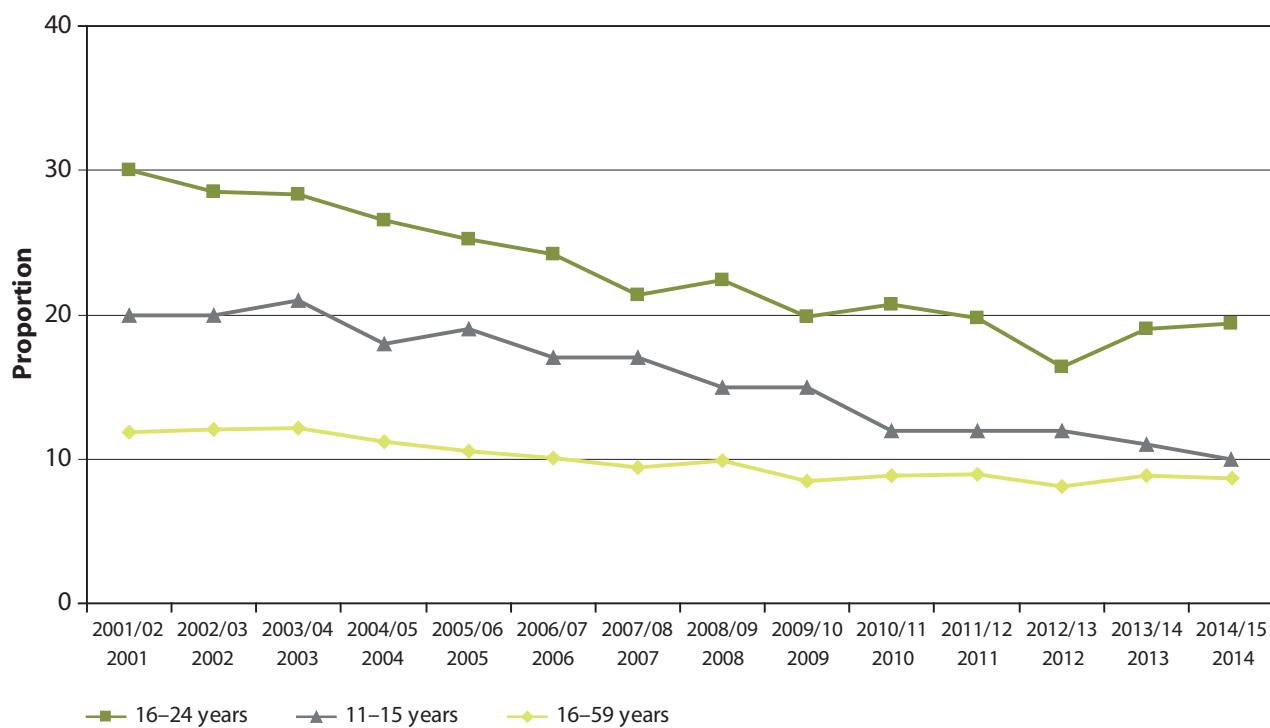
- In the 2014/15 CSEW 8.6 per cent of all adults used any illicit drug in the last year, similar to the level in 2009/10 (8.5%) prior to the start of the strategy, but lower than a decade ago (11.2% in 2004/05). The long term decline was mainly been driven by falls in cannabis use, which remains the most commonly used illicit drug (6.7% of adults reported last year use in 2014/15).
- A similar pattern is observed for young adults. In 2014/15, 19.4 per cent of young adults reported any last year illicit drug use, stable since 2009/10 (19.9%) but lower than a decade ago (26.5% in the 2004/05 CSEW).

Prevalence of **drug use among 11- to 15-year-old pupils** has shown a decline from 2009, which again is in the context of a longer-term fall since 2001 (Fuller, 2014), see Figure 2.1

- Prevalence of drug use in the last year among 11- to 15-year-olds has fallen from 15 per cent in 2009 to 10 per cent in 2014, and also since 2001, when 20 per cent of pupils reported taking any drug in the last year.
- Prevalence increases markedly with age. Four per cent of 11 year olds reported using a drug in the last year compared with 19 per cent of 15 year olds.

⁵ As a household survey, the CSEW provides an effective measure of the more commonly used drugs, for which the majority of users are contained within the household population but it is likely to underestimate the overall use of drugs such as opiates and crack cocaine. Therefore, bespoke estimates of the number of opiate and/or crack cocaine users have been produced since 2004/05.

Figure 2.1: Prevalence of any last year drug use among 16- to 59-year-olds, 16- to 24-year-olds and 11- to 15-year-olds, 2001/02 to 2014/15



Sources: CSEW, Office for National Statistics (ONS); SDD, Health & Social Care Information Centre (HSCIC)

The **number of opiate and/or crack cocaine users** (OCUs) has been falling from a peak in 2005/06; this decline appears to have continued into the period of the strategy, although estimates are only available until 2011/12 (Hay *et al.*, 2014, 2013, 2011; Singleton *et al.*, 2006).

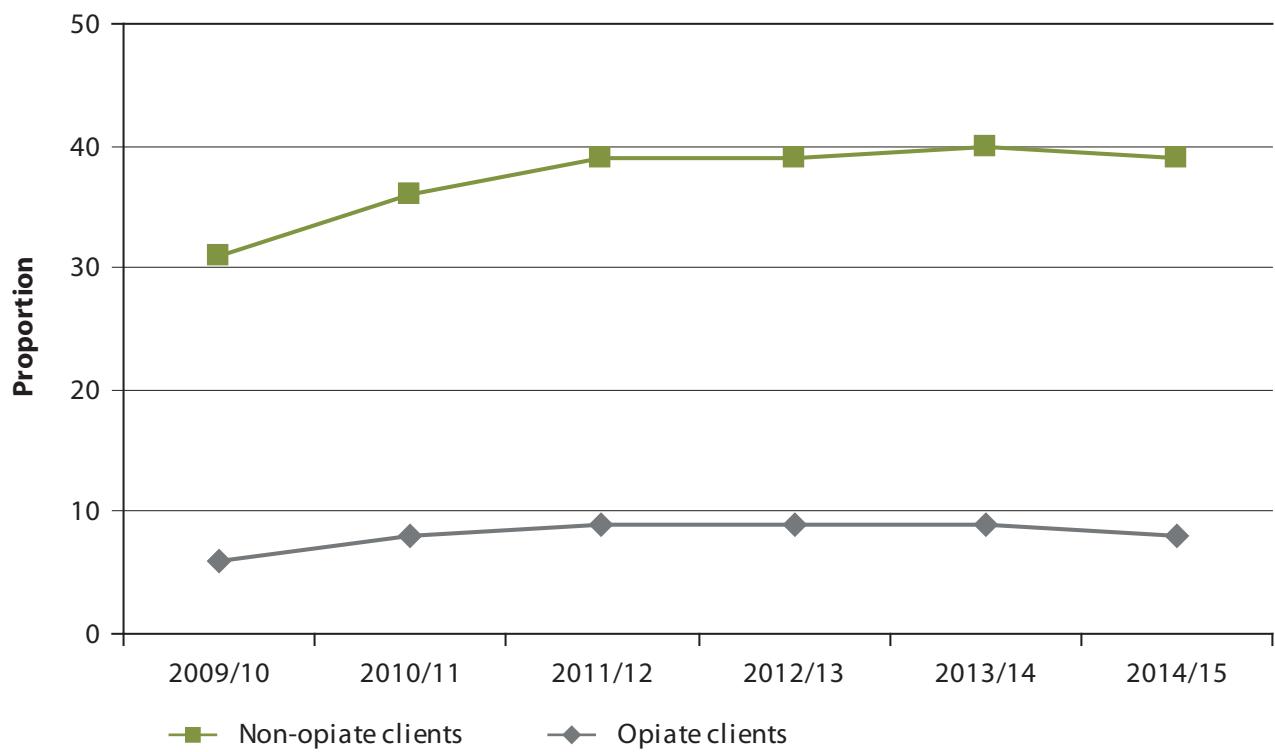
- Latest estimates show that there were around 306,000 OCUs in 2009/10, 299,000 in 2010/11 and 294,000 in 2011/12. Numbers have declined steadily from a peak of around 332,000 users in 2005/06.
- The decline is most apparent in the younger age group with increases in the older age groups, reflecting the ageing nature of users. The number of 15- to 24-year-old OCUs declined from around 140,000 in 2004/05 to 110,000 in 2011/12 compared with an increase in the numbers in the 35-64 age group (from around 114,000 in 2004/05 to 152,000 in 2011/12).

2.3 Recovery

The annual proportion of all **clients in treatment leaving successfully**⁶ has increased from before the start of the strategy (12.2% in 2009/10) to 16.1% in 2011/12, and has subsequently fallen slightly (from 16.4% in 2013/14 to 15.8% in 2014/15). The proportions for both opiate and non-opiate clients largely follow this pattern, although recovery rates for non-opiate clients have remained higher than those for opiate clients (Figure 2.2).⁷

- In 2009/10, 6 per cent of opiate clients in treatment left successfully, increasing to 9 per cent in 2011/12. This remained stable up to 2013/14, before falling slightly to 8 per cent in 2014/15.
- In 2009/10, 31 per cent of non-opiate clients in treatment left successfully, this rose to 39 per cent in 2011/12 and has remained relatively stable since.

Figure 2.2 Proportion of opiate and non-opiate clients in treatment leaving treatment successfully, England, 2009/10 to 2014/15



Source: National Drug Treatment Monitoring System, Public Health England (PHE)

6 This is determined by clinical judgement that the individual no longer has a need for structured treatment, having achieved all the care plan goals and having overcome dependent use of the substances that brought them into treatment. The denominator for this proportion is all clients in treatment in the year, including those who are retained in treatment at the end of the year.

7 Figures have been provided by PHE and have not previously been published in this form.

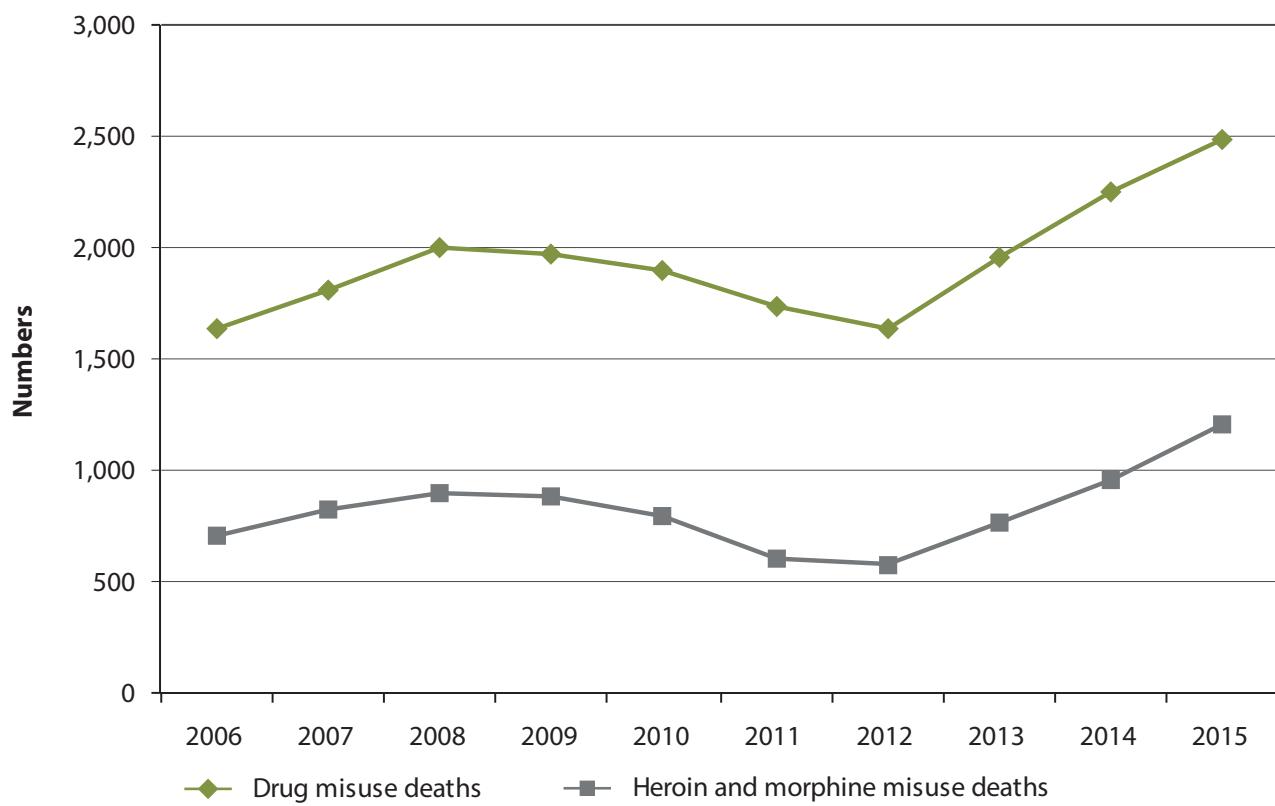
2.4 Health harms

There are several sources of data on the health harms of drug use, including drug-misuse deaths, new presentations to treatment services and hospital admissions.

Drug misuse deaths fell over the first two years of the Drug Strategy 2010 but large increases in the past two years have reversed this trend. Overall there has been a long-term increase in drug misuse deaths (ONS, 2016), see Figure 2.3.

- There were 2,479 drug misuse deaths registered in England and Wales in 2015, a 25 per cent increase from 2009 and the highest level since comparable records began in 1993.
- Heroin and morphine were related to the greatest number of deaths; 880 in 2009 rising to 1,201 in 2015.

Figure 2.3: Number of drug misuse deaths registered, England and Wales, 2006 to 2015

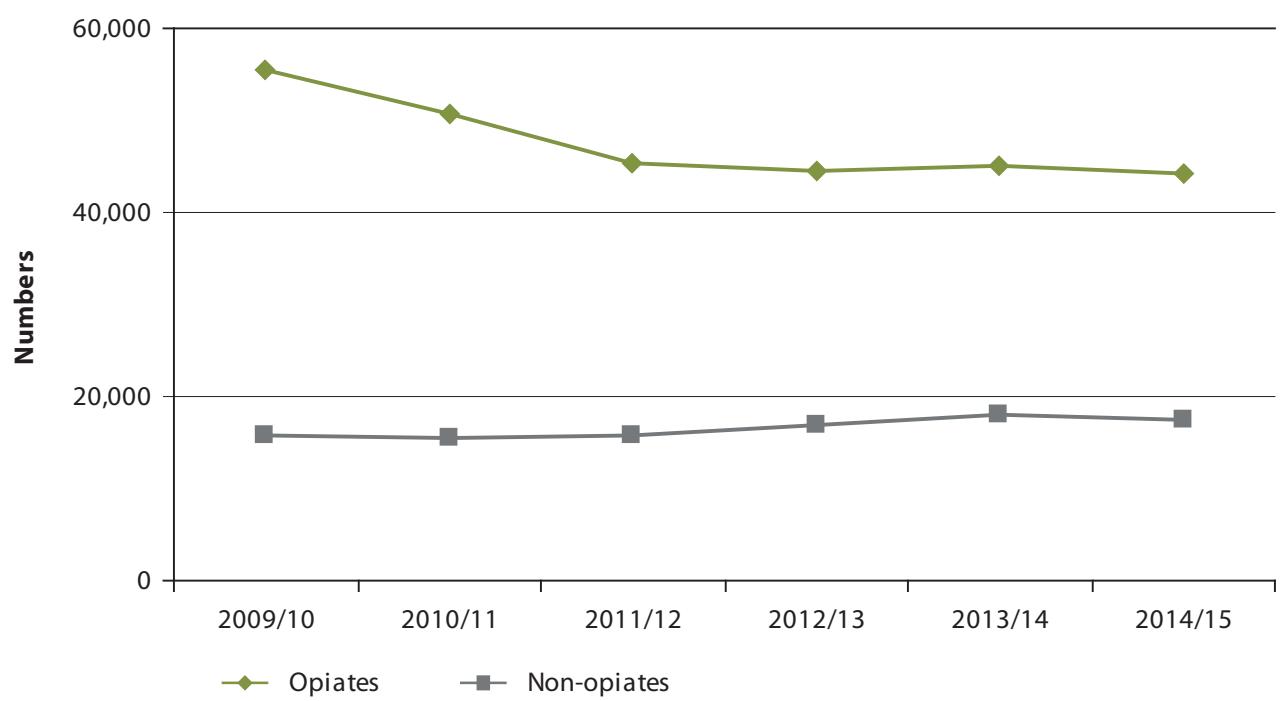


Source: Deaths related to drug poisoning, England and Wales – 2015 registrations, ONS

Trends in **new presentations to treatment** have varied by drug type: opiate presentations fell over the first two years of the Drug Strategy 2010 whereas non-opiate presentations increased up until 2013/14. Presentations for opiates stabilised in the later years of the strategy.

- The number of new adult (18 years and over) presentations to treatment for opiates in England fell sharply from 55,493 in 2009/10 to 45,491 in 2011/12 before stabilising in later years (44,356 in 2014/15).⁸
- The number of presentations for non-opiate drugs increased from 33,522 in 2009/10 to 37,361 in 2013/14, before declining in 2014/15 (35,886) (Figure 2.4).⁹
- There is an aging profile of new presentations for opiates, with decreases in presentations for all age groups below 40, and increases during the strategy period for those aged 40 and older (PHE, 2015).

Figure 2.4: New presentations to treatment, opiates and non-opiates, England, 2009/10 to 2014/15



Source: National Drug Treatment Monitoring System, PHE

8 Figures have been provided by PHE and have not previously been published in this form.

9 Figures have been provided by PHE and have not previously been published in this form.

There are two main measures of drug related hospital admissions, **poisoning by illicit drugs** and **drug related mental health and behavioural disorders**. Admissions for both of these measures have increased over the strategy¹⁰ (HSCIC, 2014).

- Between 2009/10 and 2014/15¹¹ hospital admissions with a primary diagnosis of poisoning by illicit drugs¹² increased by 23 per cent (from 11,618 to 14,279). This continues the long-term increase in hospital admissions for poisoning by illicit drugs.
- Hospital admissions with a primary diagnosis of drug related mental health and behavioural disorders have also increased, from 5,809 in 2009/10 to 8,149 in 2014/15, although these had fallen prior to 2009/10, from 7,857 in 2004/05.

2.5 Enforcement and criminal justice system activity

Data on enforcement and criminal justice system activity includes the number of drug possession and supply offences, and the number of drugs seizures. Enforcement-related indicators can be seen as a measure of enforcement activity, and the data may be affected by changes in recording practices and powers.

The number of **drug offences** has declined over the period of the Drug Strategy 2010 (ONS, 2015b), see Figure 2.5.

- In 2014/15 there were 169,964 drug offences recorded by the police, lower than the 235,584 offences recorded in 2009/10 and continuing the downward trend from 2008/09 (243,536 offences).
- The majority of police recorded drug offences are for possession (over 80%), and of these, the majority are for cannabis possession (three-quarters of drug offences in 2014/15).
- The police recorded 27,026 trafficking of drug offences in 2014/15 which has fallen from 33,233 in 2009/10.

The number of **drugs seized** by police forces and Border Force has also declined over the strategy, although this is in the context of a substantial rise in the longer term (Hargreaves and Smith, 2015).

- The number of drug seizures has declined from 224,401 in 2009/10 to 167,059 in 2014/15, although this follows a doubling in the number of drug seizures from 115,516 in 2003¹³ to 241,473 in 2008/09.
- The number of Class A drug seizures has fallen from 41,268 in 2009/10 to 29,705 in 2014/15.

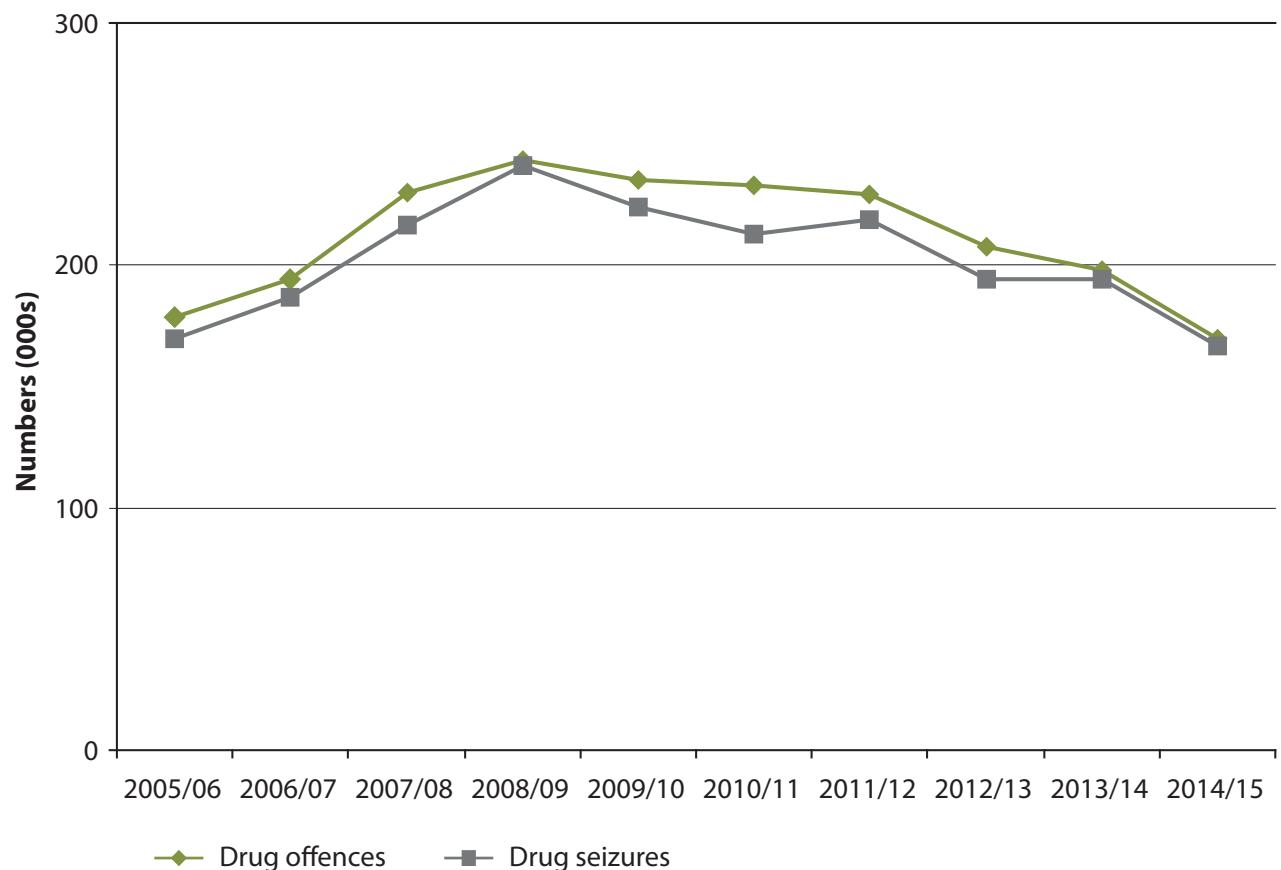
¹⁰ The quality and coverage of these data have improved over time, which should be borne in mind when interpreting trends.

¹¹ Figures for 2013/14 do not include the ICD-10 code T40.4. This was removed to avoid including a (at the time) non-controlled drug (tramadol) in the figures for illicit drugs. From August 2014 onwards tramadol has been controlled as a class C drug.

¹² Many of these poisonings are for 'other opiates', which may include both licit and illicit drugs.

¹³ Historic data on drugs seizures are available in earlier editions of the Home Office *Seizures of drugs in England and Wales* statistical series (see, e.g. Coleman, 2013).

Figure 2.5: Number of drug offences, and number of drug seizures, England and Wales, 2005/06 to 2014/15



Sources: Home Office; ONS

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Chapter 3: Early intervention activity

Summary

Activity

- Early intervention activities are central to achieving the Drug Strategy 2010's aim of reducing demand for illicit drugs. This chapter focusses on an assessment of national early intervention programmes, though further considers the evidence for other smaller, specific interventions delivered at a local level.
- Early intervention activities are designed to tackle the risk factors associated with drug misuse and other risky behaviours. They therefore can prevent a wide range of adverse social outcomes such as offending, family, education and employment harms and are not always specific to drug use.

Evidence of effectiveness

- There is more evidence of effectiveness in relation to intermediate outcomes (e.g. tackling risk factors) than the central strategy outcome of interest: reduced drug use. This is largely due to a lack of evidence of the long-term impact of early intervention activities due to the time lag between intervention and effect.
- When implemented according to the evidence of what works, early intervention activity is effective in reducing risk factors associated with drug use and in turn drug use itself. Approaches most likely to be beneficial are targeted towards multiple risk behaviours, including substance misuse, as opposed to targeting drug use alone.
- Interventions most likely to be effective include pre-school and family-based programmes, including those delivered via Children's Centres.
- There is promising evidence that interventions such as personal social health and economic education, Family Nurse Partnership programmes, Family Intervention Projects and MyPlace can positively impact on reducing risky behaviours and subsequently drug use. However, the stronger evidence is often from the USA (with different health and education structures) and that from the UK is less robust methodologically.

Spend and value for money

- Estimates, which are based on large assumptions and should be interpreted with caution, suggest that central government spend on early intervention activity under the Drug Strategy 2010 may have fallen from an estimated £269 million in 2010/11 to an estimated £215 million in 2014/15.
- Due to the absence of sufficient data on expenditure, reach of early interventions, and on drug use outcomes, it has not been possible to produce value for money estimates for early intervention activities.

3.1 Introduction

To tackle the harms associated with drug use, the Government committed in the Drug Strategy 2010 to establishing a “*whole life approach to preventing and reducing the demand for drugs*” and to “*intervene early with children and young adults*” (HM Government, 2010). Early intervention activities are central to achieving this objective and include programmes where reducing illicit drug use is the primary intended outcome, but also programmes that primarily target the risk factors associated with drug use (e.g. family interaction or educational attainment) with reducing drug use a secondary outcome.¹⁴

The reducing demand strand of the strategy was refreshed in 2014, further broadening prevention activity. Since then, action has been taken across a wide range of at risk groups, ensuring a response to new challenges including new psychoactive substances (NPS) and capitalising on the role of Public Health England (PHE) in supporting local commissioners and practitioners to implement evidence-based prevention activity (HM Government, 2015).

Definitions of early intervention vary according to whether:

- interventions target problems before they emerge or early in their life-course;
- the focus is on the individual or whole family needs; and
- interventions are focussed on particular populations according to risk.

Early intervention activities are delivered through centrally designed programmes with broad geographical coverage and also through other smaller, more specific, interventions delivered locally. Interventions can be classified into three groups, which are used throughout this chapter.

- **Universal intervention** – addresses a population regardless of level of risk and can target the development of skills and values, norm perception and interaction with peers and social life, for example, personal social health and economic (PSHE) education. Universal interventions may also include general education policy and whole school approaches that aim to foster healthy environments at all levels of school life.

¹⁴ Many are likely to be beneficial in reducing other risky behaviours in young people, such as substance misuse and offending, not only drug misuse.

- **Selective intervention** – targets those groups where the lifetime risks of substance misuse are considered greater than for the general population, or where substance misuse may already be occurring, for example, the Troubled Families Programme (see chapter 7) and Family Nurse Partnerships.
- **Indicated interventions** – work with vulnerable individuals to help them to manage the factors that make them more vulnerable for initiation into drug use and escalating drug use. Indicated interventions have a smaller coverage, as they are based on assessment of individuals, and can overlap with broader Child and Adolescent Mental Health Services. Due to this indicated interventions are not assessed in this chapter.

3.1.1 Challenges of carrying out an evaluation of effectiveness of early intervention activity

In addition to the general challenges of evaluating the Drug Strategy 2010 (see section 1.4, chapter 1), evaluating early intervention activity is particularly complicated by the time lag between intervention and reduced drug use. Indeed, many of those targeted by early intervention activity delivered under the strategy will still be some years away from the age at which young people are most likely to begin to use drugs. The key indicator of drug use amongst young people is drawn from the School Survey of Smoking, Drinking and Drug Use Among Young People in England (SDD), a school based survey of 11- to 15-year-old secondary school pupils in (see section 2.2, chapter 2). This shows that the prevalence of drug use increases with age. For example, in 2014, 6% of 11 year olds said that they had tried drugs at least once, compared with 24% of 15 year olds (Fuller, 2015).

The effectiveness of early intervention activity against the aims of the strategy is largely assessed from evidence on intermediate outcomes (i.e. that risk factors associated with drug use have been countered or their influence on behaviour reduced), or from evidence on similar early intervention activities implemented prior to the strategy that have proved likely to be effective in reducing drug use.

Some of the challenges associated with the assessment of this activity group are a result of the integrated approach of the strategy, which recognises wider societal and structural determinants of health behaviour, and acknowledges that responsibility for drug prevention lies across government departments. The Advisory Council on the Misuse of Drugs (ACMD) acknowledges that whilst scientific research supports this approach, inherent challenges are presented when identifying early intervention activities and expenditure in policy and evaluating its effectiveness (ACMD, 2015).

3.2 How early intervention contributes to achieving the aims of the Drug Strategy 2010

A high-level logic model setting out how early intervention activity is intended to result in a reduction in illicit and other harmful drug use was published in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013). This logic model has been developed and updated and consists of a number of interactions between activity and outcomes (see Figure 3.1). Activities are included to the end of 2015.

Stage 1: Reach and activity

At stage 1 the population of interest is identified (reach), the activity defined and the required resource (inputs) and dependencies secured. The population of interest may be the population at large ('universal'), sub-groups of the population where drug use is most often concentrated ('selective') or populations identified as high risk due to personality, behaviour or early signs of drug use ('indicated').

Stage 2: Activity implemented, immediate outcomes delivered

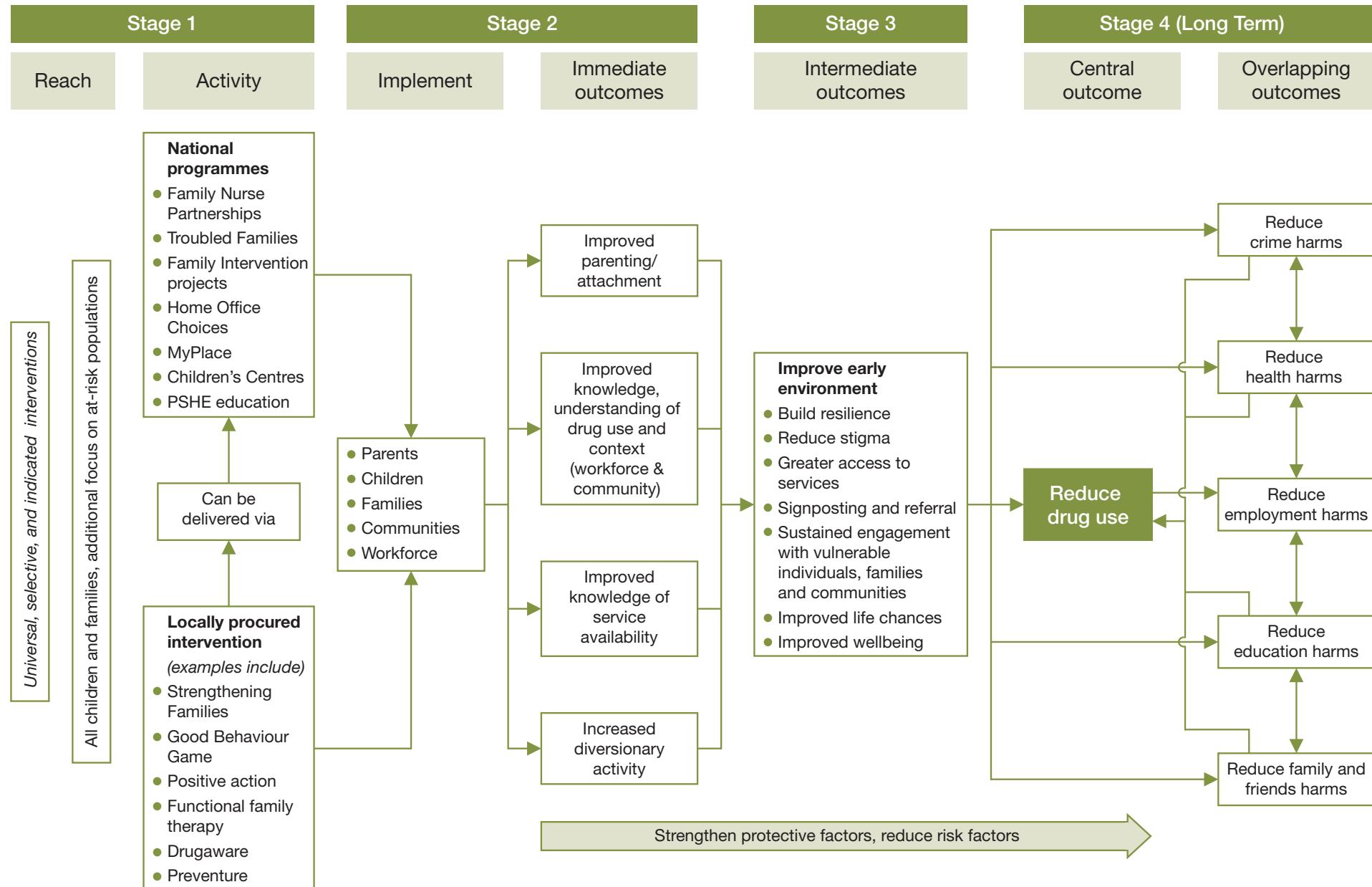
At stage 2, the activity is implemented and immediate outcomes delivered. In the case of early years interventions (e.g. Family Nurse Partnerships), these outcomes primarily relate to improved parenting and built attachment. For interventions that take a whole family approach (e.g. the Troubled Families Programme) immediate outcomes may include improved knowledge of the context around drug use, and of service availability. Immediate outcomes from programmes targeted at children from older age groups (e.g. MyPlace or Choices) may include increased take up of positive, diversionary activity.

Stage 3: Intermediate outcomes

Early intervention activity begins to affect drug use at stage 3, where the improved early environment starts to counter the risk factors and strengthen the protective factors associated with drug use. The 'early environment' here refers to the physical and social environment at any stage in the life course where the risk factors associated with drug use could develop or increase influence, or drug use itself could be initiated. In an early year's context, these factors most strongly relate to young people's interaction with their families, with key predictors of drug use including parental discipline, family cohesion and parental monitoring (Frisher *et al.*, 2007).

In many of the larger early intervention programmes delivered under this and previous strategies (including Children's Centres and Family Nurse Partnerships), these risk factors can include the adverse social outcomes that the interventions were *primarily* intended to address. These can include, for example, poor parenting or poor educational attainment, with reduced drug use a potential secondary benefit.

Figure 3.1: Logic model for early interventions



Stage 4: Long-term outcomes

Central outcome: Reduce drug use

By stage 4, work to alleviate or counter known risk factors is complete and the intended benefits of the intervention activity are realised. There is often a long time lag between the intervention and the central outcome of interest (reduced drug use), which in itself may have short- and long-term outcome measures. For example, in the short term initiation into drug use may be prevented or delayed, as might escalation into more problematic drug use in the longer term.

Overlapping outcomes: Reduce associated harms

Stage 4 also includes outcomes associated with a yet longer timescale, with the impact of activity under the strategy unlikely to be felt for some years. With most early intervention activities, there is an expectation of further benefits associated with reduced drug use (such as reductions in ill-health and crime and improved employment prospects). However, the associated time lag precludes further assessment here.

A reduction in drug use can also occur as a secondary outcome to health, crime, education or employment benefits. Many of the large programmes delivered under this and previous drug strategies (including Children's Centres and Family Nurse Partnerships) have long term aims to tackle a broad range of adverse social outcomes, some of which overlap with risk factors associated with drug use (e.g. health and education harms) so these overlapping outcomes will also feed back into reduced drug use.

3.3 The types of activities within the early intervention activity group

The **centrally designed** programmes considered in this assessment include the following. For more details on these programmes and how they contribute to the aims of the strategy, see Appendix A3.1.

Universal intervention:

Personal Social Health and Economic education (PSHE) – Department for Education (DfE), a planned programme of learning through which children and young people acquire the knowledge, understanding and skills they need to manage their lives.

Selective intervention:

Family Nurse Partnerships (FNPs) – Department of Health (DH), a selective early intervention targeted at young mothers deemed vulnerable to a variety of adverse social harms, who are provided with support to achieve a range of parenting goals from a team of nurses via home visits.

Children's Centres – DfE, aim to enhance health and wellbeing during the early years and increase the future chances of children through the provision of integrated multi-agency services at a single point of access for families with children up to the age of five. Services can include specific early interventions delivered according to local priorities (e.g. Incredible Years programmes). Children's Centres have continued to be supported throughout the life of the strategy.

MyPlace projects – DfE, aim to establish 'places' for young people (e.g. youth centres) that offered positive activities and access to services including those designed to reduce drug misuse or counter associated risk factors.

Family Intervention Projects (FIPs) – Department for Communities and Local Government (DCLG) and DfE, take an intensive and persistent multi-agency approach to supporting troubled and challenging families to overcome their problems, coordinated by a single dedicated 'key worker'.

Troubled Families Programme – DCLG, aims to change existing ways of working with these families by joining up local services, dealing with each family's problems as a whole rather than individually, and appointing a dedicated key worker to get to grips with their problems and work intensively to help them change for the long term.

Choices – Home Office, aimed at the voluntary and community sector to support their involvement in preventing and reducing substance misuse and related offending by vulnerable young people aged 10 to 19.

Positive Futures programmes – Home Office, used sport, physical activities, arts, social enterprise initiatives and education to engage vulnerable young people aged 10 to 19 and connect them to their community.

Alongside these interventions there are a range of more specific interventions that may be available, according to **local priorities**. These may have been delivered through central funding (i.e. the Early Intervention Grant and its equivalents). Examples of common activities specifically targeting drug use (or that are strongly hypothesised to affect drug use) are listed below (further detail in Appendix A3.1).

Universal intervention:

- Strengthening Families programme;
- Good Behaviour Game;
- Botvin Life Skills Training;
- Positive Action.

Selective intervention:

- Multi-Dimensional Family Therapy;
- Drugaware;
- Incredible Years programmes.

Indicated intervention:

- Functional Family Therapy;
- Preventure.

There are likely to be many more general early years programmes that may have secondary benefits including reducing drug misuse.

3.4 The effectiveness of early intervention activity

Briefing from the ACMD summarises the evidence base and recent debate in drug prevention (ACMD, 2015). It is acknowledged that whilst many prevention interventions in the UK (and elsewhere) have been evaluated, many have not, and the evidence on what works is not as clear as the evidence on what does not work. The briefing cites meta-analysis showing that approaches most likely to be beneficial in reducing drug use are targeted towards multiple risk behaviours, including substance misuse, as opposed to targeting drug use alone (Brotherhood *et al.*, 2013). Particular approaches likely to be effective include:

- pre-school, family-based programmes (e.g. Children's Centres or Family Nurse Partnerships);
- multi-sectoral programmes with multiple components (including the school and community);
- motivational interviewing; and
- some socialisation-based school programmes (e.g. 'The Good Behaviour Game').

This is supported by a recently updated European Monitoring Centre for Drugs and Drugs Addiction (EMCDDA) review (EMCDDA, 2015). However, an important caveat is that such interventions are only likely to be effective when implemented according to the evidence base of what works, and tested for generalisability, as evidence for their effectiveness often comes from other countries.

The evidence on how each of the centrally designed programmes and interventions may have contributed towards the aims of the Drug Strategy 2010, with reference to the logic model (Figure 3.1), is now outlined. Evaluations of early intervention activities mainly consider effectiveness in achieving immediate or intermediate outcomes within the logic model, rather than the central outcome of reducing drug use – for reasons explained earlier.

3.4.1 Universal interventions

PSHE education is the main universal intervention delivered under the strategy. There is insufficient evidence to assess its effectiveness on reducing drug use in England although there is robust evidence that multi-faceted approaches (like PSHE) are more effective at preventing drug use than single approach interventions.

Personal social health and economic education (school-based, ongoing, DfE)

PSHE education contributes towards the aims of the strategy by working to reduce risk factors around health behaviours that are associated with drug use and by building resilience (intermediate outcomes, logic model stage 3).

A DfE published review of the impact of and effective practice in PSHE education found there was insufficient evidence to assess the effectiveness of PSHE education (DfE, 2015a), and recent efforts to improve its provision,¹⁵ on reducing drug use in England. However there is encouraging evidence from the USA that the school-based approaches to health education promoted by drug strategy partners are proven effective (PHE, 2014). A review of 51 randomised control trials (RCTs) found that programmes combining social competence curricula (teaches generic self-management and personal and social skills to resist pressures to take drugs) and strategies which give knowledge by managing social norms and myths around drug taking, have better results than single approach interventions. They prevented cannabis use (at longer follow-up) and drug use overall. However, knowledge-based interventions alone in a school context showed no differences in behavioural outcomes (see Faggiano *et al.*, 2014).

3.4.2 Selective interventions

There is generally encouraging evidence that some selective interventions (Children's Centres, FIPs and MyPlace) have contributed towards the reducing demand aim of the Drug Strategy 2010. Evidence is not universal however, as the FNP programme is yet to be proven and there has been no impact evaluation of the Positive Futures programme (though the longer term impacts of this type of diversionary activity is unknown or potentially ineffective). The evidence for individual interventions is summarised below.

Family Nurse Partnerships (early years, 2007 to ongoing)

The logic for the FNP programme is that in the short term, young mothers are more likely to provide their infant with nurturing and sensitive care and make positive health and educational choices for themselves (immediate outcomes, logic model stage 2). In the longer term, children will be more likely to do well in school and complete their education, and less likely to present the risk factors associated with drug use.

Evidence from the USA includes RCTs which have demonstrated significant benefits including reduced high risk behaviours amongst FNP children (see DH, 2011 for an overview). However, as there is universal health visiting in England, whereas such services in the USA are more limited, there may be less opportunity for an FNP programme to impact. Elsewhere it has been argued that there was a risk that FNPs were being 'watered down' because local

¹⁵ In 2012 the Office for Standards in Education, Children's Services and Skills (Ofsted) found that PSHE provision was "not yet good enough" based on evidence from 26 school inspections across England (Ofsted, 2013). Inconsistent delivery of PSHE education was also identified by Mentor-UK in a survey of 288 schools in 2013 (Mentor-ADEPIS, 2013).

commissioners did not have the resources to support sustainability, a major determinant of success (Barnes, 2010).

Indeed, despite encouraging evidence from the USA, the FNP programme in England is yet to be proven for short- and longer-term outcomes related to reducing drug use.

- A formative evaluation of the first ten pilot sites in England concluded that the FNP programme can be replicated well in this country, had begun to make a positive connection with vulnerable families and had gained the support of practitioners (DH, 2012).
- More recently, an independent RCT found that adding FNP to usual care provided no additional short term benefit to primary outcomes including self-reported tobacco use by mothers at late pregnancy, birth weight of the baby, and emergency attendances and hospital admissions for the child within 24 months post-partum. However, there were small signs of improvement in children's early language and cognitive development (Robling *et al.*, 2015).

Children's Centres (early years, 2005 to ongoing; previously Sure Start local programmes, 1999 to 2005)

The variety of services that a Children's Centre offers (directly or through sign posting) is determined by the requirements of families in the centre's catchment area. The logic follows that building resilience and alleviating known risk factors (immediate outcomes, logic model stage 2) will reduce the likelihood of future drug misuse (intermediate outcomes, stage 3).

There are encouraging findings from preliminary evaluations that Children's Centres have contributed towards reducing the demand for drugs. The DfE-funded evaluation of Children's Centres in England has examined effectiveness both for children and families who use Children's Centre services. It found that local authorities have targeted Children's Centres to more deprived local areas (DfE, 2014a), and that centres have implemented an average of five¹⁶ early years programmes, including evidence-based programmes such as 'Incredible Years', and 'Triple P' (DfE, 2014b).

In relation to the delivery of evidence-based programmes, the evaluation found the following.

- While centres showed some understanding that well-evidenced programmes should be followed 'in full', other programmes were rolled out in a more variable manner to ensure that their support fitted the needs of families and were more flexible.
- Well-evidenced programmes were implemented with more fidelity than the 'other' programmes. Greater fidelity is known to be linked to better outcomes.
- Centre staff appeared to struggle with the concept of evidence-based practice. Some gave equal weight to research evidence and personal experience, while others were unsure over the importance of ensuring fidelity versus tailoring programmes to specific needs (DfE, 2013).

¹⁶ Based on an analysis across 117 centres in both 2012 and 2013.

The National Evaluation of Sure Start,¹⁷ which ended in 2012, used a quasi-experimental design based on data from all eligible families, rather than those only using centres.¹⁸ It found some evidence of improved home environment for families, which are broadly linked to known risk factors associated with drug misuse, such as parental monitoring, cohesion and discipline. There were, however, some negative outcomes for mothers too (e.g. being less likely to attend their child's school for parents' evenings and pre-arranged meetings). Longer term impacts such as reduced drug misuse were not measured due to the associated time lag, and caution is warranted in interpreting these results due to time of measurement effects.

In summary, there are encouraging findings from preliminary evaluations that Children's Centres have contributed towards the reducing demand aim of the strategy. This has been achieved through the implementation of a number of evidence-based programmes and the broad reach of parenting services, where intended outcomes include preventing or alleviating risk factors associated with drug misuse. However, this assessment comes with the important caveat that the fidelity with which evidence-based programmes are delivered in Children's Centres can vary according to the needs of users.

MyPlace projects (various ages, April 2008 to March 2013)

The BIG Lottery Fund managed the implementation of the programme for the DfE. An evaluation, using a case-study approach, identified some positive impacts on risk factors and reducing drug misuse (DfE, 2011a). However, the case-study methodology, with its limited coverage and non-standardised measures, limits the applicability of these findings and their usefulness for assessing effectiveness.

Family Intervention Projects (whole family target population – 2007 to 2012)

The logic for FIPs follows that in tackling social harms, drug use may reduce as a result of alleviating known risk factors. Parental substance use is an important risk factor for substance use in children, whether through genetic or environmental mechanisms. Therefore, reducing family substance use problems may lead to less chance of initiation into drugs and problematic substance use in later life as well as improving parenting and the home environment (logic model stages 2 and 3).

There are promising findings for FIPs, with an 86 per cent measure of 'service engagement' for 2011/12 (DCLG, 2012) based on families still receiving a service, or exiting the programme for a 'successful reason'.¹⁹

¹⁷ Children's Centres were launched under the Sure Start banner in 1999 as Sure Start local programmes (SSLPs).

¹⁸ For further information about the NESS, see <http://www.ness.bbk.ac.uk/>

¹⁹ Following changes to the Early Intervention Grant, local authorities were not mandated to contribute to this data collection, so these figures are likely to be an underestimate. Records suggest that during 2011/12 around 60% of areas continued to provide information to NatCen (the research agency commissioned to monitor the FIPs programme).

Family functioning and health (including drug or substance misuse) outcomes were reported on from 2007/08. A number of relevant indicators were combined and a percentage reduction of risk calculated.²⁰ Data from cases exiting FIP to March 2012 showed:

- a 49 per cent reduction in the number of families with poor parenting as an issue (logic model stage 2); and
- a 39 per cent reduction in the number of families with drug misuse as an issue. The assessment of drug misuse is family-based, involving adults, and relates to a population already involved in drug use (DfE, 2011b).

However, there are limitations: the absence of a counterfactual restricts understanding on the extent to which these outcomes were a result of the intervention alone; and the before/after measures were the subjective assessments of project workers, not verified by external data sources.

Troubled Families Programme (whole family target population – 2012 to ongoing)

The Troubled Families Programme is another family-based intervention which contributes to the aim of reducing demand and building recovery by working with families to reduce risk factors, including those associated with drug use (logic model stages 2 and 3). Further information on the programme and the available evidence is in the non-treatment rehabilitative activity strand of this evaluation (see section 7.5.3, chapter 7). Generally, though, there has been insufficient time since programme implementation for this to be evaluated as an early intervention in reducing drug use.

Choices (ages 10–19, October 2011 to March 2012)

Voluntary and community sector organisations were encouraged to evaluate their approaches and some isolated assessments were published (e.g. Home Office and Barnardo's, 2012). But essentially there is no robust or applicable evaluation evidence available to assess the effectiveness or cost-effectiveness of Choices.

Positive Futures programmes (ages 10–19, refreshed in 2011, funded to March 2013)

The logic follows that young people engaged in constructive activities are less likely to be involved in drug misuse and other behaviours harmful to their wider community. However, whilst diversionary activity is an important first step towards engaging young people vulnerable to initiating or escalating drug misuse, the longer term impacts of the provision of such activity is unknown, and has in some cases been proven ineffective (ACMD, 2015). Evidence on the effectiveness of Positive Future programmes is unavailable.

20 This was based on project worker assessments at the point that a support plan was put in place (before) and when the family had left the intervention (after).

3.4.3 Locally procured interventions

In addition to those early intervention programmes that are centrally designed, a range of smaller, specific interventions have been delivered at a local level. These include activities delivered in schools or in Children's Centres. As discussed in chapter 1, a natural consequence of devolution of powers to local decision makers means that activities are often tailored to meet local needs, and there is insufficient detail on the scale and geographical coverage of this type of smaller intervention to enable a full assessment of effectiveness and value for money.

Programmes with reduced substance misuse as an intended outcome (often alongside other outcomes such as improved family functioning, reduced crime and anti-social behaviour) impact through stages 2 and 3 of the logic model. The Early Intervention Foundation's online programmes library²¹ provides an overview of interventions implemented in the UK and offers indicative assessments on the strength of evidence for each. These are sourced from expert assessors both in the UK (such as the Centre for Analysis of Youth Transitions²²) and abroad (such as Blueprints for Healthy Youth Development²³ and Office of Justice Programmes²⁴ in the USA).

Programmes with established evidence of effectiveness

- Botvin Life Skills Training.
- Functional Family Therapy.
- Multi-Dimensional Family Therapy.
- Positive Action.
- Incredible Years pre-school programme.

Programmes with initial evidence of effectiveness

- The Strengthening Families programme.
- Good Behaviour Game.
- Preventure.

Programmes with formative evidence of potential effectiveness

- Drugaware.

To assist local commissioners, the Home Office, PHE and DfE continue to fund the Mentor-run Alcohol and Drug Education and Prevention Information Service (Mentor-ADEPIS²⁵). To date they have produced resources focussed on general principles and guidance, based on eight years work with the Drug Education Forum, which supported

21 See <http://www.eif.org.uk/about-us/>

22 This is now part of Mentor-ADEPIS <http://cayt.mentor-adepis.org>

23 <http://www.colorado.edu/cspv/blueprints/>

24 <http://ojp.gov/>

25 <http://mentor-adepis.org/>

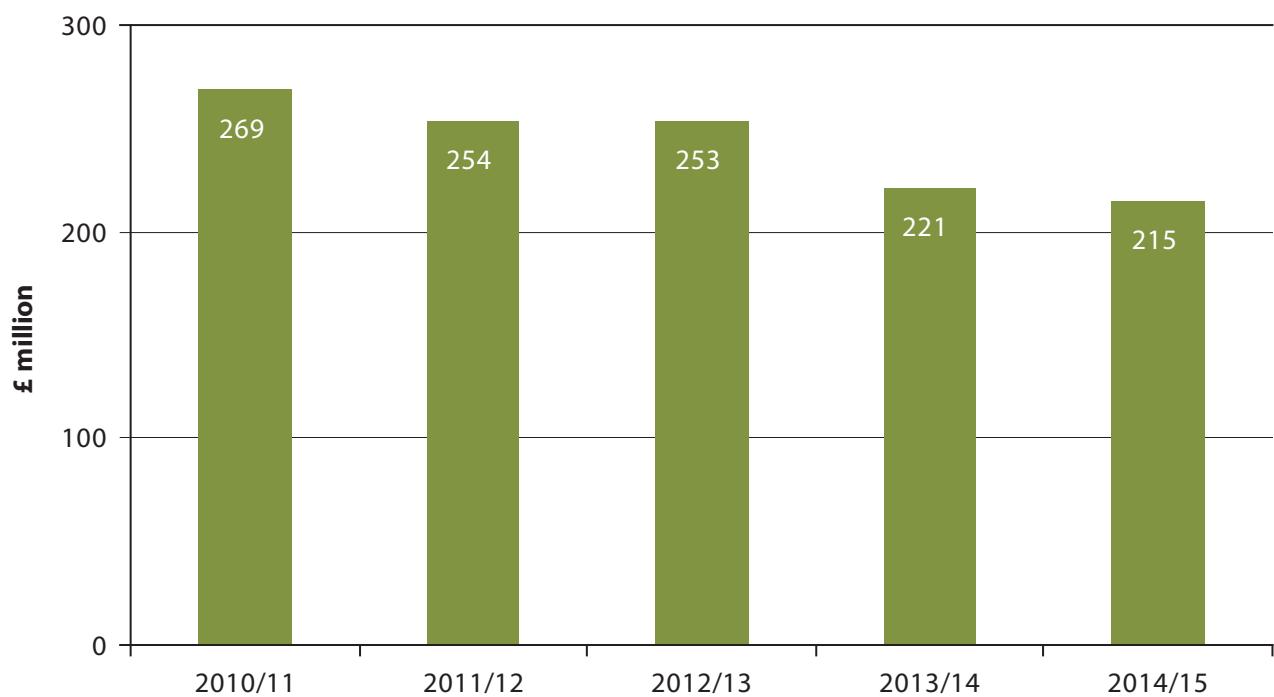
local authorities and schools to implement best practice in drug education. More tools and guidance, with a particular emphasis on promoting evidence-based programmes and approaches, are planned for 2015/16.

3.5 Central government spend and value for money of early intervention

Due to the absence of sufficient data on expenditure, reach of early interventions, and on drug use outcomes, it has not been possible to produce value for money estimates for early intervention activities. Where estimates of financial benefits are available at a programme level, these are presented in section A3.2.1, Appendix A3.2.

Updated estimates suggest that central government spend on early intervention activity under the Drug Strategy 2010 may have fallen from around £269 million in 2010/11 to around £215 million in 2014/15 (Figure 3.2). These estimates are necessarily based on large assumptions and must be interpreted with caution (see Appendix A3.2). It is not possible to ascertain whether this fall in spend since 2010/11 is due to disinvestment in early intervention activity, or other factors, for example changes in third sector provision or how local areas allocate funding.

Figure 3.2: Estimated central government spend on the Drug Strategy 2010, early intervention activity group, England, 2010/11 to 2014/15



3.6 Conclusion

The current assessment of evidence is that when implemented correctly, early intervention activity delivered under the strategy may be effective in reducing risk factors associated with drug use and in turn drug use itself. This assessment is drawn from promising evidence on how risk factors associated with drug use are being tackled (e.g. in Children's Centres) and from wider evidence on the effectiveness of interventions that the strategy promotes (ACMD, 2015). A caveat to this assessment relates to the fidelity with which interventions and activity theorised to impact upon drug misuse are delivered – with evidence highlighting inconsistencies in the delivery of, for example, PSHE education in schools and early-years interventions in Children's Centres.

However, there remain evidence gaps around the long-term impacts of some Drug Strategy 2010 activities due to:

- in part the relative infancy of programmes that may take many years for outcomes such as reduced drug misuse to materialise; and
- a general lack of longitudinal studies designed to measure the effectiveness of interventions over a long time period.

The evidence gaps prevent a meaningful assessment of the value for money provided by government expenditure on such activity at a national level – despite promising evidence on cost-effectiveness where interventions have been implemented abroad. It is, however, acknowledged that expenditure on early intervention activity may have fallen throughout the strategy, from an estimated £269 million in 2010/11 to an estimated £215 million in 2014/15.

Appendix A3.1 Types of activities within the early intervention activity group

What follows is a more detailed description of the types of activities reviewed within the chapter on early intervention activities.

National programmes

Universal interventions

PSHE education – a planned programme of learning through which children and young people acquire the knowledge, understanding and skills they need to manage their lives.

Schools have developed their own versions of PSHE education and different ways to deliver it, although programmes typically cover health and safety education, including substance misuse, sex and relationships education, careers education, economic education and financial capability.

The FRANK advisory service appears to play a key part in the planning of drug-focussed PSHE lessons with 78% of teachers reporting using FRANK (Fuller, 2015), and PHE's 'Rise Above' resilience building programme can offer further resource (both discussed in more detail in chapter 4).

DfE provide funding for the PSHE Association, a registered charity which aims to improve the quality of PSHE provision nationally.²⁶ PHE have also provided briefing for head teachers, governors and staff in educational settings, to outline the key evidence highlighting the link between health and wellbeing and educational attainment, emphasising the importance of a whole-school approach (PHE, 2014).

Selective interventions

Family Nurse Partnerships – with their origins in the USA, FNPs are a selective early intervention targeted at young mothers deemed vulnerable to a variety of adverse social harms, who are provided with support to achieve a range of parenting goals from a team of nurses via home visits.

Children's Centres – aim to enhance health and wellbeing during the early years, and increase the future chances of children through the provision of integrated multi-agency services at a single point of access for families with children up to the age of five. Services can include:

- childcare and early education programmes;
- a range of health services;
- evidence-based parenting classes; and
- specialised family support services.

26 <https://www.pshe-association.org.uk/>

Children's Centres have continued to be supported throughout the life of the strategy. On 30 June 2015 there were 2,677 main Children's Centres and a further 705 additional sites open to families and children providing Children's Centre services as part of a network.²⁷ Children's Centres were launched under the Sure Start banner in 1998 as Sure Start local programmes.

MyPlace projects – this programme arose from Aiming High for young people – a ten-year strategy for positive activities set up by the Department for Children, Schools and Families (DCSF, 2007) that aimed to establish 'places' for young people (e.g. youth centres) that offered positive activities and access to services including those designed to reduce drug misuse or counter associated risk factors.

Family Intervention Projects – support troubled and challenging families to overcome their problems, coordinated by a single dedicated 'key worker'. FIPs aim to tackle, for example, anti-social behaviour, youth crime, inter-generational disadvantage and unemployment.

Troubled Families Programme – aims to change existing ways of working with these families by joining up local services, dealing with each family's problems as a whole rather than individually, and appointing a dedicated key worker to get to grips with their problems and work intensively to help them change for the long term.

DCLG (2012) published a guide to the evidence and good practise of working with families, including five family intervention factors. To qualify for the original programme families had to have three out of the following four indicators:

- children who are regularly truanting or not in school;
- children committing crime or anti-social behaviour;
- parents not working; or
- another locally defined high-cost problem, such as drug misuse.

Locally procured interventions

Universal interventions

- The Strengthening Families programme for young people aged 10 to 14 – a family-based intervention for parents who wish to support their teenage child's development.
- Good Behaviour Game – a classroom management strategy that encourages good behaviour and cooperation in children in primary school classrooms.
- Botvin Life Skills Training – a school-based prevention programme.
- Positive Action – a school-based curriculum developed to support children's prosocial behaviour, school performance and family functioning.

27 <http://childrenscentresfinder.direct.gov.uk/snapshot-childrens-centre/>

Selective interventions

- Multi-Dimensional Family Therapy – a family therapeutic approach for those young people exhibiting behavioural and or substance misuse issues.
- Drugaware – an aspirational standard awarded to primary and secondary schools that engage in preventive activities known to discourage substance misuse.
- Incredible Years pre-school programme – a parenting intervention, for those with concerns over their child's behaviour.

Indicated interventions

- Functional Family Therapy – a family therapeutic approach for young people involved in the youth justice system, and where substance misuse may already have been initiated.
- Preventure – a school-based curriculum for young people aged 13 to 14, which aims to reduce the risk of substance misuse and other behavioural problems.

Throughout the period of the strategy under review, a range of resources has been developed to ensure that local commissioners can access information on best practice and evidence-based interventions. The Early Intervention Foundation (EIF), an independent charity and 'what works' centre, was established following the joint Department for Work and Pensions (DWP)/Cabinet Office (CO) Allen Review on early intervention, the next steps (DWP/CO, 2011), to bring together leading researchers and advisers to provide both the best evidence and implementation guidance for commissioners and practitioners.

Appendix A3.2 Estimates of central government spend on early intervention and value for money

Estimates have been derived by collating central government spend data on early intervention activity. This is complicated by several challenges as follow.

- Early interventions often intend to achieve a broad range of outcomes, of which reducing drug use is one. Therefore assumptions have been applied to estimate the proportion of component programme spend that falls under the strategy.
- Following the de-centralisation of budgets, and the increased focus on local commissioning, information on expenditure at a local level allows for only a limited assessment of spend on early intervention under the strategy.
- A number of changes have been made to funding arrangements throughout the life course of the strategy. For example, funding for prevention contained within the Young People's Substance Misuse Partnership Grant was incorporated into the Early Intervention Grant from 2011/12, and latterly into the Business Rate Retention Scheme from 2013/14. These changes make it difficult to compare spend information across each year of the strategy.

As a result of the challenges above, the estimates should be treated with caution.

The final estimates of government spend on early intervention activities under the strategy are presented in Table A3.1.

Table A3.1: Estimated central government spend on early intervention activity under the Drug Strategy 2010

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
EIG and Equivalent	248	224	237	205	203
PSHE	8.4	8.3	8.2	8.4	8.5
MyPlace	11.7	16.6	4	-	-
Troubled Families Programme	-	-	2.6	8	3.9
Positive Futures	1.5	1.3	1.3	-	-
Choices	-	4	-	-	-
Totals	269	254	253	221	215

Note

'-' intervention not running.

The 2011/12 figure (£254 million) differs from the initial estimate of £341 million spend on early intervention published in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013). The revised figure includes more recent, historic (as opposed to forecast) spend data, and refined assumptions on the proportion of spend on large programmes (e.g. MyPlace) that can be attributed to the strategy.

The following text and tables (A3.2 to A3.7) describe the total spend for each grant, programme or intervention within the early intervention activity group, as well as spend

estimated to fall under the Drug Strategy 2010. The data used to derive these estimates have been based on publicly available data where possible (and referenced) but otherwise provided by the relevant department.

The Early Intervention Grant

The Early Intervention Grant (EIG) was paid to local authorities as a non-ring-fenced grant in 2011/12 and 2012/13. It replaced a number of previous sources of funding, both ring-fenced and non-ring-fenced, and represented an 11 per cent reduction when compared with predecessor grants. The EIG was used to fund some of the large centrally designed early intervention programmes, including Children's Centres, FNPs and FIPs. However, being non-ring-fenced, it allowed local authorities to fund early intervention activity according to local needs and priorities, and therefore funded additional early intervention activity commissioned at a local level.

From 2013/14 the EIG became part of the Business Rate Retention Scheme. At the same time, funding for increased nursery school places was transferred to the ring-fenced Dedicated Schools Grant (DSG), a 'topslice' was retained by DfE to fund adoption reform, and the value of the EIG was reduced by 1 per cent in 2013/14, and by 2 per cent in 2014/15 as a result of reductions in DfE's resource budgets in those years.

In line with initial estimates of spend published alongside the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013), and to reflect the range of adverse outcomes that early intervention activity is intended to prevent, this evaluation assumes that 10 per cent of the EIG falls under the Drug Strategy 2010. Following changes made to the EIG from April 2013, this assumption has continued to apply to equivalent EIG funding in later years. However, the proportion was reduced to 5 per cent for those newly ring-fenced funding streams, where reduced drug misuse is a less explicit intended outcome (adoption reform and increased nursery places). Therefore the following assumptions on the proportion of the EIG that falls under the strategy have been made.

- In 2010/11, 10 per cent of the pre-EIG equivalent.
- In 2011/12 and 2012/13, 10 per cent of the EIG.
- In 2013/14 and 2014/15, 10 per cent of the equivalent EIG funding.
- In 2013/14, and 2014/15, 5 per cent of the DfE topslice and early years nursery funding.

Table A3.2: The Early Intervention Grant and equivalents, 2010/11 to 2014/15

	2010/11 £	2011/12 £	2012/13 £	2013/14 £	2014/15 £
Pre EIG equivalent ¹	2.48bn	N/A	N/A	N/A	N/A
EIG ²	N/A	2.24bn	2.37bn	N/A	N/A
Pre EIG, EIG and post EIG inclusive of DfE topslice and additional funding for 2-year-olds' school places ²	2.48bn	2.24bn	2.37bn	2.38bn	2.45bn
Spend under Drug Strategy 2010 early intervention activity group	248m	224m	237m	205m	203m

Notes

'N/A' grant not in existence.

1. The EIG represented a 10.9 per cent reduction when compared with predecessor grants. For further information, see the written ministerial statement on the schools financial settlement with regard to education spending: <https://www.gov.uk/government/speeches/written-ministerial-statement-by-michael-gove-on-schools-financial-settlement-education-spending--2>
2. HC Deb, 6 January 2014, c89W and <http://webarchive.nationalarchives.gov.uk/20140505104649/http://www.local.communities.gov.uk/finance/1314/settle.htm#Settle>

Personal social health and economic education

Government spend on PSHE education under the strategy (see Table A3.3) is derived by combining:

- the cost per hour of a teacher's time;
- the number of school classes in England; and
- the number of hours a class of children will spend on drug misuse education each year.

The cost per hour of a teacher's time is obtained from the Annual Survey of Hours and Earnings (ASHE) for 2010–2014 (ONS, 2014).²⁸ Figures are obtained for primary, secondary and special school teachers and cover the UK. The average of these three figures is used for pupil referral unit teachers.

The number of school classes in the England is estimated based on the number of schoolchildren and the average class size (DfE, 2015b).

The number of hours of drug misuse education each class will receive is based on estimates of the frequency of substance misuse lessons obtained from a DfE mapping exercise (DfE, 2011c). It is assumed that a lesson lasts two hours based on information from the PSHE Association, with one of those hours attributable to the strategy ('substance misuse' lessons will also cover alcohol and tobacco, which are outside the scope of this evaluation).

²⁸ Figures are available in each calendar year and have been applied to the closest financial year (e.g. 2014 to 2014/15 figures).

Table A3.3: Spend on personal social health and economic education under the Drug Strategy 2010

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Spend attributable to Drug Strategy 2010	8.4	8.3	8.2	8.4	8.5

MyPlace

MyPlace projects were funded by DfE between April 2010 and March 2013 with around £240 million of central government capital funding. This included investment in a total of 63 capital grants of between £1 million and £5 million for the development of youth centres in some of the most deprived areas of England. Since the closure of the programme, the Education Funding Agency has protected the Government's investment in MyPlace assets.

The targeting of diversionary activity and information services to the most disadvantaged young people (DfE, 2011a), who are more at risk of initiating or escalating illicit drug use than the general population, has guided the assumption that 15 per cent of government spend on MyPlace is attributable to the aims of the strategy. Annual spend information is presented in Table A3.4.

Table A3.4: MyPlace spend under the Drug Strategy 2010

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Financial year totals ¹	77.7	110.4	26.6	-	-
Spend attributable to Drug Strategy 2010	11.7	16.6	4	-	-

Note

'-' intervention not running.

1. <https://www.gov.uk/government/publications/myplace-programme/myplace-programme-information>

Troubled Families Programme

A budget of £448 million was made available to support the Troubled Families Programme. Expenditure on this programme is included in both the early intervention and non-treatment rehabilitative (NTRA) activity groups (see Appendix A7.2). In terms of reducing demand and early intervention, parental substance use is an important risk factor for substance use in children (whether through genetic or environmental mechanisms). Therefore, reducing family substance use problems may lead to less chance of initiation into drugs and problematic substance use in later life as well as improving parenting and the home environment.

It is estimated that 13 per cent of total Troubled Families Programme expenditure was spent on illicit drug users, based on analysis that showed 13 per cent of families that participated in the Programme up to December 2013 included an adult who is dependent on non-prescription drugs (DCLG, 2014). There is an assumption that the majority of programme spend falls under NTRA, so a relevant weighting of 25 per cent of spend has been applied to early intervention (Table A3.5).

This figure is likely to be an underestimate and should be treated with caution. It does not take into account child drug users in troubled families or those that may not necessarily be 'dependent' on drugs but are still regular drug users. It also assumes that the cost for families with one or more drug dependent adults is the same as the cost for families without, which may not be the case.

The first Troubled Families programme provided a cost savings calculator to Local Authorities to help them estimate costs and benefits. DCLG (2016) published a report based on analysis of the use of the calculator by sixty-seven local authorities. The first set of evaluation reports for the new Troubled Families Programme were published alongside the Troubled Families Annual Report in April 2017 (DCLG, 2017).

Table A3.5: Troubled Families Programme spend under the Drug Strategy 2010

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Financial year total	N/A	N/A	80.6	246.4	121
Spend attributable to Drug Strategy 2010	N/A	N/A	10.5	32	15.7
Spend attributable to early intervention	N/A	N/A	2.6	8	3.9

Note

'-' programme not running.

Home Office Choices

Choices was funded between October 2011 and March 2012 (Table A3.6). Funding was provided to 11 national voluntary organisations, which aimed to work with around 190 additional local voluntary and community organisations. All government spend on this programme is attributable to the aims of the strategy.

Table A3.6: Home Office Choices spend under the Drug Strategy 2010

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Financial year total	-	4	-	-	-
Spend attributable to Drug Strategy 2010	-	4	-	-	-

Note

'-' intervention not running.

Positive Futures programmes

Positive Futures programmes were funded by the Home Office from April 2010 to March 2013. They were targeted at young people with an increased risk of initiation into (or escalation of) drug misuse. As such, a large proportion (25%) of government spend has been attributed to the aims of the strategy (Table A3.7).

Table A3.7: Positive Futures spend under the Drug Strategy 2010

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Financial year totals	6	5	5	-	-
Spend attributable to Drug Strategy 2010	1.5	1.3	1.3	-	-

Note

'-' intervention not running.

A3.2.1 Value for money

There is very limited evidence on return on investment for early intervention programmes, so no attempt has been made to provide an overall value for money estimate. The following describes the programme-specific value for money evidence available.

Family Nurse Partnerships

Research from the US shows that FNPs can result in economic savings to government and to society, that are largely accrued through reduced welfare payments. Savings increased over time as the children got older, with indications that the cost of the programme can be recovered by the time the children are aged four for the highest risk families and by age 12 more broadly. The research suggests cost savings of between \$17,000 to \$34,000 (2003 prices) per child, and a \$3–5 return for every \$1 invested, depending on the target group, the studies and benefits taken into account (see DH, 2011 for an overview).

However, evidence of the value for money of FNPs delivered under the strategy remains formative. Findings from an independent randomised control trial on FNPs in England indicate that in the absence of evidence of benefit, the programme cannot be considered cost effective for the primary outcomes of smoking cessation and second pregnancies (Robling *et al.*, 2015). Longer term outcomes (including those related to drug use and associated risk factors) were not measured within the follow-up period.

Children's Centres

An economic appraisal of SSLPs reporting in 2011 concluded that whilst it was too early to make a full assessment of the economic implications, by the time children reached the age of 5, SSLPs had already delivered economic benefits of between £279 and £557 per eligible child. These benefits were accrued from parents living in SSLP areas moving into paid work more quickly than parents in comparison areas. The evaluation also estimated that longer term outcomes for children would begin to show net benefits by 2018 at the earliest as the children in the evaluation reach the age of 14 (DfE, 2011d).

- The average cost of delivering Children's Centre services is just over £10,000 each week, almost evenly divided to core running (44%) and costs attributed to specific services (56%). These figures are based on case studies of 12 centres at 2012 prices (DfE, 2012).

Positive Futures

Evaluation undertaken by Catch22, a social enterprise that led and managed the Positive Futures programmes, found that programmes guaranteed a return on investment, ensuring that for every pound invested by the Home Office an average £2 was generated locally (Catch22, 2013).

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Chapter 4: Media and information activity

Summary

Activity

- Media and information interventions fall under the reducing demand strand of the Drug Strategy 2010 and mainly consist of creating awareness of the health issues related to drug use, and providing information and support to young people and their parents/carers.
- The Government has undertaken a range of different media and information activity over the life of the strategy. This includes the continuation of the Government's national drugs campaign (FRANK), two targeted campaigns and work in prisons on new psychoactive substances, and the launch of the resilience building Rise Above programme.

Evidence of effectiveness

- Evidence suggests that well designed media and information interventions can provide reliable information to a large number of individuals, increasing knowledge and challenging misconceptions. However, there is evidence that these types of activities in isolation are unlikely to directly reduce drug use.
- The evidence of 'what works' is reflected in the design of recent government activity (FRANK and new psychoactive substance campaigns), which comprise carefully planned, targeted media campaigns alongside universal information programmes, rather than traditional mass media approaches. Other online activity (Rise Above) aims to build resilience and improve life skills in young people.
- These activities are also delivered as a component of the wider reducing demand strand that includes early interventions (chapter 3) and treatment (chapter 6), which may lead to wider synergies and increased impact. However, these combined impacts have not been assessed due to lack of evidence.
- Data show that government media and information activity has reached increasingly large numbers of people. However, there is insufficient evidence to assess whether such campaigns have led directly to behaviour change.

Spend and value for money

- There has been substantial variation in central government spend over the strategy, from £23,000 in 2010/11 to £1.5 million in 2012/13 and £166,000 in 2014/15. This variation is due to FRANK marketing undertaken in addition to routine web-based activity.
- There is insufficient evidence to assess whether government media and information campaigns represent value for money.

4.1 Introduction

Within the Drug Strategy 2010, media and information interventions fall under the reducing demand strand. They are mainly universal²⁹ interventions that create awareness of the health issues related to drug use and provide information and support to young people and their parents/carers.

Media and information activity is often based on theoretical models that can cut across approaches, using elements from several theories in a single intervention. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) have summarised the main theories underpinning media campaigns (EMCDDA, 2013). Information on the behaviour change models which are most relevant to the activity described in this chapter are presented below (health belief model, social norms theory and prototype/willingness model), although many other models exist (e.g. Darnton, 2008).

The *health belief* model regards information as essential for making decisions and focusses on an individual's perceptions of susceptibility, severity, benefits, and barriers. Therefore, providing factual information about the dangers of drugs may lead to an increase in the perceived severity of harm and susceptibility to this harm, and make drug users more likely to quit or non-users less likely to start.

The *social norms* theory states that an individual's behaviour can be influenced by perceptions about how others within their social group think and behave. For example, there may be a perception that drug use within a social group is widespread and acceptable. Interventions using this theory would challenge this, showing that drug use is less widespread and less tolerated than believed. This is similar to the *super-peer* theory that suggests media portrayals of drug use can give the impression that this is a desirable and widespread behaviour. The interventions would then aim to correct these false beliefs. However, this approach may not work in all circumstances; in certain subcultures illicit drug use may be seen in a positive way specifically because it is deviant and transgressive.

²⁹ 'Universal' interventions address a whole population, regardless of risk of drug use. Further discussion on universal prevention interventions is covered in chapter 3.

The *prototype/willingness* model is useful for conceptualising risky behaviours among young people, such as drug use (Gibbon *et al.*, 2003, cited in Darnton, 2008). This model focusses on the creation of risk prototypes, which are images of those who engage in these risky behaviours (e.g. the typical drug user), and suggests that an individual's decision will be based on rational factors (e.g. knowledge on effects of drugs) and social factors (e.g. behavioural norms), thus incorporating both elements of the health belief model and social norms theory.

4.1.1 Challenges of carrying out an evaluation of media and information activities

There are many challenges inherent to evaluating a national drug strategy (see section 1.4, chapter 1) but the following are specific to the media and information activity group.

- It is difficult to establish a non-intervention control group as many media and information interventions are delivered to entire populations, rather than to specific individuals or groups of individuals. Therefore weaker, non-experimental research designs tend to be used to measure change.
- While it is often possible to measure change in attitudes or knowledge of drugs immediately after receiving an intervention, it is considerably harder to measure whether any changes are sustained over time.
- Although improving knowledge and changing attitudes is generally the main aim of media and information activity, there is little evidence to suggest that changes in these indicators lead to drug-related behaviour change.
- Media and information activity does not take place in isolation and there are likely to be mutually reinforcing positive effects between media and information activity and wider prevention and reducing demand activity (e.g. early interventions, see chapter 3) that together create an environment that is less conducive to taking drugs. It is difficult to measure these combined effects or to attribute them to specific interventions.

4.2 How media and information activities contribute to achieving the aims of the Drug Strategy 2010

The initial high-level logic model³⁰ included in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013) has been developed to describe the hypotheses that underlie the rationale for media and information activity (see Figure 4.1). The model more clearly recognises that reducing drug use itself is not generally the primary or sole purpose of information-focussed interventions. The stages are as follows.

³⁰ Media and information was formerly described as 'education and information approaches' in the *Drug Strategy 2010 Evaluation Framework*.

Stages 1 and 2: Activity and groups of interest

Although most of the activities are universal, this stage details the groups that the activities are particularly aimed and targeted at. It also recognises that despite this targeting, the activities may be accessed by a wider audience of parents/teachers and the general public.

Stage 3: Intermediate outcomes (improve knowledge)

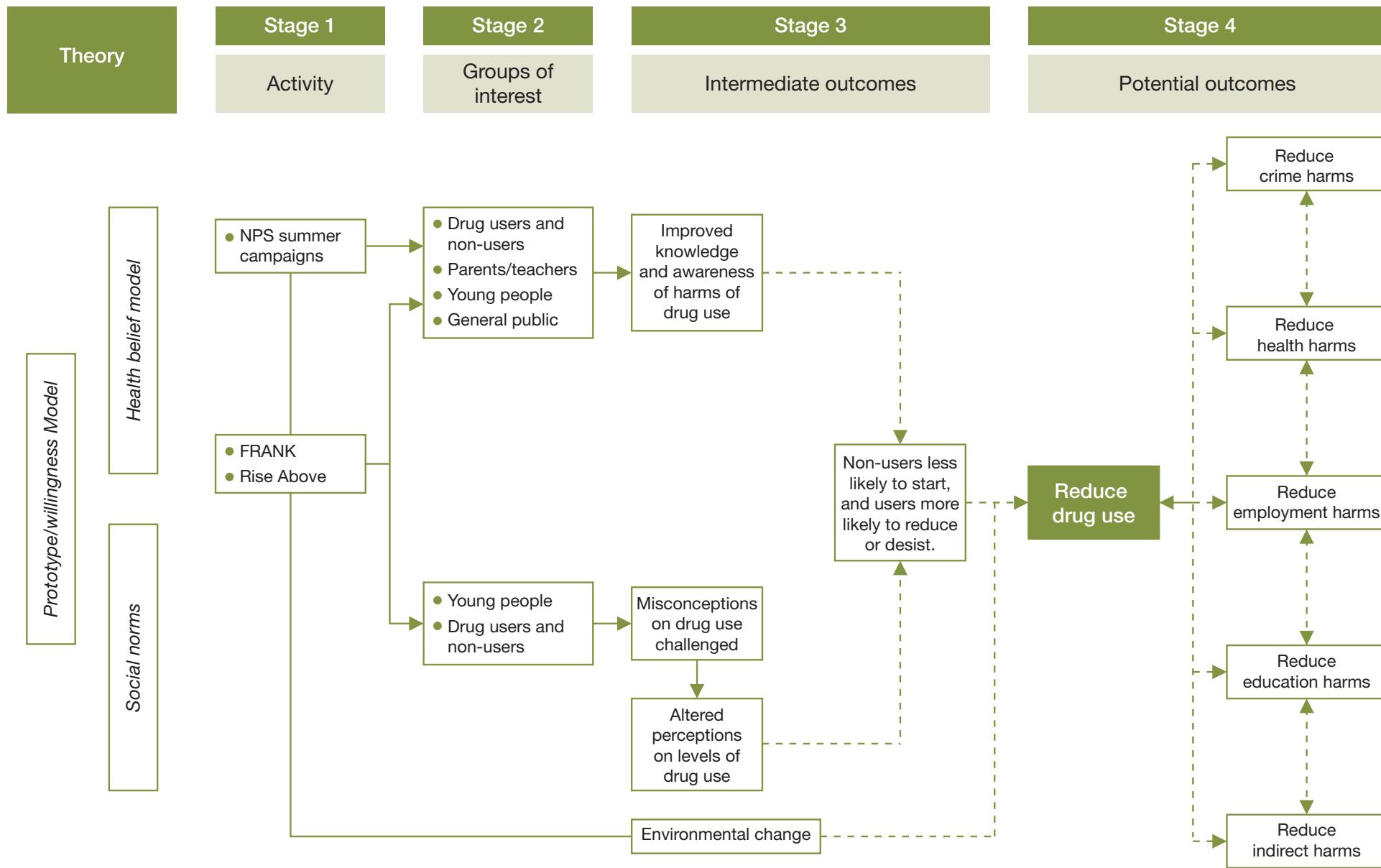
This stage of the logic model relies on the provision of information that either improves knowledge or challenges misconceptions, with the aim of enabling an individual to make informed choices. These changes are important as they can be an essential element of building resilience against drug use and also a stepping stone towards behaviour change (although the extent to which this is realised is difficult to evidence). This stage also includes wider environmental change that may make it easier for individuals to reduce drug use. However, media and information activities may not, by themselves, lead directly to behaviour change (UNODC, 2015); the dotted lines in the logic model recognise this.

Stage 4: Potential outcomes (reduce drug use and associated harms)

The final step in the logic model is a reduction in drug use. However, as mentioned previously, reducing drug use itself is not generally the primary or sole purpose of information-focussed interventions, and if it is achievable, the impact is difficult to measure and may occur many months or years after the intervention has been delivered. The impact of media and information campaigns may also be dependent on strong links to other interventions or services (e.g. treatment services).

The logic model also shows that a reduction in drug use should, in theory, lead to consequent reductions in related harms in areas such as crime, health, employment and education but also indirect harms to others that are not otherwise captured (e.g. to family, friends and community).

Figure 4.1: Logic model for media and information activities



4.3 The effectiveness of media and information activities

This section provides a short description of activity to the end of 2015, followed by an assessment of the publicly available evidence and data underpinning the assumptions in the logic model.

4.3.1 Activity and groups of interest (logic model stages 1 and 2)

Data show that the media and information campaigns funded by the Government under the Drug Strategy 2010 have successfully been delivered and have reached (or improved reach) to their target population.³¹ The figures in this chapter are robust, although many have specific caveats, which are covered within the referenced reports.

FRANK

The Government's national drugs campaign FRANK was launched in 2003 as a communications tool at both a local and national level, to provide credible and accurate information about drug misuse and to challenge misleading perceptions of drugs.³² Responsibility for FRANK transferred from the Home Office to Public Health England (PHE) in 2013.

FRANK was originally based on the prototype/willingness model (being based on both health belief and social norms models), although it is now focussed on personal vulnerability and behavioural intent. FRANK is a universal intervention; whilst being aimed at young people it is also intended to be a key resource for parents/carers and those who work with young people, such as teachers.

Data on website hits and helpline calls provide an indication of the level of the reach and use of FRANK,³³ although they cannot provide evidence of whether FRANK has led to attitude or behaviour change. Figure 4.2 shows increases in the number of website visits and emails to FRANK since the strategy began (2.76 million in 2009/10 to 7.92 million in 2014/15) while calls to the FRANK helpline have declined in the same period (from around 319,000 to 97,000).

Over the period of the strategy under review (2010/11 to 2014/15) there have been around:

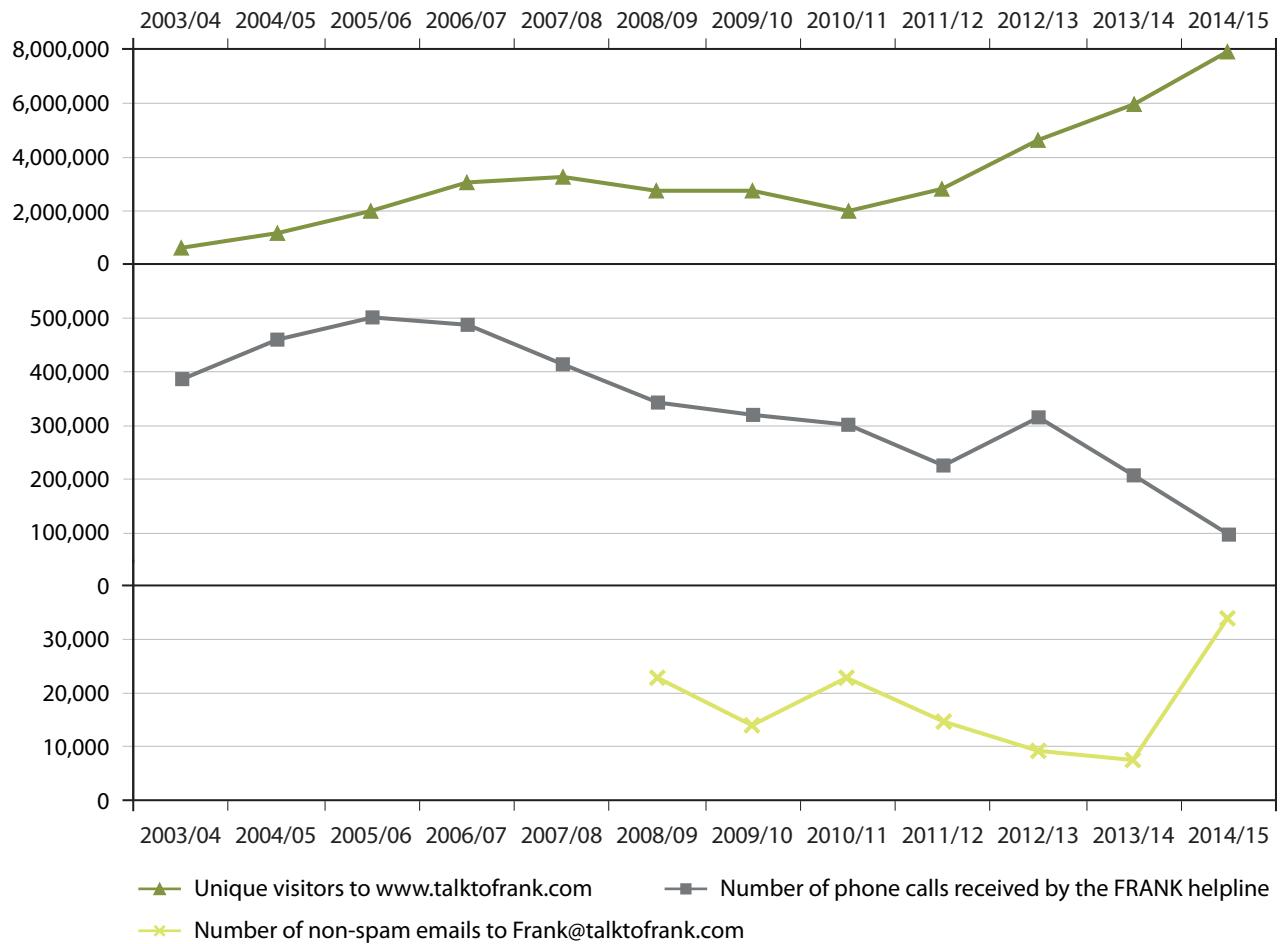
- 23,324,000 visitors to the FRANK website;
- 1,149,000 phone calls received by the FRANK phone line; and
- 88,000 non-spam emails to FRANK.

³¹ Local level activity is not within the scope of this assessment. However, the Government does provide local areas with advice and guidance. For example, in March 2015, the Home Office published a new psychoactive substances resource pack for informal educators and frontline practitioners who work with young people.

³² Across the period of the strategy FRANK has used a variety of media for communication: radio, TV, online and paper materials.

³³ As FRANK is a universal intervention, not all of those using FRANK will be at a high risk of drug use; some visits may be from parents or other interested people.

Figure 4.2: Number of FRANK website visitors,¹ phone calls and emails, 2003/04 to 2014/15



Source: Home Office

Notes

- From 2011/12 onwards, website visitor data includes FRANK's mobile site, which began operating in December 2011.

The recent decline in phone calls to FRANK may be explained by other contact services (FRANK live chat on the website and the email and text services) receiving more enquiries. Indeed emails to FRANK sharply increased from around 7,500 in 2013/14 to 34,000 in 2014/15 while phone calls at that time declined (from 208,000 to 97,000).

New psychoactive substances campaigns

In the summers of 2013 and 2014 the Home Office ran campaigns to inform and educate young people about the risks of new psychoactive substances (NPS) and signpost to FRANK for further help and advice. The campaigns targeted digital, mobile and radio messages at teenage contemplators (people who are thinking of taking NPS) and dabblers (people who have tried NPS a couple of times).

For the 2014/15 campaign, it was estimated that 74 per cent of the target audience (15–21 year old contemplators and dabblers) were reached resulting in around 117,000 visits to FRANK (HM Government, 2015). Although it is not possible to conclusively state what impact this had, there are indications of some positive effects alongside some unintended consequences. After visiting the FRANK website and completing a survey, 34 per cent of 15- to 18-year olds respondents claimed that they were less likely to take so-called 'legal highs' in the future; although 22 per cent claimed that they were more likely (Hansard, 2014).³⁴

The National Offender Management Service (NOMS) has undertaken extensive work during 2015 around communications in prisons to staff, prisoners and visitors on the risks that NPS present. This included a prison radio campaign, a DVD for prisoners, posters and leaflets distributed with prisoner canteen purchases, as well as local initiatives in many prisons.

Rise Above

In February 2015 PHE launched Rise Above.³⁵ Rise Above aims to build resilience in young people aged 11 to 16 by helping them to make better decisions in 'risky' situations (including concerning drugs, alcohol, smoking, relationships and mental health) and empowering them to make positive choices around the key health issues that affect them. It also aims to improve knowledge and to have more open and informed conversations about key health issues. Therefore Rise Above also crosses over into early interventions activity (see chapter 3), particularly if used as a personal social health and economic education resource. Rise Above contributes to the delivery of PHE's adolescent health framework.

As with FRANK, Rise Above is also based on the prototype/willingness model, incorporating health and social elements. Similarly, although Rise Above is aimed at young people, it is a universal intervention, freely available to anyone.

Since Rise Above was launched, there have been almost 300,000 unique visits to the website, 860,000 page views, and 4.2 million video views of Rise Above content across vloggers³⁶ and the Rise Above channel on YouTube. It is too early to assess what effect Rise Above may have had, although an evaluation is planned.

³⁴ 278 people responded to the survey hosted on the FRANK website. Of these, 195 were the primary target audience of 15- to 18-year olds for the NPS campaign run over summer 2014. The survey ran from the 4 August until the 7 October.

³⁵ The programme is based on Daniel and Wassell, *Domains of Resilience*, and Aumann and Hart, *Resilient Therapy Strategies* and was created following an extensive review of academic studies and a test phase with young people.

³⁶ A video blog.

4.3.2 The intermediate outcomes of media and information activity (logic model stage 3)

Although evaluations specific to these activities have not been carried out, there are some data and evidence that these types of activities can increase knowledge, improve awareness of harms and challenge misconceptions of levels of drug use.

Figures from the Health and Social Care Information Centre's (HSCIC) Survey of Smoking, Drinking and Drug Use (SDD) among 11- to 15-year old pupils in England provides some information about where pupils receive information on drugs (HSCIC, 2015).³⁷ In 2013, 18 per cent of pupils reported that they had received helpful information on drugs from FRANK, a fall from 36 per cent in 2009 (the year before the strategy began). This is the second lowest proportion of all the sources asked about, with only helplines being lower (15%) although there may be some overlap between these categories.

Although the proportion of pupils reporting FRANK as a source of helpful information is relatively low compared with other sources, this may underestimate the benefits of FRANK. It is possible that young people receive information from FRANK indirectly given that FRANK is a well-used source of information for both teachers and parents. For example, in 2014, over three quarters of teachers (78%) reported using FRANK to prepare lessons about tobacco, alcohol and drugs (*ibid.*), a figure which has remained stable in recent years (78% in 2012³⁸). Indeed, FRANK is the most frequently used source of information to prepare lessons and most pupils who recalled lessons about drugs (96%) felt that they helped them think about the risks of taking drugs (HSCIC, 2012).³⁹

Evidence from other sources also shows that media and information campaigns can be useful sources of information on illicit drugs. For example, Botvin (cited in McGrath *et al.*, 2006), reported that information dissemination approaches may have a positive impact on knowledge and attitudes related to drugs. Similarly, a World Health Organisation (WHO) review of prevention found that media campaigns could increase information levels (WHO, 2002).

Figures from the 2011 SDD describe how many pupils believed that pupils of their own age took drugs (HSCIC, 2012). Most pupils chose either "only a few" (50%) or "none of them" (39%), no pupils (0%) thought that "all of them" took drugs, and just 3 per cent thought "most, but not all" took drugs. These findings suggest that pupils' perceptions of

³⁷ Although weighted to improve representativeness, the survey only reached 40 per cent of its intended target cohort in the 2014/15 survey, the lowest since the survey began in 1982.

³⁸ Data for this question on the SDD are not published every year (e.g. 2009 and 2010), therefore 2012 has been chosen as the most relevant comparator year.

³⁹ For information on drug education in schools see chapter 3.

the prevalence of illicit drug use may be broadly accurate,⁴⁰ although it is not possible to assess the extent to which government media and information activity may, or may not, have influenced perceptions.

4.3.3 Evidence for the potential outcomes of media and information activity (logic model stage 4)

As there have been no impact evaluations of media and information campaigns in England it is necessary to draw on wider evidence to assess whether campaigns may have led to reductions in drug use and associated harms. Several systematic reviews and meta-analyses have looked at the effectiveness of campaigns, although these only include non-UK studies (mainly in the USA). These may be less applicable to the UK due to socio-cultural differences, different patterns of drug use and differences in interventions. Additionally, international studies often focus on stand-alone interventions and may miss any combined effects from wider prevention work (although this would be difficult to measure).

Two recent systematic reviews of the effectiveness of media campaigns/public service announcements concluded that there was either insufficient robust evidence to draw conclusions, or they had limited impact on the intention to use illicit drugs or on actual drug misuse (Ferri *et al.*, 2013; Werb *et al.*, 2011). Both reviews also cautioned that there was some evidence of negative effects (i.e. increased illicit drug use) and emphasised the need for further research. The EMCDDA (2013) summary of Ferri's review also concluded that there was "*no effect on reduction of use and a weak effect on intention to use illicit substances*".

The Advisory Council on the Misuse of Drugs (ACMD, 2015) has also reviewed the evidence on drug prevention, including information and media approaches. The review concluded that stand-alone mass media campaigns as a prevention approach are not effective.

The potential unintended negative consequences of universal campaigns should be borne in mind as any small negative effect can be magnified over large populations. As well as potentially increasing levels of drug use, there are also opportunity costs (the resources could be used elsewhere), the potential for poor engagement from bad campaigns, and missed opportunities if support services are not available. However, due to a lack of research the full extent of any unintended consequences has not been assessed.

Despite the lack of a direct effect on drug use, media and information campaigns should be considered within a wider system of drug prevention. The ACMD report (*ibid.*) suggests that there may be knock-on effects and interactions with other activities that could lead to a positive tipping point. The National Institute for Health and Care Excellence (NICE)

⁴⁰ Illicit drug use is very uncommon among younger pupils, 4 per cent of 11-year-olds reported use of drugs in the last year in 2014, compared with 19 per cent of 15-year-olds. This suggests that a social norms approach may be of less use for younger pupils compared with more common risky behaviours (e.g. drinking alcohol).

also reached similar conclusions, suggesting that “*more positive outcomes may be gained if [media interventions] are included as a form of delivery in multi-component drug prevention programmes*” (NICE, 2006). NICE prevention guidance is being updated and will subsequently be published.

There is also ongoing research into the benefits of combining media and information campaigns with other interventions in order to reduce drug misuse. For example, the National Institute for Health Research (NIHR) funded ASSIST-FRANK trial. This is extending an effective school-based, peer-led smoking prevention intervention (called ‘ASSIST’) to cover prevention of drug misuse (NIHR, 2014). Peer supporters from ASSIST will receive further training, information and resources on drugs from FRANK.

4.4 Central government spend and value for money of media and information activity

There has been substantial variation in central government spend on drug-related media and information across the Drug Strategy 2010, with around £23,000 spent in 2010/11 and £1.5 million in 2012/13 (Table 4.1). Estimates are based on actual central government spend and have been rounded. Further information on these estimates is available in Appendix A4.1.

Table 4.1: Central government spend on media and information activity under the Drug Strategy 2010, 2010/11 to 2014/15

2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000
23	1,392	1,520	146	166

This variation is due to marketing activity for FRANK undertaken in addition to routine web-based activity. This only took place in two years of the strategy: in 2011/12, £1.2 million was spent and a further £1.5 million was spent in 2012/13.

It has not been possible to provide a value for money figure for media and information activities due the difficulties mentioned previously, such as the lack of activity-specific impact evaluations and the synergies with other interventions.

4.5 Conclusion

The available evidence suggests that traditional mass media interventions by themselves do not directly reduce drug use and that the potential for unintended consequences of increasing interest and experimentation in drug use should not be overlooked.

However, there is evidence that these types of activities can increase knowledge and challenge misconceptions, thus achieving the intermediate outcomes within the logic model. The theoretical models of behaviour change discussed at the beginning of this chapter suggest that this can be an important step to reducing (or preventing) drug use.

While there is insufficient evidence to assess whether government media and information campaigns have directly changed behaviour or represent value for money, data show that government media and information activity has been successfully delivered throughout the life of the strategy. Campaigns such as FRANK have reached increasingly large numbers of people, with growth in both the number of website visits and the number of emails.

The evidence of ‘what works’ is reflected in the design of government media and information activity, which avoids broadcast mass media and instead focusses on targeted media (NPS campaigns) alongside universal information programmes (FRANK).

Media and information activities are also delivered as a component of the wider reducing demand strand, which includes early interventions (chapter 3) and treatment (chapter 6). There may also be wider synergies with the other reducing demand interventions that could lead to positive outcomes. However, due to a lack of relevant evidence, it has not been possible to assess any potential synergies, or the effect they would have.

Spend on media and information activity has varied substantially each year of the Drug Strategy 2010, largely due to variability of marketing activity for FRANK.

Appendix A4.1: Estimates of central government spend on media and information activity

Estimates have been calculated by collating actual government spend on centrally funded media and information activity that falls under the Drug Strategy 2010 (Table A4.1). These figures have been rounded and summed to obtain the total spend figures. Spend figures have been based on publicly available information where possible but otherwise have been provided by the relevant department or agency.

Table A4.1: Central government spend on media and information activity under the Drug Strategy 2010, 2010/11 to 2014/15

	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000
FRANK marketing	0	1,178	1,500	0	0
FRANK web hosting/maintenance	23	213	20	55	62
NPS summer campaigns	-	-	-	91	89
NOMS	-	-	-	-	10
Rise Above	-	-	-	-	5
Total:	23	1,392	1,520	146	166

Note

'-' programme not running.

Figures may not sum exactly as they have been rounded to the nearest £1,000.

These estimates update and expand on those that were previously published in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013) by providing a yearly trend.

Spend on the specific activities included in Table A4.1 is as follows.

- Marketing activity to promote FRANK: digital (including mobile), TV, and radio activity. In 2011/12, £1.2 million was spent on this additional marketing, and a further £1.5 million was spent in 2012/13. In 2010/11 there was no marketing due to Spending Review restrictions and since 2013/14 there has been no marketing budget to undertake any campaign work.
- There are ongoing costs to host and maintain the FRANK website. The higher costs in 2011/12 are due to additional spend (£190,000) on website development.
- A combined total of £181,000 was spent by the Home Office on the NPS summer campaigns: £91,000 in 2013/14 and £89,000 in 2014/15.
- The Prisons Radio Campaign was the most expensive element of the NOMS work on NPS in prisons, costing just under £10,000. The other media costs were met from within existing resources.
- As Rise Above focusses on a range of different issues, most of the spend has not been related to drugs. Therefore, out of the £16,000 spent on production costs for a video which covered drug misuse and two other topics, £5,000 has been allocated as spend under the strategy.

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Chapter 5: Enforcement and enforcement-related activity

Summary

Activity

- Enforcement activities are carried out by a range of law enforcement agencies to uphold the Misuse of Drugs Act 1971 and other more recent legislation. This activity falls under the restricting supply theme of the Drug Strategy 2010.
- Enforcement-related activities also provide rehabilitative opportunities within the criminal justice system. Programmes such as Liaison and Diversion or drug testing on arrest can divert users into treatment, thus contributing to the strategy's aims of reducing drug misuse and increasing recovery.

Evidence of effectiveness

- As it is not possible to determine what would happen in the absence of enforcement, there is a lack of high quality evidence to assess the impact of drug enforcement activities.
- Available evidence suggests that proportionate enforcement of the illegality of drugs raises prices, with drug misuse being inversely related to price.
- Illicit drug markets are resilient and can adapt to even significant drug and asset seizures. Even though enforcement may cause wholesale prices to vary, street-level prices are generally maintained through variations in purity.
- There is evidence that some enforcement activities can contribute to the disruption of drug markets at all levels, thus reducing crime and improving health outcomes, but the effects tend to be short-lived. Activity solely to remove drugs from the market, for example, drug seizures, has little impact on availability.
- However, there are potential unintended consequences of enforcement activity such as violence related to drugs markets and the negative impact of involvement with the criminal justice system.
- By diverting drug using offenders into treatment through the criminal justice system the benefits of treatment, including reductions in crime and improvements in health (see chapter 6), can be realised.

Spend and value for money

- Spend on enforcement and enforcement-related activities was estimated to be £1.6 billion in 2014/15. However, this estimate is based on large assumptions, so should be treated with caution.
- Due to the complexities involved in estimation (the proportion of police and other law enforcement time spent on enforcing drug laws or implementing other drug-related activity is not routinely recorded) no attempt has been made to determine annual spend for each year of the strategy.
- Due to the absence of sufficient data on spend or the direct impact of activities it has not been possible to produce value for money estimates for enforcement or enforcement-related activities.

5.1 Introduction

This chapter covers activity⁴¹ carried out to enforce the Misuse of Drugs Act (MDA) 1971 and other relevant legislation (see Box 5.1) under the restricting supply theme of the Drug Strategy 2010 (HM Government, 2010).⁴² Enforcement-related activity that contributes to the building recovery strand of the strategy is also included.

The strategy set out the Government's approach to restricting the supply of drugs through a co-ordinated approach across government and law enforcement. Enforcement activity is also covered within the Government's Serious and Organised Crime Strategy (HM Government, 2013a), which deals with the challenges faced by organised crime, including drug trafficking.

What follows is not an evaluation of the legislation that provides the framework for enforcement activities (i.e. the Misuse of Drugs Act) but an assessment of the effectiveness of the enforcement activities that underpin the legislation and wider drug strategy aims. That drug misuse continues at some level in England and Wales does not necessarily mean that enforcement activities have been unsuccessful. This is too simplistic a statement and does not reflect the unknowns – how much drug misuse and drug-related harm there would be without the enforcement of drug laws.

⁴¹ UK-funded enforcement activity that impacts on source countries with the aim of restricting the supply of illicit drugs within the UK are in the scope of this evaluation whereas the benefits occurring outside the UK (for example, reduced instability) are not.

⁴² Descriptions of enforcement activity included here are largely limited to England, while recognising the operating mandate for enforcement agencies is throughout the whole of the UK.

Box 5.1: The Misuse of Drugs Act 1971 and other legislation

The Misuse of Drugs Act (MDA) 1971 is the core legislative framework for enforcement.⁴³ The effectiveness of the MDA itself is not being evaluated as part of this assessment of the government's Drug Strategy. Key offences under the act include:

- Possession of a controlled drug.
- Possession of a controlled drug with intent to supply it.
- Supplying or offering to supply a controlled drug.
- Production of a controlled drug.

The MDA creates three classes of controlled drugs, A, B, and C, and ranges of penalties for illegal or unlicensed possession and possession with intent to supply are graded differently within each class.

During the course of the Drug Strategy 2010 the following key legislation was enacted.

- Temporary class drug orders (2011) and the khat ban (2014),⁴⁴ under the MDA.
- Precursor chemical licensing (2013).
- Cutting agents legislation (2015).
- Drug driving legislation (2015).

In addition, the Psychoactive Substances Act came into force in May 2016.

Further detail about the new powers is outlined in Appendix A5.1 and any evidence of the effectiveness of activity to implement the new powers is considered in section 5.5.

5.1.1 Challenges of carrying out an evaluation of enforcement and enforcement-related activity

In addition to the general challenges in evaluating the Drug Strategy 2010 (see section 1.4, chapter 1) there are specific issues that impact on the comprehensiveness and quality of the evidence relating to enforcement and related activities.

- It is not possible to assess the overall impact of enforcement as the legal framework for the control of illicit drugs covers the whole of the UK.⁴⁵ As such, establishing a robust counterfactual is not feasible as it is not possible to stop enforcing drug laws in a certain area to evaluate what happens in the absence of enforcement.

43 <http://www.legislation.gov.uk/ukpga/1971/38/contents>

44 <https://www.gov.uk/government/publications/khat-fact-sheet-for-england-and-wales>

45 An attempt was made to assess the Drugs Act 2005 but this Act enhanced, rather than created, the UK legislative framework and still it was “*difficult to make an assessment of effectiveness as there are no available statistics to enable assessment to be made.*” (Home Office, 2010).

- Comparing countries with different enforcement policies also has inherent difficulties as each country's approach is a product of their own social, legal and cultural issues (Home Office, 2014a;⁴⁶ Degenhardt *et al.*, 2009).
- There is an overall lack of high quality evaluations of drug law enforcement interventions, particularly in the UK (College of Policing, 2015). While the UK has data on drug price and purity, it remains difficult to determine causality between enforcement and impact on the market, especially due to variation in price ranges and manipulation of the street-level product size and purity.
- De-centralisation of budgets has affected funding of enforcement-related programmes such as the Drug Interventions Programme⁴⁷ which makes it difficult to determine programme spend.
- Enforcement agencies have operational independence which enables a tailored approach to suit local needs (be that within a police force or at the border) but which also presents difficulties in gaining an overall picture of enforcement activity at a national level.
- It is complicated to measure the direct impact of enforcement activities on drugs markets because enforcement activities do not exist in isolation, activities (such as seizures) have a time lag, and, there is an incomplete understanding about how drugs markets work.

5.2 How enforcement and enforcement-related activity contribute to achieving the aims of the Drug Strategy 2010

This activity group aims to deter drug misuse by enforcing the illegality of drugs and punishing and, in some cases diverting into treatment, individuals caught supplying or possessing drugs. The Drug Strategy 2010 also delivers a commitment to tackle drug-driven crime. Drugs and crime, particularly acquisitive crime, are closely linked. Offenders who regularly use heroin and/or crack cocaine are estimated to commit around 45 per cent of all acquisitive crime (Mills *et al.*, 2013).

The logic model (Figure 5.1) has been developed from that previously published in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013b). It displays the mechanisms through which enforcement and related activity is hypothesised to reduce drug use and related harms under the following four over-arching aims.

⁴⁶ Levels of drug misuse vary considerably between countries with similar policies. The complexity of country-specific policies and the nature of drugs markets mean that it is not easy to identify causality between legislation and enforcement and drug misuse levels. The Drugs: International Comparators study reviewed approaches to drugs misuse and drug addiction in other countries (Home Office, 2014a).

⁴⁷ From 1 April 2013 the Drug Interventions Programme (DIP) ceased to operate as a nationally led, centrally funded programme. The Community Safety Fund for Police and Crime Commissioners can be used to invest in locally-determined drugs, crime and community safety activities, which might include activities for drug misusing offenders as part of wider local Integrated Offender Management arrangements.

- **Restrict supply to users.** Prohibition of drugs within a market leads to scarcity which reduces availability to customers but also leads to high prices which in turn reduce levels of drug misuse, notwithstanding the addictive nature of some drugs. Even when high prices exist, continued enforcement to restrict supply further should cause inflated prices and further reduce use.
- **Asset recovery.** Cash and other assets recovered from drug dealers by enforcement agencies act as a deterrent, contribute to raising the prices of illicit drugs, relieves criminals of inappropriate financial gain and limits the distribution of drugs (seizing the means of production can be more effective than incarcerating dealers who can be more easily replaced). Both the risk of asset recovery and actual seizures are taken into account within a pricing strategy, resulting in high prices for illicit drugs.
- **Capture and punishment.** Incarceration or other punishment have a longer term effect on reducing drug misuse in terms of rehabilitation from drug use and drug-driven offending, while providing drug misusers or dealers with an incentive to avoid future punishment (deterrence). Specifically, users who are incarcerated lose access to their regular supply of drugs, thus restricting their drug misuse and reducing drug-related acquisitive crime while providing an opportunity for treatment. Equally, capture and punishment of drug dealers disrupts the supply chain, limits others' access to illicit drugs and reduces inter-dealer violence.
- **Divert users into treatment.** Contact with criminal justice agencies provides an opportunity to refer illicit drug users into treatment, which in turn leads to reductions in use, acquisitive crime and possession offences.⁴⁸

The logic model reflects the complexity of the relationship between enforcement and impact on use and harms. Each of the links is not mutually exclusive; there will undoubtedly be some overlap between them (such as an arrest leading to incarceration or diversion into treatment).

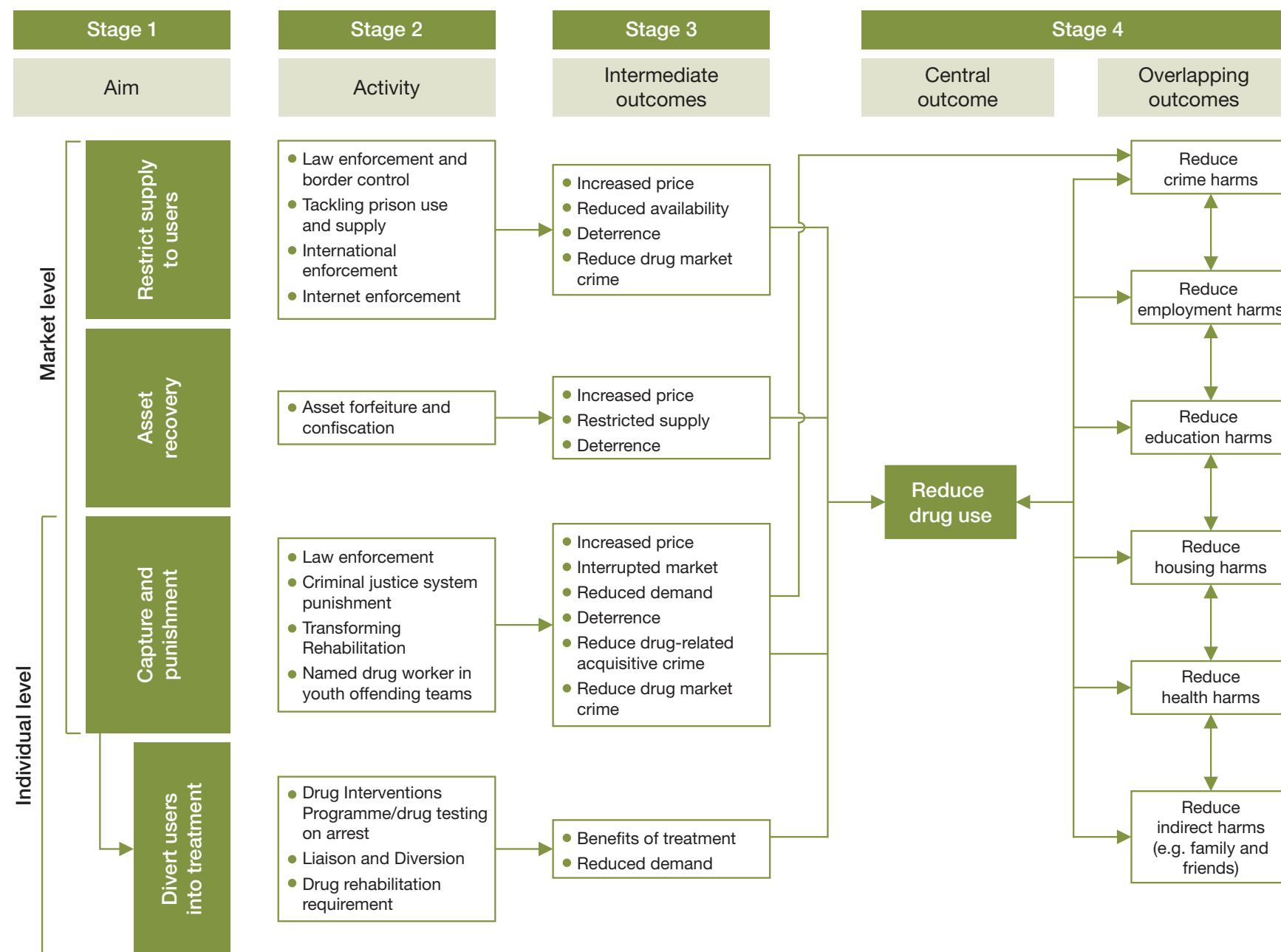
As with the other activity groups the model also recognises that reducing drug misuse should have inter-related benefits such as reducing health harms, improving employment and education outcomes but also indirect harms to others that are not otherwise captured (e.g. to family, friends and community).

Enforcement may have other benefits not explicitly captured in the logic model. For example, enforcing drug laws and reducing supply may benefit society due to a sense of 'retribution', a moral recompense as a result of those who have negatively impacted on others' quality of life being punished. This is largely unquantifiable, but worthy of consideration (see section 5.5.5).

It is also important to note that for all the expected benefits from these theoretical outcomes, there may be unintended consequences of enforcing a system that makes harmful drugs illegal. Drug market crime is a negative consequence as are the health harms from varying purity of drugs and the social and family harms that can be a consequence of incarceration. These are noted, where relevant, throughout this chapter.

⁴⁸ Treatment is covered in chapter 6.

Figure 5.1: Logic model for enforcement and enforcement-related activity



5.3 Summary of enforcement and enforcement-related activity

Table 5.1 presents a high level summary of the main enforcement and enforcement-related activities that have taken place under the Drug Strategy 2010 up to the end of 2015. These are set out in the second stage of the logic model (see Figure 5.1).

This is not meant as an exhaustive list of all activity and, similarly to the logic model, there are overlaps between some of the activity within each aim. For example, activity to capture and punish is also likely to have some impact on restricting availability of drugs and vice versa. For a more detailed description of the activities see Appendix A5.1.

Before considering the available data and evidence of effectiveness of the activity captured in the logic model, it is useful to examine the role of price and purity in understanding the illicit drug market and how this relates to the logic model.

Table 5.1: Enforcement and related activities under the Drug Strategy 2010

Aim	Key activity	Main delivery bodies ¹	Responsible department
Restrict supply to users	Law enforcement Activity by police and other enforcement agencies including drug seizures and the new powers introduced during the life of the strategy (see Box 5.1).	Police forces, NCA, BF, PCCs and NMIC	HO
	Border control Search techniques including sniffer dogs, scanners and visual searches to identify controlled drugs at the UK border.	BF, NCA and police forces	HO
	Tackling prison use and supply Activity including search and security measures, criminal justice responses (e.g. days added to sentence and losing privileges for those found with prohibited substances) and, random and targeted mandatory drug testing. New programme of work to counteract new psychoactive substances in prisons.	HMPS and police forces	MOJ
	International enforcement Disrupting criminal networks (including organised traffickers) exporting drugs, working with overseas law enforcement agencies and disrupting production in source countries.	NCA, FCO and police forces	HO/FCO
	Internet enforcement Developing methods to disrupt darknet market places and coordinated law enforcement activity across Europe and the USA.	NCA	HO
Asset recovery	Asset recovery Including use of tools such as confiscation, cash forfeiture, civil recovery, and criminal taxation to recover a person or group's assets linked to profits derived from drug-related crime.	Police forces, LAs, NCA and CPS	HO

Aim	Key activity	Main delivery bodies ¹	Responsible department
Capture & punishment	Law enforcement Activity related to uphold possession and supply offences including Stop and search and using criminal and civil powers to tackle new psychoactive substance sales.	Police forces and LAs	HO/MOJ
	Criminal justice system punishment Criminal justice system proceedings including imprisonment and out of court disposals.	CPS, HMPS and HMCTS	MOJ
	Transforming Rehabilitation Extended drug-related supervision for short-sentenced prisoners after release.	HMPS, NPS, CRCs and NHS	MOJ
	Named drug worker in youth offending team Screening young offenders for substance use and ensuring access to a substance misuse worker and appropriate interventions.	YOTs	MOJ
Divert users into treatment	Drug Interventions Programme²/ drug testing on arrest Referral of drug users into community-based treatment.	Police forces	HO/DH
	Liaison and Diversion Referral of offenders who have mental health, learning disability or substance misuse vulnerabilities when they first come into contact with the police and criminal justice system.	Police forces and NHS England	DH
	Drug rehabilitation requirement Court sentenced structured treatment tailored to individual need and involving regular drug testing.	CPS, HMCTS, NPS, CRCs and NHS	MOJ

Notes

1. List of acronyms for the main delivery bodies: BF – Border Force; CPS – Crown Prosecution Service; CRC – Community Rehabilitation Company; DH – Department of Health; FCO – Foreign and Commonwealth Office; HMCTS – HM Courts and Tribunal Service (including the Judiciary); HMPS – HM Prison Service (including contracted prisons); HO – Home Office; LAs – Local Authorities; MOJ – Ministry of Justice; NCA – National Crime Agency; NHS – National Health Service; NMIC – National Maritime Information Centre; NOMS – National Offender Management Service; NPS – National Probation Service; PCC – Police and Crime Commissioners; YOTs – Youth Offending Teams.
2. From 1 April 2013 the Drug Interventions Programme (DIP) ceased to operate as a nationally led, centrally funded programme. The Community Safety Fund for Police and Crime Commissioners can be used to invest in locally-determined drugs, crime and community safety activities, which might include activities for drug misusing offenders as part of wider local Integrated Offender Management arrangements.

5.3.1 Price and purity

According to the logic model, an intermediate outcome common to three of the four aims is to increase the price of illicit drugs with the longer-term aim of reducing drug use – drug use being inversely related to price. Enforcing the illegality contributes to raising prices due to suppliers accounting for risks along the supply chain or increasing price due to reduced availability (Caulkins and Reuter 1998; Reuter and Kleiman 1986). Miron's (2003) review found that the retail price of cocaine is two to four times higher than if it were legal, once the costs avoided by the black market (taxes, advertising etc) are offset by the impact of government enforcement. As for any illegal markets, there are additional non-law enforcement risks which also impact on price including violence, threat of violence, theft of drugs and assets (e.g. Pearson and Hobbs, 2001).

Purity-adjusted price provides a much better descriptor of the street-level market, and as a

proxy measure for availability, than price or purity data alone as adjustments in purity and/or product size enable dealers to maintain relatively stable street-level prices even when the supply of drugs is limited or more expensive (McSweeney *et al.*, 2008a). Generally dealers at higher market levels tended to change the prices charged to their customers whereas dealers at the retail level tended to keep prices the same, adjusting the purity or weight of the drug sold (Matrix Knowledge Group, 2007).

While there is evidence to suggest that enforcement of prohibition drives up the price of drugs, there may be a point of diminishing returns (Caulkins and Reuter, 2010). A recent review based mainly on US evidence concluded that sufficient enforcement to make prohibition meaningful does increase price, but there was little evidence for the impact of further enforcement (e.g. raising the risk of incarceration for drug dealers), at least in tackling established markets (Pollack and Reuter, 2014).⁴⁹ Indeed, enforcement's effectiveness at suppressing drug use declines markedly as the size of a drug market grows (see Caulkins, 2007).

It may even be that drug prices can fall in the face of tough enforcement, if enforcement is directly responsible for just a small share of the inflated price of drugs (Caulkins and Reuter, 1998).⁵⁰ This suggests there are many confounding factors and enforcement alone cannot control the prices within the market. Trends in illegal drug supply indicators of price and purity/potency suggest that average purity-adjusted prices have fallen since 1990 in the US, Australia and some of Europe, while quantity of drug seizures in these regions generally increased (Werb *et al.*, 2013). Box 5.2 presents trends in price and purity data for the UK.

49 Within a developing market, stronger enforcement may actually be effective and indeed enforcement (even at a low level) may be able to suppress new markets, but because they fail to exist it is impossible to determine that impact.

50 The authors acknowledge that enforcement has an indirect benefit because it gives force to prohibition – the enforced illegality of drugs costs money: “*the structural consequences of product illegality*” (Reuter, 1983).

Box 5.2: National level data on price and purity of illicit drugs

Price data

Drug prices are collected by the NCA throughout the year from a wide range of sources including all police forces⁵¹ (Table 5a).

Trends in price (wholesale and street-level)

Data from the NCA provide a long time series in the purchasing price of drugs representing the wholesale or street-level costs of drugs in each year (not adjusted for inflation).

Table 5a: Historic price for wholesale and street level purchasing of drugs in the UK, 2005 to 2014

Commodity	Unit size	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
		£	£	£	£	£	£	£	£	£	£
Cocaine	Street per gram	50	50	40	40	40	40	40	40	40	40
	Wholesale per kg	28,000	30,000	35,000	38,000	55,000	52,000	50,000	48,000	44,000	40,000
Heroin	Street per gram	60	60	50	50	50	50	50	50	50	50
	Wholesale per kg	17,000	17,000	14,000	13,000	16,000	16,000	22,000	29,000	29,000	28,000
Cannabis skunk (generic)	Street 1/8th ounce	20	20	20	20	20	20	20	20	20	20
	Wholesale per kg	3,400	3,500	3,500	3,500	3,500	4,250	3,750	4,500	4,500	4,500
Ecstasy	Street per tablet	4	3	3	3	3	3	3	3	3	3
	Wholesale per 10,000 tablets	4,500	4,500	4,500	4,250	3,750	3,750	3,000	3,500	4,000	4,000
Cannabis resin	Street 1/8th ounce	10	10	10	10	10	10	10	10	10	10
	Wholesale per kg	1,000	800	800	800	800	1,000	1,200	1,000	1,000	1,000

Source: National Crime Agency

Notes

Data provided represents the 'mean' (up until 2007) and more recent 'mode' (most common) price being paid for each commodity. However, even pre-2008 data are more likely to reflect a 'mode' than a real 'mean'.

1. Heroin is commonly sold at street level in '£10 bags' traditionally representing between 1/10th and 1/12th of a gram.
2. Prices for 'branded' skunk frequently exceed those for 'generic' skunk with representative prices per kg above £6,500 and 1/8th ounce prices above £30.

51 Police services collect retail to middle market drug prices on a continuous basis, with less frequent, but accurate insight of wholesale market prices. The NCA collects wholesale drug prices on a continuous basis, with less frequent, but accurate insight of the middle market. The national prices presented here are based on assessments of collated prices by drug price experts, including from the Drug Expert Witness and Valuation Association, and at a regional and NCA level. The common range and common prices are then published as reliable.

Wholesale price⁵²

For the wholesale price of cocaine 2009 was a pivotal year, reaching as high as £55,000 per kg. The price has been slowly falling since then and was around £40,000 per kg in 2014, although this is still around £12,000 higher per kg than in 2005.

For heroin, the wholesale price declined between 2005 (£17,000) and 2008 (£13,000) but jumped to £22,000 per kg in 2011 and then to £29,000 in 2012, since when prices have levelled off.

The price of skunk cannabis per kg remained at a similar level between 2012 and 2014 at around £4,500 per kg. Higher quality 'branded' skunk can wholesale for between £6,000 and £8,000 per kg while resin and herbal cannabis wholesale for much less (around £1,000 per kg).

Street-level price

The street-level price of drugs remained largely stable over the past decade. The price of mephedrone (not shown) dropped to £15 per gram in 2013 from £20 the year before.

Purity data

There is incomplete information about the purity of drugs in the UK⁵³ and purity at retail level is rarely known. The National Crime Agency (NCA) collects and analyses information from drug seizures made in the UK,⁵⁴ including for evidential purposes. These provide valuable information but are not representative of all seizures. For example low weight seizures are routinely excluded so reported purities may be higher than if data included a representative sample of street-level seizures (or perhaps lower, even). The UK Focal Point on Drugs (2014) annual report provides some information from the NCA on the domestic retail purity of some illicit drugs⁵⁵ and importantly includes estimates of purity-adjusted price⁵⁶ (Table 5b).

52 'Wholesale' in the context of drug price means what is likely to be paid when acquiring a one kg unit and takes no account of any discount available for multiple units.

53 Particularly since the closure of the Forensic Science Service in March 2012 which carried out analysis of drugs under the MDA legislation.

54 <http://www.nationalcrimeagency.gov.uk/crime-threats/drugs/forensic-intelligence> Purity for heroin and cocaine is systematically collected by the NCA for all 25 gram and above seizures. In addition, smaller seizures are also examined for purity if there is a covert benefit or an evidential issue.

55 Data on cannabis potency are not included due to concerns about the representativeness of samples submitted for forensic analysis.

56 It is important to assess data from several months (or an entire year) so that spikes and dips do not artificially inform change.

Trends in purity (street-level)

The purity of *cocaine powder* has continued to rise since its low in 2009 (20%) and is now at 38 per cent (2013). Although less pronounced, *crack cocaine* purity has followed a similar pattern and is now at 36 per cent.

Heroin purity has risen sharply to 33 per cent in 2013 following a notable decrease in purity (18% in 2011 and 20% in 2012).

Trends in purity-adjusted price (street-level)

The purity-adjusted price of *powder cocaine* has declined substantially from a peak in 2009 (the unit price has remained stable and is now less expensive when taking purity into account). It is now (2013) at the lowest level for a decade.

The purity-adjusted price of *heroin* peaked in 2011 since when there has been a year-on-year reduction, although levels are still higher than in any year since between 2004 and 2010. The purity-adjusted price of *heroin* has fallen recently despite the increase in street-level price – the result of the increased quality of street-level heroin.

Table 5b: Purity-adjusted price of cocaine powder per gram and heroin per gram in the UK, 2003 to 2013 (indexed to 2003)

Year	2003 £	2004 £	2005 £	2006 £	2007 £	2008 £	2009 £	2010 £	2011 £	2012 £	2013 £
Cocaine powder	55.00	61.58	58.75	72.70	70.94	71.11	100.89	86.05	78.17	55.65	53.89
Heroin	62.00	45.08	37.97	39.09	31.52	34.46	33.11	42.16	74.32	65.40	49.55

Source: UK Focal Point on Drugs (2014)

There have been documented examples of where activity to restrict supply has resulted in reduced availability and increased cost in the short term at least, in turn leading to reductions in use and positive and social health outcomes (including Degenhardt *et al.*, 2005; Smithson *et al.*, 2004; Topp *et al.*, 2003).⁵⁷ And while it is not possible to establish a causal link between enforcement activity, or indeed any other factors, and changes to price and purity the recent reduction in the supply of heroin in the UK and some other European countries provides some evidence of what happened to price and purity levels after disruption to the market (see Box 5.3).

57 These studies are based in Australia after the period of reduced heroin availability in 2001.

Box 5.3: Reduction in heroin supply in 2010/11

There was a well-documented reduction in the supply and availability of heroin around 2010/11 in the UK and some other European countries. According to expert opinion it is likely that the reduction in heroin supply was as a result of many factors, including (EMCDDA, 2011):

- law enforcement success disrupting heroin trafficking routes between Turkey and the UK (e.g. increased seizures);
- diversion of heroin from Western European to Russian (and Ukrainian) markets (although there was some evidence of a heroin shortage in Russia also); and
- the 2010 poppy blight in Afghanistan reduced opium production (although an 18-month lag can be expected between production and the market).

Recent research into the impact of the reduction in heroin supply in England and Wales found the heroin market reacted much as previous evidence suggested, that is by reducing purity rather increasing the street level price (Ahmad and Richardson, 2016). This analysis of data before and after the period of reduced supply (2008 – June 2012) found that the purity of heroin at street level fell from a peak of 63 per cent in December 2008 to 19 per cent in June 2012, and as low as 4 per cent in November 2010. Over a similar time period (Oct 2009 – Dec 2011) the wholesale price of heroin increased but there was little variation in street level price.

The findings are supported by feedback from Drug and Alcohol Action teams⁵⁸ and service providers who reported that heroin was often still readily available in their local area but with marked reductions in purity. In response, users altered their buying behaviour either by: changing their usual supplier or travelling further afield to find heroin of higher purity, or by supplementing use of heroin with other substances or switching to different substances (*ibid.*).

Time series analysis of a range of health and CJS data found little significant change in outcomes related to hospital admissions for overdoses or drug-related acquisitive crime over the period of the reduction in heroin supply (from around October 2010 to April 2011). However, there was a significant decline in the number of ‘possession’ and ‘possession with intent to supply’ offences for heroin and some evidence of reduction in new presentations to treatment (*ibid.*).

⁵⁸ Drug and Alcohol Action Teams were responsible for delivering the drug strategy at a local level. However, in April 2013 responsibility for commissioning of drug and alcohol services moved into local authorities, meaning that DAATs no longer exist in the majority of areas. In Wales, Community Safety Partnerships have had the statutory responsibility for delivering substance misuse services since 2003. However, in 2010 responsibility for substance misuse services was transferred to Substance Misuse Area Planning Boards.

5.4 Trends in enforcement-related indicators

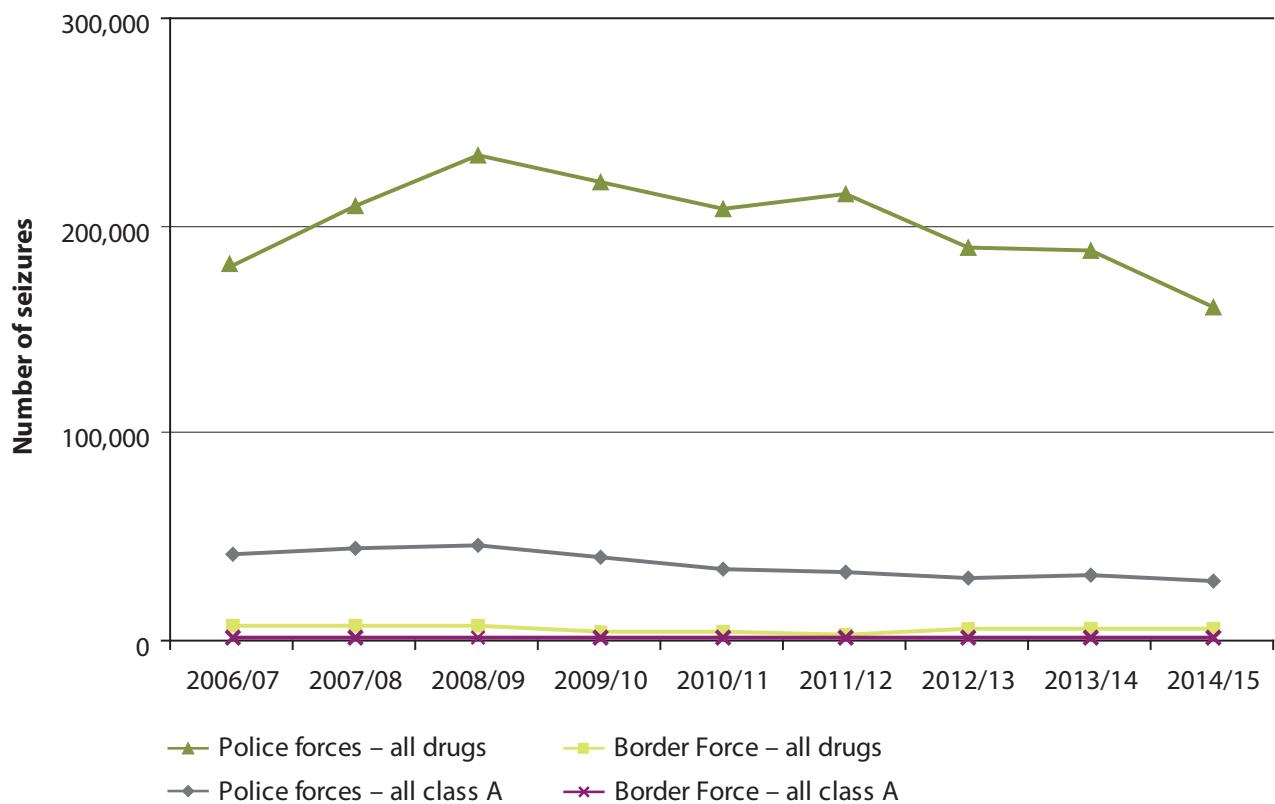
This section expands on the data presented in chapter 2. While the data do not measure the impact of enforcement activity they provide important contextual information on the scale of key enforcement activity. Enforcement-related indicators can be seen as a measure of enforcement activity, and the data may be affected by changes in recording practices and powers. The figures in this chapter are robust, although many have specific caveats, which are covered within the referenced reports. Figures from the financial year 2009/10 or calendar year 2009 are presented from which to view any change over the life of the strategy.

Drug seizures

National statistics show that in 2014/15, overall, there were 167,059 drug seizures made in England and Wales by the police and Border Force (Hargreaves and Smith, 2015). The number has increased greatly since 2004 but has fallen over the life of the drug strategy after peaking at 241,473 in 2008/09 (Figure 5.2). Overall the police made 160,933 seizures in 2014/15, considerably higher than the 6,126 made by Border Force. This reflects the nature of the different activities of these law enforcement agencies whereby the police tend to seize a greater number but smaller amounts of drugs. In 2014/15 for example:

- Border Force seized 2.7 tonnes of cocaine, 79 per cent of the quantity seized overall.
- The number of seizures of heroin by the police accounts for 99 per cent of seizures, but this accounts for only 42 per cent of the quantity of heroin seized.

Figure 5.2: Number of seizures by police forces and Border Force for all class A and all drug types, England and Wales, 2006/07 to 2014/15



Source: Home Office

Criminal justice data

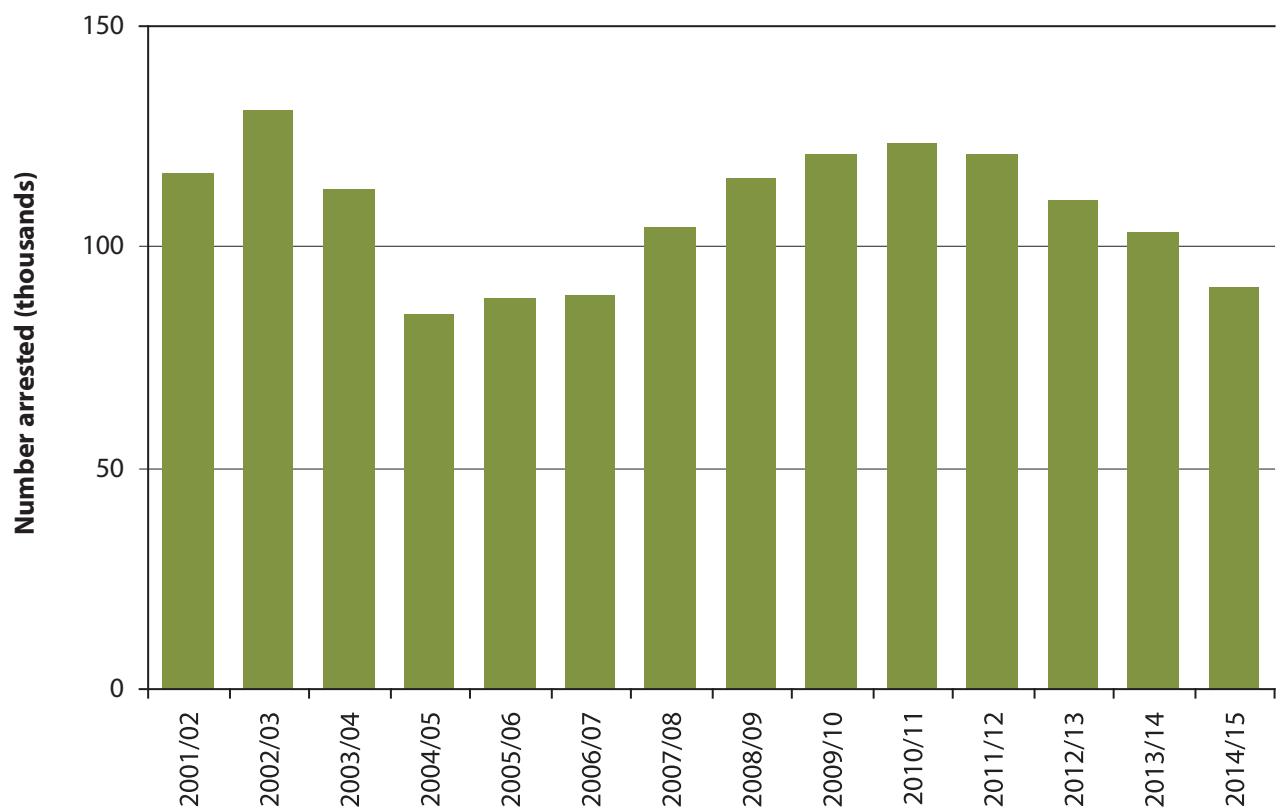
Police recorded drug offences

In 2014/15 there were 169,964 drug offences continuing the downward trend from 2008/09; there were 235,584 offences in 2009/10 (ONS, 2015). The majority of police recorded drug offences are for possession (over 80%), and of these, the majority are for cannabis possession (three-quarters of drug offences in 2014/15). The police recorded 27,026 trafficking of drug offences in 2014/15 which has fallen from 33,233 in 2009/10.

Arrests

There were 90,723 people arrested by the police for drug offences in 2014/15 which has declined over the drug strategy after a peak of 123,724 people arrested in 2010/11 (Figure 5.3; Home Office, 2015).

Figure 5.3: Number of people arrested for drug offences, England and Wales, 2001/02 to 2014/15



Source: Home Office

Out of court disposals

Out of court disposals available to the police and Crown Prosecution Service (CPS) include cannabis (and recently khat⁵⁹) warnings, penalty notices for disorder (PNDs), cautions and community resolutions. Figures from 2015 show that three in five offenders dealt with for drug offences (60%) are dealt with through an out of court disposal. The majority have a cannabis/khat warning issued (33%) while 20 per cent receive cautions and 7 per cent PNDs (MOJ, 2016⁶⁰).

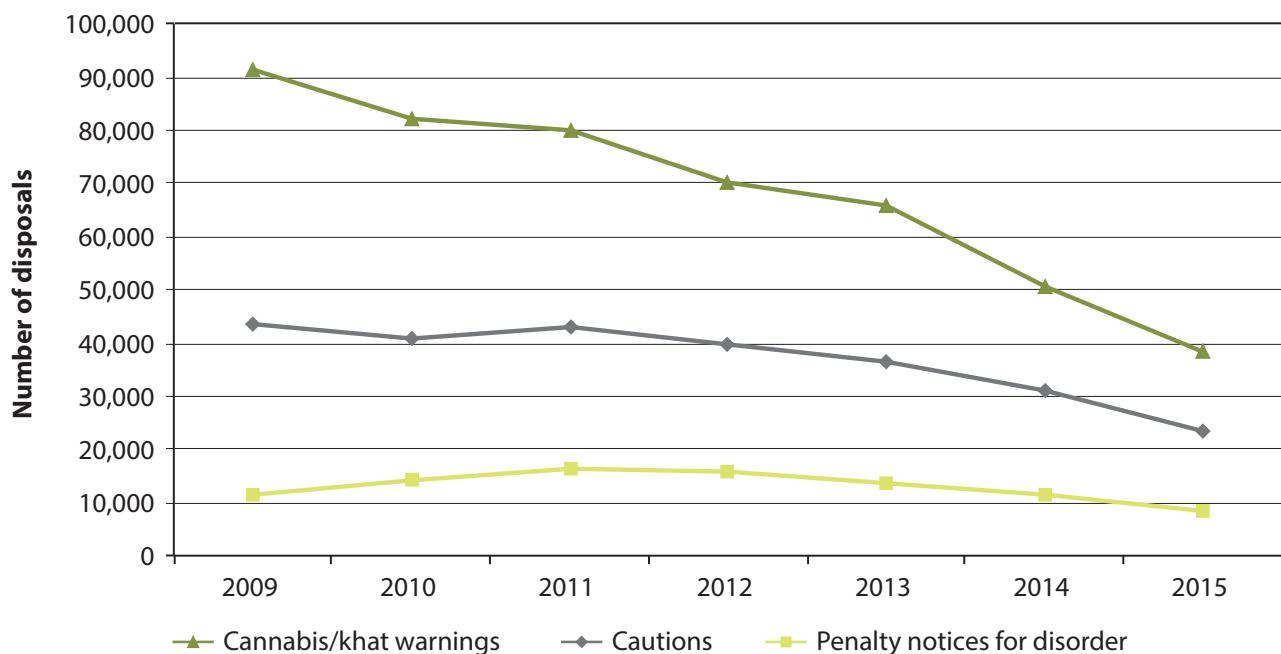
The number of cannabis/khat warnings, cautions and PNDs issued has declined over the strategy, and this has coincided with falls in defendants prosecuted for cannabis-related offences in recent years (*ibid.*), see Figure 5.4.

- Cannabis/khat warnings have declined since 2009 (91,200) to 38,300 in 2015.
- Offenders cautioned for drug offences have also declined since the start of the strategy, from 43,800 in 2009 to 23,300 in 2015.
- PNDs issued for the possession of cannabis increased from around 11,500 in 2009 to a peak of 16,300 in 2011 but subsequently have fallen to 8,400 in 2015.

59 Possession of khat was added as an offence with effect from 24 June 2014.

60 Every effort is made to ensure that the figures presented are accurate and complete. However, it is important to note that these data have been extracted from large administrative data systems generated by the courts. As a consequence, care should be taken to ensure data collection processes and their inevitable limitations are taken into account when those data are used.

Figure 5.4: Out of court disposals for proven offenders in the criminal justice system for drug offences, England and Wales, 2009 to 2015



Source: Ministry of Justice

Prosecutions

While there has been a long-term rise in the number of defendants prosecuted for drug offences since 2005, this has fallen since 2010 (MOJ, 2016). The drug offence that defendants are most commonly prosecuted for is possession of cannabis and its derivatives, accounting for three in five (59%) of those prosecuted for possession offences.⁶¹ As cannabis is the most prevalent drug, used by an estimated 2.2 million adults in the last year (Lader, 2015), on average around one per cent of cannabis users were prosecuted in 2015 (not taking into account more than one prosecution in a year).

While the vast majority of defendants prosecuted for drug possession offences are convicted (95% between 2011 and 2015), few of those sentenced receive immediate custodial sentences (3-4% for all drug possession offences and 2% for cannabis possession over the last five years). Just over half of those sentenced for drug possession offences are given a fine (e.g. 53% in 2015).

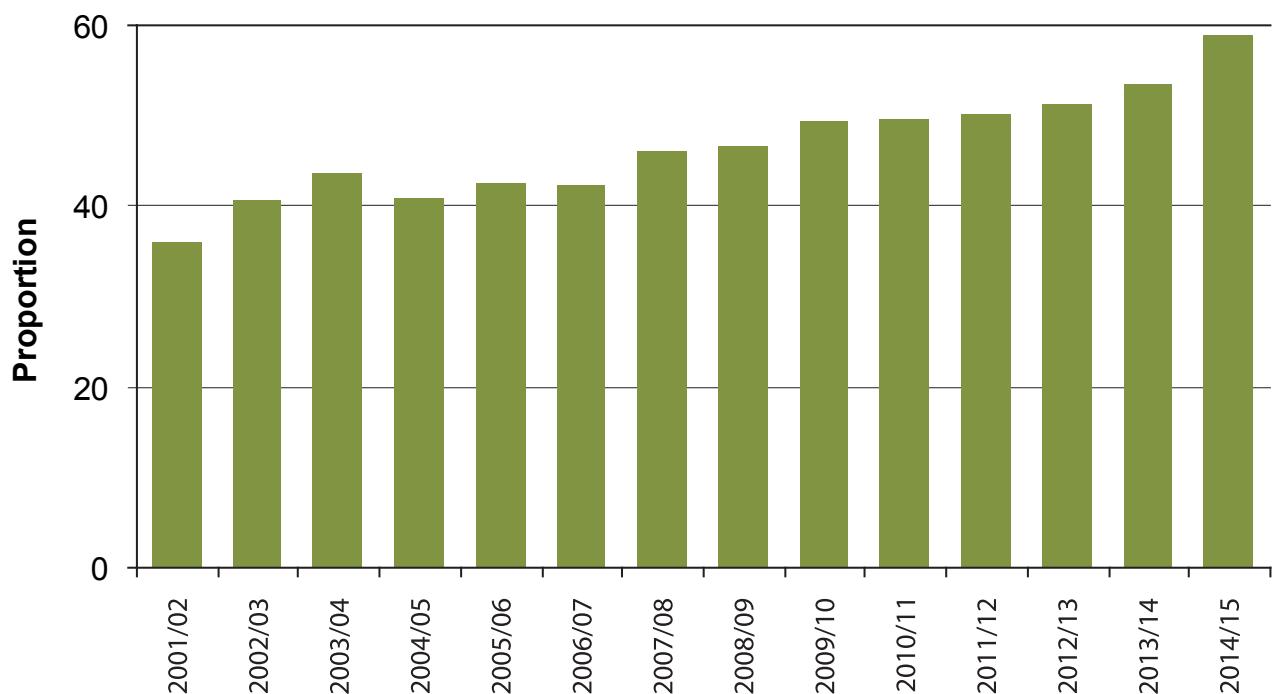
In comparison, 45 per cent of offenders in 2015 who were sentenced for drug supply offences were given an immediate custodial sentence. Sentence lengths were much lower for possession offences (on average 3.1 months, 1.6 months for cannabis) compared with 36.9 months for supply offences.

⁶¹ Within this section, 'possession offences' consist of offences of possession of a drug of any or no known class. 'Supply offences' consist of offences of production, supply, incitement of another to supply and possession with intent to supply offences for a drug of any or no known class.

Stop and search

Since 2008/09 the number of stop and searches in England and Wales has declined (Home Office, 2015). In 2014/15, and indeed in previous years, the most common reason given by police officers for conducting a stop and search was drug related: 59 per cent of searches and 47 per cent of all subsequent arrests (2014/15). The proportion of searches that were drug-related has increased since 2006/07 and continued to do so under the strategy.

Figure 5.5: Proportion of stop and searches that were drug-related, England and Wales, 2001/02 to 2014/15



Source: Home Office

The most common reasons that police officers give for conducting stop and searches have been consistent over time: drug-related searches and searches relating to stolen property are the two most common reasons. However, the proportion of resultant arrests for drug-related stop and search is one in nine (11%). This is amongst the lowest by reason for search, and has been around this level for the past decade (Home Office, 2015).

Asset recovery

The net confiscated amounts from the Joint Asset Recovery Database (JARD)⁶² for drug trafficking offences in each year since 2005/06 are shown (Figure 5.6). These amounts are actual receipts recovered (i.e. enforced) in England and Wales. Over the drug strategy net

62 The Joint Asset Recovery Database contains details on all asset recovery orders obtained (confiscation, cash seizure, civil recovery & Part 6 tax) and records information throughout an asset recovery case as it passes through the criminal justice system. Figures included here are from management information – they are not previously published or official statistics.

confiscated amounts have remained within a range of £30 to £34 million, but the proportion of receipts from drug trafficking offences are reducing as receipts from other areas (such as fraud) have been increasing.

Figure 5.6 Net confiscation receipts¹ for drug trafficking offences from the Joint Asset Recovery Database, England and Wales, 2005/06 to 2014/15



Source: Joint Asset Recovery Database

Note

- Figures exclude compensation and receiver's fees.

Perceptions of availability

The 2011/12⁶³ Crime Survey for England and Wales (CSEW) found that 4 in 5 adults (78%) who had taken any illicit drug in the last year thought that it was very or fairly easy for them personally to get illegal drugs when they wanted them: 34 per cent thought that it was very easy and 44 per cent thought it fairly easy (Home Office, 2012).

The CSEW also provides data on sources of drugs. Adults who had obtained drugs (whether bought or given) from a known dealer the last time they had taken them were most likely to think that it would be very or fairly easy for them to get illegal drugs when they wanted them (89%).

⁶³ This question was last asked in 2011/12 but was reintroduced in the 2015/16 CSEW.

Table 5.2: Source of drugs when last taken, by proportion of last-year users who thought that drugs were easy to obtain, England and Wales, 2011/12 CSEW

Activity	'Fairly' or 'very' easy to obtain	Unweighted base
A family member	76	80
Someone else well known to you (e.g. a friend, neighbour, work colleague)	77	944
Someone else known to you only by sight or to speak to casually	77	111
A stranger	65	53
A known dealer	89	179
A dealer not known to you personally	75	76

Source: Crime Survey for England and Wales, Office for National Statistics

5.5 Evidence of effectiveness

The following section summarises the evidence underpinning the assumptions in the logic model.

Where there is insufficient UK evidence on effectiveness international evidence has been taken into account. However, the differences in culture and legal frameworks between countries must be borne in mind. For example, much research is available from the USA, but there is a greater emphasis on enforcement and harsher penalties imposed which may influence drug markets and consumers more so than in the UK.

A brief description of key activity is provided for context before discussing the evidence. Further information on the activity is available in Appendix A5.1.

5.5.1 Restrict supply to users

There is, in general, a lack of robust evidence on the impact of activity to restrict supply to users, and some evidence of lack of impact for some specific activity types. There is mixed evidence that restricting supply can impact on the outcomes identified in the logic model, particularly around reducing availability and increasing price (see also section 5.3.1 on price and purity). However, it is extremely difficult to quantify the extent to which removing illicit substances from the market impacts on availability to the end user. Further evidence of the impact of restricting supply and of specific activity is summarised below, as well as an example of the control of mephedrone (Box 5.4).

Box 5.4: An example of restricting supply: mephedrone classification

In 2009, the Government asked the ACMD to consider the harms associated with cathinone derivatives and the ACMD subsequently recommended that these (including mephedrone) should be brought under the control of the MDA as class B drugs. The legislation was passed in April 2010. Although it is not possible to show a causal link, trends in indicators before and after the classification of mephedrone show the following changes in use, price and purity over time.

- **A reduction in prevalence:** Prevalence of mephedrone use among young adults aged 16–24 fell from 4.4 per cent in 2010/11 (when measurement began) to 1.9 per cent in 2013/14 and 2014/15 (Lader, 2015).
- **An increase in seizures:** The number of ‘other class B’ drug seizures in England and Wales rose from 377 in 2009/10, to 2,724 in 2010/11 and 3,209 in 2011/12. It was reported that for police seizures the increase was largely due to the control of mephedrone and other cathinone derivatives (Coleman, 2013).
- **An increase in price:** The typical retail price of mephedrone was £15 per gram in 2013, falling from £20 in 2012 (UK Focal Point on Drugs, 2014). Despite this drop, the price remains higher than in 2010 when the drug became a controlled substance (typically £10 per gram).
- **A decrease in purity:** Samples tested from South Wales revealed mephedrone purity declined from 80 per cent to 50 per cent between November 2011 and March 2013 (Miserez *et al.*, 2014).

There are however some negative consequences of restricting supply. For example, if activity results in a reduction in availability this may lead to lower purity levels which can increase the use of adulterants that raises the risks relating to health harms, although these risks may be lower than sometimes thought (Cole *et al.*, 2010).⁶⁴ Other unintended consequences include users purchasing more drugs (Strategy Unit, 2003; Weatherburn *et al.*, 2003), displacement to other drugs with associated harms (Degenhardt *et al.*, 2005; Ahmad and Richardson, 2016) and overdose risks when purity levels subsequently rise.

Law enforcement and border control

This review of the restricting supply evidence considers law enforcement and border control together as they cover similar types of activity (largely activity to take illicit drugs out of the market using existing and new powers).

Seizures are not, in isolation, considered a good measure of the size of the drugs market and are more commonly seen as an indication of the scale of law enforcement activity (Dhani, 2014). There is a lack of robust evidence to link drug seizures with a reduction in supply. Research generally shows that seizures and enforcement efforts alone have little adverse effect on the availability of illicit drugs in the UK (McSweeney *et al.*, 2008a).

⁶⁴ Illicit drugs are commonly adulterated purposefully with: benign substances (such as sugars); substances that will enhance or mimic the effects of the illicit drug (such as procaine in cocaine); or substances that will facilitate the administration of illicit drugs (such as caffeine in heroin).

In their review, Mazerolle *et al.* (2007a) summarised that out of four studies, three (Wood *et al.*, 2003; Rumbold and Fry, 1999; Weatherburn and Lind, 1997) found no effect of drug seizures on drug use patterns, drug-related deaths or overdoses, treatment enrolment or rates of crime and arrest.⁶⁵ And recent research from Australia⁶⁶ found no evidence that increases in seizures or supplier arrests for cocaine, heroin and amphetamine-type substances reduced the number of use/possession arrests in the short-term (Wan *et al.*, 2014). Indeed, their findings suggested that high quantities of seizures could signal increased, rather than reduced, supply.

Appendix A5.1 describes the new powers that have become available to enforcement agencies under the Drug Strategy 2010. As these are relatively new developments, there is little robust evidence of their impact to date.

There is some international evidence that the licensing of precursor chemicals has had a tangible effect in reducing their use in the manufacture of illicit drugs and some limited evidence that removing precursors from the supply chain may be contributing to restricting the supply of drugs such as ecstasy and LSD (UNODC, 2014).

The Department for Transport (DfT) estimated that the new drug-driving legislation should lead to fewer deaths and injuries (DfT, 2012) and there is also some European evidence that increased enforcement against drug driving can lead to reductions in drug-related road casualties (DRUID, 2011).

The Psychoactive Substances Act came into force in May 2016. The government has committed to undertake a review of the operation of the Act which is due to report 30 months after its commencement.

Tackling prison use and supply

The level of demand for drugs and the resilient nature of drug markets means that drug remain available in prisons. Given the financial benefits of the illicit drugs market there is a risk that those incarcerated continue to traffic drugs in an existing external market from within the prison estate as well as involvement in an internal prison market.

Recent data from an HM Inspectorate of Prisons (HMIP) thematic report suggests that around 18% of prisoners had used at least one illicit drug while in their current prison and 8% reported developing a problem with illegal drugs since they had been in the prison (HMIP, 2015a).

⁶⁵ The fourth study, Smithson *et al.* (2004), found reductions in non-fatal overdoses, crime and entry into methadone treatment but over the same period as the reduction in heroin supply in Australian, so results can not be clearly related to enforcement activity alone.

⁶⁶ Based on data between July 2001 and June 2011.

HM Prison Service (HMPS) deploys a range of search and security measures to detect items of contraband both at the point of entry to the prison and concealed within the prison.⁶⁷ Recent NCA-led multi-agency days, to detect contraband entering prisons, resulted in seizures of illicit substances and also in prosecutions and refused or controlled visits to prisons (NCA, 2015a).

Generally there has been limited evaluation of the measures taken to respond to the use and supply of drugs in prisons. Available data presents a mixed picture of drug finds and use in prisons. The number of illegal drug finds in prisons in England and Wales is increasing, with almost 4,500 instances of substances being taken from inmates in 2013/14, compared with just under 3,800 in 2010/11.⁶⁸ However, recent figures show that drug misuse in prisons as measured by random mandatory drug testing (rMDT) has notably declined over the past 15 years; positive rates were 24.4 per cent in 1996/97, since 2010/11 these remain around 7 per cent (NOMS, 2015; MOJ, 2014a). This is despite the fact that more drugs are now tested for. An important caveat to the drug test data however is that current testing methods are unable to detect many new psychoactive substances (NPS) or diverted prescribed medications, both of which are reported to be increasingly used in prisons (HMIP, 2015a).

While it is difficult to disentangle the direct impact of rMDT on reducing drug use in prisons, qualitative research did purport some deterrent effect, more so for cannabis than heroin use (Singleton *et al.*, 2005). There is no universal deterrent effect however; drugs remain available in prisons (31% of prisoners said illegal drugs were easy or very easy to obtain in their prison; HMIP, 2014) and, as stated above, a small proportion of offenders develop problems with illegal drugs after entering prison.

A wide-ranging programme of work is being undertaken by HMPS which aims to counteract NPS use in prisons. The impact of this new activity has yet to be assessed.

Drug recovery wings (DRWs) have also been piloted in 11 prisons⁶⁹ with the pilots completing in 2014. The final report of a major Department of Health funded independent evaluation of the DRW pilots is expected in 2017. For more information on DRWs, see section 6.4.3, chapter 6.

International enforcement (including disrupting organised trafficking)

Tackling the serious and organised criminals who import, manufacture and deal drugs continues to be a priority for the NCA, Border Force and police forces. The UK illegal drugs

67 <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2014-07-01/203390>

68 <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2014-12-17/219263/>. Note this may reflect an increase in the amount of drugs in prisons, or may be related to more effective enforcement activity, or both.

69 This encompassed five adult prisons from 2011 and a further six prisons in 2012 (which also included prisons for women and young offenders).

market is extremely attractive to organised criminals as the prices charged at street level are some of the highest in Europe and are sufficient to repay the costs of smuggling the drugs into the UK.⁷⁰

The high-priority threats of cocaine and heroin, including source countries, transport routes and distribution hubs, are well understood, with regular disruptions against UK and overseas Organised Crime Groups (OCGs). OCG mapping indicates that around 2,300 OCGs are involved in drug trafficking,⁷¹ often multi-commodity, about 40 per cent of the known 5,800 OCGs (NCA, 2015b).

Whilst there is a wealth of activity by law enforcement agencies, led by the NCA, to tackle the serious and organised criminals who import, manufacture and deal drugs it is difficult to gather robust evidence of impact.

Internet enforcement

Internet purchasing of drugs has evolved over the life of the 2010 Drug Strategy and involves both the ‘clearnet’ and the ‘darkweb’. According to the CSEW a very small proportion of individuals reported sourcing illicit drugs from the internet the last time they took drugs (6% of adults who had used NPS and less than 1% of adults who had used traditional illicit drugs in the last 12 months; Home Office, 2015b). However, these estimates do not reflect the source of drugs further up the supply chain. It is possible that the drugs supplied may have originally been sourced from the internet, either by dealers (the source for 20% of last year users) or friends (a friend, neighbour or colleague being the most common source of drugs, 42%). It is therefore plausible that the contribution of the internet to the supply of drugs may be somewhat higher.

Retailers on the ‘clearnet’ (i.e websites that are openly available on the internet) that sell drugs are likely to be trading in non-controlled NPS. In 2014 the NCA estimated there to be between 100 and 150 UK-based websites on the ‘clearnet’ – this figure varies on a weekly basis – claiming to sell non-controlled NPS (Home Office, 2014b). Under the Psychoactive Substances Act 2016, trade in non-controlled NPS is now illegal.

‘Darkweb’ describes websites not openly available on the internet and which can only be accessed with anonymising software such as Tor. Websites selling drugs on the darkweb are likely to be retailing in controlled drugs. These types of sites in particular provide a considerable challenge for law enforcement and often require tackling through international cooperation.

70 <http://www.nationalcrimeagency.gov.uk/crime-threats/drugs>

71 Note this is just drug trafficking, there will be more OCGs that are involved with drugs in other ways, for example, transportation.

There is a necessary role for the involvement of the NCA in developing methods to disrupt 'darkweb' market places trading in illegal drugs. There is some evidence that activities may bring short-term benefits and potentially act as a deterrent (Soska and Christin, 2015; Buxton and Bingham, 2014). However, this research also identified unintended consequences of enforcement activity including fragmenting and diversifying the market, and incentivising technological innovation leading to increased security developments (*ibid.*). The resilience of the drugs market is again demonstrated as multiple sites replace any, for example Silk Road 1.0, that are taken down (Soska and Christin, 2015).

5.5.2 Asset recovery

'Asset recovery' describes where a person's or group's assets (e.g. cash and other commodities such as boats used to transport illegal drugs) are confiscated by the state because they are linked to the profits derived from crime. There is some evidence that the threat of asset recovery can increase the price of drugs but the size of impact is mediated by the likelihood of conviction taking place. There is also evidence that asset recovery achieves the intermediate outcome of deterrence. Research involving dealers at different levels of the market describes how asset recovery is perceived as a threat by at least some of those involved in the drugs trade (Matrix Knowledge Group, 2007).

The net confiscated amounts from the Joint Asset Recovery Database (JARD) for drug trafficking offences show amounts have increased over the last decade and from £30 million in 2009/10 to £34 million in 2014/15.⁷²

However, in 2011 the United Nations Office for Drugs and Crime (UNODC) estimated that the global detection rate of illicit funds by law enforcement is as low as 1 per cent for criminal proceeds, and the seizure rate is possibly 0.2 per cent (UNODC, 2011). UK research that pre-dates this strategy suggested that the overall impact of asset recovery (and anti-money laundering⁷³) operations was marginal (Sproat, 2007), but more recent research from Australia estimates that for every AUS\$1 denied the criminal enterprise, AUS\$11.90 of future drug trafficking activity is disrupted (McFadden *et al.*, 2014).

⁷² These figures are from management information – they are not previously published or official statistics.

⁷³ Money from drug dealing is usually of such considerable value to warrant money laundering or hiding (an extension of laundering) from law enforcement. Money laundering hasn't been considered explicitly within this review, but anti-money laundering programmes could be considered an intervention for drug-related enforcement activities.

5.5.3 Capture and punishment

Overall, there is mixed evidence to suggest that activity to sanction drug offenders can have an impact on the logic model outcomes. In terms of law enforcement activity, positive outcomes are more likely where the activity is targeted at the most harmful offenders and where it is part of a multi-agency response. However, there is not positive evidence of impact for all types of interventions, and generally any impact is unlikely to be sustained over time. Further evidence is summarised in the following sections.

There is, in general, a lack of robust evidence as to whether capture and punishment serves as a deterrent for drug use, one of the intermediate outcomes of the logic model. The BMA review (2013) concluded that although the evidence is not strong it would be wrong to discount the effect altogether.

Law enforcement

Targeted enforcement can have an impact on illegal drug activity during an intervention, depending on the type of market being targeted. Intensive targeting of street-level heroin or crack⁷⁴ dealers and users by law enforcement can have great benefits at modest costs, reducing crime while improving health outcomes (Kleiman, 1988; Reuter and Kleiman, 1986). However, these effects tend to be short-lived and disappear once the intervention is removed or ceases to operate (Matrix Knowledge Group, 2007; Cyster and Rowe, 2006).

There is a broad consensus that effectively tackling drug markets requires cooperation from a range of agencies, including the police and local communities (McSweeney *et al.*, 2008a). A meta-analytical review of the literature found that “*problem-oriented policing*” and “*community policing*” were more effective than the standard model of policing for disrupting street level drug markets Mazerolle *et al.* (2007b).⁷⁵ In addition, problem-oriented policing interventions that were geographically targeted and involved cooperative partnerships with third parties were more effective than interventions spread across a community. Furthermore, research in the USA has found that non-intrusive enforcement interventions aiming to eliminate overt drug markets using community engagement and elevating positive social norms while helping dealers and their families have shown some success (Kennedy and Wong, 2009).

A specific law enforcement activity targeting individuals implicated in an established ‘semi-open’ retail market for Class A drugs in one English police force area provides an example of a geographically-targeted and community-wide approach. A case study of the activity found that despite successful partnership working and a high degree of community

⁷⁴ Interventions are less likely to be effective against cannabis or powder cocaine because of the size of the markets involved; heroin and crack markets are smaller and have a more exposed user base (Reuter and Kleiman, 1986).

⁷⁵ The Review characterises the ‘standard model’ of policing as relying typically on traditional law enforcement practices such as: rapid response to calls for service, routine patrol throughout a community, or increasing the number of police officers across a jurisdiction.

engagement there was little impact in terms of reductions in all recorded crime or emergency and non-emergency calls for service, although there were reductions in recorded acquisitive crime over the period (McSweeney and Gyateng, 2013).

A range of international evidence supports the concept that enforcement activities can shape drug markets so less harmful selling practices are the most competitive, while recognising that “*not all dealers are equally destructive*” (Caulkins and Reuter, 2009). Targeting known dealers identified by the local community as causing the greatest levels of harm can have maximum impact within a harm reduction approach (Caulkins, 2002).

However, it is widely acknowledged that violence is an unintended consequence of enforcing drug laws. A systematic review of evaluations of the impact of drug law enforcement on drug law violence found that they were significantly associated and indeed that disrupting supply markets may actually increase violence (Werb *et al.*, 2011). For example, violent conflict may result between a dealer displaced by law enforcement and an established dealer (Benson *et al.*, 1992).

Stop and search

Figures show that the majority of stop and searches are for drug-related reasons given by police officers relating to drugs but these drug-related searches result in among the lowest proportion of subsequent arrests (Home Office, 2015a). There is very limited evidence of the impact of stop and search on restricting supply.

New psychoactive substances

In response to concerns about crime, anti-social behaviour and health problems, police and local authorities (including Trading Standards) have been using criminal and civil powers available to them to take action against sales of NPS (e.g. in ‘head shops’). This was ahead of the implementation of the Psychoactive Substances Act 2016.

For example, local authorities⁷⁶ have been using public space protection orders to ban the consumption of NPS. Lincoln council, for example, used the order a total of 275 times in the first six months of operation and report some early indications that the action may be linked to subsequent reductions in NPS related issues (City of Lincoln Council, 2015).

Criminal justice system punishment

Among the other benefits mentioned elsewhere, contact with the criminal justice system (CJS) provides opportunity for drug-using offenders to be diverted into treatment.

Contact with the CJS can however bring with it potential unintended consequences including unemployment (Holzer, 2007) and harm to families – parental imprisonment is a risk factor for child offending, mental health problems, drug abuse and unemployment amongst others

⁷⁶ Including Blackpool, Dudley, Folkestone, Hillingdon, Lincoln, Rugby and Taunton.

(Murray and Farrington, 2008). Incarceration may also negatively impact on the indirect and unemployment harms that the logic model hypothesised drug-related enforcement activities is seeking to improve (see Figure 5.1), although few custodial sentences are given for possession offences (3% of those convicted in 2015; MoJ, 2016).

Examining recidivism helps to understand a successful outcome of punishment or treatment in rehabilitation. In 2004 the proportion of adults who tested positive for drugs and went on to reoffend was considerably higher (39%) than overall in the adult population (26%) but this gap has since narrowed. In 2011/12 (the latest available data for comparison), 25 per cent of adult offenders reoffended and 29 per cent of positive drug test offenders reoffended (MOJ, 2014b).

Transforming Rehabilitation

The Government's Transforming Rehabilitation⁷⁷ programme provides extended supervision for short-sentenced prisoners after release with the aim of reducing their likelihood of reoffending. This includes support to help them to reduce their drug use and also address any crime, health and social factors that impact on an individuals' likelihood to reoffend.

The Offender Rehabilitation Act 2014 introduced a new drug appointment requirement for offenders who are supervised in the community after release, whilst also expanding the existing drug testing requirement after release to include Class B as well as Class A drugs.

As these are recent developments within the criminal justice system there has not yet been time to determine their impact.

Named drug worker in youth offending teams

This aimed to screen young offenders for substance misuse and ensure access to a substance misuse worker and intervention programmes according to needs. No formal evaluation has been made of this service.

Youth offending teams continue to be the highest referrers of young people to substance misuse intervention and treatment services⁷⁸ (5,882 or 27% of new treatment episodes in 2013/14). But overall the proportion of youth or CJS referrals (including from YOTs and the secure estate) has been falling since 2010/11, from 39 per cent to 29% in 2013/14 (PHE, 2015a; PHE, 2011).

⁷⁷ <https://consult.justice.gov.uk/digital-communications/transforming-rehabilitation/results/transforming-rehabilitation-response.pdf>

⁷⁸ The majority of young person referrals to treatment are for alcohol and tobacco use.

5.5.4 Divert users into treatment

Overall, the available evidence for programmes that divert users into treatment show some success in achieving treatment-related benefits in both drug misuse and crime harms.

Around three in ten new presentations to treatment are as a result of referral from the CJS,⁷⁹ showing that contact with the CJS does offer offenders routes to reducing drug dependence (PHE, 2015b). The proportion of CJS referrals into treatment has perhaps diminished slightly throughout the Drug Strategy 2010.

Drug Interventions Programme/ drug testing on arrest

While not able to account for what might have happened in the absence of the intervention, an assessment of the programme (Skodbo *et al.*, 2007) found that:

- the overall volume of offending by a cohort of 7,727 individuals was 26 per cent lower following DIP identification;
- around half (47%) of the cohort showed a decline in offending of around 79 per cent (over the six-month period). However, more than half showed similar (25%) or increased (28%) levels of offending following DIP entry; and⁸⁰
- levels of retention in treatment for DIP entrants equal those of non-CJS route entrants to treatment.

There is a range of other research that supports the positive impact of DIP and similar schemes on both reducing drug use directly and also indirectly, through reducing crime harms (e.g. NTA, 2012). Notably the Drug Treatment Outcomes Research Study (DTORS) found that CJS referral schemes like DIP are valuable in re-initiating treatment contact with more criminally active drug users, who have more entrenched and chaotic problems (Jones *et al.*, 2009).

DTORS found similar outcomes for those referred into treatment from the CJS⁸¹ in England compared with other referral sources (Jones *et al.*, 2009), see also section 6.4.1, chapter 6. This is supported by other UK and European analysis for reductions both in illicit drug use and offending behaviours (Schaub *et al.*, 2010; McSweeney *et al.*, 2007). A meta-analytical literature review (Parhar *et al.*, 2008) separately found however that perhaps the reduction in recidivism was lower than if the treatment was entered into voluntarily.

There is also an argument that the CJS has a responsibility to society to help offenders into treatment since controlling drug abuse and addiction benefits society as whole (Anglin & Hser, 1991; Anglin, 1988). Although different from 'retribution' where enforcing drug laws and reducing supply may benefit society, this shows an additional non-quantifiable benefit to society.

⁷⁹ CJS referrals include direct referrals through arrest referral/Drug Interventions Programme or via other channels such as prison (including counselling, assessment, referral, advice and through-care services) drug rehabilitation requirements and the Probation Service.

⁸⁰ Independent analysis of DIP supported these findings (McSweeney and Hearnden, 2009).

⁸¹ No statistically significant effects in the continued or discontinued used of heroin or crack cocaine were found between a drug rehabilitation requirement (or other restriction on bail) group and the group with no attached legal consequences (Jones *et al.*, 2009).

Liaison and Diversion

The Liaison and Diversion (L&D) Programme currently operates by referring offenders who have mental health, learning disability or substance misuse vulnerabilities when they first come into contact with the criminal justice system to an appropriate treatment or support service.⁸² An independent evaluation that reviewed the implementation of the national core model and investigated its impact was published in 2016 (Disley *et al.*, 2016). Qualitative findings suggested the national model had resulted in significant changes across all pilot sites. These included more provision and better integration of L&D staff and strong partnership working. However, no robust findings were available from the quantitative evaluation.

Drug rehabilitation requirement

The main purpose of the drug rehabilitation requirement (DRR) is to reduce or eliminate illicit drug use and associated offending with benefits largely being realised from the treatment model (see chapter 6). Management information from NOMS shows the completion rate for DRRs for the nine months to December 2014 was 55% (4,826 DRR completions out of 8,775 terminations), an increase of three percentage points when compared with 2013/14 (MOJ, 2015).

Most available research is based on the forerunner to DRRs – drug treatment and testing orders (DTTOs) (which are similar). McSweeney *et al.* (2008b) reviewed numerous studies on DTTOs outcomes and summarised that while fewer than half of offenders complete their DTTOs, those that do, achieve statistically significant reductions in illicit drug use and offending. Additionally:

- Naeem *et al.* (2007) found that those ‘coerced’ into treatment via DTTOs reported larger reductions in illicit drug use than ‘volunteers’.⁸³
- Hough *et al.* (2003) found lower reconviction rates for those who completed DTTOs (53%) compared with those who had their orders revoked (91%).

5.5.5 Retribution

Although external to the logic model, enforcing drug laws and reducing supply may otherwise benefit society due to a sense of ‘retribution’.

Drugs can impact negatively on individuals, families and communities, whether through crime, anti-social behaviour or the impact of drug dependency. When asked about anti-social behaviours in their local area around a quarter of adults perceived drug use or dealing to be a problem but only half (48%) of those who perceived problems had personally seen evidence of drug use or dealing in their local area (Flatley *et al.*, 2008). Whilst this indicates that attitudes towards drug use or dealing may be driven by factors other than actual experience, it may still negatively impact on people’s fear and quality of life.

⁸² L&D provision is localised: within custody suites L&D workers or drug workers may be operating alone or co-located, but L&D will not become involved when drug workers are present to assess and refer. No central record is held of L&D coverage – this differs even within local authorities.

⁸³ It may be that offenders ‘coerced’ into treatment had higher levels of drug use or offending initially.

Other research shows drug dealing negatively impacts on quality of life for local communities: undermining community confidence, damaging neighbourhood reputations and hindering regeneration efforts (Lupton *et al.*, 2002). However, in other research communities found positives (strong sense of community identity, bringing in money and goods to neighbourhood) alongside the negatives (area reputation, fear of reprisals (May *et al.*, 2005). Fear of crime has also commonly been mentioned by surveys of local communities affected by drug markets (Cyster and Rowe, 2006).

Retribution can be considered an outcome of punishment: enforcement to restrict drug supply to communities, tackling street-level drug use or dealing, or seizing proceeds of crime from drug dealers can all benefit individuals and communities. There may also be an expectation from society that drug laws (as for any other laws) should be upheld – public attitudes suggest lengthy custodial sentences for medium to large-scale supply and large-scale importation offences were required, although custodial sentences for drug possession offences were not (Jacobson *et al.*, 2011).

Although the benefits of retribution may not be quantifiable, seizing the proceeds of crime from drug trafficking offences can be beneficial to society. £34 million was removed through asset recovery orders for drug trafficking in 2014/15 (JARD; see Figure 5.6). This money has been reinvested in resources dedicated to attacking criminal finances and in local community projects to prevent people becoming involved in crime. However, the National Audit Office suggested that the process for confiscating criminals' assets was not working well enough (NAO, 2013). A cross government plan is now in place.

5.6 Central government spend and value for money of enforcement and enforcement-related activity

5.6.1 Estimates of spend on enforcement and related activity

Overall, the estimated central government spend on enforcement activities in 2014/15 was £1.6 billion (see Appendix A5.2 for more details). This is an indicative figure only and should be treated with caution due to the complexities involved in estimation, for example the proportion of police and other law enforcement time spent on enforcing drug laws or implementing other drug-related activity is not routinely recorded.

The 2014/15 figure provides a more recent and comprehensive estimate than that published in the evaluation framework (HM Government, 2013b). No attempt has been made to determine annual spend for each year of the strategy.

5.6.2 Value for money

It has not been possible to produce an overall value for money estimate of the impact of enforcement activity. The evidence base (see section 5.5) is insufficient to obtain any rigorous estimates of return on spend, due to the challenges previously mentioned and without the required data and high quality research of the impact of enforcement. In their review of UK published literature McSweeney *et al.* (2008a) did not find any comprehensive evidence of the relative effectiveness of different enforcement approaches or any comparative cost–benefit or value-for-money analysis of these approaches.

USA-based research that attempted to determine the value for money of enforcement argued that “*the evidence base was at present simply too weak to support scientific evaluation of the benefits and costs of drug law enforcement*” (Manski *et al.*, 2001). This holds in the UK, and has not changed substantially since that time.

It should be also noted that in a thorough assessment of cost-effectiveness, the unintended consequences of enforcement would have to be taken into account. For example, imprisonment is costly for public expenditure and also has a number of harms for the individual prisoners and also their families. For the part that enforcement-related activities may play in diverting drug users into treatment, or supervising treatment post-incarceration, the cost-benefit of the treatment model can be realised in some cases (see chapter 6).

5.7 Conclusion

As highlighted throughout the report, there is a lack of evidence and data to robustly measure the overall impact of enforcement or enforcement-related activity on levels of drug use and harm, or value for money. Importantly, we do not know how much drug use and drug-related harm there would be without enforcement or related activity, and enforcement is required to uphold the legal framework. This, together with the complex nature of drug markets, means that it is not possible to categorically state whether the activities within the logic model directly lead to the intended outcomes.

The review of the evidence suggests that enforcing the illegality of drugs increases prices over and above what would be expected in the absence of enforced control, albeit that there is likely to be a point of diminishing returns.

At higher levels of the market, targeting the most violent drug dealers or organised crime groups is likely to be most beneficial in reducing harm. Furthermore, while there is little evidence for the impact of higher intensity enforcement in tackling established markets, enforcement may be effective at suppressing emerging markets of dependence- drugs.

Activity solely to remove drugs from the market, for example, drug seizures, has little impact on availability. But enforcement activities can impact on the operation of drug markets at all levels, from production through to distribution, although given the resilience of markets any impact is likely to be short lived. At street level, geographically-targeted interventions that involve good partnership working with local communities are likely to be the most effective than traditional policing methods. Joint working between the criminal justice and the health sector is now well established in the UK with high proportions of referrals into treatment coming from criminal justice agencies. By diverting drug using offenders into treatment through the CJS the benefits of treatment, including reductions in crime and improvements in health, can be realised.

Whilst it is plausible that some of the activity described in this chapter may have contributed, at least in part, to the outcomes outlined in the logic model it appears that drugs are still widely available to those who want them. The 2011/12 CSEW found that over three quarters of adults who had taken any illicit drug in the last year thought that it was very or fairly easy for them personally to get illegal drugs when they wanted them (Home Office, 2012). And HMIP figures (2015a) show that drug use continues within prisons.

While there are some positive outcomes for enforcement and enforcement-related activities, there are naturally unintended consequences from establishing any illegal market, drug market crime for one. Reductions in purity to maintain street prices may also have unintended consequences by potentially increasing offending or health harms. And incarceration may negatively impact on unemployment and other indirect harms.

Estimated spend on enforcement in 2014/15 was £1.6 billion covering a range of cross-government activities. Due to the lack of robust impact data it is not possible to adequately assess the cost benefit of enforcement activity.

Appendix A5.1 Enforcement activity under the Drug Strategy 2010

This section provides a more detailed overview of the activity summarised in the logic model and Table 5.1.

A5.1.1 Restrict supply to users

There are various mechanisms and legislative controls which aim to restrict the supply of drugs with the following agencies largely responsible for enforcing them:

- The NCA became operational in October 2013⁸⁴ and leads the UK law enforcement's efforts to cut serious and organised crime. Specific to tackling the supply of drugs, the NCA is involved in international drug seizures and disruptions of serious and organised criminals (relating to drug trafficking) using their multi-agency partnerships.
- The police (including British Transport Police) and Border Force⁸⁵ are responsible for making drug seizures, in England and Wales and at the UK borders, respectively. Police and Crime Commissioners (PCCs) have individual plans to help meet the national strategy aim of restricting supply.⁸⁶
- The National Maritime Information Centre launched in 2014⁸⁷ combines cross-departmental⁸⁸ multi-agency efforts to tackle drug smuggling threats.
- HM Prison Service is responsible for disrupting supply by preventing drugs being used and smuggled into prisons.

Law enforcement and border control

Seizures provide an indication of the scale of law enforcement activity (Dhani, 2014). Most seizures (96%) are made by the police but these tend to be small quantities while Border Force seizes the greatest quantities of drugs reflecting its high profile operations involving large quantities of drugs, for example at airports or ferry ports⁸⁹ (Hargreaves and Smith, 2015;⁹⁰ see Box 5.5). And in its first year NCA-led and coordinated activity resulted in 213 tonnes of drugs seized, both in the UK and upstream (HM Government, 2015a).

At the border, Border Force works in collaboration with the NCA and other law enforcement agencies to tackle those attempting to smuggle controlled drugs into the UK. Border Force use a range of search techniques (including sniffer dogs, scanners, visual searches) to find illegal drugs that would otherwise end up causing harm.

⁸⁴ Before being subsumed into the NCA, this role was carried out by the Serious Organised Crime Agency (SOCA, launched April 2006).

⁸⁵ Border Force has invested in mobile technology that has enhanced its capability in detecting illicit drugs and also enables the identification of previously unknown compounds that have the potential to cause harm.

⁸⁶ For example: <http://www.warwickshire-pcc.gov.uk/advice-guidance/drugs/>

⁸⁷ <https://www.gov.uk/government/news/minister-for-portsmouth-opens-new-4-million-maritime-intelligence-centre>

⁸⁸ Includes 16 government departments and agencies, at the forefront of these are the Foreign and Commonwealth Office, the Ministry of Defence, the Home Office and the Department for Transport.

⁸⁹ For example <https://www.gov.uk/government/news/lorry-driver-jailed-for-38m-cocaine-smuggling-attempt>

⁹⁰ Some data may duplicate NCA seizure figures where they relate to operations conducted jointly between the NCA and the police/Border Force.

- In September 2015 Border Force officers seized 1.2 tonnes of cocaine with an estimated potential street value in excess of £56 million from a yacht at Dover.
- In April 2015 more than 3 tonnes of cocaine (potential street value of more than £500 million) was recovered from an ocean-going tug following a joint Border Force, NCA and Royal Navy operation in the North Sea.

The NCA estimate that between 18 and 23 tonnes of heroin and 25 and 30 tonnes of cocaine are imported into the UK annually (NCA, 2014), so it may be that only a small proportion of imports are seized. For example:⁹¹

- police and Border Force seized 0.6 tonnes of heroin in 2013/14, around 3 per cent of the estimated import market;⁹² and
- police and Border Force seized 3.4 tonnes of cocaine in 2013/14, between 11 and 14 per cent of potential imports.

New powers

The following powers have become available to enforcement agencies during the time span of the Drug Strategy 2010.

- **Temporary class drug orders (TCDOs).** In response to the increasing number of new psychoactive substances not controlled under the MDA and concerns about potential harms, the Government implemented TCDOs in November 2011.⁹³ Under an amendment to the MDA, a substance becomes controlled for up to 12 months to give the Advisory Council on the Misuse of Drugs (ACMD) time to provide full, independent and expert advice on the drug; however, possession is not an offence. A number of compounds including those from the methoxetamine, NBOMe, Benzofuran, methiopropamine, and methylphenidate-based families and their simple derivatives have been subjected to a TCDO. Of these, the methoxetamine, NBOMe and Benzofuran compounds and their simple derivatives are currently subjected to permanent control under the MDA 1971 (November 2015). TCDOs have provided the opportunity to review health harms relating to emerging drugs but naturally there have been very few police offences recorded against TCDOs⁹⁴ (these are solely for possession and for a very limited number of drugs).
- **Khat ban.** From June 2014 khat was controlled as a class C drug under the MDA. Police forces have a proportionate policy for possession which includes issuing khat warnings, penalty notices for disorder and finally arrest or charge for possession offences.⁹⁵

⁹¹ These estimates are based on police and Border Force seizures in England and Wales (Dhani, 2014) as a proportion of the scale of UK imports (NCA, 2014).

⁹² Separate analysis of the heroin market in Scotland estimated that heroin seizures typically amounted to around 1% of the total amount of heroin consumed (McKeganey et al, 2009).

⁹³ <https://www.gov.uk/government/publications/temporary-class-drugs-orders-factsheet>

⁹⁴ According to Home Office data from 25 police forces, only 38 offences were recorded against trafficking or possession of drugs controlled by TCDOs during 2014/15 (data are unpublished and unverified by the police forces).

⁹⁵ <https://www.gov.uk/government/publications/khat-fact-sheet-for-england-and-wales>

- **Precursor chemical licensing.** In 2013 regulations were amended to limit 'precursor' chemicals being used in the manufacture of illicit drugs and psychotropic substances while allowing for legitimate commercial use.⁹⁶ On average about 15 per cent of precursor chemicals for cocaine and heroin were diverted from the illicit drug trade worldwide between 2007 and 2012 (UNODC, 2014).
- **Cutting agents ban.** The Serious Crime Act 2015⁹⁷ provided enforcement agencies with powers to seize, detain and destroy chemical substances suspected of being used as cutting agents for illegal drugs.
- **Drug driving legislation.** In 2012, the Government announced a new offence in regard to driving with a specific controlled drug in the body above a specified limit. In October 2014 new regulations set lower levels for eight illegal drugs and higher levels for eight prescription drugs.⁹⁸ In March 2015 further regulations set a limit for amphetamine that balanced the legitimate use for medical purposes against its abuse.⁹⁹ The police may use a roadside saliva test which can lead to prosecutions for the most prevalent specified drugs. All drugs must be confirmed by an evidential blood test.
- **Psychoactive Substances Act.** In 2015 the Government announced new legislation to ban the new generation of psychoactive drugs and other psychoactive substances not already controlled under the MDA.¹⁰⁰ The act excludes specified substances and drugs that are already regulated under the MDA but aims to limit the potential health and social harms from these new substances.

Tackling prison supply (including mandatory drug testing)

The National Offender Management Service (NOMS) deploys a range of search and security measures to detect items of contraband both at the point of entry to the prison and concealed within the prison.¹⁰¹ These include targeted searching, random and targeted mandatory drug tests, the use of x-ray machines and CCTV surveillance cameras, the imposition of closed (non-contact) visits, and the use of specialist dogs to search and detect synthetic drugs. NOMS continues to explore new methods of preventing drugs coming into prisons such as new generation body scanners (an assessment of the most effective way to deploy these across prisons is underway). The Serious Crime Act 2015¹⁰² introduced a new offence of throwing or projecting items over a prison perimeter wall – a common way of introducing contraband to the prison including synthetic drugs.

96 <https://www.gov.uk/precursor-chemical-licensing>

97 <http://www.legislation.gov.uk/ukpga/2015/9/contents/enacted>

98 <http://www.legislation.gov.uk/uksi/2014/2868/regulation/2/made>

99 <http://www.legislation.gov.uk/uksi/2015/911/contents/made>

100 <http://www.legislation.gov.uk/ukpga/2016/2/contents/enacted>

101 <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2014-07-01/203390>

102 <http://www.legislation.gov.uk/ukpga/2015/9/contents/enacted>

As a deterrent, both visitors and prisoners are subject to the criminal justice process where there is sufficient evidence of attempt to supply. Prisoners found with prohibited items such as illegal drugs (including synthetic drugs¹⁰³) may have days added to their custody, be transferred to a different prison or lose privileges. NCA-led multi-agency days to detect contraband (particularly drugs and mobile phones) entering prisons resulted in seizures of illicit substances and also in prosecutions and refused or controlled visits to prisons (NCA, 2015a).

A programme of mandatory drug testing (MDT) has been part of the prison strategy for reducing the supply of drugs in establishments since March 1996.¹⁰⁴ MDT aims to detect and measure drug misuse within prisons in order to offer assistance to those who want it and also discourage initiation.¹⁰⁵ While MDT contributes to the overall outcome of the Drug Strategy 2010 of reducing drug use and associated harms, tests also aim to minimise risks within the prison environment, such as drug-related violent crime. The majority of testing is done under the random mandatory drug testing (rMDT) programme.

Recent reports of an increase of use and availability of new psychoactive substances (NPS) within prisons may in part be due to current drug testing technology being unable to detect many of these (HMIP, 2015a). Latest findings suggest use continues to grow and has led to problems such as bullying, debt and hospital admissions, with many prisons having inadequate strategies to reduce supply (HMIP, 2015a). However, a wide-ranging programme of work is being undertaken by NOMS which aims to counteract NPS in prisons:

- joint working with the Home Office on the re-classification of drugs to enable the control of most NPS substances and to make most NPS illegal to supply;¹⁰⁶
- developing new drug tests to detect NPS substances through the MDT programme; and
- ensuring Prison Governors have the powers and support that they need.

The Drug Strategy 2010 (HM Government, 2010) committed to creating drug-free environments in prisons. Drug Recovery Wings (DRWs) were piloted in 11 prisons¹⁰⁷ with the pilots completing in 2014. The final report of a major Department of Health funded independent evaluation of the DRW pilots is expected in 2017. For more information on DRWs, see section 6.4.3, chapter 6.

103 <https://www.gov.uk/government/news/new-crackdown-on-dangerous-legal-highs-in-prison>

104 https://www.justice.gov.uk/downloads/offenders/psipso/PSO_3601_mandatory_drugs_testing.doc
Powers to require prisoners to provide a sample for drug testing purposes were introduced as part of the Criminal Justice and Public Order Act 1994 <http://www.legislation.gov.uk/ukpga/1994/33/contents>.

105 The MDT programme includes on-reception, random, suspicion, frequent and risk testing.

106 This will allow prisons to press for the prosecution of those smuggling NPS into prisons or throwing them over perimeter walls.

107 This encompassed five adult prisons from 2011 and a further six prisons in 2012 (which also included prisons for women and young offenders).

International enforcement (including disrupting organised trafficking)

The NCA leads UK law enforcement's approach to tackling organised crime, including drug trafficking. The Foreign and Commonwealth Office (FCO) also works globally in partnership with the NCA to support local law enforcement agencies to restrict the supply of drugs to the UK, and to inform UK citizens of drug laws abroad. The FCO administers a Drugs and Crime Fund (DCF) that is allocated to projects to counter narcotics and organised crime by enhancing the capacity of local law enforcement agencies and seeking to maximise their impact. In addition to the DCF, the NCA and FCO play an active role in programme management of the Conflict, Stability and Security Fund in order to support delivery of the NCA country/regional strategies and help build local law enforcement capability to target serious and organised crime in fragile and conflict-affected states.

The most recent *National Strategic Assessment of Serious and Organised Crime 2015* (NCA, 2015b) makes the following points.

- The high-priority threats of cocaine and heroin, including source countries, transport routes and distribution hubs, are well understood, with regular disruptions against UK and overseas OCGs.
- The intelligence picture on synthetic drugs, NPS and cannabis is less developed, including UK OCG involvement.

Cross-government activities carried out during 2014 include:

- A major programme of cooperation in Afghanistan to disrupt criminal networks exporting drugs from Afghanistan through jurisdictions synonymous with UK supply routes, with NCA officers training and mentoring Afghanistan's counter-narcotics police and criminal justice sector (HM Government, 2015a).
- “*...a number of individuals ... received lengthy prison sentences for their part in an OCG engaged in the importation and distribution of Class A drugs. The OCG had a national and international dimension with links to Belgium, the Balkans and South America*” (NCA, 2015a).

Internet enforcement

The Drug Strategy 2010 noted that the internet has changed the way that people buy drugs. Subsequent annual reviews¹⁰⁸ stated that law enforcement agencies would continue to deal with unlawful advertising and sales of banned drugs on the internet, aiming to restrict the supply of drugs through this type of marketplace.

In 2013, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) identified some 650 websites selling psychoactive substances in Europe: in 2014 targeted internet snapshots identified websites offering specific drugs such as the synthetic opioid MT-45 for sale, sometimes in kg quantities (EMCDDA, 2015).

108 For example, HM Government (2015b).

The use of the ‘darkweb’ has expanded. The first drug market to exist was The Drugstore,¹⁰⁹ launched in 2009. Since then ‘darkweb’ drug markets have developed to include similar features to legitimate online marketplaces and offer sellers and customers a reduced-risk environment in relation to street sales (e.g. minimising risk of arrest or violence). Silk Road¹¹⁰ revenue was estimated to be \$1.2 billion from 2–5 years of operations (UNODC, 2014) while recent estimates put total sales volume for ‘darkweb’ transactions at around \$100–\$180 million a year (Soska and Christin, 2015).

Darknet sites provide a considerable challenge for law enforcement often requiring international cooperation to tackle the sites. For example, the NCA carried out arrests in the UK (NCA, 2015a) as part of coordinated law-enforcement activity across Europe and the USA, while partners from the European Cybercrime Centre took out the technical infrastructure key to hosting on the ‘darkweb’.¹¹¹

A5.1.2 Asset recovery

‘Asset recovery’ describes where a person’s or group’s assets are removed by the state because they are linked to the profits derived from crime. These include cash forfeiture and the removal of other commodities such as boats used to transport illegal drugs. For example drug smugglers sentenced in September 2014 under POCA had to pay around £700,000 to the NCA.¹¹²

In June 2014 the CPS launched their CPS Asset Recovery Strategy¹¹³ which will be delivered by the new CPS Proceeds of Crime Service¹¹⁴ in support of the Government’s Serious and Organised Crime Strategy.¹¹⁵ The service uses tools such as confiscation, cash forfeiture, civil recovery, and criminal taxation under the Proceeds of Crime Act 2002 (POCA)¹¹⁶ to deprive criminals of illegal revenues and deter further offending. Law enforcement agencies that can exercise the powers under POCA are the police and local authorities, NCA and also other government departments, for example HM Revenue and Customs, the Department for Work and Pensions and the Department for Business, Innovation and Skills.

¹⁰⁹ The Drugstore was the first ‘.onion’ drugs market that operated on the ‘Tor’ network.

¹¹⁰ Silk Road was an online black market that operated on the ‘Tor’ network and was best known as a platform for selling illegal drugs.

¹¹¹ The action seized around 400 domains associated with the black market websites on the darknet, including taking down Silk Road 2.0 <https://www.europol.europa.eu/content/global-action-against-dark-markets-tor-network>

¹¹² <http://www.nationalcrimeagency.gov.uk/news/676-in-flight-meal-drug-smugglers-lose-700-000> Money in bank accounts and the value of houses and other valuables were taken into account.

¹¹³ http://www.cps.gov.uk/publications/docs/cps_asset_recovery_strategy_2014.pdf

¹¹⁴ Within the Drug Strategy 2010, asset recovery was formerly led by the NCA (previously, SOCA) with other law enforcement agencies (for example, the Serious Fraud Office and HM Revenue and Customs). The CPS participates in the Asset Recovery Incentivisation Scheme whereby along with other agencies it receives a proportion of recovered assets to fund ongoing work seizing assets.

¹¹⁵ <https://www.gov.uk/government/publications/serious-organised-crime-strategy>

¹¹⁶ <http://www.legislation.gov.uk/ukpga/2002/29/contents>

A5.1.3 Capture and punishment

Under the MDA 1971 it is an offence to possess or traffic illicit drugs – the following agencies are largely responsible for this enforcement.

- The NCA, Border Force, Regional Organised Crime Units and individual Police Forces are involved in disrupting serious and organised criminals relating to drug trafficking.
- The police (including British Transport Police) are responsible for enforcement relating possession of controlled drugs and drug-related crime. PCC plans include reducing drug use and associated acquisitive crimes¹¹⁷ but are also involved in the wider agenda of Transforming Rehabilitation.
- HM Prison Service is responsible for preventing drugs being used in prisons, using mandatory drug testing programmes among other activities.

In addition to international enforcement, the NCA also operates at the local, regional and national levels, in partnership with police forces. For example, the Drugs Threat Group operates in support of the government's Serious and Organised Crime Strategy, co-ordinating the UK/international drugs effort across the NCA police and other agencies. For example, the NCA/Metropolitan Police Service (MPS) Organised Crime Partnership achieved the following outcomes (NCA, 2015a).

- An investigation into the smuggling of 28 tonnes of cannabis into the UK resulting in the conviction of 2 men.
- The convictions of 8 Albanian men involved in a drugs ring which laundered hundreds of thousands of pounds (sentences totalled 53 years).
- Bringing charges against 2 men in connection with the supply of cocaine (leading to the seizure of six kg of cocaine, around £100,000 in cash and drug cutting and packaging equipment).

Stop and search

Under the Police and Criminal Evidence Act 1984¹¹⁸ police have the power to search persons and/or vehicles for a range of items, including controlled drugs. Figures show that the majority of stop and searches are for reasons given by police officers relating to drugs but these drug-related searches result in among the lowest proportion of subsequent arrests (Home Office, 2015; see section 5.4). Recent reforms of the use of these powers aim to reduce the use of stop and search with more intelligence-led targeted operations and better arrest ratios.

Taking action against new psychoactive substances

In response to concerns about crime, anti-social behaviour and health problems, police and local authorities (including Trading Standards) have been using powers available to them to take action against sales of NPS (e.g. in 'head shops'). Although these types of drugs may not be controlled under the MDA 1971, and ahead of implementation of the Psychoactive Substances Act, there are criminal and civil offences that can be utilised (in addition to wider

¹¹⁷ For example: <https://www.police.uk/northamptonshire/pcc/>

¹¹⁸ <http://www.legislation.gov.uk/ukpga/1984/60/contents> Associated legislation includes stop and search powers under section 47 of the Firearms Act 1968, section 23 of the Misuse of Drugs Act 1971, section 43 of the Terrorism Act 2000 as well as other legislation.

engagement in the community by local partners). The four main types of offences that a 'head shop' may be committing are:¹¹⁹

- selling controlled drugs;
- selling drugs paraphernalia (in particular, cannabis-related equipment);
- breaching the Intoxicating Substances (Supply) Act 1985;¹²⁰ and
- breaching consumer protection regulations and other legislation (the General Product Safety Regulations 2005¹²¹ have proved most useful).

The police and local authorities can also use powers under the Anti-Social Behaviour Crime and Policing Act 2014¹²² particularly to deal with related anti-social behaviour and violence.¹²³ The impact of local enforcement activities largely depends on how well established the market is.

Transforming Rehabilitation

The Government's increased emphasis on recovery is reflected in the Transforming Rehabilitation¹²⁴ programme which provides extended supervision for short-sentenced prisoners after release. The Offender Rehabilitation Act 2014¹²⁵ includes:¹²⁶

- a new licence condition that mandates drug appointments, not limited to class A and B drugs, and specifically aimed at drug-dependent prisoners as part of their on-going supervision in the community after release; and
- an expansion of the existing drug testing requirement after release to include class B as well as class A drugs.

Community rehabilitation companies manage medium and low-risk offenders¹²⁷ and the new National Probation Service manages the most high-risk offenders, ensuring that offenders comply with their requirements to attend drug (and alcohol and mental health) treatment. Discretionary conditions that can be imposed to those released on licence or within the supervision period include a drug testing or a drug appointment requirement.¹²⁸ These options for offender rehabilitation seek to address the central outcome of the Drug Strategy 2010 which is to reduce drug use but also to reduce crime and health harms.

119 <https://www.gov.uk/government/publications/action-against-head-shops>

120 <http://www.legislation.gov.uk/ukpga/1985/26>

121 http://www.legislation.gov.uk/ksi/2005/1803/pdfs/ksi_20051803_en.pdf

122 <http://www.legislation.gov.uk/ukpga/2014/12/contents/enacted>

123 These three notices are available under Part 4 of the Act and came into effect on 20 October 2014: community protection notices, public space protection orders and closure of premises orders.

124 <https://consult.justice.gov.uk/digital-communications/transforming-rehabilitation/results/transforming-rehabilitation-response.pdf>

125 <http://www.legislation.gov.uk/ukpga/2014/11/contents/enacted/data.htm>

126 <https://www.gov.uk/government/news/new-law-will-see-support-extended-to-50000-more-prisoners>

127 <https://www.justice.gov.uk/downloads/offenders/probation-instructions/pi-30-2014-drug-appointment-testing.doc>

128 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/387795/target-operating-model-3.pdf These conditions and requirements are different from those that form part of a community sentence drug rehabilitation requirement (DRRs) – where the offender has agreed to participate in a course of treatment.

Named drug worker in youth offending teams

Funding was first made available through the Spending Review 2000 for all youth offending teams (YOTs) to have substance misuse workers in place by April 2002.¹²⁹ This aimed to screen young offenders for substance misuse and ensure access to a substance misuse worker and intervention programmes according to needs. As such the YOT substance misuse worker often takes the role of a 'care co-ordinator'.

Responsibilities for resettlement planning and implementation are shared between YOTs, local authorities and custody providers. A number of initiatives and pilots have been launched by the Youth Justice Board (YJB) to improve resettlement and have a positive impact upon re-offending. The Resettlement and Aftercare Provision (RAP) initiative was targeted at young people in custody with substance misuse and mental health needs. An evaluation indicated that young people on RAP were more likely to reduce the severity of their substance misuse over time compared with those not on RAP (based on the smaller follow-up sample; YJB 2010).

A5.1.4 Divert users into treatment

Routes for referrals into treatment from the CJS can be from possession offences or drug-related offences (e.g. acquisitive crimes) and have included, across the life of the Drug Strategy 2010:

- the Drug Interventions Programme;
- Liaison and Diversion; and
- drug rehabilitation requirements.

These programmes, through sanctions and rewards, seek to obtain treatment-related reductions in both drug use and crime harms (see chapter 6). Although some diverted users will be entrenched users who are re-entering the treatment programme, it is possible that this diversion from the CJS means that some users may enter treatment earlier than they otherwise would have done, or indeed, reaches a new population (this, of course, is difficult to determine).

Drug Interventions Programme/ drug testing on arrest

The Drug Interventions Programme (DIP) was introduced in April 2003 to bring together a range of agencies to provide tailored treatment for offenders with drug problems in order to reduce drug misuse and offending behaviour. DIP addressed drug misuse by referring users into treatment using community-based initiatives;¹³⁰ the benefits of the programme effectively come from the treatment model. In the community, DIP was delivered by criminal justice integrated teams (CJITs). These are specialist criminal justice, healthcare and social-care teams responsible for case-managing offenders.¹³¹ Although no longer nationally led, 27 police forces were known to be conducting drug testing on arrest programmes at the end of 2015.

129 <http://yjpublications.justice.gov.uk/en-gb/scripts/prodView.asp?idProduct=298&eP=>

130 <http://www.nta.nhs.uk/community-based.aspx>

131 From 1 April 2013 the Drug Interventions Programme (DIP) ceased to operate as a nationally led, centrally funded programme. The Community Safety Fund for Police and Crime Commissioners (PCCs) can be used to invest in locally determined drugs, crime and community safety activities, which might include activities for drug misusing offenders as part of wider local Integrated Offender Management arrangements.

Liaison and Diversion

The L&D programme was created in 2010 as a recommendation from the Bradley review (2009). The programme was set up with partners from DH, NHS England, HO, MOJ, YJB, HM Courts and Tribunals Service, PHE, Offender Health Collaborative, Bradley Review Group, NOMS and CPS. From 1 April 2014, the Programme transitioned from DH to NHS England to reflect the move into its implementation phase.

L&D operates by referring offenders who have mental health, learning disability or substance misuse vulnerabilities when they first come into contact with the criminal justice system to an appropriate treatment or support service. L&D services aim to reduce re-offending and improve health and social care outcomes through identifying, screening, assessing and referring offenders. However, there is no requirement to attend assessment and no compulsion to take up any referral.

Originally L&D services helped support offenders with mental health needs (subsequently widen to include substance misuse) and between 2011 and 2013 services developed in a variety of forms according to local needs. The first national service specification was then developed, encompassing all ages and vulnerabilities, which was trialled in 10 regions¹³² from April 2014. This service specification was then rolled out further to cover half of the population in England by 2015/16.

L&D provision is localised: within custody suites L&D workers or drug workers may be operating alone or co-located, but L&D will not become involved when drug workers are present to assess and refer. No central record is held of L&D coverage – this differs even within local authorities.

Drug rehabilitation requirement

The Criminal Justice Act 2003¹³³ introduced a new community based Court Sentence, targeted at drug users who have committed offences linked to their use of illicit drugs: a Community Order or Suspended Sentence Order which included a Drug rehabilitation requirement (DRR). DRRs involve structured treatment tailored to individual need and regular drug testing and are subject to rigorous enforcement.¹³⁴ Additionally, courts may provide for the review of any DRR and must do so in the case of requirements lasting twelve months or more. The main purpose of the DRR is to reduce or eliminate illicit drug use and associated offending and benefits would be realised from the treatment model (see chapter 6).

¹³² Leicester, Merseyside, Dorset, Bristol, Sunderland and Middlesbrough, Coventry, London, South Essex, Wakefield, Sussex – this took a few months to bed in so reached full capacity around July.

¹³³ <http://www.legislation.gov.uk/ukpga/2003/44/contents>

¹³⁴ <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2015/pi-04-2015-implementation-of-the-support-delivery-of-the-drug-rehabilitation-requirement-specification.pdf>

Appendix A5.2: Estimates of central government spend on enforcement and enforcement-related activity

Based on the best available data, overall central government spent an estimated £1.6 billion on enforcement and enforcement-related activities in 2014/15, the most recent financial year of the strategy period under review. Due to the complexity no attempt was made to provide a yearly figure for each year of the strategy, nor is it possible to compare 2011/12 estimates with 2014/15 due to changes in methodology (see below for further detail).

As the proportion of police and other law enforcement time spent enforcing drug laws or implementing other drug-related activity is not routinely recorded it is particularly challenging to accurately estimate enforcement spend on tackling drugs. Much enforcement activity is across different threat groups and it is difficult to disentangle financially the drugs element from an organised crime operation that might have, for example, drugs, money laundering and firearms dimensions. Equally, some enforcement-related activity encompasses all substance abuse, not only drugs; again it is not simple to apportion spend to activities under the Drug Strategy 2010. As a result estimates should be considered indicative only and should be treated with caution. They are included to provide a sense of the scale of government spend and to update the figure included in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013b) which estimated that £1.5 billion was spent on enforcement activity during 2011/12. Much of the methodology used to reach an estimate of enforcement spend has changed in this time and as such the figures cannot be accurately compared. In particular, costs to the police and the criminal justice system have been calculated using new methodologies which aim to provide a fuller picture of estimated spend.¹³⁵

The data used to derive these estimates have been based on publicly available data where possible (and referenced) but otherwise provided by the relevant department or agency. The derivation of component figures is described below by each government department or agency in turn.

Home Office enforcement and enforcement-related activity

Table A5.1: Enforcement and related activities under the Drug Strategy 2010 and associated central government spend, Home Office, 2014/15

Activity	Lead department	Estimate of spend £m
Police enforcement (including drug seizures)	HO	592
Border control	HO	74
Drug testing on arrest	HO/DH	9

¹³⁵ However, given the decrease in possession and supply offences over recent years it is highly probable that spend on enforcement and enforcement-related activity has fallen over the lifetime of the strategy.

Police enforcement

The estimated total spend by the police on police enforcement was approximately £592 million for 2014/15. This is calculated using the Activity Based Costing (ABC) data from 2006/07 (the last year of the ‘activity analysis’ that was reliably collected from police forces).

- Using this data, the share of the police budget that is directed towards investigations was established.
- Then ABC data was cross-referenced with recorded crime data, so as to establish a set of costs ratios for investigating different types of crime. For example, the estimated cost of investigating one drug offence in 2006/07 was about twice as high as the cost of investigating a violence against the person offence (s47 and less serious category). These ratios were assumed to be the same in 2014/15 as they were in 2006/07, recognising that this is a limiting assumption.
- Using these ratios, together with the volumes of each crime in 2014/15 and the police budget in that year, the average cost of a drug offence investigation was estimated.
- Then overheads were accounted for by calculating the share of the police budget spent on crime-related overheads according to the ABC data. This was then apportioned to each crime-type based on its share of overall investigative spend.
- Finally, to estimate the total police spend on drug offences, the estimated unit cost of a drug investigation (plus overheads) was multiplied by the total number of recorded drug crimes in 2014/15.

Although the 2014/15 police budget is taken into account, the estimates of police activity are based on ABC data that are almost ten years old. These do not reflect subsequent changes in policing priorities or technological developments which likely mean that the relative costs of investigating different types of crime in 2006/07 do not hold for 2014/15.

- According to the Strategic Policing Requirement,¹³⁶ which sets out the appropriate national policing capabilities required to counter national threats, the relative priority of different crimes has changed over time with greater emphasis recently on safeguarding, fraud and cyber crimes.
- In the absence of more recent data the *relative* cost of each crime in 2006/07 is assumed to be the same in 2014/15. However, there have been advances in surveillance systems and technology meaning that police forces can be more efficient and may resolve investigations faster. This particularly applies to drug offences, which are largely based on proactive investigation rather than being reported to the police (e.g. burglary offences).

In recognition of the lack of detailed data around police spend there is currently work underway to better estimate this.

¹³⁶ <https://www.gov.uk/government/publications стратегичні потреби патрульної поліції>

Border control

It is estimated that in 2014/15 the cost for Border Force (BF) drug enforcement activities was £74 million. This estimate was calculated by applying the relevant proportion of time spent on drug enforcement activities by BF staff to total BF costs.

Information on the amount of time spent on drug enforcement is gathered through 'end of shift' reports. The 'end of shift' report is a report completed by operation staff that records the activities undertaken by staff each day. Using this information, BF has apportioned a proportion to total BF costs and Home Office allocated costs that relate specifically to drug enforcement.

Drug testing on arrest

In 2014/15 the Community Safety Fund for PCCs was used to invest in locally determined drugs priorities, which might include activities for drug misusing offenders such as drug testing on arrest. However, because priorities are locally determined, national costs are not available these are estimated below.

Not all police forces in England and Wales currently carry out, or submit data to the Home Office on, drug testing on arrest. Some police forces began submitting these data in September 2014 so this evaluation relies on data from a three-month period (January, February and March 2015) from the 19 forces that are part of the central data collection. The average taken across the months *where data were submitted* (to account for some variability, for example, forces not reporting in all months) was 6,056 completed tests per month.

However, these data represent only 19 forces. Dividing the number of arrests made by all drug test forces in 2014/15 (647,950) by the total for the 19 forces (483,967) gives a multiplier of 1.3 (for arrest data, see Home Office, 2015). Using this factor to upscale to all drug testing on arrest forces gives an estimated 8,100 tests conducted across England and Wales per month on average. That is, approximately 97,300 tests conducted in a year.

Three forces (which accounted for around 11% of the average number of drug tests completed) were sampled from centrally-held information on their drug testing on arrest annual budget. To make the estimates as robust as possible, forces providing similar elements of the drug testing process were included and an average of these costs was taken to generate a national average cost of £89. Combining this with the estimated number of tests in 2014/15 (97,300) gives an estimated spend of £8.7 million for the drug testing on arrest programme.

MOJ enforcement and enforcement-related activity

Table A5.2: Enforcement and related activities under the Drug Strategy 2010 and associated central government spend, MOJ, 2013/14

Activity	Lead department	Estimate of spend £m
Overall criminal justice system costs	MOJ	680
	CPS	50
Mandatory drug testing	MOJ	6
Named drug worker in youth offending team	MOJ	2

As shown for police enforcement costs, using costs of crime estimates from the MoJ and the CPS provides a basis on which to estimate spend relating to the CJS. In the *Drug Strategy Evaluation 2010 Framework* (HM Government, 2013b) the enforcement spend estimate was based on the published costs of crime methodology (2003/04), and used old underlying cost data. For this report, the MOJ and CPS have provided updated costs for the downstream CJS (e.g. court and prison costs) based on a mixture of estimation approaches.¹³⁷ This results in a rounded estimate of £730 million for the costs of drug offences in 2013/14¹³⁸ for the following CJS bodies.

Crown Prosecution Service

- Costs are determined from the finalised estimates of the number of defendants and the cost per defendant for each offence category, based on assumptions for casework and advocacy unit costs.

HM Courts and Tribunals Service

- Costs are determined from the Activity Based Costing (ABC) model (magistrates court) and crown court timings data, these are then applied to 2013/14 costs.
- As the data presents primary offence type only, secondary offences are not accounted for in the volumes.
- Categories have been mapped as the data grouping does not match exactly.
- Excludes costs/revenue from fine enforcement and any revenue from criminal courts charging.

Legal Aid Agency (LAA)

- Costs are based on the breakdown of the Legal Aid Statistics 2013/14, matching LAA offence categories to their Home Office equivalents.

¹³⁷ While most costs will have been incurred in 2013/14, knock-on CJS costs associated with drug offences in 2013/14 have also been included, even if the expenditure will not take place until subsequent years (e.g. prison sentences).

¹³⁸ 2013/14 is the latest year in which MOJ and CPS costs are available.

National Offender Management Service (prisons, probation and headquarters)

- Costs are determined using headquarter costs, NOMS data on the cost per prison place, and NOMS probation trust unit costs.
- Costs have been allocated using offence data with details on outcomes and sentences. This is based on 2013 data.
- These are only costs to NOMS and do not include spend on offenders by other departments or agencies, for example, the cost to DH for health provisions including drug-misuse related costs.

Youth Justice Board

- Costs are determined using the Youth Justice Annual Statistics 2013/14, excluding costs covered by NOMS but including grants to Youth Offending Teams, Secure Training Centres, Secure Children's Homes, Secure Escort Contracts, Community Programmes and Operating Costs.
- Youth costs excludes the cost to YJB of commissioning places from NOMS.
- Custodial service costs are apportioned based on custodial-only sentencing data and all non-custodial service costs are apportioned based on both custodial and community sentencing data.
- Assumes that all Young Offenders Institute costs are covered by NOMS.

These encompass numerous elements of CJS costs and related activities including:

- asset recovery;
- CJS activity (including imprisonment) and Transforming Rehabilitation; and
- drug rehabilitation requirements.

Additional costs not incorporated within the CJS costs of crime are derived below.

Mandatory drug testing

The NOMS estimates an annual cost of £6 million for mandatory drug testing in prisons in 2014/15. These costs include:

- laboratory services and urine testing equipment for prisons in England and Wales (including contracted and juvenile establishments); and
- prison staff cost of implementing the testing.

It should be noted that these are direct costs only and do not include overheads. Staff costs only cover adult public sector prisons. As a result, these costs may be an underestimate but some costs will also be included within NOMS headquarters costs subsumed within the CJS costs of crime data.

Named drug worker in youth offending team

Estimating the cost of a named drug worker in a YOT is based on:

- the number of named workers across England and Wales in 2014/15;
- the average cost for each worker; and
- the proportion of their time spent on drug misuse.

Data from the National Careers Service show that drug and alcohol workers earn on average between £20,000 and £25,000 in salary.¹³⁹ The midpoint (£22,500) was used as the best estimate for an average salary of a named drug worker. This figure was uplifted by 19.8 per cent¹⁴⁰ to take account of non-wage labour costs such as national insurance contributions, which gives an annual estimated cost per drug worker of £27,000.

The workforce figures provided by YOTs to the YJB showed there were 106 substance misuse workers in YOTs in 2014/15.¹⁴¹ Hence the estimated annual cost of workers (106) was £2.9 million, accounting for non-wage related costs.

Data do not allow for the identification of directly employed workers specifically assigned to drug (rather than alcohol) work. An estimated 80 per cent of young people under the age of 18 who were receiving treatment for drug and alcohol problems in 2013/14 received treatment for drug problems (PHE, 2015b).¹⁴² Applying this proportion to substance misuse workers' time (as a proxy for time spent on drug misuse) suggests an estimated cost of named drug workers of £2.3 million over 2014/15.

NCA enforcement and enforcement-related activity

The estimated NCA figure for 2014/15 was £132 million. This figure represents an estimated overall NCA spend in relation to drugs activity for the year 2014/15. The figure has been calculated by applying the percentage of tasked operational effort in respect of drugs, to NCA spend by i) different UK-based NCA departments and ii) in different regions and NCA locations overseas. The figure relates to core business and excludes externally-funded overseas projects.

It is essential to note that this figure is a best estimate of overall spend. NCA resources are not deployed in a way which easily allows the agency to quantify the cost of tackling a particular threat. The NCA targets those organised crime groups that cause the most harm to the UK, very often those groups are engaged in more than one threat. For example, those who undertake drug trafficking also may be involved in firearms trafficking and money laundering. Therefore it is difficult to delineate between specific threats. The NCA's resources are flexible, and NCA tasked activity is reprioritised as and when threats change.

¹³⁹ <https://nationalcareersservice.direct.gov.uk/advice/planning/jobprofiles/Pages/drugandalcoholworker.aspx>

This is a suitable proxy and also aligns with 'Youth and community workers' in the ONS Annual Survey of Hours and Earnings (ASHE). <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/previousReleases>

¹⁴⁰ From guidance based on 2014 Eurostat data: http://ec.europa.eu/eurostat/statistics-explained/index.php/Hourly_labour_costs.

¹⁴¹ These are full time equivalent figures taken from a quarterly return to the YJB and are assumed to remain constant over the whole financial year. Figures have not previously been published.

¹⁴² This may include cases where alcohol is an adjunctive (non-primary) use.

FCO enforcement and enforcement-related activity

Spend is allocated to counter narcotics and organised crime projects from the DCF across priority geographic directorates. In 2014/15, allocations were: Americas £500,000; Africa £500,000; South Asia £100,000; Turkey/Balkans £70,000; Overseas Territories £30,000.

Not all of the funding will have been spent on counter narcotics and it is difficult to disaggregate spend as budgets are devolved across FCO geographic directorates. The FCO estimate that approximately 66 per cent of the £1.2 million fund was spent on counter narcotics enforcement activities (£0.8 million).

DH enforcement and enforcement-related activity

Liaison and Diversion

The estimate of spend on the L&D pilot under the Drug Strategy 2010 is based on determining the proportion of cases with an identified substance misuse need (4,369) out of the total number of cases referred within the programme (16,273). This proportion (27%) is then applied to the total amount spent on the L&D pilot in 2014/15 (£25 million).¹⁴³ This provides a best estimate of £6.7 million for the 2014/15 financial year.

This is only an estimate and will not reflect exact spend relating to drug misusers as many of L&D costs are fixed – certainly just because substance-misuse offenders constitute 27 per cent of the L&D population does not mean that they make up the same proportion of the cost.

This estimate only covers the L&D *pilot* scheme, launched in April 2014, covering 10 different regions across England. It does not cover any other L&D programmes or similar initiatives funded before or during 2014/15 (which are likely to have been locally funded).¹⁴⁴

Financial benefits

In 2014/15, £34 million was the total net receipt, including NCA receipts, for drug trafficking offences.¹⁴⁵ This excludes amounts that have been or will be paid out as receiver's costs and compensation to victims and therefore constitutes a financial benefit to enforcement under the Drug Strategy 2010. Over the past decade this figure has remained within a range of £28 million to £34 million, although the *proportion* of receipts from drug trafficking offences is reducing as receipts from other areas (such as fraud) are increasing.

143 This is funding for the L&D pilot only, it excludes any additional funding for any other L&D schemes.

144 For example, referral schemes seeking to reach the national specification for L&D may have received local authority or clinical commissioning group funding.

145 There is no double counting as financial investigators only record one primary offence per operation.

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Chapter 6: Treatment

Summary

Activity

- Drug treatment is an essential component of the building recovery in communities strand of the Drug Strategy 2010, and for achieving the aim of increasing the numbers recovering from dependence.
- Since the strategy began there have been several changes to how treatment is delivered, including commissioning responsibility moving to local authorities and the creation of Public Health England. The strategy also signalled a greater focus on recovery than ever before.

Evidence of effectiveness

- There is, to a large extent, robust evidence for the coverage and effectiveness of drug treatment in England and also evidence that, overall, treatment offers good value for money.
- Progress has been made in treatment outcomes, with an increase in the proportion of clients leaving treatment free of dependency from before the start of the strategy (12.2% in 2009/10) to 16.1 per cent in 2011/12, although this has subsequently fallen slightly (15.8% in 2014/15).

Spend and value for money

- The figures from 2014/15 show that estimated central government spend on adult drug misuse services was £541 million, of which £433 million was spent on structured treatment. A further £24 million was spent on substance misuse (including alcohol) services for those under 18. In 2013/14 £109 million was spent on treatment in prisons (spend in 2014/15 is not available).
- Overall, spend on adult drug treatment remained stable for the first three years of the strategy although there are signs that spend may have fallen in 2013/14. The level of spend was similar in 2014/15. The fall may in part be accounted for by the different method used to collect information on spend in 2013/14; however this also coincides with reports of disinvestment in treatment services.
- The best available estimate shows that for every £1 spent on structured drug treatment it is likely £2.50 was saved to society. This leads to an estimated £1.1 billion in benefits from structured treatment spend in 2014/15 (excluding prison spend).

- It has not been possible to produce a total benefit figure for non-structured treatment. However, as there is good evidence for the effectiveness and cost effectiveness of the specific interventions within non-structured treatment, it is likely that the total benefits of the treatment system may be even higher.

6.1 Introduction

Drug treatment is the principal mechanism for achieving the Drug Strategy 2010's aim of enabling people to recover from dependence and also contributes to reducing illicit and other harmful drug use.¹⁴⁶ The drug treatment system in England is wide-reaching and easily accessible (NTA, 2013). There are two broad categories of treatment:

- **structured treatment** refers to a package of specialist and intensive interventions where clients receive an individually tailored care plan with a recovery focus, which will be regularly reviewed; and
- **non-structured treatment** refers to information, advice and other services related to substance misuse provided in general and open-access services.

The evaluation covers all drug treatment (structured and non-structured) that aims to deliver the outcomes presented in the logic model (see Figure 6.1). This chapter briefly covers key developments and trends in drug treatment over the life of the strategy, describes how drug treatment contributes towards recovery and then summarises the available evidence on the effectiveness and value for money of treatment.

6.1.1 Developments in the delivery of treatment

The National Treatment Agency (NTA) was created in 2001 to improve the availability, capacity and effectiveness of drug treatment in England. From 1 April 2013, the NTA ceased to exist and its functions were transferred to Public Health England (PHE).

Also from 1 April 2013, the lead responsibility for commissioning community based drug and alcohol services transferred to local authorities as part of their new public health role introduced by the Health and Social Care Act 2012.¹⁴⁷ As a result, drug treatment funding is no longer ring-fenced but comes out of the local authorities' public health grant which funds all public health interventions in an area. Local area prioritisation of drug treatment continues to be informed by needs assessments, with data and commissioning prompts provided to local authorities to assist their Joint Strategic Needs Assessments (JSNAs).¹⁴⁸ With decentralisation, the Government's role is increasingly the national provision of best practice tools and evidence for use by local areas, alongside oversight, performance management, and incentives.

¹⁴⁶ Non-treatment rehabilitative activities are covered in chapter 7.

¹⁴⁷ <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

¹⁴⁸ <http://www.nta.nhs.uk/healthcare-JSNA.aspx>

There have also been changes to the way that drug treatment services in prisons are funded and commissioned over the strategy period. In April 2011 responsibility for funding psychosocial treatment in prisons in England was transferred from the National Offender Management Service (NOMS) to the Department of Health (DH), bringing together clinical and non-clinical commissioning and funding. From 2013 all prison healthcare has been funded and commissioned by NHS England.

A further development during the Drug Strategy 2010 has been trialling a payment by results (PbR) approach to commissioning and delivering drug and alcohol misuse treatment at eight pilot sites between April 2012 and March 2014. Under PbR, a proportion of a treatment provider's payments are conditional on the achievement of positive outcomes for their service users. The conditional proportion of the payment has varied across the pilot sites, from a modest proportion to the entire amount (in three areas). Other local areas are also free to incorporate PbR into their commissioning.

A £1 million DH funded independent evaluation of the drugs and alcohol recovery PbR pilots programme, comprising process, outcomes, and economic components, has yielded several published interim outputs to date (Mason *et al.*, 2015; Disley *et al.*, 2014). Interim findings relating to the first year of the pilots show that PbR had a negative impact overall on treatment completion and treatment continuation (Mason *et al.*, 2015). The final evaluation report, covering the whole period of the pilots programme, is being considered and is expected to be published in 2017.

Throughout the life of the strategy the Government, through the National Institute for Health Research, has continued to invest in improving the evidence base for effective drug misuse interventions.

6.1.2 Challenges of carrying out an evaluation of effectiveness of drug treatment

In addition to the overarching challenges of carrying out a national evaluation of the Drug Strategy 2010 (see section 1.4, chapter 1), there is a specific challenge, largely due to ethical and methodological reasons, with identifying a suitable counterfactual to evaluate the impact of drug treatment. That is, identifying a group of people with a treatment need, and then denying them treatment for comparative purposes. This tends to be more of an issue for assessing the impact of the treatment system overall, as trials of individual treatment interventions can compare the relative effectiveness of different treatment interventions, rather than no intervention at all.

6.2 How treatment contributes to achieving the aims of the Drug Strategy 2010

Figure 6.1 shows the logic model for drug treatment,¹⁴⁹ which describes the pathways and outcomes underlying the rationale for drug treatment. This builds on the high-level logic model included in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013).

The logic model shows the two broad categories of treatment (structured and non-structured) and links the intended outcomes with treatment activities, the target for the activity, and intermediate outcomes. Although there are differences between the adult and young people treatment populations (covered later), the expected high-level outcomes (e.g. reduced drug misuse, reduced health harms) from treatment are assumed to be similar, albeit with less focus on some of the overlapping outcomes (e.g. crime and unemployment) and more focus on others (e.g. improving education) for young people.

Interventions under the strategy are included up to the end of 2015. The logic model consists of a number of interactions between an intervention and different levels of outcomes that are outlined below. Subsequently evidence is used to test whether the assumptions that underpin the pathways in the logic model hold (see section 6.4).

Stage 1: Activity

This stage outlines the main types of treatment activity broken down within the structured and non-structured treatment categories. The logic model mentions the individual interventions within the system and focusses on the outputs it delivers, rather than detailing the specific working and processes of each intervention.

Stage 2: Target population

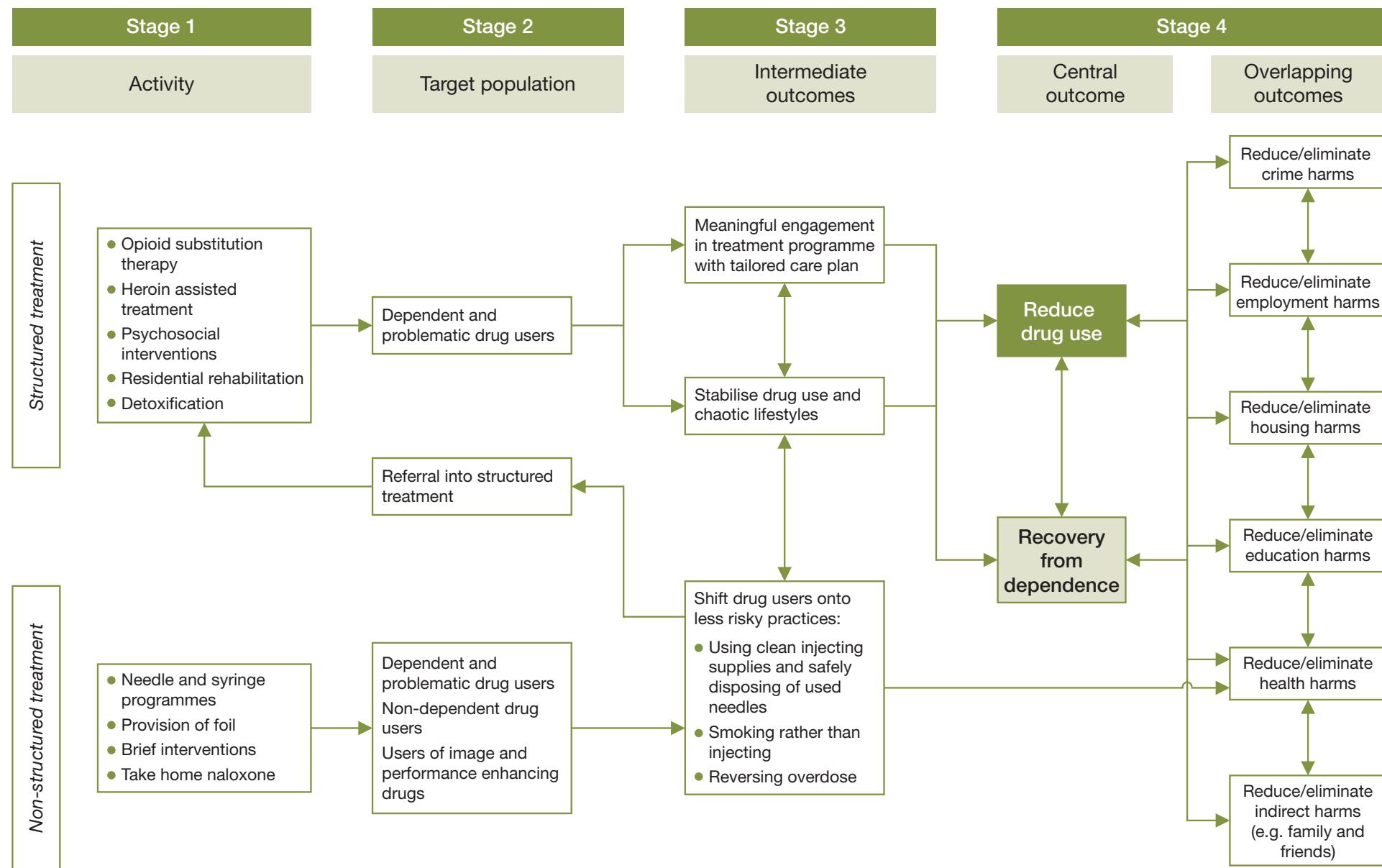
This stage shows the intended recipients of structured and non-structured treatment interventions. It recognises that structured treatment is often only required for individuals who have a clinically assessed need relating to addiction or more problematic use, and that non-structured interventions can target a wider range of drug users.

Stage 3: Intermediate outcomes

This shows the intermediate outcomes that the treatment system can achieve. Many of these are not in themselves directly related to altering drug misuse, and are instead part of the path towards the final stage.

¹⁴⁹ This logic model only covers clinical treatment, it does not cover wider areas such as building recovery capital; these are covered chapter 7. As clinical treatment providers also offer non-treatment rehabilitative activity (NTRA), clients in treatment can also receive NTRA.

Figure 6.1: Logic model for drug misuse treatment



Stage 4: Central and overlapping outcomes

The logic model shows recovery from dependency as the central outcome for drug treatment, while recognising that reducing and managing drug misuse is an important stepping stone to this goal and for some entrenched users may be more achievable, especially in the shorter term. The model also recognises that dependent drug misuse can occur as part of a range of problems that users experience. While treatment can play a part in reducing harms, there are also mutually-reinforcing positive feedback loops from reduced drug misuse and improvements in the other harms (e.g. improved health could provide motivation to lower drug misuse, which could then further improve health).

In addition to the central outcome of reducing and stopping dependent use, drug treatment also has positive benefits on a range of overlapping outcomes. These include crime, health, employment and education but also indirect harms to others that are not otherwise captured (e.g. to family, friends and community). The logic model recognises that reductions in these harms are still desirable even if they cannot be eliminated.

6.3 Drug treatment indicators

The National Drug Treatment Monitoring System (NDTMS) provides robust statistics on structured drug¹⁵⁰ treatment activity in England (PHE, 2015a).¹⁵¹ While NDTMS data do not measure the impact of treatment, they provide valuable and robust contextual information, and give a general sense of direction of travel in treatment trends over the life of the strategy – so figures from the year prior to the introduction of the strategy (2009/10) are used to measure change.¹⁵² These statistics provide evidence to support the first two stages of the logic model. NDTMS recovery rates are covered separately in section 6.4.1. A high-level overview of indicators related to this and other areas of the strategy is presented in chapter 2.

6.3.1 Access to treatment

NDTMS data show that the treatment system is responsive to need: 98 per cent of clients were seen within three weeks of referral in 2014/15, a slight increase from 2009/10 (94%) and up from 87 per cent in 2006/07. Overall the average (mean) wait to commence treatment (first interventions only) was three days in 2014/15 (PHE, 2015a).

¹⁵⁰ All figures presented in this section refer to those in treatment for drug use, although in some cases clients may also be treated for problematic alcohol use. Totals for all drug use are comprised of the following NDTMS categories: opiates, non-opiates, and non-opiates and alcohol.

¹⁵¹ <http://www.nta.nhs.uk/statistics.aspx>

¹⁵² Due to changes in 2014/15 in way that NDTMS data are reported, some indicators from 2014/15 are not comparable with previous years. When this is the case data from 2013/14 have been used.

6.3.2 Types of treatment received

With a total of 206,117 clients in treatment in 2014/15, there is a substantial overlap between psychosocial and prescribing interventions, with many clients receiving both types of interventions (PHE, 2015a) (Table 6.1).

Table 6.1: Number of individuals in treatment for drug use, by intervention and setting, England, 2014/15

Intervention	Total number of individuals
Psychosocial	193,588
Prescribing	150,678
Setting	Total number of individuals
Inpatient Unit	7,796
Residential	4,596

Source: National Drug Treatment Monitoring System, PHE

6.3.3 Trends in treatment presentations

Trends in new presentations to treatment differ across drug types (see Figure 2.5, chapter 2).

- The number of new adult (18 years and over) presentations to treatment for opiates in England fell sharply from 55,493 in 2009/10 to 45,491 in 2011/12 before stabilising in later years (44,356 in 2014/15).¹⁵³
- The number of new adult presentations for non-opiate drugs increased from 33,522 in 2009/10 to 37,361 in 2013/14, before declining in 2014/15 (35,886).¹⁵⁴

Treatment penetration¹⁵⁵ rates have remained high under the strategy. In 2011/12, 56.0 per cent of opiate and/or crack cocaine users were in treatment (164,671 out of 293,879). This is a similar level to 2009/10 (56.8%), but higher than 2005/06 (44.3%).

153 Figures have been provided by PHE and have not previously been published in this form.

154 Figures have been provided by PHE and have not previously been published in this form.

155 Treatment penetration is the proportion of drug users in contact with treatment services. Rates are calculated by using the following NDTMS categories (opiates only, opiates and crack, and crack only) (PHE, 2014a) and the separate estimates of the number of opiate and/or crack cocaine users, (Hay *et al.*, 2014.). It is not possible to calculate rates for any later years as estimates are not yet available for 2012/13 onwards.

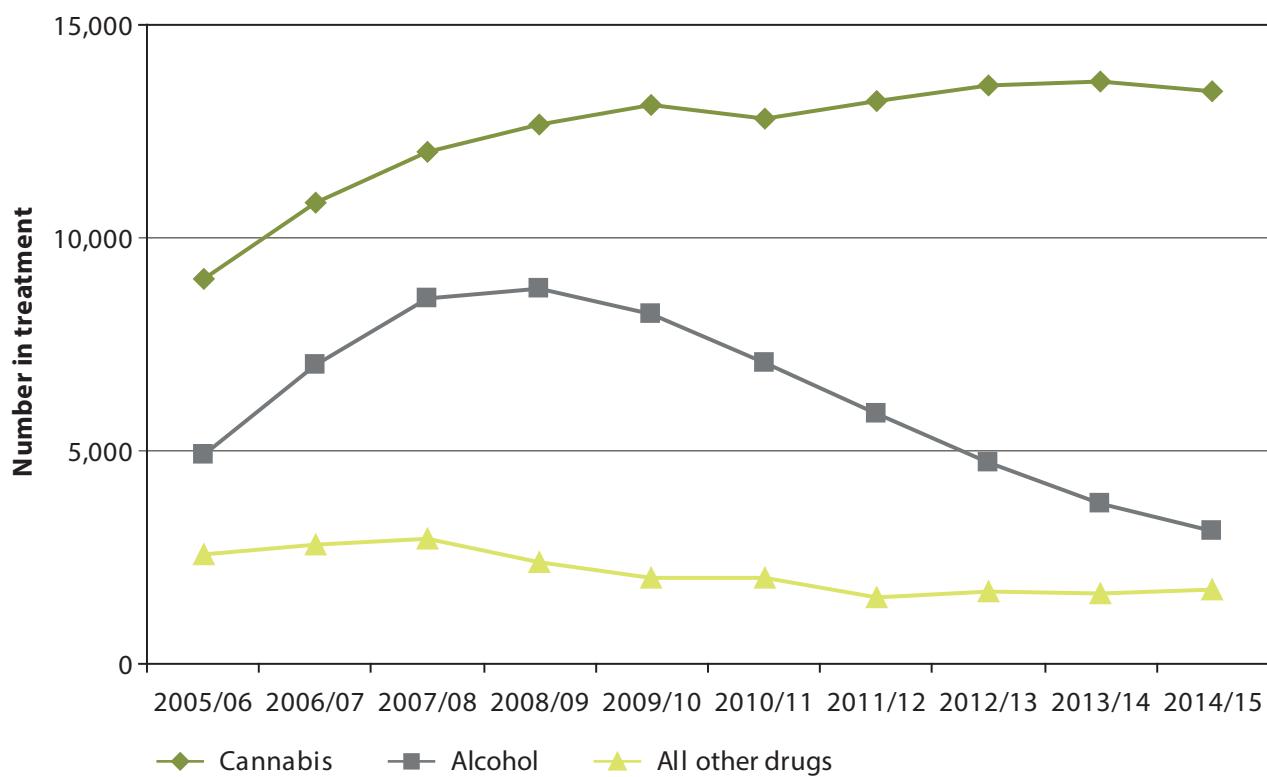
6.3.4 Young people

Substance misuse services for young people under the age of 18 tend to deal collectively with drugs and alcohol. In 2014/15 18,349 young people accessed specialist treatment (PHE, 2015b). The substance use profile of young people accessing specialist substance misuse services is very different from those in adult drug treatment.

- In 2014/15, the majority (73%) of young people in treatment were primary cannabis users, and 17 per cent were primary alcohol users, whereas just 1 per cent were primary¹⁵⁶ opiate and crack users (PHE, 2015b).
- In addition to their primary drug, 86 per cent of young clients have adjunctive (secondary) drug use.

Figure 6.2 shows that the number of young people in treatment with cannabis as their primary problem substance has been increasing, whereas the number for alcohol and all other substances has been falling.

Figure 6.2: Number of under-18s in treatment, by primary substance, England, 2005/06 to 2014/15



Source: National Drug Treatment Monitoring System, PHE

¹⁵⁶ NDTMS records the main (primary) drug causing problems for clients, alongside adjunctive (secondary) drugs.

6.3.5 New psychoactive substances

In response to changing patterns of drug misuse, a new category was added to NDTMS in 2013/14 to capture those accessing specialist substance misuse services for new psychoactive substances (NPS) use. The number of adults and young people accessing treatment for NPS use is low compared with other drugs: 1,370 adults and 890 young people in 2014/15 (PHE, 2015a, 2015b).

6.4 Evidence for the impact of treatment

The NDTMS statistics presented above support the first and second steps of the logic model as they show activity in the treatment system and suggest that the treatment system is responsive to demand. This section summarises the evidence to support, or otherwise, the outcomes in the logic model.

Evidence is presented for the impact of the treatment system overall and then by specific intervention. The focus is largely on drug treatment for adults (aged 18 and over) but also includes evidence on the effectiveness of treatment for young people (under 18s). Although there are differences between the adult and young people treatment populations, the expected outcomes from treatment are assumed to be similar.

Evidence for treatment in prisons is separately reviewed because although treatment delivered in prisons should be equivalent to that delivered in the community, it is acknowledged that outcomes may vary due to the unique environment in prisons and, potentially, a different treatment population.

As evidence of cost-effectiveness often covers multiple outcomes at once this has been assessed separately in section 6.6.

The drug treatment system in England has a solid, evidence-based foundation including rigorous clinical guidelines and guidance from the National Institute for Health and Care Excellence (NICE). The UK-wide clinical consensus guidelines were last published by DH in 2007 and largely focus on the medical management of opioid dependence (DH and the devolved administrations, 2007). Since publication there have been changes in drug treatment, such as a more recovery-orientated focus, an ageing opiate and crack cocaine-using population, and changing patterns of drug misuse such as the use of new psychoactive substances (NPS). In response, the guidelines are being updated and are expected to be published in 2017.

Box 6.1: Types of evidence used

There are numerous sources of good evidence available on the impact of drug treatment:

- evaluations of the overall system on a range of outcome measures;
- randomised controlled trials (RCTs) of specific interventions; and
- systematic reviews and meta-analyses of wider evidence.

This is due to the nature of treatment interventions in clinical settings being amenable to high quality experimental methods, and a strong culture of evidence-based practice existing within the healthcare system.

The evidence used for this assessment broadly falls into the following two areas.

System-level research: There are several studies that focus on outcomes from the treatment system as a whole, for example, the Drug Treatment Outcomes Research Study (DTORS).¹⁵⁷ These tend to be large-scale cohort studies that follow the progress of clients in treatment from the start (baseline), and then at several stages in their treatment journey (e.g. six months, one year, and five years). While these studies have strengths, they also have several limitations.

- They lack a non-treatment control group, and subsequently are unable to prove a causal link between treatment and outcomes. However, there are inherent practical and ethical difficulties with establishing an adequate control group in treatment settings (e.g. denying access to effective treatments).
- Clients may present to treatment services at times of crisis, therefore regression to the mean could also explain the positive findings.¹⁵⁸
- Behaviours (such as offending) are often self-reported, and therefore may be under- or over-reported.
- Some analyses have not been age adjusted, therefore reduced drug misuse and criminal activity may in part be down to clients 'growing out' of crime.
- Follow up tends to be biased toward clients who remain in treatment or are contactable, and clients with the worst outcomes are likely to be difficult to contact. Therefore, the findings can reflect changes about the most stable clients, rather than the entire group.

¹⁵⁷ DTORS was a longitudinal study that explored the outcomes of structured drug treatment in England (Jones *et al.*, 2009). The study comprised three key elements: a quantitative study of outcomes, a qualitative study of treatment-related issues, and a cost benefits analysis. DTORS measured outcomes at a first follow-up three to five months after the initial baseline interview, and then again at a second follow-up interview 11 to 13 months after the baseline. DTORS followed a similar study, the National Treatment Outcome Research Study (Gossop *et al.*, 2001).

¹⁵⁸ When measuring observations at two different points, on average those with extreme (either high or low) scores observed in the first round of measurement will tend to be nearer the average score when observed the second time.

In addition, secondary analysis of existing data, including an increase in analysis that matches datasets, has produced a growing body of evidence on treatment outcomes. This research can often overcome some of the limitations mentioned above (e.g. self-reporting).

Intervention-specific studies: These are studies or systematic reviews that focus on interventions within the treatment system. This assessment has prioritised the use of systematic reviews, although when these are not available other studies have been used.

Generally, intervention specific studies are higher quality evidence than the overall studies, and several are able to demonstrate a causal link between the intervention and the stated outcomes. However, while these studies provide good evidence of the effectiveness of a specific intervention, they do not cover the entirety of a client's treatment journey as typically clients will receive a combination of treatments. They also tend to measure more limited outcomes than the national cohort studies.

6.4.1 Central outcomes: Reducing drug use and recovery from dependence

The central outcomes of a reduction in drug use and recovery from dependence are closely connected and are therefore covered together. Overall there is good evidence that drug treatment leads to a reduction in drug use and also positive recovery outcomes.

NDTMS data show that 15.8 per cent of clients in treatment for drug use left successfully¹⁵⁹ in 2014/15 (PHE, 2015a). This has increased from before the start of the strategy (12.2% in 2009/10) to 16.1 per cent in 2011/12, although this has subsequently fallen slightly.

Successful completion of treatment differs substantially by drug type, with higher rates among non-opiate clients than among opiate clients: 39 per cent of non-opiate and 8 per cent of opiate clients in treatment left successfully in 2014/15.¹⁶⁰ Both of these are rates are higher than before the start of the strategy (31% and 6% in 2009/10 respectively), see section 2.1.1, chapter 2, for more detail.

¹⁵⁹ This is determined by clinical judgement that the individual no longer has a need for structured treatment, having achieved all the care plan goals and having overcome dependent use of the substances that brought them into treatment. The denominator for this proportion is all clients in treatment in the year, including those who are retained in treatment at the end of the year.

¹⁶⁰ Figures have been provided by PHE and have not previously been published in this form.

DTORS provides evidence on reduced drug use (Jones *et al.*, 2009).

- All drug types were used by lower proportions of respondents at the follow-up interviews compared with the baseline interviews.
- The proportion using heroin, crack, cocaine, amphetamines or benzodiazepines approximately halved by follow-up. The proportion using non-prescribed methadone or opiates other than heroin or methadone fell by considerably more than half, whereas the proportion using cannabis or alcohol fell by considerably less.
- Among heroin users involved in the baseline interviews, 44 per cent had stopped using at the first follow-up and 49 per cent had stopped using at the second follow-up. Corresponding figures for stopping crack use were higher (53% and 61% respectively).

The NTA (2010) found that there was “*strong evidence that suggests sustained recovery from addiction was found for almost half of all the clients discharged from treatment during 2005/06. Around 46 per cent [did not] come back into treatment... in the following four years.*” It also found that more than two fifths of those clients with an unplanned exit (43%) did not re-present at any time in the subsequent four years, suggesting that many had already received what they needed to overcome their dependency before choosing to leave.

However, this analysis did not determine the reasons why clients did not re-present, and lack of re-presentation to treatment may not always be for positive reasons (e.g. mortality). The study also found that whether someone was discharged from treatment free of *all* illegal drugs, or free of *dependency* made little difference to how likely they were to need further treatment or commit drug-related crimes.

The 2014/15 NDTMS statistics also present evidence on treatment outcomes and representations. These shows that over the period from 2005/06 to 2014/15, a total of 490,246 unique individuals have been recorded in treatment, of whom:

- 132,342 (27%) were retained in treatment on 31 March 2015;
- 182,411 (37%) had exited (treatment incomplete); while
- the remaining 175,493 (36%) had completed treatment and not since returned (PHE, 2015a).

Whilst chapter 5 provides more detail of the role of the criminal justice system (CJS) in diverting drug users into treatment, it is worth noting here that the CJS is an important route into treatment. CJS referrals accounted for around a quarter (24%) of referrals to treatment in 2014/15 (PHE, 2015a). Evidence from DTORS shows that those referred into treatment from the CJS have similar outcomes to other referral sources (Jones *et al.*, 2009), and other studies also show similar results (Schaub *et al.*, 2010. McSweeney *et al.*, 2007).

Opioid substitution therapy

Systematic reviews of the effectiveness of opioid substitution therapy (OST, see section 6.8) found that it reduces drug misuse (Mattick *et al.*, 2014; 2009). Those taking methadone were a third less likely to have morphine positive drug tests compared with the control group (*ibid.*, 2009). Buprenorphine also shows similar reductions (*ibid.*, 2014).

The Advisory Council on the Misuse of Drugs (ACMD)'s Recovery Committee found that "*there is international consensus, and a strong evidence base, supporting the effectiveness of OST in the reduction and cessation of heroin use*" (ACMD, 2014).

Heroin assisted treatment

There is evidence to show that the supervised prescription of heroin (diamorphine) (see section 6.8) as part of a structured treatment plan is effective at reducing illicit drug use in a small group of heroin users who have not been successful in less intensive types of treatment (e.g. methadone or residential rehabilitation). The Randomised Injectable Opiate Treatment Trial (RIOTT) in England found that treatment with supervised injectable heroin leads to lower use of street heroin than supervised injectable methadone or optimised oral methadone (Strang *et al.*, 2010). Studies conducted in other countries show similar findings for supervised injectable heroin, alongside reductions in crime and improvements in health (EMCDDA, 2012).

Residential rehabilitation

The evidence for residential rehabilitation is generally positive, showing that residential rehabilitation can be an effective treatment for some clients and lead them to reducing their drug use and overcoming their dependency. However, the evidence also shows that clients who enter residential rehabilitation differ substantially from clients in community treatment, and that there are high drop out rates from residential rehabilitation.

The NTA (2012a) tracked 4,166 clients in residential rehabilitation during 2010/11, following them up to March 2012. Around three-quarters (76%) had treatment in community services before accessing residential rehabilitation. Around a third of clients (28%) left the treatment system directly from residential rehabilitation, having overcome their dependency and having no further structured treatment need. However, the NTA found that there was a high drop out rate with 36 per cent of clients having left in an unplanned way. Although most of these went back into community treatment, 11 per cent dropped out of residential rehabilitation and left the treatment system.

When assessing the effectiveness of residential treatments over treatment delivered in the community, it is important to be aware that many comparisons are not made on a like-for-like basis. Clients are allocated to pathways based on a clinical judgement about the most appropriate intervention for them, alongside considerations such as availability and funding. Additional analysis of DTORS data showed that clients who entered residential rehabilitation differed in several key respects from those who received OST in the community (Millar *et al.*, 2014). While these clients had worse problems in some respects (more likely to report problematic use of non-prescribed methadone, other opiates, or alcohol), they also had higher motivation than those in community OST; an important indicator of treatment retention.

The Drug Outcome Research in Scotland (DORIS) study recruited 1,033 clients from drug treatment centres (McKeganey *et al.*, 2006) and found that those who had experienced residential rehabilitation were more likely than their peers to have experienced a 90-day period of total abstinence.

The NICE (2007d) guidelines that cover residential rehabilitation found, at the time, a lack of well-conducted studies, and therefore found it difficult to draw conclusions as to whether residential treatments confer any advantages over well-delivered community-based intervention.

Detoxification

NICE (2007d) guidelines on opioid detoxification (see section 6.8) in different settings (such as community, inpatient and prison) recommended that detoxification should be a readily available treatment option for people who are opioid dependent and have expressed an informed choice to become abstinent.

The British Association of Psychopharmacology (BAP) review found that there was robust evidence of effectiveness for three pharmacological approaches to opioid detoxification: methadone at tapered doses; buprenorphine; or adrenergic agonists such as lofexidine (Lingford-Hughes *et al.*, 2012).

The Scottish Executive (2004) reviewed the evidence on the effectiveness of residential detoxification and found that completion rates for residential detoxification programmes (75 to 80%) were considerably higher than community detoxification programmes (20 to 53%). It also found that successful detoxification is often followed by relapse, which can lead to elevated mortality. Therefore detoxification should best be viewed as part of a treatment process that is then followed up with further structured care.

Psychosocial interventions

'Psychosocial interventions' cover a broad range of interventions, including brief interventions, counselling, cognitive behavioural therapy and contingency management (see section 6.8). These are often delivered as part of structured day programmes providing a range of interventions where a client must attend several days per week.

NICE (2007d) guidelines on psychosocial interventions include the following evidence on brief interventions.

- People who misuse cannabis or stimulants and are not in formal drug treatment (i.e. those who are unlikely to be dependent) appear to respond well to brief interventions, both in terms of increased abstinence levels and reduced drug misuse.
- People who misuse opioids who are not in formal drug treatment may also benefit from brief interventions. For those already in treatment (i.e. those who have been diagnosed as dependent) it does not appear that brief interventions have any effect on drug misuse or abstinence.

These guidelines also found that cognitive behaviour therapy (CBT) appeared to be effective for cannabis dependence. However, CBT was not effective for the treatment of cocaine dependence.

NICE (*ibid.*) guidelines state that there is evidence that contingency management is effective in reducing illicit drug use for those who misuse stimulants and those on OST, and that it is also effective at improving participation in testing and immunisation interventions.

NICE guidelines do not support the use of psychosocial treatments as a stand-alone intervention for opioid dependence, although psychosocial treatments can be used alongside OST (in 2012/13,¹⁶¹ there were 27,855 clients receiving prescribing alongside psychosocial interventions) (PHE, 2013). A systematic review (Amato *et al.*, 2011a) found that a combination of OST and psychosocial interventions were more effective than OST alone for opioid detoxification, with reductions in dropouts and use of opioids. However, another systematic review that looked at treatment for dependence (rather than detoxification) found that adding psychosocial support to standard OST did not add additional benefits (Amato *et al.*, 2011b).

6.4.2 Overlapping outcomes

6.4.2.1 Reduce/eliminate health harms

It is likely that treatment is effective at reducing the health harms from drug misuse, as evidenced below. For example, DTORS found the following reductions in self-reported health harms (Jones *et al.*, 2009).

- Of those who reported sharing injecting equipment at the baseline, 72 per cent did not share at the first follow-up, rising to 77 per cent at the second follow-up. This is likely to lead to a reduction in health harms such as blood borne viruses.
- Rates of overdose in the three months prior to interview among treatment seekers more than halved from 9 per cent at the baseline to 3 per cent and 4 per cent at the first and second follow-ups.
- Measures of self-reported mental well-being improved by the first follow-up, but stayed below the UK norm.

White *et al.* (2015) linked NDTMS data to drug-poisoning death data from 2008 to 2011 and estimated that an average of 880 fatal opioid-related poisonings were prevented by drug treatment each year. Assuming that this preventative effect has been constant, this would mean that the treatment system has prevented an estimated 4,400 opioid-related deaths over the life of the Drug Strategy 2010.

Treatment can also have additional benefits to clients' health by acting as a gateway to wider health services (e.g. access to vaccines, identification of other health problems, and referral into other health services). For example, uptake of the hepatitis B vaccine among injecting drug users increased from around half in 2004 to almost three-quarters in 2014, although uptake has declined slightly over the strategy period (from 76% in 2011 and 72% in 2014) (PHE, 2015c). Uptake of testing for hepatitis C¹⁶² among injecting drug users has remained stable over the life of the strategy (83% had ever had a test in 2014, a similar level as 2010, 82%).

¹⁶¹ That last year that data were presented in this manner.

¹⁶² Unlike hepatitis B, currently there is no vaccine available for hepatitis C.

Specific interventions are also effective at reducing health harms (as shown below), and for certain interventions (e.g. needle and syringe programmes) this is the primary aim.

Opioid substitution therapy

Systematic reviews of the effectiveness of OST found that it improves health (Mattick *et al.* 2014; 2009). For example, the risk of death for those on methadone is around half that of the control group who are not on methadone (relative risk of 0.48) (*ibid.*, 2009).

The ACMD's Recovery Committee found that "*there is international consensus, and a strong evidence base, supporting the effectiveness of OST in the reduction of drug injecting and related blood-borne viruses*" (ACMD, 2014). The Scottish Government's (2013) independent expert review into OST also found similar results, finding that "*the benefits to positive physical health and reduction in blood-borne viruses are strongly supported by the evidence*".

Needle and syringe programmes

The NICE (2014) guidelines on needle and syringe programmes (NSPs, see section 6.8) report that there is strong evidence that NSPs reduce the sharing of needles among intravenous drug users and that NSPs can reduce the incidence of infectious diseases such as HIV (see also WHO, 2004).

Other studies have also found evidence of the effectiveness of NSPs in reducing health harms:

- MacDonald *et al.* (2003) analysed data from 63 cities without NSPs and 36 cities with NSPs across the world and found that HIV prevalence decreased by 18.6 per cent per annum in cities with NSPs, and increased by 8.1 per cent in cities that had never introduced NSPs.
- Turner *et al.* (2012) conducted a meta-analysis and pooled-analysis across six UK cities, finding that OST alongside high NSP coverage can reduce hepatitis C transmission among injecting drug users.

Although reducing health harms is the primary aim of NSPs, these services may also have additional benefits. The low threshold nature of these services can help to make the first contact with users who are not in treatment. They can subsequently engage them with services, and act as a referral point into structured treatment.

In August 2014, legislation was laid that allows the lawful provision of foil in NSPs and other treatment providers, to encourage users into treatment and also to encourage a move from injecting to smoking heroin, thus reducing injection related harms.¹⁶³ Unlike other drug paraphernalia (e.g. needles), it is a condition that foil can only be provided in the context of structured steps either to engage people in a treatment plan or as part of a treatment plan.

¹⁶³ <https://www.gov.uk/government/publications/circular-0142014-lawful-supply-of-foil>

Qualitative research with needle exchange professionals found that they considered foil provision as beneficial to treatment and recovery outcomes (Home Office, 2016). This included: broadening the reach of services; contemplation of treatment; engagement with treatment services; reduced injecting occasions; and reduced dangerous injecting. The conditions attached to the lawful provision of foil were generally adhered to by providers interviewed.

There is some limited additional evidence that providing foil can help to engage NSP attendees in discussions about ways of reducing injecting risks and can support users in the move towards engaging in structured treatment (Pizsey and Hunt, 2008). The ACMD (2010) also reached positive conclusions on foil's effectiveness including:

- reducing injecting behaviour;
- increasing contact between users and treatment services;
- reduced systematic infections; and
- lower risk of overdose.

Take home naloxone

Over the period of the Drug Strategy 2010 there has been an increased focus on expanding the provision of naloxone (see section 6.8) and the easing of prescription restrictions took place in October 2015 (PHE, 2015c). Research is underway to strengthen the evidence base on naloxone in the UK. For example, researchers are evaluating the provision of naloxone to released prisoners in Scotland (Bird *et al.*, 2015).

There is wider international evidence that supports the effectiveness of naloxone in reducing opioid deaths:

- The ACMD's (2012) review of national and international evidence on naloxone reported that "*The efficacy of naloxone is not in dispute. ...efficacy has been proven in several published studies and pilots*".
- WHO (2014) guidelines on the community management of opioid overdose strongly recommend that "*People likely to witness an opioid overdose should have access to naloxone and be instructed in its administration*".

6.4.2.2 Reduce/eliminate crime harms

Evidence from studies examining the impact of treatment and studies of specific interventions shows reductions in drug-related crime following treatment.

DTORS showed reductions in several self-reported measures of crime¹⁶⁴ following entry into structured treatment (Jones *et al.*, 2009).

¹⁶⁴ Self-reported offending can be a more accurate measure of offending than recorded crime, as it will include offences that have not been detected or reported to the police. DTORS collected this information in a self-completion section of the interviews in order to encourage honest responses, although (as with most self-reported data) it was not possible to verify the reported offending.

- The proportion who reported committing any acquisitive offences in the 4 weeks prior to interview fell from 40 per cent at the baseline to 21 per cent at the first follow-up (six months) and 16 per cent at the second (12 months).
- 61 per cent of those reporting some offending in the baseline interviews reported no offending in the 4 weeks prior to the first follow-up, rising to 68 per cent at the second follow-up.
- The proportion who reported committing any crime specifically to fund their drug use fell from 22 per cent at the baseline to 8 per cent at the first and 7 per cent at the second follow-up.

The NTA published three studies that looked at the overall effectiveness of the drug treatment system in reducing offending. All were based on the analysis of matched data (i.e. individual treatment and criminal justice data) to see if treatment reduced offending.

- The NTA (2010) matched four years' of data from the NDTMS, Drug Test Records (DTR) and the Drug Interventions Programme (DIP) to evaluate the long-term outcomes of those in drug treatment. This found that around 46 per cent of treated clients did not have a drug-related contact with the criminal justice system in the following 4 years. The study also found that whether someone was discharged from treatment free of all illegal drugs or just free of their drug of dependency made little difference to how likely they were to need further treatment or commit crimes.
- The NTA (2012b) used data from NDTMS, DTORS and the Police National Computer to create a value for money model that estimated the crime prevention benefits of treatment and recovery. This estimated that drug treatment in England may have prevented approximately 4.9 million crimes in 2010/11.
- The NTA (2012c) analysed the impact of treatment on reoffending using data from those who started a new course of drug treatment in 2006/07 and who had at least one conviction during the previous two years. Those who were retained in treatment for 2 years showed an average 47 per cent reduction in convictions compared with the 2 years prior to treatment. Those who dropped out of treatment only reduced their convictions by 15 per cent.

As well as evidence on the effectiveness of the treatment system, there is also evidence that specific interventions within the treatment system reduce crime harms, these are detailed below.

Opioid substitution therapy

Systematic reviews that have looked specifically at the effect of OST on crime outcomes find that it is effective at reducing crime (Perry, *et al.*, 2014; Holloway, *et al.*, 2006.). The ACMD's Recovery Committee's review of the OST evidence base also supports this (ACMD, 2014). The previously mentioned studies of the wider treatment system can also be related to OST.

Other reviews of the effectiveness of prescribing methadone and buprenorphine for opioid dependence have not found statistically significant reductions (Mattick *et al.*, 2014; Lingford-Hughes *et al.*, 2012; Mattick *et al.*, 2009). However, it is likely that these findings are down to the selection criteria used for the reviews, which focussed primarily on opioid

dependence rather than criminality. The BAP state that the trials included “*were not suitable to measure the effects on criminality, and that large-scale cohort studies show substantial effects on these outcomes*”.

Heroin assisted treatment

Findings from the RIOTT in England, which operated in three locations, show that treatment with supervised injectable heroin leads to lower levels of offending (Byford, *et al.*, 2013; Strang, *et al.*, 2010). A smaller proportion of the injectable heroin group reported committing any crimes over the treatment period (37% compared with 43% of the oral methadone group and 45% of the injectable methadone group). In addition, the number of crimes committed in each group was lower in the injectable drug groups (241 crimes in the injectable heroin group, 278 crimes in the injectable methadone group, and 764 crimes in the oral methadone group).

In 2012 DH commissioned a three-year Injectable Opioid Treatment (IOT) pilot with sites in the same three locations as RIOTT. The aim of this was to explore the delivery of supervised injectable heroin treatment and possible appropriate referral pathways into and out of the treatment, and to consider the cost-effectiveness of the provision. The report of the Expert Group overseeing the pilots is due to be published in 2017.

6.4.2.3 Reduce/eliminate unemployment harms

There is a relative lack of evidence to support this part of the logic model. Given the other benefits of treatment (e.g. increased stability, reduced drug misuse and reduced offending), it is plausible that treatment would have a beneficial impact on employment. It is also likely that improved employment prospects aid recovery (see chapter 7 on non-treatment rehabilitative activity).

DTORS is one of the few UK studies that included employment as an outcome measure so provides some evidence (Jones *et al.*, 2009).

- Employment levels improved from 9 per cent at the time of the baseline interviews to 11 per cent at the first follow-up and 16 per cent at the second.
- The proportion classed as unemployed and not looking for work fell from 24 per cent to 17 per cent and 11 per cent.

6.4.2.4 Reduce/eliminate harms to education

Other benefits gained from treatment that stabilise clients (e.g. reducing crime and health harms) should also help to improve a client’s educational outcomes although there is relatively limited UK evidence for this. However, being in education can be a protective factor against drug misuse (see chapter 3 for further information).

Data from NDTMS show that in 2014/15, 53 per cent of young people accessing specialist substance misuse services were in mainstream education, 19 per cent were in alternative education, 17 per cent were not in employment, education or training (NEET), and 5 per cent

were in apprenticeships or training (PHE, 2015b). This suggests that while many of these young people face a range of problems, some will be attending school or college (NTA, 2012d).

There is some evidence that treatment can improve educational attainment. Liddle *et al.* (2001) conducted an RCT on 182 cannabis- and alcohol-misusing young people in the USA (the substance misuse profile is similar to the UK). This found that several different types of treatment were effective in improving educational outcomes.

As most adults are not in full-time education, few studies of adults in treatment include education as an outcome. There is some limited evidence from DTORS that shows the proportion of clients in full-time education increased from 1 per cent at the baseline to 3 per cent at the second follow-up and there were also increases in those on training schemes (Jones *et al.*, 2009).

6.4.2.5 Reduce/eliminate harms to housing

Improving the stability of client's lives is an important step towards recovery and getting a client into stable accommodation is one way of achieving this. Although this is not a commonly included outcome in studies, there is some evidence that shows that treatment can have a positive impact on housing.

For example, findings from DTORS show improvement in housing status (Jones *et al.*, 2009).

- The proportion of treatment seekers who had stayed only in stable accommodation during the previous four weeks increased from 60 per cent at the baseline to 77 per cent at the second follow-up.
- The proportion who stayed only in unstable accommodation fell from 21 per cent at the baseline to 15 per cent at the second follow-up.

Evidence from NDTMS also shows improvements in housing. In 2014/15, 20 per cent of opiate clients and 14 per cent of non-opiate clients had a housing problem when entering treatment; this improved to 14 per cent and 7 per cent respectively when these clients were reviewed (PHE, 2015a).

6.4.2.6 Reduce/eliminate indirect harms

Of the five outcomes at this stage in the logic model, this has perhaps the least supporting evidence as very few studies include other indirect harms (e.g. to friends, family and community) as outcome measures. Given the other benefits of treatment (e.g. increased stability, reduced drug misuse, lower crime) it is likely that treatment will reduce these indirect harms. Equally, it is also likely that supportive families and friends will also help individuals to achieve recovery (NTA, 2012e). Findings from DTORS show reductions in harms to families as the proportion of parents of dependent children having all their children living with them rose from 22 per cent at the baseline to 34 per cent by the second follow-up (Jones *et al.*, 2009).

The ACMD's Recovery Committee (ACMD, 2013) focussed on the role that families can play in recovery and concluded that there is evidence that:

- those who come from troubled or dysfunctional families are more likely to develop drug or alcohol dependence than others; and
- families or partners may hinder recovery (if they are dysfunctional or have dependence issues themselves) or aid recovery (if they are supportive). There is emerging evidence that supportive local communities can enable recovery.

6.4.3 Treatment in prisons

Drug treatment in prisons follows the same NICE (2007d) and DH guidelines (DH and the devolved administrations, 2007) as those interventions delivered in the community. The evidence shows effectiveness across several of the outcomes in the logic model, including reductions in drug use, reoffending and health harms. However, a great deal of evidence in this area is from the USA, and the same results may not necessarily translate to the UK prison system due to differences in cultural and legal differences.

Patel (2010) reviewed the evidence base for drug treatment and interventions in prisons (incorporating over 160 peer reviewed papers) and found:

“...good quality drug treatment and interventions are effective and can contribute to a reduction in re-offending and reduced mortality from accidental drugs overdose or chronic health problems such as blood borne viruses.”

Mitchell *et al.*'s (2012) systematic review on the effectiveness of prison-based drug treatment on criminal behaviour found that the overall average effect was approximately a 15 to 17 per cent reduction in recidivism and drug relapse. However, effects varied depending on the specific intervention delivered:

- therapeutic communities had relatively consistent but modest reductions in recidivism and drug relapse;
- counselling programmes reduced recidivism but not drug relapse;
- maintenance programmes reduced drug relapse but not recidivism; and
- boot camps had negligible effects on both recidivism and drug relapse.

Another systematic review (Hedrich *et al.*, 2012) found that the benefits of OST in prisons were similar to those found in a community setting. Prison-based OST helped to reduce illicit opioid use and risk behaviours in prison and potentially minimised overdose risks on release.

Recidivism rates among prisoners who completed the 'Rehabilitation for Addicted Prisoners Trust' (RAPt) programme were lower (less likely to offend within a year of release) than those who completed another prison-based treatment programme and those who did not complete RAPt (Kopak *et al.*, 2015).

Drug Recovery Wings (DRWs) have also been implemented during the period of the Drug Strategy 2010. Piloted in 11 prisons,¹⁶⁵ these are dedicated wings, or entire prisons that are targeted at those serving sentences under 12 months (although they are open to all) who are dependent on drugs/alcohol with the aim of offering a route out of dependency, increase the number of short sentenced offenders participating in recovery-focussed interventions, and improve continuity of care, support and treatment between prisons and the community. Findings from a process evaluation identified lessons from the pilot (NOMS, 2014). A major Department of Health funded independent evaluation of the DRW pilots has yielded several interim publications to date (e.g. Liebling *et al.*, 2014) and the final publication is expected in 2017.

The integrated drug treatment system (IDTS) was launched in 2006 and continued into the period of the strategy; it has now been mainstreamed into prison treatment. The primary aim of IDTS was to expand and improve drug treatment provision in prisons. An independent evaluation of IDTS found that “*the expansion of treatment under IDTS was felt to have increased access to psychosocial and clinical treatment for substance misuse. However, staff and prisoners were also of the view that unmet need remains within the prison population*” (NatCen, 2015). The evaluation also showed evidence of reduced drug misuse, 94 per cent of respondents stated that they had taken an illicit drug in the four weeks prior to entering custody, whereas 57 per cent had taken illicit drugs in the four weeks prior to the post-release survey.

6.4.4 Young people

There is evidence that treatment for young people under 18 is effective at reducing substance use (NTA, 2009). Different treatment interventions have been compared in long-term outcome studies (Morral *et al.*, 2006 and Dennis *et al.*, 2004, cited in NTA, 2009) and all were able to demonstrate effectiveness, although no intervention was found to be statistically significantly more effective than any other.

In 2003 the Youth Justice Board (YJB) secured funding for an initial three-year period to develop integrated substance misuse services for the secure estate for children and young people (National Specification for Substance Misuse for Juveniles in Custody).¹⁶⁶ This was introduced across the secure estate in 2004, becoming largely integrated by 2006. Comparisons with 2003 showed reductions in cannabis, ecstasy, crack and heroin use and, generally, increases in screening, treatment provision and access to services (YJB, 2009). During the period of the Drug Strategy 2010, the Young People Substance Misuse Service has moved from being centrally-funded by NOMS to being commissioned through local NHS providers of health services to custodial establishments.

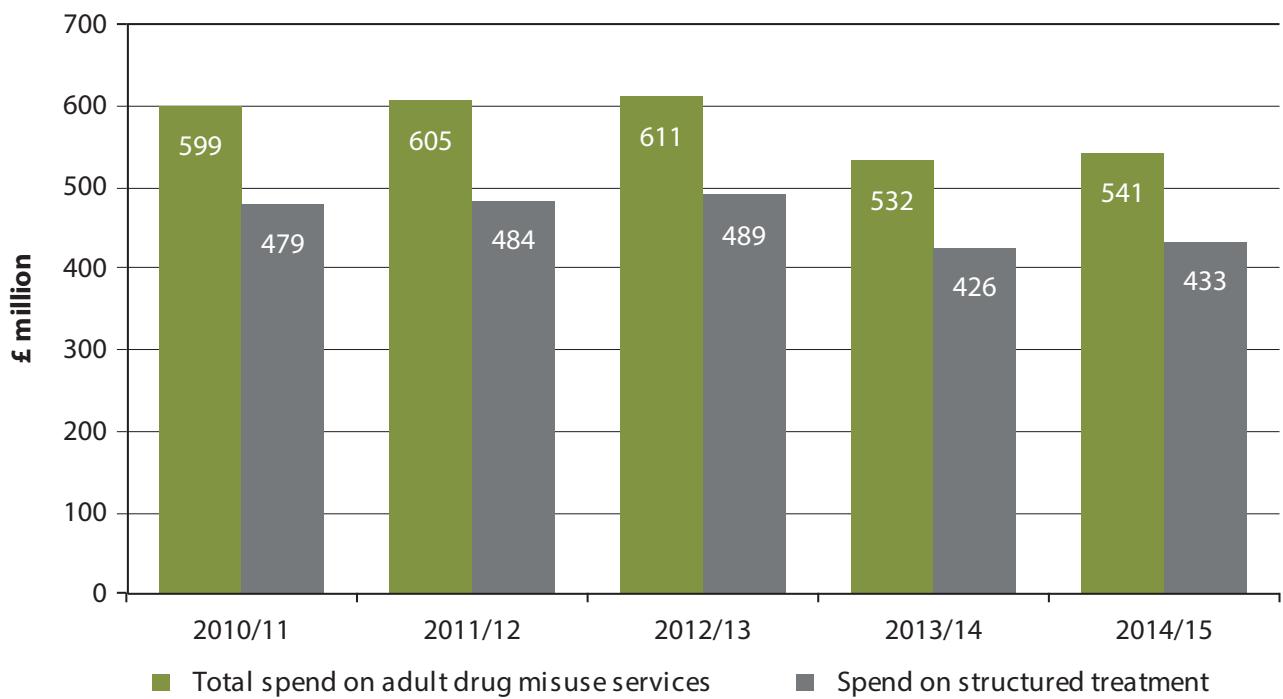
¹⁶⁵ This encompassed five adult prisons from 2011 and a further six prisons in 2012 (which also included prisons for women and young offenders).

¹⁶⁶ This was based on best practice guidance and quality standards covering five main elements: identification and assessment; education and prevention; support and programmes; detoxification and clinical management; and throughcare and resettlement.

6.5 Estimates of central government spend on treatment

The estimated central government expenditure on adult drug misuse services was £541 million in 2014/15,¹⁶⁷ of which £433 million was spent on structured treatment (see Figure 6.3). A further £24 million was spent on substance misuse (including alcohol) services for young people. In 2013/14 £109 million was spent on treatment in prisons (spend in 2014/15 is not available). Although these are the best available estimates of spend on drug treatment, caution is advised as there is uncertainty over the accuracy of some of these figures. Further information on how these estimates have been produced is available in Appendix A6.1.

Figure 6.3: Estimates of central government spend on adult drug misuse services (excluding prisons¹⁶⁸), England, 2010/11 to 2014/15



Source: Public Health England

Overall, spend on adult drug treatment (excluding prisons) remained stable for the first three years of the strategy although there are signs that spend may have fallen in 2013/14. The fall may in part be accounted for by the different method used to collect information on spend in 2013/14 (see Appendix A6.1). The level of spend was similar in 2014/15 at an estimated £541 million.

¹⁶⁷ This figure excludes spend in prisons.

¹⁶⁸ Estimated spend in prisons and on young people are not included in Figure 6.3 due to differences in how these figures are estimated.

However, the fall in 2013/14 did also coincide with reports of disinvestment in treatment services. A PHE review (2014b) found that while the majority of councils (52.2%) had no planned change to investment in drug and alcohol services in 2014/15, 27.7 per cent of councils planned to reduce their investment.¹⁶⁹ The State of the Sector survey by DrugScope (2015) supported these findings.

Spend on substance misuse (including alcohol) services for young people and on treatment in prisons has largely remained stable under the strategy.

- £25 million was spent in each year between 2010/11 and 2013/14 and £24 million in 2014/15 on substance misuse (including alcohol) services for young people.
- £108 million was spent on treatment in prisons in 2011/12, a similar level to 2013/14 (£109 million).

6.6 Evidence of the value for money of central government spend on treatment

This section presents evidence on cost effectiveness, alongside an estimate of benefits from structured adult drug treatment.¹⁷⁰ It shows that the benefits of the treatment system outweigh the costs, with studies of the overall system and individual interventions showing positive value for money.

The included studies are mainly cost–benefit analyses, which have been used to determine quality-adjusted life years (QALYs) in NICE guidelines (see Box 6.2). Cost-effectiveness can include both direct savings to public spending (e.g. savings to the NHS from not having to treat HIV infections that have been prevented) and benefits to wider society (e.g. costs to victims of physical or psychological harm).

¹⁶⁹ Some local authorities planned to only reduce spend in 2015/16. 12 local authorities intended to reduce funding in both 2014/15 and 2015/16.

¹⁷⁰ The *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013a) suggested evaluating structured and non-structured drug treatment separately. However, it has not been possible to produce an estimate of benefits for non-structured treatment due to a lack of applicable evidence.

Box 6.2: Types of evidence used to assess value for money

Cost–benefit analysis looks at the total cost of delivering an intervention and compares this against the total benefits delivered from the intervention. For example, if an intervention cost £10,000 to deliver, but produced benefits of £30,000, it would have a benefit–cost ratio (BCR) of 3:1.

The QALY is used for assessing medical interventions, and considers both the quality and the quantity of life lived, alongside the cost of achieving this. This is usually expressed as the cost of gaining one QALY; the higher this is, the greater the cost to achieve one extra year of life. High values can indicate that an intervention may be effective but very expensive to deliver, or less effective but cheaper to deliver. Similarly, a low value would suggest an intervention is both effective and cost-effective. For example, if an intervention cost £10,000 for each individual, and this caused an individual to live for an extra two years in perfect health, it would cost £5,000 per QALY.

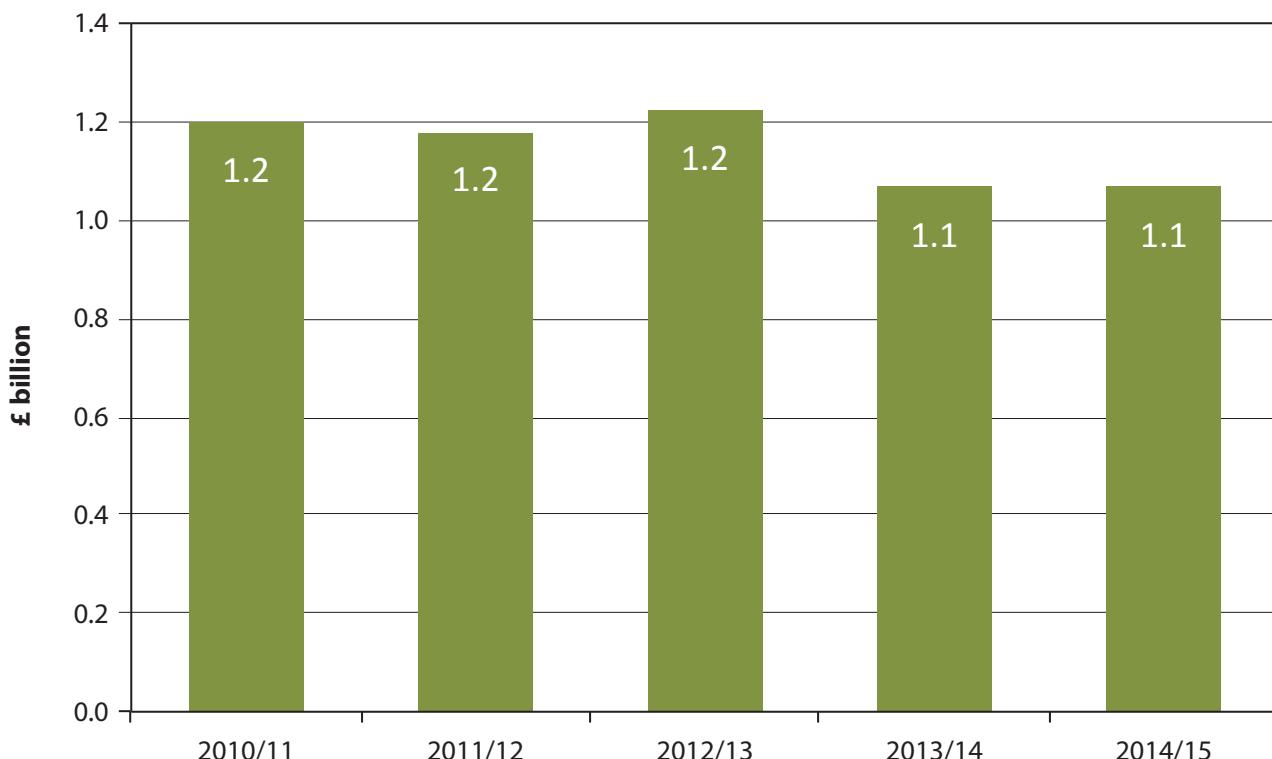
Generally, NICE considers interventions costing the NHS less than £20,000 per QALY as cost-effective. Those costing between £20,000 and £30,000 per QALY gained may also be cost-effective, if certain conditions are satisfied.

QALYs may underestimate the true benefits of some interventions, as they only look at the benefit (in life-years) for the individual treated. Therefore this misses out benefits to wider society such as reduction in crime, and other costs (e.g. social security costs). This means that some interventions that appear only marginally cost-effective using QALYs, may be more cost-effective if wider benefits were also costed. For this reason, cost–benefit analyses should not just look at QALYs in isolation; wider savings (e.g. a reduction in crime) should also be considered.

Overall structured treatment – cost-effectiveness

DTORS estimated that for every £1 spent on structured treatment, there was a benefit of £2.50 to society (Davies *et al.*, 2009). Estimating the benefits from spend on structured adult drug treatment under the Drug Strategy 2010 results in around £1.1 or £1.2 billion of benefits from each year's spend under the strategy between 2010/11 and 2014/15 and total benefits of £5.8 billion (Figure 6.4).

Figure 6.4: Estimated benefits of structured adult drug treatment, England, 2010/11 to 2014/15



Overall, the net benefits of structured drug treatment were estimated to be positive, both overall and at the individual level, in around 80 per cent of cases. The average cost per client of drug treatment over the whole DTORS sample was estimated to be £6,064. However, it is uncertain how applicable the findings are to the current situation as DTORS presents costs and benefits from 2006/07, prior to the implementation of the Drug Strategy 2010 and subsequent changes to commissioning.

The NTA (2012b) estimated that drug treatment in England resulted in savings to society of £960 million in 2010/11. They also calculated the impact of potential disinvestment, finding that for every £1 million taken out of the treatment system there could be an increase of approximately 9,860 drug-related crimes per year at an estimated cost to society of over £1.8 million.¹⁷¹

Opioid substitution therapy – cost-effectiveness

It is likely that OST in general is cost-effective, with certain forms of OST likely to be more cost-effective than others. Comparing methadone with buprenorphine, NICE reports £13,700 per QALY for methadone and £26,400 per QALY gained for buprenorphine (NICE, 2007a).

¹⁷¹ The crimes included are trigger offences known to be strongly associated with drug use, such as acquisitive crimes.

However, the recent launch of generic buprenorphine and the subsequent reduction in cost will have narrowed this difference.

NICE (2007b) guidelines also support the use of naltrexone in a selected group of people who are highly motivated to achieve abstinence. The QALY (£42,500) for naltrexone plus psychosocial therapy compared with psychosocial therapy alone is much higher than other forms of OST.

Heroin assisted treatment – cost-effectiveness

Cost benefit analysis of the RIOTT trial found that the cost of injectable heroin is higher than oral methadone. Over the 26-week intervention, injectable heroin cost £8,995, injectable methadone cost £4,674 and oral methadone cost £2,596 (Byford *et al.*, 2013). Since injectable heroin had greater benefits, the overall costs (including crime) were higher for oral methadone (£15,805) compared with £13,410 for injectable heroin and £10,945 for injectable methadone. The lower overall cost for injectable methadone reflects the lower cost of providing this treatment compared with injectable heroin, although the overall benefits are also lower.

It is important to note that injectable heroin is only given to a small minority of deeply entrenched heroin users, although for this group there is a 70 per cent chance that injectable heroin is more cost-effective than oral methadone.

Residential rehabilitation – cost-effectiveness

Although typically accessed for a limited and pre-determined amount of time, residential rehabilitation is much more expensive per week than community treatment. On average for a heroin user, the annual cost for treatment that includes residential rehabilitation is about £10,000, compared with £2,000 for community treatment only (NTA, 2012a).

Total spend on residential rehabilitation was reported to be £42 million in 2010/11 and “*although residential rehab only accounts for 2 per cent of treatment activity in terms of user numbers, the additional cost means it accounts for 10 per cent of central community treatment funding*” (NTA, 2012a).

The Department for Work and Pensions (DWP, 2015) analysed the different costs and savings of treatment pathways (including residential rehabilitation) for those dependent on opiates. This is an inherently difficult task due to the very small number of clients in residential rehabilitation and the fact that it is not possible to directly compare clients on different pathways.¹⁷² A relatively small population of the treatment population are in residential rehabilitation: 4,596 clients in 2014/15 out of a total of 206,117 clients (PHE, 2015a). The decision to send a client to residential rehab is a local one based on clinical assessment and advice, and often the decision of a local funding panel. Many clients will also spend time in community treatment both before and after their time in residential treatment.

172 Although adjustments were made for client complexity in this study.

The indicative analysis suggested that opiate clients on pathways with a residential component generally had better outcomes in terms of positive completions than those on a community-only pathway. However the average cost of treatment on a residential pathway was much higher than a community pathway. Even with the benefits from residential treatment, the savings (which may not be cashable) did not fully offset the higher cost of residential pathways over the 3-year period considered (assumed continued savings, it could take approximately 12 years for savings to offset the additional cost of residential pathways compared with community based pathways).

Detoxification – cost-effectiveness

A costing report published alongside the NICE (2007c) guidelines on opioid detoxification found that inpatient treatment was substantially more expensive than community-based detoxification. Nevertheless, NICE found that healthcare savings for implementing the full guidelines on detoxification would be £4.1 million, and there would be an additional £37.2 million of savings to society outside of the NHS in the CJS.

Psychosocial interventions – cost-effectiveness

The NICE (2007d) guidelines on psychosocial interventions give the cost of QALYs for a number of individual interventions.

- Contingency management¹⁷³ had a cost of £11,222 to gain 1 QALY over standard care.
- CBT had a cost of £31,151 per QALY for cannabis users, suggesting that it is not cost-effective in this instance. However, as this is just over the standard NICE threshold (see Box 6.2), consideration of additional benefits outside of QALYs may mean that it is cost-effective.

The NICE (2007d) guidelines are accompanied by a detailed costing report. This states that a full national implementation of the guidelines on psychosocial interventions would cost £13.4 million, with healthcare benefits of £4.1 million, and wider social (mainly CJS) benefits of £37.2 million.

Needle and syringe programmes – cost-effectiveness

Given the low costs of NSPs and the potentially high cost of any blood-borne viruses, it is likely that NSPs are cost-effective. It is estimated that the cost of injecting equipment for a person who injects psychoactive drugs is around £200 per year and for a person who injects image and performance enhancing drugs around £6 per year plus dispensing costs (NICE, 2014). This compares with treatment costs for hepatitis C infection of between £22,000 and £41,000 and the annual cost of anti-retroviral and other treatment for a person with HIV infection being between £10,000 and £42,000 (NICE, 2014).

The NICE guidelines model the cost-effectiveness of expanding NSP provision. This modelled a range of different scenarios (a 12.5% and 25% increase in NSP coverage for a high and low incidence city) and found QALYs costs between £12,300 and £38,700.

¹⁷³ The provision of incentives to clients; these are contingent on maintaining or avoiding specified behaviours, such as avoiding the use of illicit drugs.

NSPs can also act as referral point into treatment, and when these effects were modelled, it showed that a 13.5 per cent increase in the rate of referral to opioid substitution therapy resulted in a cost per QALYs of between £11,000 and £17,000, depending on prevalence (*ibid.*).

The WHO (2004) report that “*...a number of careful studies...have demonstrated convincingly that needle syringe programmes are cost-effective*”.

Young people’s treatment – cost-effectiveness

A Department for Education funded study estimated a benefit of between £4.66 and £8.38 for every £1 spent on drug and alcohol treatment for young people under 18 (Frontier Economics, 2011); higher than the BCR identified for adult structured treatment. This is likely to be due to the inclusion of predicted long-term benefits. When only the immediate benefits are considered, the ratio falls to £1.93 of benefits for every £1 spent. There is a high level of uncertainty when predicting over a long timescale and the estimate also relied on self-reported crime (from treatment outcome profiles).

6.7 Conclusion

Generally there is evidence to support the assumptions in the logic model. A wide range of treatment activity is delivered to a large proportion of the target population and there is robust evidence for the effectiveness of drug treatment in England.

Evidence from evaluations of the treatment system as a whole, and from individual interventions, suggests that treatment results in reduced drug use and increased recovery from dependence. In turn, the benefits from being in treatment and reducing or ceasing drug use also lead to reductions in drug-related harms.

The central government spend on adult drug treatment was £541 million in 2014/15, of which £433 million was spent on structured treatment. A further £25 million was spent on substance misuse (including alcohol) services for those under 18. In 2013/14 £109 million was spent on treatment in prisons. But while spend on adult drug treatment (excluding prisons) remained stable for the first three years of the strategy, there are signs that spend may have fallen in 2013/14.

At a system level DTORS estimated that for every £1 spent on structured drug treatment £2.50 was saved to society. This leads to an estimated £1.1 billion in benefits from structured treatment spend in 2014/15, meaning the benefits from structured treatment alone were greater than the total spend on the entire treatment system that year.

As there is good evidence for the effectiveness and cost-effectiveness of the specific interventions within non-structured treatment, it is possible that the total benefits of the treatment system will be even higher. This suggests that the treatment system is providing good value for money, as well as considerable benefits to individuals and wider society.

6.8 Glossary of interventions

Brief interventions are short interventions that comprise two parts:

- identification of problematic drug use; and
- brief advice on the harms of this use and how to reduce it.

These types of interventions are commonly used to treat problematic alcohol use, but are also used for drug misuse. These interventions last between 5 and 30 minutes and are generally delivered in a primary care setting.

Cognitive behavioural therapy (CBT) is a time-limited intervention with an emphasis on identifying and modifying irrational thoughts, managing negative moods and intervening after a lapse to prevent a full-blown relapse.

Contingency management provides incentives to clients that are contingent on maintaining or avoiding specified behaviours, such as avoiding the use of illicit drugs. These can include vouchers, prizes or money.

Detoxification is the process by which the effects of drugs are eliminated from dependent users in a safe and effective manner, so that withdrawal symptoms are minimised.

Heroin assisted treatment is a form of opioid substitution therapy (OST) (see below), not widely available in the UK, where diamorphine (pharmaceutical heroin) is prescribed to dependent users, usually for supervised use. This is typically confined to a small group of deeply entrenched heroin users for whom oral OST (e.g. methadone) has not been effective.

Needle and syringe programmes (NSPs) are services that supply free injecting equipment (e.g. needles, syringes, sharps bins) to illicit drug users. They aim to discourage the sharing and reuse of injecting equipment, and therefore reduce the transmission of infectious diseases, and improve the health of users. They also aim to reduce drug-related litter, the risk of needlestick injuries to the public, and act as a referral point into the wider drug treatment system.

Non-structured treatment refers to information, advice and other services related to substance misuse provided in general and open-access services.

Opioid substitution therapy (OST) is an intervention where individuals who are dependent on opioids (primarily heroin) are prescribed a substitute. Most commonly this is either methadone or buprenorphine prescribed in community settings. OST aims to stabilise the individual on the substitute drug (for example, methadone). Doses are titrated to establish a suitable starting level, followed by either a withdrawal regimen (where the dose is gradually reduced) or maintenance treatment.

Psychosocial interventions are interventions that focus on psychological or social factors, such as cognitive behavioural therapy and contingency management.

Residential rehabilitation is a broad term used to describe treatment interventions that are delivered in a residential setting where clients are expected to stay for a set period of time. This contrasts with community interventions, where clients are not required to be resident.

Structured treatment includes comprehensive packages of specialist drug- and alcohol-focussed pharmacological, psychosocial and other interventions that follow a comprehensive assessment of need and are delivered according to a recovery care plan that is regularly reviewed with the client.

Take-home naloxone is the practice of giving naloxone, the emergency antidote to opioid overdoses, to those at risk of opioid overdoses. This could be opioid users who have just been released from prison, those using opioids, or family members of opioid users. This ensures naloxone is immediately on hand to reverse overdoses, so that users will not have to wait for professional emergency medical attention to receive naloxone.

Appendix A6.1: Estimates of central government spend on treatment

The best estimates of central government spend on drug treatment under the strategy are presented for 2010/11 to 2014/15 (see Table A6.1). Due to differences in the methods used to estimate these figures a total spend figure covering all treatment activity has not been produced. Publicly available spend data are used where possible (and referenced) but otherwise figures have been provided by the relevant department or agency.

Table A6.1: Estimated Government spend on drug treatment under the Drug Strategy, England, 2010/11 to 2014/15

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Total drug treatment for adults	599	589	611	532	541
Structured drug treatment for adults	479	472	489	426	433
Substance misuse treatment in prisons	N/A	108	118	109	N/A
Substance misuse treatment for young people (under-18s)	25	25	25	25	24

Notes

'N/A' spend not available.

Drug treatment for adults

Total spend for 2010/11, 2011/12, 2012/13 was provided by PHE using data on the pooled treatment budget (PTB). Following April 2013 changes to the drug treatment system, the PTB no longer exists. Therefore figures for 2013/14 and 2014/15 spend on drug treatment is estimated from local authorities reporting their annual forecasted and actual public health expenditure to the Department for Communities and Local Government (DCLG). PHE's standard assumption is that 80 per cent of spend is on structured treatment. This results in estimates of £426 million in 2013/14 and £433 million in 2014/15 spend on structured treatment (no further breakdown is available from DCLG returns).

However, these returns may not provide an accurate estimate of spend, for the following reasons.

- Isolating the specific spend on drug treatment is challenging since adult substance misuse treatment services are mostly integrated (providers typically treat both illicit drug and alcohol clients) and drug users often present with both drug and alcohol problems. Consequently, some areas report combined alcohol and drug treatment budgets rather than disaggregated spend with other areas merely allocating half their substance misuse budget to drug and half to alcohol treatment.
- Disaggregating drug treatment spend by structured and non-structured intervention and/or setting is harder still. Reporting spend at this more detailed level is not required by DCLG and it is not known how much local authorities spend on different types of services.

To help local authorities break down their integrated substance misuse spend into that on specific structured and non-structured services and interventions, PHE, in conjunction with an

advisory group comprising cross-government economists, policy leads and local alcohol and drug treatment commissioners, developed a cost calculator. This is solely intended for alcohol and drugs commissioners in local authorities who want to understand their expenditure and improve the value for money of the services they commission. This may lead to improvements in spend estimates in future years.

As well as central government funding through the public health grant, local areas may also provide extra funding, for example, through clinical commissioning groups. The scale of this is unknown, so is not included in the overall spend figure.

Drug treatment for adults: Benefits

DTORS provides typical benefit figures from structured treatment (Jones *et al.*, 2009). The study estimates that £1 spend on structured treatment generates £2.50 of benefit. This cost benefit ratio results in the following benefits from treatment expenditure (Table A6.2) Note that these benefits are only applied to structured drug treatment for adults, not for any young persons (under-18s) or those in prison.

Table A6.2: Estimated benefits from spend on non-prison structured drug treatment for adults, 2010/11 to 2014/15

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Total planned structured treatment spend	479	472	489	426	433
Total estimated benefit	1,197	1,179	1,221	1,065	1,083

Notes

1. Data on 'planned' spend is used as data on 'actual' spend is not available for every year.

Substance misuse treatment in prisons

The DCLG returns provide an estimate of spend on prison drug treatment. Data are only available for two years (2010/11 and 2011/12). These figures have not been used as they underestimate actual spend as they do not include funding from other sources, such as Primary Care Trusts.

In April 2011 responsibility for funding psychosocial treatment in prisons was transferred from the NOMS to DH. Estimates from DH are included for 2011/12 (£108m) and 2012/13 (£118m), as they are more accurate than DCLG returns.¹⁷⁴ Funding was transferred to NHS England for 2013/14 (£109m) who provided the estimate in this year. Since 2013/14 the NHS England commissioning approach is one which supports integrated service provision, with appropriate information sharing between services to support the best possible patient outcomes. Due to this, an absolute figure for substance misuse spend in prisons during 2014/15 is not available.

¹⁷⁴ Comparable estimates for 2010/11 are not available as this is before DH assumed responsibility.

There are some caveats for these figures.

- Spend in 2012/13 also includes spend within the young person's secure estate and immigration removal centres. Estimates for other years do not so this year is not directly comparable with other years.
- The estimate in 2013/14 is spend on contracts that include a range of issues, one of which is substance use, so the figure may be an overestimate of spend. However, prisons may also top up spend on substance use, so this may also be an underestimate.

Substance misuse treatment for young people

Central government spend on substance misuse treatment for young people was compiled using actual spend from 2010/11 to 2012/13 and an estimate for 2013/14.

- In 2010/11, £24.7 million was allocated to young people's treatment as part of the Department for Education Young People's Substance Misuse Partnership Grant (YPSMPG).
- In 2011/12 and 2012/13 this increased to £25.4 million and was allocated directly to PCTs as part of the PTB when the YPSMPG ceased to exist.
- In 2013/14, funding was transferred into the public health grant. DCLG returns show that £71 million was spent in 2013/14 and £67 million in 2014/15. However, these figures are likely to be inaccurate as they may also include spend on prevention (which should be being reported separately) and may be double counted. Therefore spend for 2013/14 and 2014/15 has been estimated by adjusting the 2012/13 figure by the change in the treatment population, and then up-rating. This gives an estimated spend of £25 million in 2013/14 and £24 million in 2014/15.

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Chapter 7: Non-treatment rehabilitative activity

Summary

Activity

- Non-treatment rehabilitative activity (NTRA) is defined as initiatives, other than treatment, aimed at improving aspects of a drug user's life to help them to reach and sustain recovery and reintegrate into society where necessary.
- NTRA supports the Drug Strategy 2010's theme of building recovery in communities and reduce adverse social outcomes such as harms from lack of stable housing or unemployment.

Evidence of effectiveness

- There is a growing body of evidence that NTRA is beneficial to recovery and some positive indications that NTRA initiatives, such as Family Drug and Alcohol Courts and the Recovery Champions, may be improving outcomes for drug users.
- There is, however, a lack of robust evaluation evidence to assess the extent to which NTRA initiatives under the strategy directly impact on outcomes.

Spend and value for money

- NTRA programmes by their nature are not targeted at drug users, so it is difficult to disaggregate central government spend specifically to activity under the strategy.
- The best estimate of spend on NTRA was £240 million in 2013/14, when the majority of NTRA initiatives under the strategy were running. However, estimates are based on large assumptions, so should be treated with caution.
- Trends in spend over time are not commented on as different programmes were available in different years and not all have associated spend estimates.
- Due to the absence of sufficient data on spend, or impact of initiatives on drug use outcomes, it has not been possible to produce value for money estimates for NTRA.

7.1 Introduction

Within this evaluation of the Drug Strategy 2010, non-treatment rehabilitative activity (NTRA) is defined as initiatives, other than treatment, aimed at improving aspects of a drug user's life to help them to reach and sustain recovery and reintegrate into society where necessary.¹⁷⁵ Recognising the focus on achieving recovery, the Recovery Committee was formed in 2011.¹⁷⁶ It supports the Advisory Council on the Misuse of Drugs (ACMD) by advising the government on how best:

- to support people to recover from dependence on drugs and alcohol; and
- to prevent drug and alcohol misuse and the harms it causes.

NTRA largely sits under the 'building recovery in communities' theme of the strategy. Its aim is to accrue 'recovery capital' for individuals which should increase an individual's capacity for achieving sustained recovery (ACMD, 2013a). Recovery capital is the sum of resources necessary to initiate and sustain recovery from substance misuse (Granfield and Cloud, 1999). As noted in the strategy, there are four dimensions of recovery capital (Best and Laudet, 2010). The Recovery Committee's first report (ACMD, 2013b) summarises the evidence on how each of these contributes to recovery:

Social capital: *The sum of resources that each person has as a result of their relationships, support from and obligations to groups to which they belong.* Building family and social support networks of non-users, alongside psychological interventions, can be beneficial to an individual's recovery. A recent UK study highlights the advantages that community engagement, well-being and support groups can have in securing long-term recovery from drug abuse (Best et al., 2015). The strategy recognises that support groups and providing support to families of users are key ways to foster increasing social capital.

Physical and economical capital: *Tangible assets such as property and money that may increase recovery options.* The limited research in this area suggests that having a job and help with financial issues (e.g. personal finances, debt counselling) can improve a range of intermediary outcomes. Being in work is a means of obtaining economic resources for material well-being and full participation in society (Waddell and Burton, 2006). Evidence shows that employment is associated with improved recovery, reduced frequency of relapse and reduced severity of relapse (Henkel, 2011; Platt, 1995). NTRA can help to build physical and economical capital through support to secure paid employment and secure, suitable housing.

175 Although there is likely to be a large overlap between drug users receiving NTRA and those in treatment, in theory an individual might be in receipt of either component without necessarily engaging in the other.

176 Formed in response to an invitation from the Inter-Ministerial Group on Drugs.

Human capital: *Personal skills and education, positive health, aspirations and hopes.*

Substance dependency can result in physical harms (those with a dependency have a shorter life expectancy than the general population, e.g. Pierce *et al.*, 2015) and mental health harms (those with mental health problems have reduced recovery potential). Among those with complex needs, the highest prevalence for overlap with mental health issues (58%) is among individuals in the substance misuse only category without homeless or offending issues (Bramley *et al.*, 2014). The interactions between substance misuse and mental ill health can be complex and can vary from person to person.¹⁷⁷

Human capital can be built via harm-reduction or treatment programmes, but also initiatives aimed at up-skilling individuals. Work can be seen as a therapeutic activity which brings a range of tangible (e.g. greater financial resources and autonomy) and indirect (e.g. a non-substance misuse connected social network, structure, routine, self-esteem etc) benefits. Waddell and Burton (2006) found evidence that being in work meets psychosocial needs, contributes to identity and social status while having the potential to improve physical and mental health. Jobs are generally beneficial for health, although health benefits can vary from person to person and depend on the quality of the job, training or volunteering placement.

Cultural capital: *Values, beliefs and attitudes that link the individual to social attachment and the ability to fit into dominant social behaviour.* This is a complex area and there is a lack of research to fully understand the impact of cultural capital of individuals and communities on substance use and also recovery from dependence. The low social acceptability of drug misuse can lead to lower rates of use and dependence, but can also lead to stigmatisation that, in turn, can impact negatively on community integration and on the employment and housing prospects of users. One survey (UKDPC, 2010) found there was more stigma associated with drug users than those with mental illness and specifically that almost two-thirds of employers would not employ a former heroin and crack user even if they were fit for the job.¹⁷⁸

In recent years 'visible' recovery has been gaining momentum in the UK and there is already evidence from the USA that having visible recovery initiatives (e.g. recovery cafes and high profile people in recovery) can positively influence community perceptions of recovery (McGinty *et al.*, 2015).

¹⁷⁷ In some cases, substance misuse can be a way of coping with the symptoms of mental ill health, in other cases substance misuse (or withdrawal) might lead to psychiatric symptoms or illness or a worsening of symptoms that already exist. Finally, in some cases, substance misuse and mental ill health may coexist without appearing to be directly related (MOJ/DH, 2009).

¹⁷⁸ Drug (and alcohol) dependency is excluded from protection under the Equality Act 2010, other than where the drugs of abuse were originally prescribed. <http://www.legislation.gov.uk/ukpga/2010/15/contents>

7.1.1 Challenges of carrying out an evaluation of non-treatment rehabilitative activity

In addition to the overarching challenges discussed in section 1.4, chapter 1, the following challenges apply particularly to NTRA, impacting on the availability and quality of the evidence to assess the effectiveness of NTRA within the strategy.

- Many people who misuse drugs are likely to have multiple and complex needs, including housing problems, alcohol misuse, poor mental health and offending behaviours (Bramley *et al.*, 2015; Fitzpatrick *et al.*, 2011). Hence support from multiple services is likely and distinguishing the impact of each service on reducing drug use is difficult.
- The relationships, including the causal relationships, between recovery from drug dependency and the outcomes of NTRA can be complex and also vary from person to person. It can be hard to determine whether recovery from drug dependency is a direct result of the rehabilitative activity, or vice versa. Furthermore, rates of recovery vary by how far along their recovery journey an individual is and by drug of dependence; heroin and cocaine, for example, have much lower recovery rates than cannabis (ACMD, 2013a).
- Evaluations of NTRAs are not independent of external environments: employment outcomes and housing outcomes are likely to be affected by local or national economic factors (such as the labour market).

7.2 How non-treatment rehabilitative activity contributes to achieving the aims of the Drug Strategy 2010

The previous high-level logic model theorising how NTRA would contribute to reductions in drug use in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013) has been further developed (see Figure 7.1). Overall, the model hypothesises that the provision of NTRA such as employment, housing and support networks should feed into the recovery cycle by helping people to accrue capacity for recovery and reducing associated harms. This is expected to reduce drug-related harms and drug use and, in building recovery, ultimately lead to freedom from drug dependency. The logic model breaks down the process into four stages, described below.

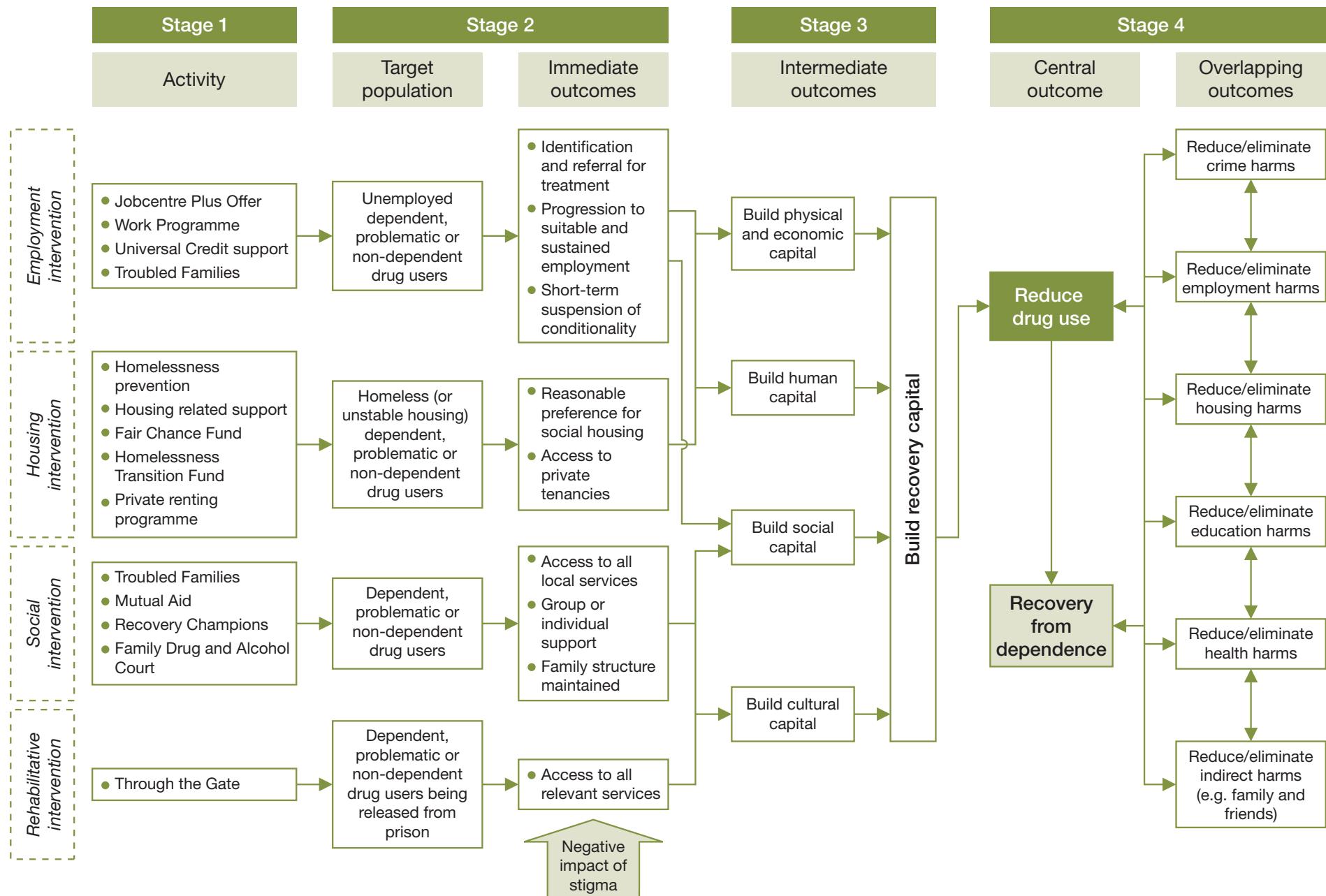
Stage 1: Rehabilitative activity

Stage 1 represents the types of programmes or initiatives that fall within scope of this activity group. Those included here are generally considered ‘major’ in terms of coverage or spend.

Stage 2: Immediate outcomes for target populations

Stage 2 is identifying the target population and determining appropriate support activity. The activity then leads to immediate outcomes such as finding stable housing and accessing support groups being achieved. The logic model also recognises that stigma can be a barrier to progression across multiple domains, including securing housing or employment.

Figure 7.1: Logic model for non-treatment rehabilitative activity



Stage 3: Intermediate outcome

After having commenced the activity and had support in addressing immediate outcomes, the logic model moves towards achieving the intermediate outcome of building recovery capital. This can happen through a variety of interventions, for example, the Troubled Families Programme providing support to increase social capital.

Stage 4: Central outcomes

NTRA should enable drug users to build recovery capital and then help them to reduce drug use and to become free from dependence. There is an inevitable time lag between initiation of interventions and outcomes; long-term measurement and evaluation is required. It is difficult to attribute directly changes at this stage with the activities provided at stage 1.

Stage 4: Overlapping outcomes

Stage 4 also includes overlapping outcomes associated with reduced drug use, including crime, health, housing, employment and education but also indirect harms to others that are not otherwise captured (e.g. to family, friends and community). While these overlapping outcomes will also feed back into reduced drug use, the key for NTRA is that these are also the building blocks to recovery. For example, improving access to stable housing can build human capital (effectively reducing harms from the lack of stable housing) which can lead to reduced drug use, and in turn also reduce the indirect harms from being homeless.

The following overview of indicators (section 7.3) and the review of evidence in section 7.5 considers whether these hypotheses are supported by the available evidence.

7.3 Indicators related to non-treatment rehabilitative activity

Data that measure aspects of drug use and harm at a national level provide the wider context and a general indication of direction of travel over the life of the strategy – using figures from 2009/10 to measure any change (see also chapter 2). Data on the coverage or outcomes of NTRA programmes or initiatives are not routinely recorded – although even with improved monitoring (rather than evaluation) data it would not be possible to relate directly any changes observed to the interventions that fall under the strategy.

What follows are the most relevant national figures available, from the National Drug Treatment Monitoring System (NDTMS)¹⁷⁹ which collects information on clients who are receiving treatment for drug dependence. However, in addition to issues of attribution, the data cannot be considered to reflect all those receiving NTRA as not all those with

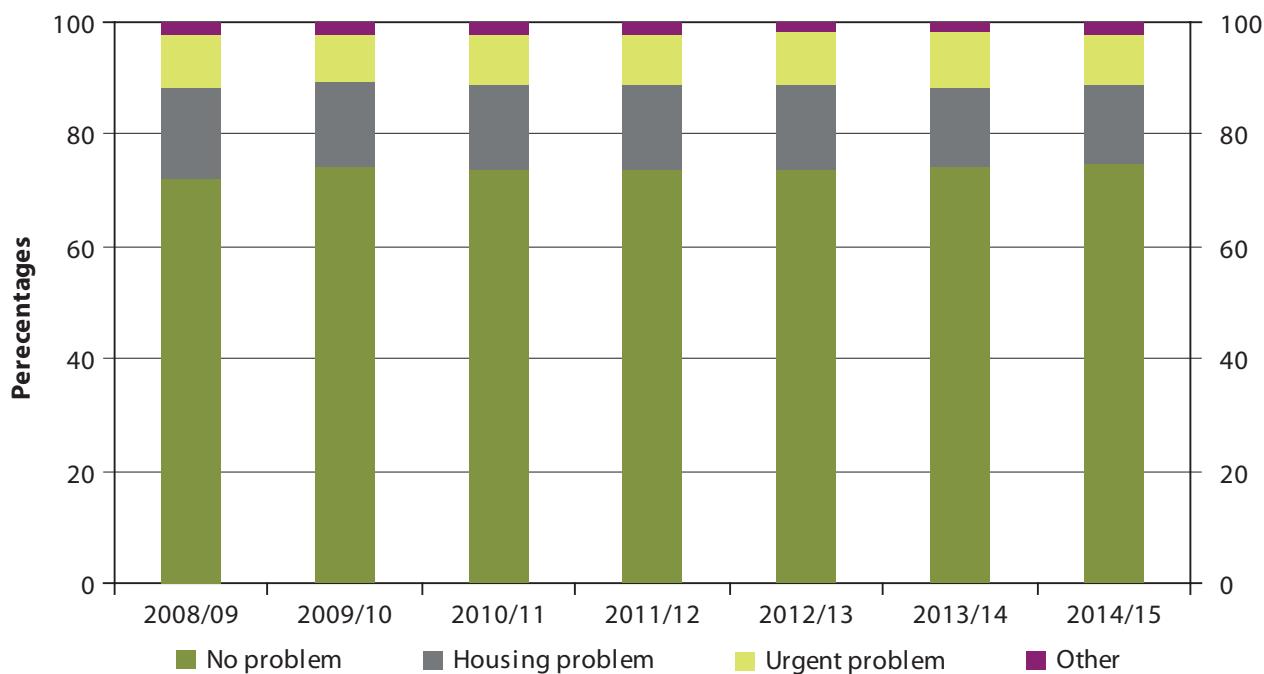
179 <http://www.nta.nhs.uk/statistics.aspx>

drug dependence are in treatment, despite a high level of treatment penetration in the UK compared with internationally.¹⁸⁰

7.3.1 Reducing harms from lack of stable housing

One of the ways NTRA can help to build recovery from drug use is by reducing harms from the lack of stable housing; to help people to achieve better treatment outcomes, to help to prevent relapse for those successful with treatment and to protect those in recovery from individuals who may seek to exploit them. Treatment data show around 23 per cent of new presentations to drug treatment in 2014/15 had a housing problem (Figure 7.2).¹⁸¹

Figure 7.2: Housing situation of new presentations to treatment, 2008/09 to 2014/15, England¹⁸²



Source: NDTMS, PHE

¹⁸⁰ In 2011/12 (latest available data) around 56 per cent of the opiate and crack user population were in treatment (see section 6.3.2, chapter 6).

¹⁸¹ An 'urgent housing problem' is where the client has no fixed abode and a 'housing problem' would be, for example, staying with friends or family as a short-term guest or residing at a short-term hostel.

¹⁸² 2014/15 figures may not be fully comparable with previous years as they have been calculated using a different method.

Data from the NDTMS Treatment outcome profiles (TOPs)¹⁸³ show changes in housing status between the start of a treatment journey and subsequent review. In 2014/15, 20 per cent of opiate clients and 14 per cent of non-opiate clients had a housing problem when entering treatment; this improved to 14 per cent and 7 per cent respectively when these clients were reviewed.^{184, 185}

Overall, the data show that there has been little change in the proportion of adults entering treatment with a housing problem over the life of the strategy. Neither has there been notable change across time in the levels of housing status at review among those receiving treatment.

Table 7.1: Change in housing status between start of treatment and review, 2010/11 to 2014/15, England

		2010/11	2011/12	2012/13	2013/14	2014/15
Opiates	Baseline %	19	20	21	21	20
	Review %	14	14	15	14	14
Non-opiates	Baseline %	15	15	15	15	14
	Review %	9	9	9	8	7

Source: NDTMS, PHE

Table 7.2: Change in employment status between start of treatment and review, 2010/11 to 2014/15, England

		2010/11	2011/12	2012/13	2013/14	2014/15
Opiates	Baseline	Employed %	14	14	13	15
		Mean days	17.7	17.5	17.6	17.7
	Review	Employed %	17	17	17	18
		Mean days	17.4	17.3	17.3	17.5
Non-opiates	Baseline	Employed %	25	25	25	26
		Mean days	17.2	17.3	17.4	17.5
	Review	Employed %	27	27	28	29
		Mean days	17.2	17.4	17.5	17.8

Source: NDTMS, PHE

¹⁸³ TOPs is a clinical tool which follows individuals through their treatment journeys. It allows for a comparison of responses given at the start of treatment with follow-up data. The data are self-report measures which are not externally validated and they have an element of bias in that the responses are provided by those who have completed treatment.

¹⁸⁴ Based on 52,515 clients who had both start and review data.

¹⁸⁵ An 'acute housing problem' means no fixed abode.

7.3.2 Reducing harms from unemployment

New treatment presentations in 2014/15 were most commonly made through self-referral (46%) with less than 1 per cent of referrals from an 'Employment service'.¹⁸⁶ This proportion has been at the same level since 2008/09 despite initiatives to identify drug users and encourage disclosure within Jobcentres under this strategy (see section 7.5.1). TOPs show that the proportion in employment increased by a few percentage points between the baseline and six-month review but not in mean number of days worked (Table 7.2).^{187, 188}

There may have been slight improvements in employment outcomes for drug users over the duration of the strategy. However, for reasons explained earlier (including a general increase in national employment rates and the commonly complex characteristics of the treatment population) these cannot be attributed directly to the strategy or NTRA initiatives.

7.4 Types of non-treatment rehabilitative activity

This section describes the NTRA initiatives carried out under the Drug Strategy 2010 before considering any evidence of effectiveness of how these programmes contribute to the strategy's aim of reducing illicit and other harmful drug use, with a particular focus on achieving and sustaining recovery. Some initiatives overlap between the five defined activity groups of the evaluation (e.g. the Troubled Families Programme in chapter 3) and indeed across the NTRA logic model.

Table 7.3 sets out the initiatives which fall under NTRA with a brief description; more information on these activities can be found in Appendix A7.1.

¹⁸⁶ This category has remained consistent through NDTMS data collection, but an Employment Service would currently be Jobcentre Plus.

¹⁸⁷ It is not possible to determine from these data whether employment has been lost by some clients while being gained by others.

¹⁸⁸ 2014/15 data are estimated to be similar to those in 2013/14.

Table 7.3: Non-treatment rehabilitative activity under the Drug Strategy 2010

Initiative	Key activity	Responsible department(s)
Employment	Jobcentre Plus Offer Seeks to reduce unemployment harms through helping people with drug or alcohol dependencies into work, in turn helping to achieve recovery or sustain recovery.	DWP
	Work Programme Supports people who are long-term unemployed, or who are at most risk of becoming so, to find work.	DWP
	Universal Credit support Work Coaches have the ability to suspend or tailor conditionality for people entering structured recovery-orientated drug treatment.	DWP
	Troubled Families Programme Key workers join up local services to 'turn around' the lives of families with multiple, high cost problems.	DCLG
Housing	Homelessness prevention Local authorities taking action to prevent households becoming homeless.	DCLG
	Housing related support Housing related support services help vulnerable people to continue to live independently.	DCLG
	Fair Chance Fund Seeks to improve outcomes for homeless young people whose complex support needs were poorly met by existing services.	DCLG
	Homelessness Transition Fund Supports a wide range of services including vital frontline services in the voluntary sector.	DCLG
Social	Private renting programme Schemes enabling single homeless people and ex-offenders to access the private rented sector.	DCLG
	Troubled Families Programme Key workers join up local services to 'turn around' the lives of families with multiple, high cost problems.	DCLG
	Mutual Aid Social, emotional and informational support provided by, and to, members of a group at every stage of recovery.	PHE
	Recovery Champions People with experience of recovery from substance misuse championing recovery and serving as role models.	PHE
Rehabilitative	Family Drug and Alcohol Court An alternative approach to care proceedings where parental substance misuse is a key element in those proceedings.	DfE/DH/MOJ
	Through the Gate Provides supervision to those leaving prison, enabling engagement between probation and treatment services.	DH/MOJ

Notes

1. List of acronyms for the Main Departments and agencies: DWP – Department for Work and Pensions; DCLG – Department for Communities and Local Government; PHE – Public Health England; DfE – Department for Education; DH – Department of Health; MOJ – Ministry of Justice.

7.5 The effectiveness of non-treatment rehabilitative activity

There is some limited evidence that NTRA is beneficial to recovery but this activity group within the strategy does not have the same quantity or quality of evidence as some other areas, such as drug treatment (chapter 6). There have been some evaluations of specific initiatives (e.g. payment by results) and of wider initiatives including the impact of the Work Programme. Most of the evidence of effectiveness provided is either from these evaluations of programmes/initiatives or based on the following key reviews (including international evidence and case studies).

- The ACMD Recovery Committee review of the evidence relating to the factors that contribute to recovery (ACMD, 2013a; 2013b).
- An international review by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA, 2012).
- A review of the relationship between work and recovery by the UK Drug Policy Commission (UKDPC, 2008).

The ACMD (2013a; 2013b) reports cite some promising evidence that NTRA is important in enabling individuals to sustain positive drug recovery outcomes. However, they also highlight the lack of good quality impact evaluations that link NTRA to recovery.

7.5.1 Employment initiatives

There is evidence that stable housing and suitable employment can contribute to improved outcomes for drug users, for example, increasing engagement and retention in drug treatment, improving health and social well being and reducing re-offending (UKDPC, 2008; Tuten *et al.*, 2003). However, there is a lack of impact evaluation focussed on the drug misusing population for the initiatives included in this review.

Substance use status of benefits claimants has been historically under-reported thereby limiting the extent to which it has been possible to offer tailored support to this group and to determine outcomes. This means that the evidence of the effectiveness is limited and largely qualitative for the drug misusing population (this is an area that the Dame Carol Black review¹⁸⁹ will report upon).

Encouraging claimants to disclose dependency voluntarily to JCP and Work Programme providers continues to be a key operational challenge. Previous Department for Work and Pensions (DWP) evaluations (e.g. DWP, 2013) indicated that among the key reasons for claimants not disclosing their substance misuse were:

- never having been asked about substance misuse by JCP staff;
- being worried about stigma and how their benefits would be affected; and
- a lack of privacy in the JCP office.

¹⁸⁹ Dame Carol Black conducted 'An independent review into the impact on employment outcomes of drug and alcohol addiction, and obesity' which will inform evidence-based government activity. The review reported in December 2016: <https://www.gov.uk/government/publications/drug-and-alcohol-addiction-and-obesity-effects-on-employment-outcomes>.

Data on adults in treatment for drug dependency and those receiving work-related benefits (DWP, 2015a) provide some understanding of the scope of the substance-misuse client group.

- The majority of clients in drug treatment were in receipt of one or more DWP working-age benefit.
- Less than a quarter of those on benefits were on JobSeeker's Allowance (JSA).¹⁹⁰
- Just under half of all individuals who successfully exited drug treatment were on benefits at the point they left treatment.

Apart from the 'Recovery Works' and 'Recovery and Employment' proof of concepts, no other initiatives specifically target claimants with drug dependencies.

Jobcentre Plus Offer

If JCP advisers identify that a claimant has a drug and/or alcohol problem but is not in treatment, they can refer the claimant to a voluntary discussion with a treatment provider. However, given the issues with disclosure of substance misuse, it is likely that a relatively small proportion of the estimated number of opiate and crack cocaine users who are claiming benefits and are not in treatment are disclosing their substance misuse.¹⁹¹

The final evaluation report for the JCP Offer (DWP, 2013) was based on interviews with staff and claimants, a longitudinal survey¹⁹² of new JSA and Employment and Support Allowance (ESA) claimants and an additional cross-sectional survey to boost sample numbers within potentially 'disadvantaged' groups (including 182 claimants with a drug or alcohol dependency). This cross-sectional survey found that after being on the JCP Offer, 51 per cent of JSA claimants with a drug or alcohol dependency reported increases in their motivation to find work and 59 per cent felt that their job prospects had improved. The interviews with staff found that:

- ESA claimants who had a drug or alcohol dependency were less likely than those without a dependency to discuss all job searching issues, including the types of jobs they were interested in, previous work experience, skills and qualifications, or the possibility of changing career.
- Advisers were treating ESA claimants with a drug or alcohol dependency as being further away from finding work than those without a dependency (this may be appropriate in a large number of cases).

Without knowing how many drug users have undertaken the Offer and whether their outcomes in terms of moving towards or into paid work are successful or indeed, any different to other JCP users, it is not possible to determine whether it has successfully reduced unemployment harms.

190 <https://www.gov.uk/jobseekers-allowance/overview>

191 Previous DWP-commissioned research (Hay and Bauld, 2008) found that, in 2006, 6.6 per cent of the sampled population claiming the main benefits from DWP were opiate and crack cocaine users.

192 This survey covers a period before and after sanctions changed. It is possible that the conditionality regime post-2012 may have altered the way people approach, or what they expect of, JCP.

While there is no reliable record of JSA claimants with a drug and/or alcohol dependency, for ESA (and previously Incapacity Benefit), DWP has a record of a claimant's dependency if it is classified as their primary medical condition.¹⁹³ There is some evidence that, at least for ESA claimants in the Work-Related Activity Group (WRAG), those with a primary medical condition of drug and alcohol misuse are at a disproportionate risk of receiving a sanction.¹⁹⁴ However, the figures only cover a small number of people and some drug misusers may well have a different medical condition recorded based on their coexisting health or mental health needs. Overall, less than 1 per cent of ESA WRAG claimants are sanctioned each month and the latest data available shows that the number of sanctions across ESA WRAG claimants has decreased over the past year (DWP, 2015b).¹⁹⁵

Work Programme

Between June 2011 and June 2015, 1.76 million individuals were referred to the Work Programme in Great Britain, with around 459,000 achieving an employment outcome¹⁹⁶ (DWP, 2015c).¹⁹⁷ More recent intakes contain a higher proportion of individuals expected to require more support and assistance. However, there are no robust figures specifically for drug-using individuals.¹⁹⁸

An externally commissioned evaluation of the Work Programme included four waves of cross-sectional and longitudinal participant interviews in 12 local authority areas and also observations of provider-participant meetings (DWP, 2014a; 2014b). Although the evaluation included a large scale survey of participants, only 0.5 per cent of those surveyed disclosed issues with substance misuse¹⁹⁹ so results could not be presented separately for participants with drug misuse issues.

Participants were asked similar questions in the first (6–9 months after start) and second participant surveys (about 18 months later) about the usefulness of support in helping them to find, or move closer, to work. For all types of support and in both surveys, 70 to 80 per cent of participants reported that the support was very or fairly useful (DWP, 2014a). A high proportion of participants found the help they received in relation to rehabilitative-type activities very or fairly useful, including the following.

¹⁹³ In November 2014, 1.3% of the 2,550,480 claimants entitled to Incapacity Benefit/Severe Disability Allowance and Employment and Support Allowance had drugs misuse recorded as their primary disabling condition (DWP, 2015d). This will likely be an under-estimate of the total number of drug misusing claimants as some may not record this as their primary disabling condition, but also due to reluctance to disclose.

¹⁹⁴ <http://drugsScope.blogspot.co.uk/2015/03/a-fair-chance-sanctions-and.html>

¹⁹⁵ http://tabulation-tool.dwp.gov.uk/100pc/esa/tabtool_esa.html

¹⁹⁶ A successful outcome is at least three or six months in work depending on the level of support an individual needs.

¹⁹⁷ The House of Commons Work and Pensions Committee stated that “Nearly 70% of participants are completing the Work Programme without finding sustained employment. In particular, the Work Programme is not working well for people with more complex or multiple barriers to employment who need more intensive help.” <http://www.publications.parliament.uk/pa/cm201516/cmselect/cmworopen/363/36302.html>

¹⁹⁸ While these figures can be collected by providers, quality varies and no data are collected centrally.

¹⁹⁹ The report shows that 26.4 per cent of survey participants reported a health condition lasting 6 months or more and within that group 1.9 per cent reported problems with drugs/alcohol, so overall 0.5% of the total survey population reported substance misuse problems.

- According to participants, 85 per cent and 87 per cent (respectively across the surveys) found help with housing issues useful.
- Among participants, 76 per cent and 81 per cent (respectively across the surveys) found help with work experience placement or voluntary work useful.

Other research²⁰⁰ has found:

- Work Programme performance for harder-to-help²⁰¹ groups is below expectations and support for the harder-to-help participants is lower than for those with better employment prospects (NAO, 2014a); and
- government funding for harder-to-help participants on the Work Programme is much lower than originally planned (NAO, 2014a; Riley *et al.*, 2014).

Two Work Programme proof of concepts took place during the strategy period. These intended to better support individuals with a drug and/or alcohol dependency²⁰² into employment. DWP commissioned qualitative evaluations of these proof of concepts in spring 2013. In summer 2014 DWP commissioned further research in non-proof of concept areas to obtain a broader, national picture of relationships between the employment support and dependency support sectors and of approaches to supporting clients with a dependency. This comprised interviewing a range of stakeholders – Work Programme, Treatment and Specialist Support Providers, as well as local authority and PHE representatives. The report will bring together the findings from both studies and is due for publication by the end of 2016.

Recovery and Employment proof of concept

The Recovery and Employment proof of concept ran from April 2013 to March 2016 and sought to test the impact of the DWP encouraging closer working relationships between Work Programme providers and Support Providers (both Treatment and Specialist Support Providers).

Recovery Works proof of concept

The Recovery Works proof of concept ran between April 2013 and March 2015 and sought to test the impact of awarding Work Programme providers an additional job outcome payment of £2,500 per participant achieving sustained employment. This is important since some qualitative evidence showed providers concentrated resource on those more likely to achieve outcomes (“creaming and parking”) despite a differential payment system (Newton *et al.*, 2012).

200 <http://www.publications.parliament.uk/pa/cm201516/cmselect/cmworopen/363/36302.html>.

201 Payment groups do not match directly to how hard individual people are to help, so for the purposes of this report NAO refer primarily to Jobseeker's Allowance 18 to 24 (payment group 1) and Jobseeker's Allowance 25 and over (payment group 2) as examples of easier-to-help groups and new ESA claimants (payment group 6) as harder-to-help.

202 These include drug or alcohol users who are undergoing or have undergone structured recovery-orientated treatment (including community-based or residential treatment).

Universal Credit support

The role of Jobcentre Plus ‘work coaches’ is increasingly important with the implementation of Universal Credit. Work coaches have the ability to suspend conditionality²⁰³ for six months for people entering structured recovery-orientated drug treatment and then also have the discretion to ‘tailor’ conditionality for a further six months after treatment has ended. As Universal Credit is being gradually rolled out (being available for single claimants in all areas of Great Britain from spring 2016) this support is only slowly becoming available to drug-misusers, hence no evaluation of impact.

7.5.2 Housing initiatives

Similarly to employment initiatives, there is wider evidence (e.g. UKDPC, 2008; Tuten *et al.*, 2003) that stable housing contributes to the outcomes in the logic model. However, again there are few impact evaluations of the effectiveness of the housing programmes described.

The Localism Act 2011²⁰⁴ brought about changes to the social housing system to allow greater flexibility for councils to target social housing at those who genuinely need it the most for as long as they need it. It preserved the statutory ‘reasonable preference’ categories which prioritises those who need to move on welfare grounds, including someone moving on from a drug or alcohol recovery programme that requires social housing to build a stable life (DCLG, 2012a).

Homelessness prevention

DCLG’s focus on homelessness prevention has resulted in local authorities preventing around 935,800 households from becoming homeless since 2010 (DCLG, 2015a; DCLG, 2015b). The vast majority of homelessness prevention activities are small scale by local authorities, typically to help households without complex needs to stay in their home or find another one. There are no evaluations of impact on assisting drug users in gaining or sustaining recovery.

Housing related support

Housing related support services help to build physical and economical capital for drug-dependent individuals, or those in recovery, aiming to reduce harms from lack of stable housing.

A practice compendium for the role of housing in drug recovery recognises the important role that “*appropriate housing and related support have in supporting recovery*” (Chartered Institute of Housing, 2012). The compendium fits within the construct of ‘localism’ where local government has wider freedoms and flexibilities to tailor programmes in the best interest of their local community.

203 Acceptance of a ‘claimant commitment’ is a basic condition of entitlement to Universal Credit and being subject to work-related requirements are central to conditionality.

204 <http://www.legislation.gov.uk/ukpga/2011/20/contents/enacted>

In 2011, ten local authorities chose to participate in the Supporting People (a housing related support service) Payment by Results (PbR) pilot, developing their own approaches to commissioning and delivery of the PbR services. The final evaluation of the PbR pilot is qualitative and does not compare drug users with other groups (DCLG, 2014a). There is some mention of drug users stopping or reducing use of drugs as a result of stable housing but service providers felt the outcome timescales were unrealistic for people recovering from drug dependence.

Fair Chance Fund

The £15 million programme has allocated funding to seven innovative schemes between 2015/16 and 2017/18 using a payment by results model. The schemes must provide additional support to young homeless people with complex needs. The aim is to create long-term savings as a result of the impact on reducing crime, poor health and long-term benefit dependency amongst the target group. Although drug misuse is not a key outcome, this programme targets a group with a high risk of having substance abuse problems. An evaluation will be published by 2018.

Homelessness Transition Fund

The Homelessness Transition Fund (HTF) has provided funding for the introduction of the Housing First model in areas of England and Wales. The model was developed in the USA and has demonstrated considerable success in both housing and supporting those who are chronically street homeless with multiple and complex needs (Stefancic and Tsemberis, 2007). Housing First requires individuals to meet the terms of their tenancy agreement, being given intensive support to do so, and does not require people to resolve their wider social care and support needs in order to secure long-term accommodation.

An observational study of nine pilot Housing First services in the UK showed high levels of success in reducing long-term and repeated homelessness. It also showed some evidence of reductions in illegal drug use, although the pattern was not uniform and the sample size was small (Bretherton and Pleace, 2015).

Private renting programme

The private renting programme covers all types of homelessness. A mix of types of organisation received funding under the scheme, some of which focussed on high risk clients such as drug-users and those in drug recovery programmes (Rugg, 2014). Overall, the programme fulfilled its expected outcome in that new schemes across all the English regions have been established. As the evaluation was designed to review programme outcomes rather than individual outcomes, it is not possible to determine the exact benefits for the drug user group.

7.5.3 Social initiatives

The ACMD review found that family and social support, together with psychological interventions, may benefit an individual's recovery (ACMD, 2013b). This is supported by a UK study describing the advantages that community engagement, well-being and support groups can have in securing long-term recovery from drug abuse (Best *et al.*, 2015).

There are few programmes that focus exclusively on support groups for illicit drug users and their friends or family, or that solely address reducing stigma associated with illicit drug users (UKDPC, 2008). However, multi-agency family-based interventions covered here which support individuals and families in overcoming inter-generational disadvantage, such as the Troubled Families Programme, also cover issues relating to drug misuse. These are explored below and the preventative impact of this type of intervention is discussed in section 3.4.2, chapter 3.

Troubled Families Programme

In July 2014 DCLG published a report setting out the characteristics of the families who were being worked with through the programme. It suggested that 13 per cent of adults on the current programme were dependent on non-prescription drugs and 15 per cent of young people have substance misuse problems that reach the threshold for structured treatment (DCLG, 2014b).²⁰⁵

By the end of the initial programme, over 116,000 troubled families' lives had been 'turned around', largely through improvements in crime, anti-social behaviour or employment outcomes (DCLG, 2015c). Although these outcomes do not specifically relate to drug misuse, they may be related to achieving or sustaining recovery from drug dependence, though it is not possible to assess the scale to which this may have occurred.

The independent evaluation of the first Troubled Families Programme included some measures of drug and alcohol misuse (DCLG, 2016a). Local authorities reported monitoring data which recorded problems being experienced by families, including assessments of drug and alcohol dependency in adults and young people. Where completed information was available at entry and exit to the programme, the monitoring data indicated a reduction in these issues for around a third of families at exit from the programme.

The evaluation also included a family survey which contained self-reported drug and alcohol misuse questions. It compared responses from families starting the intervention with those nine months from the start of the intervention. There were no significant differences identified between the responses of these two groups in relation to their self-reported drug and alcohol use. However, a majority of the families at nine months after the intervention were identified subsequently as still receiving the intervention at the time of interview, so limited conclusions can be drawn from these findings.

²⁰⁵ Based on Family Monitoring Data provided by local authorities of a sample of 6,577 families on the programme.

The first set of evaluation reports for the new Troubled Families Programme were published alongside the Troubled Families Annual Report in April 2017 (DCLG, 2017).

Mutual Aid

There is evidence that engagement with Mutual Aid groups improves drug recovery outcomes (ACMD, 2013a). Mutual Aid has an additive effect when combined with structured treatment and reduces rates of post-treatment relapse by providing a continuing support structure (*ibid.*).

PHE lead a programme of work in 2013 and 2014 to improve mutual aid engagement to ensure that everyone in treatment can benefit from this support. The proportion of opiate clients in treatment who were recorded as having received a 'Mutual Aid intervention' has doubled (8% to 16%) between October 2013 and February 2015.²⁰⁶

Recovery champions

DrugScope surveyed treatment providers in 2014 and found that around two thirds (68%) of all respondents utilised recovery champions roughly the same proportion of as in 2013 (DrugScope, 2015a). Providers reported that the role of the champions varied considerably. Some roles were considered a stepping stone to paid employment, thus potentially gaining physical and economical capital for the recovery champions, while others were seen as carrying out work that paid staff might otherwise do. Recovery champions were also thought to play a part in raising the visibility of recovery to those in strategic positions.

Commissioners and others in strategic roles highlighted the importance of making recovery visible to others in strategic positions, for example, Directors of Public Health and Police and Crime Commissioners (DrugScope, 2015b). This visibility, including that of recovery champions, aims to secure local support and can help to get those in strategic positions on board with the recovery agenda.

Family Drug and Alcohol Court

The Family Drug and Alcohol Court (FDAC) ran as a pilot between January 2008 and March 2012 and has subsequently been rolled out to more local areas. The two-stage independent evaluation of the pilot provided evidence that FDAC was more successful than ordinary care proceedings in helping parents overcome substance misuse in order to be reunited with their children (Harwin *et al.*, 2014). It also found that FDAC enables parents to access and stay in treatment.

²⁰⁶ Data from the NDTMS have been provided by PHE and have not been previously published.

7.5.4 Rehabilitative initiatives (including Through The Gate)

Through The Gate is a comprehensive 'end-to-end' approach to tackling addiction from custody to the community, being tested in ten resettlement prisons in the North West. It is based on the premise that key to a successful drug treatment outcome for those leaving prison is continuity of treatment following release. A process study to assess the implementation and delivery of the work is due to report in 2017 and will inform the commissioning and delivery of substance misuse services for offenders more broadly.

7.6 Central government spend and value for money of non-treatment rehabilitative activity

Due in part to de-centralisation of budgets it has not been possible to obtain accurate estimates of how much is spent on each NTRA initiative. Additionally, the broad nature of NTRA programmes (e.g. the Troubled Families Programme and the Work Programme) and the data available mean that it is not possible to attribute spend specific to the drug misusing population. These factors, along with the limited evidence of the impact of NTRA, have prevented the inclusion of national value for money estimates. Where estimates of financial benefits are available at a programme level, these are presented in section A7.2.1.

Estimates of central government spend on NTRA delivered under the strategy from 2010/11 to 2014/15 have been produced (see Table 7.4). For each initiative, estimates are based on a proportion considered to be attributable to the drug-using population (see Appendix A7.2 for further details).²⁰⁷

Estimated spend on NTRA was £240 million in 2013/14, when the majority of NTRA initiatives under the strategy were running. However, these estimates are based on large assumptions, so they should be treated with caution. As not all NTRA initiatives were running in every year, and not all could be costed, it is not possible to comment on any trend in the amount spent on NTRA under the strategy.

²⁰⁷ Spend does not relate to an individual drug user, but instead direct government spend on activities to reduce drug use, in this case on non-treatment rehabilitative activities.

Table 7.4: Estimates of central government spend on non-treatment rehabilitation initiatives relating to drug misuse under the Drug Strategy 2010, 2010/11 to 2014/15

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Jobcentre Plus Offer	152	164	168	159	123
Work Programme	-	21	33	46	N/A
Troubled Families Programme	-	-	7.9	24	11.8
Homelessness Transition Fund	-	1.4	0.6	0.6	0.6
Through The Gate	-	-	-	10.2	3
Family Drug and Alcohol Court	0.4	0.4	0.5	0.5	0.7
Total	152	187	210	240	139

Note

'-' initiative not running.

'N/A' spend not available.

7.7 Conclusion

There is a growing body of evidence that NTRA strengthens an individual's recovery capital. However, partly reflecting the relative newness of this research area, the range and quality of evidence to draw upon is quite limited.

While the available evidence suggests that NTRA could be effective in supporting individuals to reduce drug dependency, in reality the programmes are broad and often not specific to the complex needs of drug users. In order to address the paucity of programme-specific evaluations currently available, more research is required to produce evidence on the effectiveness of the NTRA interventions for drug users. Certainly, without further research it is not possible to assess categorically the extent to which NTRA directly impacts on outcomes for drug users, or to measure the possible risk of unintended consequences of well-intended recovery programmes.

It is difficult to fully understand spend related to drug misuse reduction within NTRA programmes. This is partly due to the restrictions in the knowledge of programme spend and implementation due to localism but it is also due to the requirements of the programmes to address multiple and complex needs, and the difficulty in disentangling both spend and value for money. As such little evidence of cost-benefit exists and available evidence is insufficient to provide an overall view of the value for money of NTRA within the Drug Strategy 2010.

Appendix A7.1: Types of non-treatment rehabilitative activity

What follows is a more detailed description of the types of activities reviewed within this chapter.

Employment initiatives

Jobcentre Plus Offer

JCP is an agency that aims to help people of working age to find employment in the UK, providing resources to enable job-searchers to find work or training opportunities. Launched in April 2011, the JCP Offer was designed to increase focus on outcomes rather than procedural targets for JCP districts and staff, enabling tailored support to move claimants towards and into paid work. A more localised approach, 'Freedom and Flexibility', allows local Jobcentre Plus (JCP) managers to best meet local needs (BIS, 2013). Meeting local priorities means that the focus may be on different groups across the country but can include getting drug-dependent adults into employment, though there is potentially a risk that more support would be given to any easier-to-help groups.

New sanction rules came into force for JSA claimants in October 2012²⁰⁸ and in December 2012 revised sanctions were also introduced for ESA claimants in the WRAG.²⁰⁹

Work Programme

The Work Programme is a payment-for-results programme launched throughout Great Britain in June 2011. It is delivered by a range of private, public and voluntary sector organisations supporting people who are long-term unemployed, or who are at most risk of becoming so, to find work.

Two Work Programme proof of concepts took place during the strategy period. These intended to better support individuals with a drug and/or alcohol dependency²¹⁰ into employment.

Recovery and Employment proof of concept

The Recovery and Employment proof of concept began in April 2013. It sought to test the impact of the DWP encouraging closer working relationships between Work Programme providers and Support Providers (both Treatment and Specialist Support Providers). The trial finished at the end of March 2016. The DWP-commissioned qualitative evaluation will report before the end of 2016.

²⁰⁸ <https://www.gov.uk/government/publications/jobseekers-allowance-overview-of-sanctions-rules>

²⁰⁹ <https://www.gov.uk/government/collections/jobseekers-allowance-sanctions>

²¹⁰ These include drug or alcohol users who are undergoing or have undergone structured recovery-orientated treatment (including community-based or residential treatment).

Recovery Works proof of concept

The Recovery Works proof of concept started in April 2013. It sought to test the impact of awarding Work Programme providers an additional job outcome payment of £2,500 per participant achieving sustained employment. The trial finished in March 2015. The DWP-commissioned qualitative evaluation will report before the end of 2016.

Universal Credit support

Support from JCP work coaches enables an individual in treatment to focus on recovery and gain the best possible chance of finding appropriate work to then help sustain recovery. This approach relies on the ability of work coaches to identify claimants who qualify, treatment providers encouraging their clients to disclose to their work coach, and providing an environment where individuals feel comfortable to disclose their drug dependency.

Housing initiatives

The Government has made over £500 million funding²¹¹ available to prevent and tackle homelessness since 2010. Although several housing initiatives are national, each area will have used available funding to address locally-identified priorities.

In June 2010 a cross-government working group on homelessness²¹² was established to improve the lives of those who do become homeless and to help rough sleepers to stay off the streets. The working group reported on its activities, including providing strategic support to help the authorities to deliver effective prevention services (DCLG, 2015d).

Housing related support

Housing related support services help vulnerable people to continue to live independently. This can include, for example, hostels for homeless people, specialist supported housing and floating support. Such support helps to build physical and economical capital for drug-dependent individuals, or those in recovery, aiming to reduce harms from lack of stable housing.

Funding for Supporting People has been included within wider funding to local authorities since 2010; finances are not ring-fenced and spend may have been merged with other types of funding, so continued investment in Supporting People at local authority level is uncertain. Most spending reductions in housing services have come from planned reductions in the Supporting People programme; spend has fallen by a median of 45.3 per cent across single tier and county councils (NAO, 2014b).

211 Funding for the Fair Chance Fund, Homeless Transition Fund and Private renting programme are included within the £500 million.

212 <https://www.gov.uk/government/collections/ministerial-working-group-on-preventing-and-tackling-homelessness>

Fair Chance Fund

The Fair Chance Fund is a payment by results scheme launched by DCLG and the Cabinet Office in February 2015 to improve outcomes for a group of 1,600 18- to 24-year-old homeless individuals, whose complex support needs were poorly met by existing services. This group would not be offered support under homelessness legislation and with multiple and inter-linking needs, the young people may go onto increasing involvement in crime, rough sleeping, substance misuse and long-term benefit dependency.²¹³

Homelessness Transition Fund

DCLG made £20 million available to the voluntary sector between 2011 and 2014 for the HTF,²¹⁴ which was administered by homelessness sector membership organisation Homeless Link. The programme supports vital frontline services in the voluntary sector and supports communities to deliver the cross-Ministerial Working Group ambition to roll-out 'No Second Night Out' to find and support rough sleepers off the streets quickly.

HTF has supported a wide range of services including:

- No Second Night Out assessment hubs and peer outreach;
- Housing First models;
- young people's services;
- supported reconnections; and
- person-centred services.

Private renting programme

Between 2011 and 2016 DCLG provided £13 million to Crisis – a national charity for single homeless people – to set up private rented sector access schemes²¹⁵ for single homeless people and ex-offenders, including recovering drug users.²¹⁶

213 <https://www.gov.uk/government/news/23-million-to-help-homeless-turn-around-their-lives>

214 <http://www.homeless.org.uk/our-work/national-projects/homelessness-transition-fund>

215 Formerly the Crisis Private Rented Sector Access Development Programme (2010–2014).

216 <https://www.gov.uk/government/policies/providing-housing-support-for-older-and-vulnerable-people/supporting-pages/dealing-with-homelessness>

Social initiatives

Troubled Families Programme

The Troubled Families Programme was launched in 2012. This committed the government to work with local authorities and their partners to 'turn around'²¹⁷ the lives of 120,000 families with multiple, high cost problems by May 2015. The Troubled Families Programme²¹⁸ advocates using dedicated key workers to join up local services and deal with each family's problems as a whole to help them change for the long term: getting children into school, reducing crime and anti-social behaviour and getting adults into work.

To qualify for the initial programme families were required to have three out of the following four indicators:

- children who are regularly truanting or not in school;
- children committing crime or antisocial behaviour;
- parents not working; or
- another locally defined high-cost problem, including drug misuse.

In July 2014 DCLG published a report setting out the characteristics of the families who were being worked with through the programme. It showed that on average troubled families have nine serious problems relating to employment, education, crime, housing, child protection, parenting or health on entry to the programme (DCLG, 2014c). It also suggested that 14 per cent of adults on the current programme are dependent on alcohol and/or non-prescription drugs (13% dependent on drugs) and 15 per cent of young people have substance misuse problems that reach the threshold for structured treatment (DCLG, 2014b).²¹⁹

The expanded Troubled Families Programme rolled out nationally in April 2015²²⁰ (with £200 million investment available in 2015/16). The new programme retains the first programme's focus on families with multiple high cost problems and will continue to include families affected by poor school attendance, youth crime, anti-social behaviour and unemployment. But it will also reach out to families with a broader range of problems including physical and mental health problems (including substance misuse).

²¹⁷ 'Turned around' means that: all children have been back in school for a year when they were previously truant or excluded; youth crime and anti-social behaviour has been significantly cut across the whole family; or an adult in the home has moved off benefits and into work for three consecutive months or more. <https://www.gov.uk/government/news/more-than-105000-troubled-families-turned-around-saving-taxpayers-an-estimated-12-billion>

²¹⁸ *Working with Troubled Families* is a guide to the evidence and good practise of working with families (DCLG, 2012b).

²¹⁹ Based on Family Monitoring Data provided by local authorities of a sample of 6,577 families on the programme.

²²⁰ By January 2015, over two thirds of local areas were delivering the programme.

Mutual Aid

Mutual Aid refers to the social, emotional and informational support provided by, and to, members of a group²²¹ at every stage of recovery, including the 12-step fellowships (PHE, 2013).

PHE, in conjunction with representatives from the major mutual aid organisations as well as commissioners and service managers, delivered a programme of work in 2013 and 2014 to improve mutual aid engagement to ensure that everyone in treatment can benefit from this support. The aim of the PHE-led work was to help those in treatment to achieve their recovery goals by increasing awareness of Mutual Aid.

Recovery champions

The recovery champions approach was designed to enable people with experience of recovery from substance misuse to champion recovery and provide real, local examples of individuals who are successful in recovery and to serve as role models to others. These individuals champion routes to recovery and challenge partnerships and services to retain a recovery focus at all stages of a treatment service user's journey. The Drug Strategy 2010 urges local areas to establish recovery champions at a strategic level (such as local Directors of Public Health), at a therapeutic level (e.g. among treatment providers) and at a community level (e.g. mentors for those in treatment who are themselves in recovery) (see HM Government, 2012).

Family Drug and Alcohol Court

The FDAC is an alternative approach to care proceedings where parental substance misuse is a key element in those proceedings. A multi-disciplinary specialist team works closely with the court and with social workers, substance misuse professionals and others to support parents to overcome their substance misuse problems within the framework and timescales of care proceedings.

The FDAC ran as a pilot from January 2008 to March 2012 at the Inner London Family Proceedings Court but was subsequently launched in Central London, Gloucestershire, Milton Keynes and Buckinghamshire (July 2014). The East Sussex, Coventry and the South West Peninsula FDAC launched in 2015.

The evaluation tool that was developed continues to be used and an external evaluation is being conducted as part of the Innovation Programme requirements.

²²¹ Groups often include people who are abstinent and want help to remain so but can include people who are thinking about and/or actively trying to stop their drug use. Groups also exist to support families, children and friends affected by substance misuse.

Rehabilitative initiatives

Through The Gate

The introduction of Through The Gate resettlement services (as well as the enactment of the Offender Rehabilitation Act 2014²²²) means that all sentenced prisoners will be supervised for a minimum of 12 months, enabling probation to promote engagement with treatment.²²³

The Ministry of Justice (MOJ) agreed with DH to develop and test a comprehensive 'end-to-end' approach to tackling addiction from custody through the gate into the community. DH funding has enabled the National Offender Management Service, NHS England and PHE to test new pathway arrangements, develop products that can be used across the country, and capture learning by working closely with ten resettlement prisons in the North West.²²⁴

222 <http://www.legislation.gov.uk/ukpga/2014/11/contents/enacted>

223 In addition, the act introduced a new licence condition to attend drug appointments and extended testing powers which will support continuity of treatment plans – these are covered within chapter 5.

224 <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2014/psi-08-2014-north-west-drug-testing-project.pdf>

Appendix A7.2: Estimates of central government spend on non-treatment rehabilitative activity

This Appendix includes the estimates of spend on NTRA attributable to drug misuse under the strategy from the financial year 2010/11 to 2014/15. In 2013/14, when the majority of NTRA initiatives under the strategy were running, estimated spend on NTRA under the Drug Strategy 2010 was £240 million (Table A7.1). However, these estimates should be treated with caution as they are based on large assumptions and not all NTRA programmes could be costed.

Table A7.1: Estimates of central government spend on NTRA initiatives attributable to drug misuse under the Drug Strategy 2010, 2010/11 to 2014/15

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Jobcentre Plus Offer	152	164	168	159	123
Work Programme	-	21	33	46	N/A
Troubled Families Programme	-	-	7.9	24	11.8
Homelessness Transition Fund	-	1.4	0.6	0.6	0.6
Through The Gate	-	-	-	10.2	3
Family drug and alcohol court	-	-	-	0.3	0.3
Total	152	187	210	240	139

Note

'-' initiative not running.

'N/A' spend not available.

It is worth noting that the revised 2011/12 figure from Table A7.1 varies from the figure of £155 million for 2011/12 in the *Drug Strategy 2010 Evaluation Framework* (HM Government, 2013a). This is largely due to no estimates from DWP being included in the previous estimate as spend was assumed to be cost-neutral at that time (i.e. benefits were equal to the cost),²²⁵ but also more programmes have been included in these estimates subsequent to the previous publication.

What follows is an explanation of how estimates of spend on NTRA attributable to drug misuse were calculated – the figures are described as ‘Spend attributed to drug users’ within tables – dealt with in turn by government department or agency. The data used to derive these estimates have been based on publicly available data where possible (and referenced) but otherwise provided by the relevant department or agency.

²²⁵ In addition, the JCP Offer was launched in 2011 so was not included in the previous estimate.

DWP initiatives

Table A7.2: Estimated DWP spend on initiatives relating to drug misuse under the Drug Strategy 2010, 2010/11 to 2014/15

		2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Jobcentre Plus Offer	Total programme spend	2,295	2,487	2,535	2,404	1,859
Work Programme	Spend attributed to drug users	152	164	168	159	123
Jobcentre Plus Offer	Total programme spend	-	284	454	637	N/A
Work Programme	Spend attributed to drug users	-	21	33	46	N/A

Note

'-' initiative not running.

'N/A' spend not available.

Jobcentre Plus Offer

There is no specific spend allocated to the JCP Offer under the strategy since the Offer is open to all who are eligible on the same terms. There is no recent data recorded on the number of drug users that access JCP Offer benefits.

The yearly breakdown of spend on the JCP Offer between 2010/11 and 2014/15 is shown in Table A7.2 (DWP, 2014c). The estimate of spend specifically relating to the strategy is a proportion of this overall programme spend according to DWP-commissioned research that found that 6.61 per cent of benefit claimants were 'problem drug users' (Hay and Bauld, 2008).

This is the latest available data but it is almost ten years old so may not be relevant to claimants today. Indeed, this is likely to be an overestimate because the number of opiate and crack cocaine users has declined steadily between 2006/07 and 2011/12.

Work Programme

Total spend on the Work Programme is available between 2011/12 and 2013/14 (DWP, 2014c).²²⁶ Total spend on drug users was estimated based on research that found that 8.22 per cent of JSA claimants were 'problem drug users' as were 4.42 per cent of IB claimants (Hay and Bauld, 2008). According to data from September 2014, a quarter of the intake is from ESA groups and the remainder JSA (DWP, 2014d). These proportions have been applied to the proportion of claimants who were problem drug users to determine that an estimated 7.3 per cent²²⁷ of Work Programme spend in each year can be attributed to the strategy (Table A7.2).

These figures are used in the absence of better data. As above, the original estimates are almost ten years old and the opiate and crack using population has been in decline. Also,

226 Figures for 2014/15 do not yet have a confirmed publication date.

227 That is: $(0.75 * 8.22\%) + (0.25 * 4.42\%) = 7.27\%$

estimated spend on drug users is unlikely to be accurate as spend on 'harder-to-help' claimants was expected to be higher than for all claimants – but also that these participants were receiving less funding than originally planned under the PbR model (NAO, 2014a).

Universal Credit support

Universal Credit support is not included because it is an approach rather than a programme and as such attributable spend is encompassed by the overall spend on the Work Programme.

DCLG initiatives

Table A7.3: Estimated DCLG spend on initiatives relating to drug misuse under the Drug Strategy 2010, 2010/11 to 2014/15

		2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Troubled Families Programme	Total programme spend	-	-	80.6	246.4	121.0
	Spend attributed to drug users	-	-	10.5	32.0	15.7
	Spend attributed to drug users under NTRA	-	-	7.9	24.0	11.8
Homelessness Transition Fund	Total programme spend	-	8.0	3.6	3.6	3.5
	Spend attributed to drug users	-	1.4	0.6	0.6	0.6

Note

'-' programme not running.

Troubled Families Programme

An estimated 13 per cent of total Troubled Families Programme expenditure was spent under the strategy, based on 13 per cent of families participating in the Troubled Families Programme up to December 2013 including an adult who was dependent on non-prescription drugs (DCLG, 2014b). This spend is specifically on the non-treatment rehabilitative aspects of this programme but not treatment provision (this is covered in chapter 6).

This proportion is likely to be an underestimate. It does not take into account child drug users in troubled families or those who may not necessarily be 'dependent' on drugs but are still regular drug users. It also assumes that the cost for families with one or more drug-dependent adult is the same as the cost for families without, which may not be the case.

There was no spend before 2012/13 as the programme was implemented in April 2012. Total funding available for the programme (£448 million) covers three financial years (2012/13, 2013/14 and 2014/15) and has been allocated proportionally according to the number of families in touch with the programme during that time – 2012/13: 21,471 (18%); 2013/14: 64,098 (55%); 2014/15 – 31,085 (27%), see Table A7.3.

Troubled Families Programme expenditure has been split between the NTRA and early intervention activity groups with a weighting of 75 per cent for NTRA as the majority of programme spend is assumed to fall here.

According to DCLG, nearly £50m of the £448m made available for the programme was spent on Troubled Families Programme co-ordinators – a strategic role within local authorities. The rest was part of the PbR for the programme – decisions on how to spend the PbR were made locally, for example on Troubled Families Programme data management, key workers and specialist provision if required.

The first Troubled Families programme provided a cost savings calculator to Local Authorities to help them estimate costs and benefits. DCLG (2016b) published a report based on analysis of the use of the calculator by sixty-seven local authorities. The first set of evaluation reports for the new Troubled Families Programme were published alongside the Troubled Families Annual Report in April 2017 (DCLG, 2017).

Homelessness Transition Fund

The HTF ran between January 2011 and January 2014 and has been split into four spending rounds (Table A7.4). There has been no more funding since Round 4.

Table A7.4: Homelessness Transition Fund funding from 2011/12 to 2013/14

Spending round	Amount £m	When awarded	Financial year	Spend apportioned to drug users £m
Round 1	8.0	January/April 2012	2011/12	1.4
Round 2	3.6	October 2012	2012/13	0.6
Round 3	3.6	March 2013	2012/13	0.6
Round 4	3.5	Jan 2014	2013/14	0.6

Out of 63,826 individuals supported by funded projects during the lifetime of the fund (Homeless Link, 2014) there were 10,934 with drug-related issues (data provided by Homeless Link).²²⁸ There are no further data available so this proportion (17%) has been applied to spend to give a minimum (but best) estimate.

Fair Chance Fund

The Fair Chance Fund was only launched operationally in January 2015. The programme works by making payments in arrears every quarter of each calendar year. It made its first payment in the first quarter of 2015 and hence is outside the financial scope of the evaluation.

²²⁸ It is difficult to fully estimate the number of substance misuse cases reported clearly as there are two reporting categories where substances misuse cases could be recorded: people with a drug-related need or people with more than one health need.

Homelessness prevention, housing support, Crisis private rented sector development programme

It is particularly difficult to determine what elements of spend on homelessness prevention and housing support programmes relate to drug misuse as these programmes very much focus on homeless needs. To that extent, no spend data that can be apportioned to drug users are available.

PHE initiatives

Mutual Aid

Mutual Aid networks are locally managed and by their nature (peer support) require little funding.²²⁹ Some capital funding has been made available to support projects, such as site developments for Mutual Aid.

The work to improve access to Mutual Aid is a set of briefings and guidance supported by some local activity so spend was minimal – no specific data are available.

Recovery Champions

There are no appropriate data to be used to estimate spend attributable to recovery champions due to:

- community recovery champions typically being volunteers, and therapeutic recovery champions, who may be paid staff, assuming the recovery champion role alongside their other responsibilities;
- no component of the public health grant being indicated specifically for recovery champions;
- assessments of and decisions about level of need, funding and commissioning being made locally; and
- the expenditure data returned by local authorities to DCLG being global figures relating to adult drug treatment, adult alcohol treatment and young people's drug and alcohol services only.

PHE does provide a cost calculator to help councils to understand their social return on investment, which is made available for all local authorities to complete voluntarily. However, even if authorities chose to complete and submit this to DCLG, the figures provided would not map directly onto specific interventions.

²²⁹ Some models specifically prohibit seeking government or local authority funding as a means of demonstrably maintaining independence.

MOJ initiatives

Table A7.5: Estimated MOJ spend on initiatives relating to drug misuse under the Drug Strategy, 2010/11 to 2014/15

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Through The Gate	Spend attributed to drug users	-	-	-	10.2 3.0

Note

'-' initiative not running.

Through the Gate

Spend on Through the Gate (Table A7.5) provided by MOJ relates to those with substance misuse issues (alcohol as well as drugs) so this is likely an overestimate of spend relating to drug users.

DfE/ DH/ MOJ initiatives

Table A7.6: Estimated spend on Family Drug and Alcohol Court relating to drug misuse under the Drug Strategy 2010, 2010/11 to 2014/15

	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000
Family Drug and Alcohol Court	Total programme spend	-	-	-	150 150
	Spend attributed to drug users	-	-	-	125 125

Note

'-' programme in pilot stage.

Family Drug and Alcohol Court

The FDAC pilot which ran from January 2008 to March 2012 was funded by a cross-government grant.²³⁰ The spend included here covers DfE funding in 2013/14 and 2014/15 of a 2-year development project to roll the FDAC model to new sites (£150,000 per year). In 2015 a £2.5 million investment (Innovation Programme) supported the set up of a National FDAC Unit to coordinate roll out and build the evidence base and also provided funding for launching FDACs in new areas.

²³⁰ The pilot was funded by DfE, MoJ, Home Office, DH and three inner-London pilot local authorities (Camden, Islington, and Westminster).

An independent evaluation (Harwin *et al.*, 2014) found that of a sample of 106 families referred to the FDAC (consisting of 169 parents) a total of 65 parents had drug misuse problems only and a further 76 parents had both drug and alcohol misuse problems (the categories are mutually exclusive). Therefore around 83 per cent of parents had some drug misuse issues. Applying this proportion to the yearly spend provides estimates of spend attributable to drug users (Table A7.6).

A7.2.1 Value for money

Estimates of the value for money associated with individual NTRAs delivered under the strategy are now considered. Whilst they are indicative of the potential financial benefits of NTRA, they are subject to a range of limitations, as described at section 7.6 and are reliant on the quality of the underlying data and research.

Housing related support

Earlier research (DCLG, 2009) into the financial benefits of Supporting People found that within the 'people with drug problems' group there was a cost of £30.1 million per annum leading to a net financial benefit of £157.8 million. This analysis precedes the Drug Strategy 2010, but the programme has continued and an assumption could be made that the positive relative financial benefits (if not absolute spend) have remained.

Troubled Families Programme

DCLG published detailed information from seven local authority areas on the costs and benefits of the Troubled Families Programme. This found that the average gross fiscal benefit across the seven areas was £11,200 per family in the 12 months after the family received the intervention (DCLG, 2015e). This is more than twice the average cost of the programme's intervention (£5,214) in these areas. However, it was not possible to isolate the saving relating to drug users specifically in this early report.

The first Troubled Families programme provided a cost savings calculator to local authorities to help them estimate costs and benefits. A report based on analysis of the use of the calculator by sixty-seven areas has been published (DCLG, 2016b). This details the costs to local authorities of delivering the programme and demonstrates the sorts of fiscal benefits that may have arisen after these families received support. However, it is not possible to directly attribute any benefits to the Troubled Families Programme because they may have arisen if families had not taken part in the programme.

The first set of evaluation reports for the new Troubled Families Programme were published alongside the Troubled Families Annual Report in April 2017 (DCLG, 2017).

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²³¹ As part of the Innovation Programme bid to DfE for funding, the National FDAC Development Unit carried out a value for money case study. This estimate covers the amount of money saved to the CJS, the NHS and local authorities for the London FDAC during 2012/13 which are considered to be financial benefits (Table A7.7).

Table A7.7: Summary of savings to local authorities, NHS and to the CJS from the Family Drug and Alcohol Court, 2012/13

	Local authorities £000	NHS £000	CJS £000	Total savings £000
Proceedings related costs	1,160			1,160
Post proceedings care	401			401
Parental drug misuses	4	29	244	277
Total Savings	1,565	29	244	1,838
Cost of delivering FDAC				617
Total cost				617
Net savings				1,221

Approximately £620,000 was spent on the programme in 2012/13 which resulted in cost savings of £1,840,000, meaning there was an average of £3.1 saved for every £1 spent. Assuming that the same ratio holds in subsequent years and in different areas, this gives an estimated cost saving from the FDAC initiative of £0.6 million in 2013/14 and 2014/15 (Table A7.8).

Table A7.8: Annual cost savings for the Family Drug and Alcohol Court, 2010/11 to 2014/15

Year	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000
Annual spend	-	-	-	150	150
Annual savings/ cost avoidance	-	-	-	465	465
Total net savings	-	-	-	315	315

²³¹ This information was provided by the National FDAC Unit. It is based on a value for money project carried out in 2012/13 by Ernst and Young and Ryan Tunnard Brown but is not publicly available.

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