

Report by the Comptroller and Auditor General

Tackling problem drug use

HC 297 Session 2009-2010

ISBN 978 0 10 296355 7

CORRECTION

Page 8, paragraph 19

Paragraph 19 reads:

19 The proportion of adults who drop out of treatment has fallen from 74 per cent in 2004-05 to 44 per cent in 2008-09. An increasing number of problem drug users leave treatment free from dependency on heroin or crack cocaine or the illegal drugs for which they sought treatment, but with evidence of other illegal drug use.

Paragraph 19 should read:

19 The proportion of problem drug users who drop out of treatment has fallen from 20 per cent in 2004-05 to 11 per cent in 2008-09. An increasing number of problem drug users leave treatment free from dependency on heroin or crack cocaine or the illegal drugs for which they sought treatment, but with evidence of other illegal drug use.

Figure 6 in the published report reads:

Figure 6

Indicators of the quality, effectiveness and accessibility of drug treatment for problem drug users 2004-05 to 2008-09

	2004-05	2005-06	2006-07	2007-08	2008-09
Percentage of problem drug users in effective treatment ¹	83%	85%	87%	93%	94%
Percentage of adults who did not complete their treatment (dropped out) ²	74%	69%	61%	51%	44%
Average waiting time to access treatment	2 weeks	2 weeks	1 week	1 week	1 week
Number of problem drug users leaving treatment in the year	36,000	40,000	39,000	41,000	42,000
Number of problem drug users leaving treatment free of dependency ³	3,500	4,500	5,300	7,000	9,300
Number of problem drug users leaving treatment free from illegal drug use ⁴	2,500	2,800	3,300	4,000	5,700
Drug related deaths ⁵	1,420	1,510	1,470	1,480	1,620
Prevalence of Hepatitis C infections among injecting drug users ^{5, 6}	45%	46%	44%	42%	41%
Needle and syringe sharing among injecting drug users ^{5, 7}	28%	28%	23%	24%	19%

Sources: National Statistics National Statistics <http://www.statistics.gov.uk/statbase/Expodata/Spreadsheets/D7892.xls>
Health Protection Agency's Unlinked Anonymous Prevalence Monitoring Programme survey of injectors in contact with drug agencies: Figure 6 (Hepatitis C virus prevalence among current injecting drug users) & 19 (needle & syringe sharing); Health Protection Agency: 'Hepatitis C in the UK: 2009 report' http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1259152221464

NOTES

- 1 The percentage of all problem drug users admitted for drug treatment who were discharged from treatment 12 weeks or more after triage, or who remain in treatment 12 weeks after triage, or who were discharge from treatment within 12 weeks in a planned way.
- 2 Percentage of all adults admitted for treatment after triage.
- 3 Free of dependency: The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine. There is evidence of other illicit drug use but this is not judged to be problematic or to require treatment.
- 4 Free from illegal drug use: The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine or any other illicit drug.
- 5 The data are for calendar years. Drug-related death is 'Death where the underlying cause is poisoning, drug abuse, or drug dependence and where any of the substances are controlled under the Misuse of Drugs Act (1971).' Source: Office of National Statistics: ONS Health Statistics Quarterly 31 (2006).
- 6 Reliable estimates of Hepatitis C prevalence among current and previous injecting drug users in England are difficult to obtain because of the indeterminate size of the former number of injecting drug users. Trends in Hepatitis C prevalence among current injectors (those who had last injected in the four weeks prior to participating in the unlinked anonymous prevalence monitoring programme are the best available, proxy measure of disease prevalence in this population.
- 7 Unlinked Anonymous Prevalence Monitoring Programme trend data on the proportion of current injectors who report recent needle & syringe sharing.

Figure 6 should read:**Figure 6**

Indicators of the quality, effectiveness and accessibility of drug treatment for problem drug users 2004-05 to 2008-09

	2004-05	2005-06	2006-07	2007-08	2008-09
Percentage of problem drug users in effective treatment ¹	83%	85%	87%	93%	94%
Percentage of problem drug users who dropped out of treatment ²	20%	19%	15%	13%	11%
Average waiting time to access treatment	2 weeks	2 weeks	1 week	1 week	1 week
Number of problem drug users leaving treatment in the year	36,000	40,000	39,000	41,000	42,000
Number of problem drug users leaving treatment free of dependency ³	3,500	4,500	5,300	7,000	9,300
Number of problem drug users leaving treatment free from illegal drug use ⁴	2,500	2,800	3,300	4,000	5,700
Drug related deaths ⁵	1,420	1,510	1,470	1,480	1,620
Prevalence of Hepatitis C infections among injecting drug users ^{5, 6}	45%	46%	44%	42%	41%
Needle and syringe sharing among injecting drug users ^{5, 7}	28%	28%	23%	24%	19%

Sources: National Statistics National Statistics <http://www.statistics.gov.uk/statbase/Expodata/Spreadsheets/D7892.xls>
Health Protection Agency's Unlinked Anonymous Prevalence Monitoring Programme survey of injectors in contact with drug agencies: Figure 6 (Hepatitis C virus prevalence among current injecting drug users) & 19 (needle & syringe sharing); Health Protection Agency: 'Hepatitis C in the UK: 2009 report' http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1259152221464

NOTES

- 1 The percentage of all problem drug users admitted for drug treatment who were discharged from treatment 12 weeks or more after triage, or who remain in treatment 12 weeks after triage, or who were discharge from treatment within 12 weeks in a planned way.
- 2 Percentage of all problem drug users in treatment.
- 3 Free of dependency: The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine. There is evidence of other illicit drug use but this is not judged to be problematic or to require treatment.
- 4 Free from illegal drug use: The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine or any other illicit drug.
- 5 The data are for calendar years. Drug-related death is 'Death where the underlying cause is poisoning, drug abuse, or drug dependence and where any of the substances are controlled under the Misuse of Drugs Act (1971).' Source: Office of National Statistics: ONS Health Statistics Quarterly 31 (2006).
- 6 Reliable estimates of Hepatitis C prevalence among current and previous injecting drug users in England are difficult to obtain because of the indeterminate size of the former number of injecting drug users. Trends in Hepatitis C prevalence among current injectors (those who had last injected in the four weeks prior to participating in the unlinked anonymous prevalence monitoring programme are the best available, proxy measure of disease prevalence in this population.
- 7 Unlinked Anonymous Prevalence Monitoring Programme trend data on the proportion of current injectors who report recent needle & syringe sharing.



National Audit Office

**REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL**

**HC 297
SESSION 2009–2010**

MARCH 2010

Tackling problem drug use

Our vision is to help the nation spend wisely.

We promote the highest standards in financial management and reporting, the proper conduct of public business and beneficial change in the provision of public services.

The National Audit Office scrutinises public spending on behalf of Parliament. The Comptroller and Auditor General, Amyas Morse, is an Officer of the House of Commons. He is the head of the National Audit Office which employs some 900 staff. He and the National Audit Office are totally independent of Government. He certifies the accounts of all Government departments and a wide range of other public sector bodies; and he has statutory authority to report to Parliament on the economy, efficiency and effectiveness with which departments and other bodies have used their resources. Our work leads to savings and other efficiency gains worth many millions of pounds: at least £9 for every £1 spent running the Office.



National Audit Office

Tackling problem drug use

Ordered by the House of Commons
to be printed on 3 March 2010

Report by the Comptroller and Auditor General

HC 297 Session 2009–2010
4 March 2010

London: The Stationery Office
£14.35

This report has been
prepared under section 6
of the National Audit Act
1983 for presentation to
the House of Commons
in accordance with
Section 9 of the Act.

Amyas Morse
Comptroller and
Auditor General

National Audit Office

2 March 2010

Central and local Government spend £1.2 billion a year tackling drug use, a problem which costs society an estimated £15 billion a year. The Government has a 10 year drug strategy designed to reduce the harm that drugs cause to society, communities, individuals and their families.

© National Audit Office 2010

The text of this document may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not in a misleading context.

The material must be acknowledged as National Audit Office copyright and the document title specified. Where third party material has been identified, permission from the respective copyright holder must be sought.

Contents

Summary **4**

Part One

Tackling problem drug use
through the Drug Strategy **12**

Part Two

Tackling drug-related
offending, drug treatment
and reintegration **21**

Appendix One

Audit methodology **31**

The National Audit Office study team
consisted of:

Craig Adams, Jon Cable,
Miguel Garcia-Sanchez, Rachel Nugent,
Andrew O'Reilly, Nick Ormiston-Smith
and Robert Sabbarton, under the
direction of Aileen Murphie

This report can be found on the
National Audit Office website at
www.nao.org.uk/druguse10

For further information about the
National Audit Office please contact:

National Audit Office
Press Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Tel: 020 7798 7400

Email: enquiries@nao.gsi.gov.uk

Summary

Background

1 Central and local government spend around £1.2 billion a year tackling drug use in England. The cost to society of problem drug use is around £15.3 billion a year (2003-04 estimate); 90 per cent of which is attributable to drug-related offences (mainly acquisitive crimes such as theft and burglary committed by problem drug users). There are an estimated one third of a million problem drug users in England. Within this examination, problem drug users are defined as those using opiates (mainly heroin) and/or crack cocaine, which are Class A drugs.

2 The case for Government intervention to tackle problem drug use is strong. If the harms from problem drug use can be reduced significantly, then the costs to society should fall. Effective interventions could also help limit the size of future generations of drug users. In February 2008, the Government introduced a new Drug Strategy 'Protecting families and communities' (the Strategy), which aims 'to reduce the harm that drugs cause to society, to communities, individuals and their families'. This wide ranging Strategy runs from 2008 to 2018, and is supported by three-year action plans.

3 The Strategy's approach includes getting problem drug users into effective treatment to reduce their drug related offending and re-integrating them into society to reduce harm to families and costs to communities. It also sets out much broader measures such as: preventing drug use; working with international partners to intercept drugs before they reach the United Kingdom; tackling organised crime; increasing the street price of drugs; the seizure of assets generated by drug dealing; and disrupting local drug markets. The Strategy set out the Public Service Agreements (PSAs) relating to each of its strands, with PSA 25 – 'Reduce the harm caused by drugs and alcohol', including the main indicators of progress.

4 This report examines progress against three strategic objectives of the current action plan which cover over £900 million of the current annual expenditure of £1.2 billion and which aim to:

- **target and manage problem drug using offenders:** to reduce drug related offending;
- **improve the quality and effectiveness of treatment:** to reduce drug related offending; increase the number of problem drug users in effective treatment; lower relapse rates following treatment; achieve a greater proportion of drug users becoming free from dependence; fewer drug related deaths; fewer blood borne virus transmissions; and fewer health harms; and

- **help problem drug users re-establish their lives:** to achieve reductions in drug users with housing problems, and those claiming benefits, and to get more drug users into work.

5 The examination assesses whether the 2008 Drug Strategy is supported by a robust evidence base for Government intervention and expenditure of public funds on tackling problem drug use. It considers whether the programme of interventions put forward to achieve the three strategic objectives are achieving value for money and whether the Strategy is supported by a robust framework to evaluate overall performance, and the degree to which the Strategy achieves its aims.

6 The examination does not cover broader objectives in the Strategy such as drug treatment in prisons, safeguarding children, tackling the supply of drugs, or measures to prevent drug use. These account for around £249 million of the £1.2 billion annual funding to deliver the Strategy.

Key findings

The Government's new Drug Strategy is wide ranging but has no overall framework for evaluation

7 In 2008, the Government introduced a new 10-year Drug Strategy supported by a series of three year action plans which followed a review of evidence for some of the measures included, and extensive public consultation. The Strategy sets out a governance structure for delivery of the Strategy and the underpinning Service Delivery Agreements. It also outlines the anticipated impacts from each strategic theme. We found that a number of the objectives in the Strategy are supported by robust sources of evidence including the effectiveness of drug treatment (£581 million a year adult drug treatment funding in 2008-09), but there are some gaps where further research is needed, for example, in getting problem drug users into stable work (£13 million a year Department for Work and Pensions funding) and into placing problem drug users into suitable accommodation (£30 million a year Department for Communities and Local Government funding). The new Strategy builds on the previous Drug Strategy from 1998 to 2008, although there was no overall evaluation of the outcomes of the first Strategy undertaken to feed into the new plans.

8 Neither the current Strategy, nor the supporting action plan for 2008-2011, set out an overall framework for evaluating and reporting on the degree to which the Strategy is achieving the intended outcomes or the value for money provided. The Home Office notes that the Strategy sets out a programme of measures which can deliver multiple outcomes. It considers there would be significant difficulties in determining links between its measures and the intended outcomes. The Home Office also notes there are limitations in the data generated across the different areas of activity covered by the Strategy that make overall evaluation challenging. The Home Office considers that evaluating individual measures is a preferable and cost effective approach and it considers it has made good progress in its evaluation. While a number of individual

measures have been evaluated, others such as the Drug Rehabilitation Requirement, and the £30 million funding on housing related support services for drug users, have not. The Cross-Government Research Programme on Drugs aims to continue to develop a robust scientific evidence base.

9 The Action Plan for 2008-11 identified 22 strategic objectives, supported by a total of 87 key actions. Ten strategic objectives had at least one related measure, national indicator or Public Service Agreement that could be used to judge progress against key actions, and a further four strategic objectives did not require a measure. For the remaining eight strategic objectives however, there was no identified metric that could be used to assess how much progress had been made to achieving them.

Structures for delivering the Strategy and for funding are complex

10 The multiplicity of Departments and Agencies involved add to the complexities in delivering the Strategy. The Home Office has overall policy responsibility for delivering the Strategy while a number of other Government Departments and Agencies at both national and local levels also have responsibility for taking forward aspects of the Strategy. These organisations are providing total funding to tackle drugs of £1.2 billion in 2009-10. The Strategy shows that annual funding for the duration of the first action plan is expected to stay broadly constant.

11 Generally, the central Government providers had a good understanding of their responsibilities, although there was varied understanding as to how to deliver them, and their capacity to deliver them. The capacity and capabilities of the Government Offices for the Regions, which are responsible for working with local partnerships, in delivering the Strategy, also showed marked variations.

Government has given increased attention to targeting and managing drug-using offenders

12 The estimated annual cost to society of problem drug use is £15.3 billion (2003-04 estimate), of which £13.9 billion is the estimated cost of drug related offences. Between a third and a half of acquisitive crime is estimated to be drug related. The majority of drug related acquisitive crime is committed by 25 to 35 year-olds. Young people who take illegal drugs are more likely to commit offences, additional to drug possession, than those not taking illegal drugs. Nearly half of young people under 25 committing an offence additional to drug possession, had taken any drug compared with 19 per cent who had not taken any drug, in the same 12 month period.

13 The Drug Interventions Programme aims to drive down drug-related offending by facilitating access to drug treatment and other services for drug users who are arrested, charged or convicted of crimes. The Programme is delivered by local partnerships and costs £150 million a year. In 2009-10, between 4,000 and 4,500 problem drug users have commenced drug treatment in the community each month following referral from the Programme.

14 Home Office research in 2007, indicated that crimes committed by those on the Programme fell by 26 per cent overall compared to their frequency of offending before they entered the Programme. Around half showed a decline in offending of 79 per cent. A quarter showed similar levels of offending although 28 per cent showed a sharp increase in their volume of offending, possibly indicating a hard core of problem drug-using offenders. However, the lack of a comparison group in the research meant that any changes in offending could not be directly ascribed to the Programme.

15 The Drug Interventions Programme puts a greater focus on reducing crime and on hard core prolific problem drug-using offenders who require closer management in the community. Home Office research indicated that the Programme could further increase its impact and value for money and that local operation of the Programme has been inconsistent. Some local partnerships have focused too narrowly on facilitating problem drug-using offenders' access to treatment while funding in some local partnerships was up to seven times higher per drug user than the least expensive. In some local partnerships, the local authority provided no support to drug users to obtain accommodation despite problem drug-using offenders' views that housing was the major problem they faced. The Home Office is planning changes to the operation of the Programme from April 2010 to achieve greater consistency across the local partnerships.

16 Around half of convicted problem drug users complete their Drug Rehabilitation Requirement while on a community sentence. The Ministry of Justice provides £42 million a year to the Department of Health to facilitate access to treatment for problem drug-using offenders serving a Drug Rehabilitation Requirement. The Ministry of Justice is including the Drug Rehabilitation Requirement as part of an offender community cohort study. The Ministry of Justice aims to gather data on the characteristics of offenders who typically receive the Requirement, and which types of offenders could benefit most from the Requirement. Without an effectiveness evaluation, the Ministry is not able to assess the impacts of the Requirement, such as any change in offenders' drug use and criminal activity. Nor will it be able to understand how to improve the percentage of drug users who comply with, and complete, the Requirement, or the value for money provided.

Central funding for adult drug treatment is contributing an increasing share of funding for drug treatment

17 Between 2004-05 and 2008-09, funding for adult drug treatment increased from £481 million to £581 million (at 2008-09 prices). The numbers in effective treatment increased from 134,000 to 195,000 over that period. Central Government funding (the 'Pooled Treatment Budget') accounted for all this increase in funding. The proportion of funding from the Pooled Treatment Budget increased from 53 per cent to 64 per cent of total funding. Total funding per adult in effective treatment fell from £3,700 in 2006-07 to £3,000 in 2008-09. In the first 18 months since a 2008 baseline, the number of problem drug users in effective treatment has increased by 7.1 per cent, against a planned three per cent target increase by 2011.

The goal of all drug treatment is for drug users to achieve abstinence

18 The goal of all drug treatment is for drug users to achieve abstinence from their drug(s) of dependency, with treatment supporting drug users to achieve this as soon as they can. The Home Office Drug Treatment Outcomes Research Study estimated a benefit cost ratio for all drug treatment of around 2.5:1, as the mean benefit per drug user in treatment was £12,000, compared to a mean cost of treatment of £4,900.

19 The proportion of adults who drop out of treatment has fallen from 74 per cent in 2004-05 to 44 per cent in 2008-09. An increasing number of problem drug users leave treatment free from dependency on heroin or crack cocaine or the illegal drugs for which they sought treatment, but with evidence of other illegal drug use.

Getting drug users back into work and appropriate accommodation is challenging

20 The shortage of suitable housing and support in local authorities remains a significant constraint to reintegrating drug users. There is currently no UK research on the efficacy of measures to put problem drug users in appropriate accommodation. About 100,000 problem drug users have a housing problem. The Strategy requires the Department for Communities and Local Government to improve access to appropriate accommodation and support for drug users who are in treatment and leaving treatment.

21 Many employers are reluctant to recruit drug users, even after treatment. Around 80 per cent of problem drug users claim benefits at an annual cost of £40 million. Around 100,000 of problem drug users on benefits are not in treatment. Getting them fit for work, and into and holding down a job, can take a long time and be expensive.

22 Only eight per cent of drug users receiving help into employment are able to obtain a job and keep it for 13 weeks or more and the cost for each drug user helped into a job was £11,600 in 2008-09. The Department for Work and Pensions is providing around £13 million a year across Great Britain for 'progress2work'. This initiative aims to get drug users into employment, through arranging skills training, mentoring and support. Between 2006-07 and 2008-09, the numbers joining the programme stayed broadly constant at around 12,500 a year. But the number who started a job after taking part in the programme fell from 2,500 to 1,950.

Value for Money Conclusion

23 There is significant Government activity aimed at tackling problem drug use, building the evidence base and evaluating its effectiveness. The Government is spending £1.2 billion in 2009-10 with the objective of bringing down the costs to society of problem drug use of £15 billion a year. There is no framework in place for evaluating the achievements of the 2008 Strategy which limits Departments' understanding of the overall value for money achieved and where future resources should be prioritised. Without an evaluative framework for the Strategy as a whole we are not able to conclude

positively on value for money. There has been good progress in a number of activities, including an increasing number of problem drug users in drug treatment; and an increasing percentage leaving treatment free from dependency. The Drug Treatment Outcomes Research Study has estimated the benefit cost ratio for drug treatment is 2.5 to 1. The most significant and costly objectives of the Drug Strategy are supported by robust evidence and plans are in place to develop a robust scientific evidence base.

24 The number of initiatives underway, the cross-departmental nature of the Strategy, and the complex arrangements for delivery at national, regional and local levels add to the difficulties in assessing whether value for money is being achieved. A framework for evaluation could draw upon the existing individual evaluations of measures in the Strategy and would help assess whether funding is being optimally directed at different strategic objectives. The Home Office agrees with the National Audit Office that producing such an evaluative framework would be desirable. This will not be a straightforward task. The Home Office will work with the National Audit Office to achieve satisfactory measures.

Recommendations

- a** **The Drug Strategy does not state how an overall evaluation of the outcomes achieved from the £1.2 billion annual expenditure on delivering the Strategy will be undertaken, reported on, or the value for money assessed.**

Given the £15 billion annual cost to society of problem drug use and the risks to the £1.2 billion annual public funding of measures to deliver the Strategy, the Departments responsible for delivering the Strategy should develop a framework for evaluating value for money. They should ensure ongoing evaluation covers all areas of spending, with regular reporting, on the degree to which measures in the Strategy are reducing the costs of problem drug use, and delivering value for money, together with an assessment of the success of joined up working. We acknowledge this will be challenging, given the wide range of intended outcomes set out in the Strategy, the need to understand the influence of wider factors on the harms from problem drug use and the levels of offending, and the volume of data needed to assess the effects of measures in the Strategy on the intended outcomes.

To ensure a framework for evaluation is economic and achievable, we recommend that development work should initially identify and include only those factors which have the greatest influence on the harms from problem drug use. The Departments should then identify a research design that enables an understanding of the linkages between expenditure on measures in the Strategy and the achievement of the intended outputs and outcomes and seeks to control where possible for wider factors affecting the intended outcomes.

Running the evaluation framework will require timely and accurate costing, activity, output and outcome data. The evaluation approach should identify the data systems required for the framework, and where data are not already available they should ensure these are in place to enable value for money to be assessed.

b Only 10 of the 22 strategic objectives in the 2008-2011 Action Plan included metrics to monitor progress and delivery.

Future action plans should ensure each strategic objective is accompanied by a robust evidence base for the activity proposed, linking it to the intended outputs and outcomes, the funding identified for the activity, time related targets for delivery, and robust performance measures. This will enable progress against targets to be monitored and reported on for each strategic objective, and enable robust assessment of value for money achieved.

c Departmental capacities required to deliver their responsibilities under the Strategy vary and the strength of corporate commitment to delivery reflects how closely responsibilities are aligned to Departments' strategic objectives.

All Departments should ensure that they:

- are focused on collective delivery and the collective achievement of targets;
- have clear linkages between their central performance indicators and local indicators;
- have levers through the Government Offices designed to help provide local partnerships with the support and influence required to deliver the Strategy's aims; and
- work together to ensure greater consistency in performance between Government Office regions, and to facilitate improved communications and collaboration between regions.

d The impacts of Drug Rehabilitation Requirements on drug users' offending levels and ongoing drug use are not known and value from expenditure on the Requirement is not known.

The National Offender Management Service should undertake an effectiveness evaluation of the outcomes of the Requirement and how to improve completion rates. The National Offender Management Service should also ensure it is supervising more closely those drug users on the Requirement who are causing the greatest financial costs to society.

- e** The National Treatment Agency has delivered significant growth in the number of problem drug users in effective treatment and drug treatment has an estimated cost-benefit ratio of 2.5:1. The Drug Strategy considers that too many drug users relapse, do not complete treatment programmes or stay in treatment too long.

National Treatment Agency regional managers, working with regional partners should examine treatment performance data in each partnership to identify trend data in relapse rates, drop out rates and time in treatment. Where this identifies relatively weak or declining performance, they should collaborate on targets for local treatment services to improve performance in these areas and promote local adoption of evidence-based guidance from the National Treatment Agency to assist local treatment services improve performance in line with the Strategy's goals.

- f** There is no UK research on which measures are most effective in helping drug users' access and live in accommodation without harming their communities due to drug possession, dealing, committing acquisitive crimes and anti-social behaviour.

The Department for Communities and Local Government should commission independent research to establish which measures provide best value for money in accommodating problem drug users, while protecting local communities. Measures by local authorities to accommodate drug users must be part of a coordinated approach to their reintegration and emphasise the protection of families and communities. They should link closely to services retaining problem drug users in treatment.

- g** Performance of measures to get drug users off benefits and into work is below the target success rate of 20 per cent. The Department for Work and Pensions plans to introduce a new programme from October 2010 to offer additional employment support for recovering drug users.

The Department for Work and Pensions should review 'progress2work', to identify how to improve value from expenditure on this programme, and to determine those aspects which have been successful. It should use this knowledge to ensure the new programme to help problem drug users into work is evidence based, and can demonstrate value for money.

Part One

Tackling problem drug use through the Drug Strategy

There are an estimated 330,000 problem drug users in England

1.1 One third of a million adults in England are problem drug users, of whom 166,000 are in effective treatment in the community. Problem drug users may also receive treatment in prison. In the Strategy, and within this examination, problem drug users are defined as those using opiates (mainly heroin) and/or crack cocaine, which are Class A drugs. Problem drug use may also be associated with the consumption of other illegal drugs and problematic alcohol consumption.

1.2 The definition of 'problem drug use' as the use of opiates and/or crack cocaine is drawn from the 2008-2018 Drug Strategy 'Drugs: protecting families and communities' (the Strategy). The Strategy identifies opiates and crack cocaine as problem drugs as it estimates they account for 99 per cent of the costs to society of Class A drug use. These include acquisitive crime, health harms, social harms and disrupted employment and education.

1.3 People taking illegal drugs may have different levels of dependency. They may respond differently to measures used to tackle their offending and to treatments to reduce their dependency. And their personal motivation changes over time. This means the links between measures to tackle problem drug use and their intended outcomes are not straightforward and relationships are complex.

1.4 Drug addiction is defined by the World Health Organisation as:

'A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state'.¹

'A multi-factorial health disorder that often follows the course of a relapsing and remitting chronic disorder'.²

1 Source: Mental and behavioural disorders due to psychoactive substance use; Chapter V; International Classification of Diseases, 10th Revision; World Health Organisation.

2 Source: Principles of Drug Dependence Treatment; United Nations Office on Drugs and Crime and World Health Organisation, 2008.

Problem drug use costs society over £15 billion a year

1.5 The case for Government intervention in this issue is strong. The estimated annual costs to society associated with problem drug use are £15.3 billion (2003-04 estimate). Of this figure £13.9 billion is the estimated annual cost of drug-related offending (mainly acquisitive crimes committed by problem drug users such as theft and burglary). Of the £13.9 billion, £9.9 billion are the costs to the victims of these crimes and £4.0 billion are the costs incurred by the criminal justice system³. There are further social costs, such as the harm suffered by families and children, and those borne by neighbours and local communities.

1.6 If problem drug use can be reduced significantly, then the cost to society will be reduced, along with the wider detrimental effects on the current generation of drug users and those who come into contact with them. It should also help to limit the creation of a future generation of users.

1.7 Between a third and a half of acquisitive crime is estimated to be drug related, much of which is committed by young people. Young people who take illegal drugs are more likely to commit offences, other than drug possession, than those not taking illegal drugs. Nearly half of young people under 25 committing an offence, other than possession of drugs, had taken any drug compared with 19 per cent who had not taken any drug, in the same 12 month period⁴.

The 2008 Drug Strategy 'Drugs: protecting families and communities' aims to bring down the costs to society

There is no framework for overall evaluation of the Drug Strategy

1.8 In 2008, the Government produced a 10-year Drug Strategy for England 'Drugs: protecting families and communities' which 'aims to reduce the harm that drugs cause to society, to communities, individuals and their families'. The current Strategy follows a 1998 Strategy, which was reviewed and updated in 2002. The Home Office, Ministry of Justice and National Treatment Agency evaluated a number of the measures for which they were responsible, but there was no collective evaluation of the degree to which the first Strategy achieved its objectives overall, to inform the current Strategy.

³ The economic and social costs of Class A drug use in England and Wales, 2003-04' <http://www.homeoffice.gov.uk/rds/pdfs06/rdsolr1606.pdf>. Estimating the costs and benefits of problem drug use is complex, involving a wide range of direct and indirect factors, and is subject to a degree of uncertainty. Our evaluation of the methodology used to develop an overall estimate of the costs identified scope to produce a more precise estimate, but recognised that the research itself noted the limitations of its approach and pointed the way to further research to refine the estimate.

⁴ Young people and crime: Findings from the 2005 Offending, Crime and Justice Survey, Home Office statistical bulletin, 17/06.

1.9 The current Strategy aims to bring down costs associated with problem drug use through measures, including:

- offering drug treatment, supporting drug users in trying to achieve abstinence as soon as they can;
- imposing responsibility on drug users claiming benefits to engage in treatment with the ultimate aim of getting work;
- prosecution of drug dealers and those committing crime to feed their addiction, with the aim of driving down crime; and
- prevention campaigns with an increasing focus on young children.

1.10 The Strategy is supported by action plans designed to run concurrently with the Comprehensive Spending Review cycles. It sets out a governance structure for delivery, both for the Strategy itself and underpinning Service Delivery Agreements and outlines the anticipated impacts from each strategic theme. PSA 25, 'Reduce the harm caused by drugs and alcohol', includes the selected indicators of progress.

1.11 It is important when embarking on a new Strategy, with a large programme of expenditure, to build in a framework to evaluate the degree to which the Strategy achieves its aims and delivers value for money. However, neither the Drug Strategy, nor the supporting Action Plan for 2008-2011, set out a framework to evaluate the actions and measures proposed, and to assess the degree to which it will reduce the harms from problem drug use and deliver value for money. The importance of an evaluation is emphasised by the £15 billion annual costs to society the Strategy aims to reduce; the £1.2 billion annual public funding to deliver the measures set out in the Strategy; the complex funding flows; the wide ranging themes addressed by the Strategy; its cross-Departmental nature; and the complex delivery and accountability arrangements involving central, regional and local government.

1.12 We consider a framework for evaluation is required to safeguard the ongoing use of public funds; to understand the extent to which the Strategy is achieving the intended objectives, and how this could be improved, and to report on performance in reducing the costs to society of problem drugs. We recognise constructing an overall framework for evaluation is challenging. However, we consider that development work should initially identify and focus on factors which have the greatest influence on the harms from problem drug use. We recognise that the research design will require an understanding of the linkages between expenditure on measures in the Strategy and the achievement of the intended outputs and outcomes and need to control for wider factors affecting the desired outcomes. An evaluation framework will also require data systems to provide timely and accurate costing, activity, and output and outcome data.

1.13 The Home Office agrees with the National Audit Office that producing such an evaluative framework would be desirable. This will not be a straightforward task. The Home Office will work with the National Audit Office to achieve satisfactory measures.

The 2008-11 Action Plan supporting the Strategy contains a number of objectives but around half do not have metrics which allow progress to be measured

1.14 The Action Plan for 2008-11 identified 22 strategic objectives, supported by a total of 87 key actions. Ten of these strategic objectives had at least one related measure, national indicator or Public Service Agreement (PSA) that could be used to judge progress against it, and a further four strategic objectives did not require a measure. For the remaining eight strategic objectives, however, there was no identified metric that could be used to assess how much progress had been made to achieving them. In some cases, there was no evidence of a link between the key action described and the intended outcome. The Government has published 'The 2008 Drug Strategy: one year on', to outline progress and to set out future priorities and intentions, but the document did not include data on outcomes against key actions and targets in the action plan to enable measurement of progress.

1.15 The Strategy set out the PSAs relating to each of its strands. The National Audit Office examines data systems underpinning PSAs and rates them as 'Red', 'Amber' or 'Green'. **Figure 1** shows the findings from our review of PSA 25 – 'Reduce the harm caused by drugs and alcohol'.

Figure 1
National Audit Office validation of the data systems underpinning PSA 25

PSA	Validation rating
PSA 25.1: the number of drug users in effective treatment	Green
PSA 25.3: the rate of drug-related offending	Red
PSA 25.4: the percentage of the public who perceive drug use or dealing to be a problem in their area	Green

Source: Drugs: protecting families and communities 2008-2018 National Audit Office Validation Reports; Measuring Up: Findings by Public Service Agreement, http://www.nao.org.uk/publications/0809/measuring_up_psa_validation-1/findings_by_psa.aspx¹

NOTE

1 Green: The data system is fit for the purpose of measuring and reporting performance against the indicator; Amber: Broadly appropriate, but needs strengthening to ensure that remaining risks are adequately controlled; Red: The data system does not permit reliable measurement and reporting of performance against the indicator.

1.16 The validation work rated as 'Red' the data system for measuring changes in the rate of drug-related offending as it was not able to provide reliable measurement or reporting of performance in reducing the rate of drug-related offending.

The evidence base supporting the Strategy contains some gaps

1.17 Our review of the Strategy found that while some objectives are supported by robust sources of evidence, for example, on tackling drug-related offending and the effectiveness of drug treatment, there are gaps in the evidence base where further research is needed. The establishment of a Cross-Government Research Programme on Drugs aims to address these needs, through developing a robust scientific evidence base. This involves UK Research Councils, Government Departments and the Police. High level findings from our review of the Strategy's evidence base are in **Figure 2**.

Figure 2

Findings from our review of the evidence base for the 2008 Drug Strategy

Drug use and crime

- The Strategy stated that 'the relationship between drug use and crime is complex' and that 'the exact nature and direction of the link between drugs and crime is less clear'. We found that the referenced evidence on drug use and crime was robust, drawing upon randomised controlled trials and high quality statistical analysis.

Treatment for drug users

- The quality of evidence for the effectiveness of drug treatment was robust, focusing on systematic reviews and those which have been quality assured. However, the success of treatment was not always defined by outcomes. Common weaknesses included:
 - no identifiable causal mechanisms;
 - small sample sizes; and
 - an absence of comparator groups, although ethical reasons may inhibit the use of control groups.
- There was little evaluation of the extent to which drug treatment may shorten the average duration of drug use by problem drug users.

Reintegration

- The Strategy stated that drug treatment was often most effective when combined with additional support to reintegrate problem drug users, to tackle homelessness, long-term unemployment and mental health problems. This was not research based.
- The Strategy claimed that meeting the housing needs of drug users significantly reduces drug use. We found that this was based on research in the USA.
- The Strategy claimed that successful completion of treatment significantly improved the probability of employment, but this was based only on observational data.

Source: National Audit Office

Government spends £1.2 billion a year tackling problem drug use

A large number of national and local Government Departments and Agencies are involved in taking forward the Strategy

1.18 The Home Office has overall responsibility for the Strategy while a number of other Government Departments and Agencies at national, regional and local levels also have responsibility for delivering the Strategy. **Figure 3** overleaf shows the key Departments, individual funding contributions in 2009-10, totalling £974 million, and their responsibilities. **Figure 4** on page 19 details a further £153 million of central Government expenditure to tackle drug use embedded within wider programmes bringing central Government funding to over £1.1 billion. Local partnerships have also received £65 million funding in 2009-10 for drug treatment from police, probation and social care services, making total Government expenditure in tackling problem drug use of £1.2 billion. The Strategy shows annual funding for the duration of the first action plan is expected to stay broadly constant.

Responsibilities for delivering the 2008 Drug Strategy are spread between different organisations

Departmental responsibilities for delivering the Strategy are generally clear but their capacity to deliver those responsibilities varies

1.19 Our review of central Government Departments and the National Treatment Agency found that they generally have a good understanding of their responsibilities for delivering the Strategy. For example, the National Offender Management Service within the Ministry of Justice has set out its vision within its own drug strategy. However, clarity over how to deliver their responsibilities and the comprehensiveness of their plans varies. For example, the Department of Health has developed detailed delivery plans, a performance committee, and terms of references for those responsible for delivery. Actions in the Strategy which are reflected in Public Service Agreements require cross-Departmental working and a clear understanding of the linkages across the indicators and the wider set of related PSAs. The PSAs also include governance arrangements requiring significant engagement of the relevant Departments.

1.20 We also found that Departmental capacities to deliver their responsibilities vary. The strength of corporate commitment to delivery was a reflection of how closely responsibilities were aligned to the Department's strategic objectives. The Departments and the National Treatment Agency demonstrated an appetite for close joint working. However, joint governance arrangements are an important requirement to secure effective partnership working to ensure objectives are shared, and that strong links and communications are in place at the right levels between Departments.

Figure 3

Departments' funding and responsibilities to deliver the Strategy

Department	2009-10 contribution: Funding specific to tackling illegal drugs (£m)	Responsibilities
Home Office	170	<ul style="list-style-type: none"> Overall responsibility for delivery Development and delivery of the Strategy Delivery of the Drug Interventions Programme Providing research and statistical information Improving performance against objectives and outcomes that require cross-partnership working
Ministry of Justice	112	<ul style="list-style-type: none"> Targeting problem drug-using offenders to receive community sentences, through Drug Rehabilitation Requirements Reducing the supply of drugs and drug testing in prisons Strengthening continuity of case management between community and custody Drug treatment and counselling in prison
Department of Health	623	<ul style="list-style-type: none"> Core funding for the National Treatment Agency Delivery of targets to increase the number of drug users in effective treatment Delivering treatment, care and prevention aspects of the Strategy Overseeing the availability, capacity and effectiveness of drug treatment Improving the commissioning of drug treatment services Promoting evidence-based and coordinated practice to improve the performance of drug treatment commissioners and practitioners Funding drug treatment in prisons Funding access to employment for drug users on benefits
Department for Children, Schools and Families	31	<ul style="list-style-type: none"> Advising schools on drugs education Prevention and early intervention
Foreign and Commonwealth Office	38	<ul style="list-style-type: none"> Efforts to counter narcotics production in Afghanistan
Total Funding	974	

Source: National Audit Office analysis

Figure 4

Other central Government expenditure to tackle drug use

Department	2009-10 funding to tackle drug use embedded within wider programmes (£m)	Responsibilities
UK Border Agency	74	Tackling drug supply
Department for Communities and Local Government	30 ¹	Supporting People programme to provide housing support for drug users
Department for Children, Schools and Families	7	Young people's substance use
Department for Work and Pensions	13 ²	progress2work Supporting access to employment for drug users on benefits Referring drug users on benefits into treatment Requiring drug users on working-age benefits to attend a discussion with a drug treatment provider
Home Office	29	Young people's substance use
Total	153	

Source: National Audit Office analysis

NOTES

1 2008-09 funding figure, as funding for 2009-10 is not yet available.

2 Department for Work and Pensions funding for progress2work is for Great Britain.

Regional responsibilities for delivering the Strategy are clear but there are significant variations in their capacity to deliver

1.21 Government Offices for the Regions are responsible for working with Local Strategic Partnerships, Crime and Disorder Reduction Partnerships and drug (and alcohol) action teams; these include representatives from police, probation, fire and rescue, primary care trusts and local authorities which support the roll-out of the Strategy. Government Offices should:

- ensure all relevant partners are involved in the partnership and the local area agreements designed to deliver the Strategy;
- review progress and coordinate action to respond to underperformance;
- identify and share good practice; and
- work with regional partners.

1.22 We found marked variations in Government Offices' capacity and capabilities to meet their commitments to deliver the Strategy. This creates a risk that regions may differ in their commitment to, and progress in, delivering the Strategy's objectives. Some regional drug leads reported limited resources while others considered they were well resourced. Some regional drug leads also reported difficulties in identifying good practice due to having limited contacts with Local Strategic Partnerships and drug action teams, because the drug lead role was only one of their responsibilities. Others felt they had a detailed picture of local practice and performance, frequent local contacts, and were able to focus their time on the drug lead role. Regional drug leads targeted available resources at the locations in their Region which they considered were underperforming or required additional support. National Treatment Agency regional teams directly contribute to delivery of the Strategy by taking local responsibility for delivery of PSA 25.1, other aspects of the Drug Strategy and implementation of the Drug Interventions Programme. They work closely with the National Treatment Agency centrally, Government Office drug leads, and with the Local Strategic Partnerships.

Local Strategic Partnerships have overarching responsibility for delivering the Strategy at local level

1.23 Local Strategic Partnerships have overarching responsibility at local level for delivering the strategy, supported by Drug Action Teams and Crime and Disorder Reduction Partnerships and Criminal Justice Boards. The Strategy states that tackling problem drug use should be part of core local planning and delivery. Local agencies also need effective joint working. The Strategy recognised that local delivery arrangements should be determined in line with local needs and structures. Local partners also have statutory responsibilities to formulate local drug strategies, such as Crime and Disorder Reduction Partnerships, with each local area free to determine how it delivers the aims of its strategy.

1.24 One intention of the Strategy is to deliver new approaches to drug treatment and reintegration. Pilot locations, known as 'system change pilot areas', are testing differing approaches to identify better systems to manage drug users, secure more effective use of pooled funding and individual budgets, and bring a greater focus on outcomes. The pilot areas have been granted funding flexibilities to enable them to implement their own approaches and test new ideas. The pilot programme is operating over two years from April 2009, and will be subject to independent evaluation. In July 2009, thirteen pilot locations began operating the 'Total Place' initiative, with £5 million funding from the Department for Communities and Local Government. Three of the locations are scrutinising expenditure on alcohol and drug abuse. The initiative aims to improve local services and generate efficiency savings through collaboration and local leadership. The pilots will report in 2010.

Part Two

Tackling drug-related offending, drug treatment and reintegration

Introduction

2.1 This part of the report examines the main measures designed to address three strategic objectives: to tackle drug-related offending; to get problem drug users into treatment; and to reintegrate them into society. Specifically, this part of the report examines:

- the Drug Interventions Programme;
- the Drug Rehabilitation Requirement;
- the National Treatment Agency's role in improving the availability, accessibility, quality and effectiveness of drug treatment; and
- measures to help problem drug users into appropriate housing, training and work.

The Drug Interventions Programme aims to drive down drug related offending

2.2 In April 2003, the Home Office established the Drug Interventions Programme, which aims to identify and bring problem drug users arrested, charged or convicted for offences into drug treatment in the community and other interventions, to reduce the number of crimes they commit and to help them re-establish their lives. Delivering the Programme brings together the police, courts, the prison and probation services, drug treatment providers, and aftercare support services, and costs £150 million a year. The Strategy states that problem drug-using offenders have priority access to treatment and support once identified through this Programme. In 2009-10 between 4,000 and 4,500 problem drug users have commenced drug treatment in the community each month following referral from the Programme.

Overall offending by problem drug users in the Drug Interventions Programme fell; half showed a sharp decrease and 28 per cent a sharp increase in offending

2.3 The overall level of crimes committed by problem drug users taking part in the Drug Interventions Programme, and on drug treatment, is 26 per cent lower than before they entered the Programme. Initial Home Office research on the effectiveness of the Programme issued in 2007⁵ indicated that:

- around half showed a decline in offending of 79 per cent in the six months following contact with the Programme;
- a quarter showed similar levels of offending;
- twenty-eight per cent showed a sharp increase in the volume of offending than before they entered the Programme, indicating further analysis is needed to examine if these represent a hard core of problem drug-using offenders; and
- the lack of a comparison group meant that any changes in criminal behaviour could not be directly ascribed to the Programme.

2.4 Intensive Programme areas are those locations which suffer the highest levels of acquisitive crimes and they operate drug testing on arrest for trigger offences. The Home Office's evaluation of the overall Programme indicated that crime was falling faster in intensive Programme areas, perhaps due to earlier referrals to treatment and other support.

A Home Office review indicated that local operation of the Drug Interventions Programme has been inconsistent

2.5 In May 2009, the Home Office published a review of the Programme to improve its ability to reduce drug-related offending⁶. Findings in the review included that:

- areas considered the Programme had driven significant improvements in capability and services;
- some areas had focused primarily on improving drug using offenders' access to treatment, but needed to broaden their focus to other interventions aimed at reducing drug-related offending;
- some local areas received seven times more central funding per drug-using offender than others; and
- some local areas reported no support was available from local authorities to help problem drug-using offenders obtain accommodation.

5 The Drug Interventions Programme: addressing drug use and offending through 'Tough Choices' <http://www.homeoffice.gov.uk/rds/pdfs07/horr02c.pdf>.

6 'Moving up a gear – the next steps for the Drug Interventions Programme' <http://drugs.homeoffice.gov.uk/publication-search/dip/moving-up-a-gear?view=Binary>.

2.6 The Home Office will be implementing the recommendations from the review from April 2010. This will include a new operating model and funding model for the Programme. The operating model defines how local areas should ensure consistency in delivering the Programme and sets out best practice each area should adopt with the aim of securing optimum outcomes. The funding model provides a zero-based calculation of the total funding requirement to deliver the Programme and an allocation mechanism to indicate each area's share of funding.

Drug Rehabilitation Requirement aims to tackle offenders' drug use while on community sentences

2.7 The Drug Rehabilitation Requirement aims to identify actions to reduce problem drug users' offending and drug use. It requires the offender to undergo drug testing and Court review hearings while on a community sentence. The Requirement was introduced for offences committed after 4 April 2005, and was preceded by Drug Treatment and Testing Orders, which had been in operation from 1998. Drug users may be placed on a Requirement for between six months and three years. The Ministry of Justice provides £42 million a year to facilitate access to treatment for problem drug-using offenders on a Drug Rehabilitation Requirement.

Around half of convicted problem drug users complete their Drug Rehabilitation Requirement

2.8 Around half of convicted problem drug users complete their Drug Rehabilitation Requirement. While completion rates have increased from 28 per cent in 2003-04, only 47 per cent were completed in 2008-09. The Requirement can be revoked where the drug user breaches the terms, for example, by failing to attend drug-testing appointments. The outcome may then be a custodial sentence.

The Ministry of Justice has not evaluated the Drug Rehabilitation Requirement

2.9 The Ministry of Justice is including the Drug Rehabilitation Requirement as part of its Offender Management Community Cohort Study to be completed in 2012. The study is collecting data on the characteristics of offenders who receive community orders, including offenders who receive Drug Rehabilitation Requirements, what combinations of interventions they also receive, and which types of offenders could benefit most from interventions (including interventions related to problem drug use). The study will also look at the re-offending of the offenders in its sample. The study is not, however, designed to evaluate the impact of the Drug Rehabilitation Requirement or answer definitively questions on what aspects are most effective. Without a separate evaluation of the Requirement, the Ministry will not be able to fully assess its effectiveness in addressing offenders' problem drug use. The Ministry of Justice is reviewing the extent to which the Requirement is being delivered to the standards of a best practice operating model.

More money is going into drug treatment although funding per adult in treatment has started to fall

2.10 Central and local funding increased from £481 million to £581 million between 2004-05 and 2008-09, in real terms (**Figure 5**). Central funding (the 'Pooled Treatment Budget') contributed an increasing share: up from 53 per cent to 64 per cent of total funding. Total funding per adult in effective treatment has reduced between 2006-07 and 2008-09.

The National Treatment Agency is responsible for improving the quality and effectiveness of drug treatment

2.11 The role of the National Treatment Agency is to improve the availability, accessibility, quality and effectiveness of treatment for drug dependency in England. It is also responsible for achieving the performance indicator 'The number of drug users recorded as being in effective treatment' in PSA 25: 'Reduce the harm caused by alcohol and drugs'. This is the primary mechanism for monitoring progress in tackling problem drug use. The number of drug users in effective treatment is regarded as the key intervention to reduce drug-related offending. In the first 18 months since the 2008 baseline, the total number of problem drug users in effective treatment increased by 7.1 per cent to 168,000 against a three per cent target increase by 2011, thereby exceeding the target.

Figure 5

Drug treatment budgets, activity and outcome data 2004-05 to 2008-09

	2004-05	2005-06	2006-07	2007-08	2008-09
Adult Pooled Treatment Budget ¹	£255m	£300m	£380m	£383m	£373m
Local funding ¹	£226m	£226m	£224m	£207m	£208m
Total funding ¹	£481m	£526m	£604m	£590m	£581m
Number of adults in effective treatment ²	134,000	145,000	164,000	183,000	195,000
Total treatment funding per adult in effective treatment	£3,600	£3,600	£3,700	£3,200	£3,000

Source: National Audit Office analysis

NOTES

- 1 Funding figures are shown at 2008-09 prices.
- 2 Effective treatment: Adults who are discharged from treatment 12 weeks or more after triage, or who remain in treatment 12 weeks after triage, or who were discharged from treatment within 12 weeks in a planned way.

2.12 The goal of all drug treatment is for drug users to achieve abstinence from their drug(s) of dependency, with treatment supporting drug users to achieve this as soon as they can. The aims of treatment include reducing drug-related offending, reducing illegal drug use, and reducing drug injecting. The Drug Strategy considered that too many drug users relapse, do not complete treatment programmes or stay in treatment too long. In its 2008-09 Business Plan,⁷ the National Treatment Agency set out its commitment to minimise dropouts from treatment; minimise unplanned discharges; maximise the opportunities for drug users to complete treatment appropriately and with the best possible outcomes; reduce drug related deaths; and reduce blood-borne virus infections.

2.13 We examined the trends in relevant variables between 2004-05 and 2008-09 as indicators of changes in the quality, effectiveness and accessibility of drug treatment over this period (**Figure 6** overleaf).

The Home Office's Drug Treatment Outcomes Research Study shows an overall positive cost benefit ratio for drug treatment

2.14 A study commissioned by the Home Office published in December 2009 (The Drug Treatment Outcomes Research Study) examined the characteristics of a sample of 1,800 drug users on entering any type of drug treatment, by any referral route, and aimed to follow up the sample of drug users between three and five months later and again 11 to 13 months after entering treatment. The results indicate improvements after entering drug treatment, whether drug users were still in treatment (the majority of the sample followed up) or had left treatment (**Figure 7** on page 27). These include reductions in offending, in illegal drug use, and in drug injecting. The study did not sample a non-treatment control group and the research noted that these findings cannot compare outcomes with those that would have occurred without drug treatment. The study did not assess whether outcomes differed dependent on the different types of drug treatment received.

⁷ Business Plan 2008-09, National Treatment Agency http://www.nta.nhs.uk/publications/documents/nta_bus_plan_0809.pdf.

Figure 6

Indicators of the quality, effectiveness and accessibility of drug treatment for problem drug users 2004-05 to 2008-09

	2004-05	2005-06	2006-07	2007-08	2008-09
Percentage of problem drug users in effective treatment ¹	83%	85%	87%	93%	94%
Percentage of adults who did not complete their treatment (dropped out) ²	74%	69%	61%	51%	44%
Average waiting time to access treatment	2 weeks	2 weeks	1 week	1 week	1 week
Number of problem drug users leaving treatment in the year	36,000	40,000	39,000	41,000	42,000
Number of problem drug users leaving treatment free of dependency ³	3,500	4,500	5,300	7,000	9,300
Number of problem drug users leaving treatment free from illegal drug use ⁴	2,500	2,800	3,300	4,000	5,700
Drug related deaths ⁵	1,420	1,510	1,470	1,480	1,620
Prevalence of Hepatitis C infections among injecting drug users ^{5, 6}	45%	46%	44%	42%	41%
Needle and syringe sharing among injecting drug users ^{5, 7}	28%	28%	23%	24%	19%

Sources: National Statistics National Statistics <http://www.statistics.gov.uk/statbase/Expodata/Spreadsheets/D7892.xls>
 Health Protection Agency's Unlinked Anonymous Prevalence Monitoring Programme survey of injectors in contact with drug agencies: Figure 6 (Hepatitis C virus prevalence among current injecting drug users) & 19 (needle & syringe sharing); Health Protection Agency: 'Hepatitis C in the UK: 2009 report' http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1259152221464

NOTES

- 1 The percentage of all problem drug users admitted for drug treatment who were discharged from treatment 12 weeks or more after triage, or who remain in treatment 12 weeks after triage, or who were discharge from treatment within 12 weeks in a planned way.
- 2 Percentage of all adults admitted for treatment after triage.
- 3 Free of dependency: The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine. There is evidence of other illicit drug use but this is not judged to be problematic or to require treatment.
- 4 Free from illegal drug use: The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine or any other illicit drug.
- 5 The data are for calendar years. Drug-related death is 'Death where the underlying cause is poisoning, drug abuse, or drug dependence and where any of the substances are controlled under the Misuse of Drugs Act (1971)'. Source: Office of National Statistics: ONS Health Statistics Quarterly 31 (2006).
- 6 Reliable estimates of Hepatitis C prevalence among current and previous injecting drug users in England are difficult to obtain because of the indeterminate size of the former number of injecting drug users. Trends in Hepatitis C prevalence among current injectors (those who had last injected in the four weeks prior to participating in the unlinked anonymous prevalence monitoring programme are the best available, proxy measure of disease prevalence in this population.
- 7 Unlinked Anonymous Prevalence Monitoring Programme trend data on the proportion of current injectors who report recent needle & syringe sharing.

Figure 7

Drug Treatment Outcomes Research Study examination of a sample of drug users on entering, during and after treatment

Characteristic	When entering treatment (%)	At first follow up (%)	At second follow up (%)
In paid employment	9	11	16
In stable accommodation	60	67	77
Heroin use	62	38	36
Crack cocaine use	44	25	24
Injecting drugs	33	17	12
Committing acquisitive crimes	40	21	16
General health 'excellent' or 'very good'	20	27	25
Sample size of drug users	1,800	900	500

Source: *Analysis of Drug Treatment Outcomes Research Study, December 2009*

2.15 The Drug Treatment Outcomes Research Study included an economic analysis of the cost effectiveness of drug treatment. This covered all types of drug users receiving treatment, not just problem drug users. The research estimated the costs incurred per drug user over the 51 week follow-up period for those receiving drug treatment against the estimated costs incurred if no drug treatment were received. It assumed the drug user's drug taking, health, offending and other characteristics at the baseline would remain constant, if no treatment were received. The self-reported reductions in offending made up the largest contribution to the overall reduction in costs, and this reduction alone exceeded the costs of drug treatment received. Improvements in drug users' health and personal circumstances were relatively small for those in drug treatment, and the reduction in the cost of health and social care provided was less than the cost of the drug treatment they received. This indicates that the cost of drug treatment for those who are not committing drug-related offences (mainly those who are not problem drug users) was greater than the savings from receiving drug treatment (**Figure 8** overleaf).

Figure 8

Estimated mean costs incurred per drug user over a 51 week follow-up period from start of drug treatment, compared with the estimated mean costs per drug user not receiving drug treatment

	With drug treatment (£)	Without drug treatment (£)	Saving (£)
Cost of drug treatment received	4,900	0	(4,900)
Cost of health and social care received	3,100	4,500	1,400
Cost of drug-related offending committed by the drug user	40,000	50,600	10,600
Total cost	48,000	55,100	7,100

Source: Drug Treatment Outcomes Research Study 2009

2.16 The Study estimated a benefit cost ratio for treatment of around 2.5:1 (a mean drug treatment benefit per user of £12,000 against a mean treatment cost of £4,900). The research considered that drug treatment is cost effective for four out of five drug users.⁸

Actions to help drug users re-establish their lives have had limited results

The shortage of suitable housing remains a significant constraint to reintegrating problem drug users

2.17 There is a tension for local authorities between protecting communities from the anti-social behaviour of drug users and the requirement to accommodate drug users. Up to 100,000 problem drug users in England have a housing problem⁹. In our visits to Local Strategic Partnerships, shortage of accommodation was highlighted as the greatest barrier to drug users re-establishing their lives.

2.18 Courts can grant a possession order where a tenant has been convicted of using accommodation for drug possession or dealing. The police can apply for a closure order where premises are being used for the production or supply of class A drugs, and where the use results in disorder or serious nuisance. The Tenant Services Authority also aims to protect the rights of tenants 'not to be plagued by the effects of others' anti-social behaviour', including that caused by drugs use.

⁸ Drug Treatment Outcomes Research Study: December 2009 <http://www.homeoffice.gov.uk/rds/pdfs09/horr23.pdf>.

⁹ Statistics from the National Drug Treatment Monitoring System 1 April 2008 – 31 March 2009 http://www.nta.nhs.uk/areas/facts_and_figures/0809/docs/ndtms_annual_report_200809.pdf.

2.19 There is currently no UK research on the efficacy of measures to put problem drug users in appropriate accommodation. The Strategy requires the Department for Communities and Local Government to improve access to accommodation for drug users in treatment through ensuring that local government housing strategies better reflect the accommodation needs of vulnerable groups, as part of its funding for the Supporting People programme. In 2008-09, local authorities spent £30 million on housing-related support services for drug users, funded by the programme. The Department for Communities and Local Government is developing a tool for local authorities to help them assess the financial benefits from supporting drug users.

Getting problem drug users ready for employment and training and keeping them in employment is difficult and expensive

2.20 Many employers are reluctant to recruit drug users, even after treatment. Around 80 per cent of problem drug users (270,000 people in England) claim state benefits. The Department for Work and Pensions has estimated the cost of providing Incapacity Benefit and Severe Disability Allowance to drug users was £40 million in 2006-07. Nearly seven per cent of claimants of the main benefits use heroin and crack cocaine. Around 100,000 problem drug users claiming benefits are not receiving drug treatment, and thus missing an opportunity to improve their fitness for work.

2.21 Potential employers may be reluctant to employ former or current problem drug users. For example, only 35 out of 135 employers surveyed by the University of Manchester, for the United Kingdom Drug Policy Commission, stated that if the prospective employee were 'fit for the job', they would 'unreservedly offer them the job'. Many employers expect drug users to have been abstinent for two years before considering any employment.

2.22 In 2002, the Department for Work and Pensions introduced 'progress2work' across Great Britain. The scheme aims to improve problem drug users' employability and to support them into employment or training. 'Progress2work' received initial funding of £40 million investment for the first three years. In 2008-09, expenditure across Great Britain was £12.7 million. But the programme is expensive for each drug user helped into a medium to long term job, the success rate is low and below target, and the Department for Work and Pensions considers the economic downturn may partly impact on its performance. Between 2006-07 and 2008-09:

- the numbers joining the programme remained broadly stable at between 12,000 and 13,000 a year;
- the percentage who started a job after joining the programme fell from 20 per cent in 2006-07 to 15 per cent in 2008-09, against a target of 20 per cent;
- the percentage of drug users from the programme who gained a job which they kept for 13 weeks or more was eight per cent in 2006-07 and 2008-09, having reached 11 per cent in 2007-08;

- the cost of the programme for each drug user who was initially placed in a job was £4,400 in 2006-07, fell to £4,300 in 2007-08 and increased to £6,600 in 2008-09. This is higher than the £5,330 cost for New Deal claimants (25 years and older), and nearly three times the £2,350 cost for New Deal for Disabled People;
- the cost of the programme for each drug user who kept a job for 13 weeks or more was £10,900 in 2006-07, fell to £8,000 in 2007-08 and increased to £11,600 in 2008-09; and
- other drug users also benefited from further education and training under the scheme.

2.23 The Department of Health and the Department for Work and Pensions are funding measures to get problem drug users on benefits into drug treatment to get them fitter for work. Since 2008, the Department of Health has provided funding for drugs coordinators in Jobcentre Plus: £1 million in 2008-09, rising to £4 million in 2009-10 and a further £4 million in 2010-11. Their role is to develop strong links with the rest of the local drugs sector and to support drugs measures within Jobcentre Plus. Since April 2009, self-declaring heroin and crack cocaine users claiming either Jobseekers' Allowance or Employment Support Allowance have been referred to treatment providers. The voluntary process will be made mandatory in 2010.

2.24 The Department for Work and Pensions will pilot a new approach from October 2010, in which Jobseekers' Allowance or Employment Support Allowance claimants in drug treatment will be offered a Treatment Allowance and a place on a new drug and employment support programme on a voluntary basis. This allowance will be payable for up to 12 months as long as the claimant stays in treatment and on the programme. Problem drug users not in drug treatment will be required to sign up to a rehabilitation plan. This will direct them to assessments and a motivational programme, to encourage them into treatment.

Appendix One

Audit methodology

Selected method	Purpose
Review the definition of 'problem drug use' and 'problem drug user' in the Drug Strategy, academic and other literature	To identify if there is a shared understanding of 'problem drug use' and 'problem drug user' and the implications of the Strategy's definition
Review of the Drug Strategy's evidence base	To determine whether the evidence sources underpinning the Strategy were robust, comprehensive, timely, representative, and appropriately drawn together and used
Review of the costs to society of problem drug use in England and the underlying methodology and data sources	To assess the precision and robustness of the estimate in the Strategy, strengths and any limitations in the methodology and data sources, and the nature and range of costs included
Quantitative analysis of data Analysis of national, regional and local data from Government Departments and Agencies, Regional Offices and Local Strategic Partnerships on funding services to tackle problem drug use and related outputs and outcomes data	To identify public expenditure directly and indirectly related to tackling problem drug use and outcomes and performance achieved
Cross Department Reference Group, for consultation at regular stages through the examination	To consult the wider body of Government Departments and Agencies that have a role to play in supporting delivery of the Drug strategy
Semi-structured interviews with Government Departments and Agencies responsible for delivering the Strategy	To gather evidence on their role in delivering their responsibilities to the Drug Strategy and to assess the extent of joint working between Departments.
Semi-structured interviews with drug leads in Government Office for the Regions and National Treatment Agency regional managers in six regions	To gather evidence on the role and objectives of the drug leads and regional managers. We also assessed regional capacity to support Local Strategic Partnerships and the extent of joint working
Evaluative case studies of six Local Strategic Partnerships	To examine local arrangements to tackle problem drug use through commissioning and delivering drug services, local practices and performance
External advisory panel	To obtain feedback on emerging findings and key messages from a broad spectrum of external perspectives in the drugs field
External data panel	To discuss data analysis outcomes with expert academics



Design and Production by
NAO Marketing & Communications Team
DP Ref: 009236-001

This report has been printed on Consort 155 and contains material sourced from responsibly managed and sustainable forests certified in accordance with FSC (Forest Stewardship Council).

The wood pulp is totally recyclable and acid-free. Our printers also have full ISO 14001 environmental accreditation this ensures that they have effective procedures in place to manage waste and practices that may affect the environment.

Published by TSO (The Stationery Office) and available from:

Online

www.tsoshop.co.uk

Mail, Telephone, Fax & Email

TSO

PO Box 29, Norwich, NR3 1GN

Telephone orders/General enquiries: 0870 600 5522

Order through the Parliamentary Hotline

Lo-Call 0845 7 023474

Fax orders: 0870 600 5533

Email: customer.services@tso.co.uk

Textphone: 0870 240 3701

The Parliamentary Bookshop

12 Bridge Street, Parliament Square,
London SW1A 2JX

Telephone orders/General enquiries 020 7219 3890

Fax orders: 020 7219 3866

Email: bookshop@parliament.uk

Internet: <http://www.bookshop.parliament.uk>

TSO@Blackwell and other Accredited Agents

Customers can also order publications from:

TSO Ireland

16 Arthur Street, Belfast BT1 4GD

028 9023 8451 Fax 028 9023 5401

£14.35

