Community Safety Overview and Scrutiny Committee

Briefing Paper on the Work of the Drug Action Team (DAT)

Background

The Crime and Disorder Reduction Act 1998 placed a requirement on responsible authorities (local authorities, primary care trusts, police, prisons and probation) to undertake audits and development plans in relation to drug misuse. In York, a Drug Action Team (DAT) was established to oversee this alongside wider local strategic needs assessment and planning processes.

The Government's 10-year drug strategy builds on the successes of its predecessor in reducing overall levels of drug use, expanding and improving the treatment system and reducing drug related crime. In addition to actions to sustain these improvements, the strategy indicates significant shifts in emphasis and prioritisation, in part made possible by the achievements of the previous ten years. In particular (and reflecting the conclusions of the Hidden Harm report), there is recognition that the potential for parental drug misuse to damage the life opportunities of their children, may have received insufficient priority in the previous strategy. Reducing the negative impact of parental drug use on families is therefore a key priority in the new strategy, alongside reducing drug related crime, improving the effective engagement of problem drug users, reducing the barriers to accessing drug treatment and improving opportunities for drug users to enter employment and improve their housing status.

The key mechanisms through which the Drug Strategy's aims will be delivered, are the government's three year Public Service Agreements (PSA) for 2008/11. The Home Office is responsible for the leadership of the Government Drug Strategy Public Service Delivery Agreement 25 – to reduce the harm caused by alcohol and drugs. This PSA sets out the Government's commitment to produce a long term and sustainable reduction in the harms associated with alcohol and drugs.

DATs are formally accountable to the Home Secretary. They are supported by the Home Office teams in the nine Regional Government Offices and centrally by the Drugs Strategy Directorate. The 150 English DATs have been aligned with local authority boundaries since April 2001. A single DAT can cover a large area such as North Yorkshire or a smaller more densely populated area, for example York.

Structure & Accountability

Each Drug Action Team consists of a DAT Chair and a DAT Co-ordinator: In unitary authorities, DATs and CDRPs (Crime and Disorder Reduction Partnerships) adopt local arrangements in order to achieve integration. DATs and CDRPs should operate on an aligned basis "as a single partnership". This may mean that DATs and CDRPs formally become a single partnership. In York this is the Safer York Partnership.

The DAT Chair is the most senior official within the DAT and is the Chair of Safer York Partnership. They work on a part time basis and will also have a senior position within one of the constituent agencies.
The DAT Co-ordinator is responsible for the day-to-day management of the DAT. The DAT Co-ordinator works alongside the Community Safety Director in the CDRP and usually has a small team working for them. The team will usually be hosted by one of the statutory partners.

What does the DAT do?

The DAT ensure that the work of local agencies is brought together effectively and that cross-agency projects are co-ordinated successfully. The DAT takes strategic decisions on expenditure and service delivery within four aims of the National Drugs Strategy; treatment, prevention, communities and supply.

The DAT commissions specialist treatment services, including supporting structures, and ensure partners fulfill their obligations in respect of drug treatment. A comprehensive needs assessment is undertaken each year to evaluate the provision in the area, identify gaps in treatment provision and inform on future requirements. Monitoring and reporting on performance across the partnership includes measuring availability and access to all modalities of treatment, effectiveness of treatment. Communicating plans, activities and performance to stakeholders is a key role of the partnership.

Funding

Delivery of the National Drug Strategy is funded from a range of sources:

- Central Government - the Department of Health and the Home Office have combined the funding provided for drug treatment. This is known as the pooled treatment budget. The money is allocated to the DAT. The primary care trust acts as the banker for this funding. The Home Office also provide Drug Interventions Programme Main Grant funding. The DAT uses this, and other local sources of funding, to commission services from the NHS, voluntary and private sector in order to meet local needs. The PTB for 10/11 is £1,433,708.00.DIP Main Grant 10/11 is £184,591.00. The NTA monitors how this funding is spent.

- Local funding: The DAT receives funding from the local organisations that form part of the DAT. This includes PCT (NHS North Yorkshire & York), Local Authority (City of York Council), strategic health authorities and North Yorkshire Police. The NTA monitors how this money is spent.

Contributions to drug treatment from funding partners include:

- Partnership Grant £58,000
- PCT £230,558

- Police £17,274 for arrest referral
- Supporting People (SP) £160,000 - managed by SP to provide floating support for drug users.
- Social Services £52,511 (notional expenditure) - historically the City of York allocations (to Compass and rehab placements) have not been aligned within the DATs Pooled Budget. A proportion of the funding (£33,801) is paid directly to Compass Treatment Service as a grant, and is managed and monitored by the local authority. The second part of the funding (£18,710) is provided to pay for access to residential rehabilitation for drug users. The pathway for drug users to access this provision is being reviewed as it has not been effective.

Areas for further consideration (as identified by the 2009/10 needs assessment)

Detoxification & Residential Rehab

The tier 4 element of the treatment system shows very few people moving into tier 4 from tier 3 provision, reasons for this have been given as the inappropriateness of the detox bed within the acute mental health ward for the detoxification of drug users, it has also been proven problematic for service users to access residential rehab with difficulties in setting up rehab to correspond with people leaving detox leaving service users vulnerable to relapse in this break of treatment provision. The budget for residential rehab and detox is not currently being fully utilised therefore the level of need is still a little unknown, the feedback from services ahs been that this element of the treatment system has not been fully published with key workers as a realistic option for people and that is why access has historically been low. It would be a recommendation of this report that the option of community detoxification is explored by the partnership as well as a more appropriate inpatient detoxification element. A further recommendation would be to conduct a survey with service users asking if appropriate detox and rehab were available would this be a viable option for them, as a consequence of this survey it may be appropriate to conduct a pilot with a group of service users to fast track them into detox and rehab, however this will only work if the first recommendation is in place, it would be detrimental to the development of the treatment system and a service users journey to not have appropriate structures in place such as financial support and appropriate provision as you would then be setting people up to fail and this would not be of benefit to anyone. There is a need for the treatment plan for 2010/11 to focus on the outstanding actions identified through the HCC Improvement review which reinforces some of the points above relating to criteria for assessment and pathways into detox and rehab however it also highlights the need for appropriate contracting arrangements to be put in place to ensure that the monitoring of outcomes are integral to these contracts.

Blood Borne Virus (BBV) Treatment

Hepatitis C treatment provision is currently provided for York service users at four main locations: Hull Teaching Trust; James Cook Hospital, Middlesbrough; St. James Hospital, Leeds; and Airedale. Outreach provision is provided by James Cook Hospital into Scarborough. During 2008 / 09, 423 referrals were received, of these 189 entered treatments, mostly from a referral catchment area across Yorkshire and The Humber,

Prior to the recruitment of two posts in January 09 there was a 5 month waiting list in Leeds. It has been recognised through the stakeholder interviews that treatment provision for York clients is inappropriate as people had previously had to wait a long time to access treatment and travel quite a distance to access treatment, with tiredness and fatigue being a symptom of hep C this is a realistic barrier to people accessing services. It would be a recommendation of this report that satellite provision of hep C treatment is set up as part of the tier 2 treatment provision in York. A further recommendation would be to improve the data completeness on NDTMS relating to Hep C.

Housing

A recurrent theme throughout the stakeholder and partner interviews has been lack of access to appropriate housing, with the treatment outcome profile for clients in services reporting an increase amongst service users after 27 weeks in their acute housing need. Appropriate housing is a problem in York with the cost of housing and premises on par with levels in London. An average privately rented accommodation in York costs approximately £600 a month, which makes it in in-affordable to service users. There is a commitment for all new builds in the city to have 50% affordable housing however the number of new builds has declined substantially due to the builders not being able to sell the rest of the housing stock. It is acknowledged that the work of the hostels such as Arclight continue to provide good provision for service users however all four hostels are currently full with feedback from service providers that it is virtually impossible to get someone housing provision within the York area. Housing is seen as a national problem in many cities and seems to be further compounded in York due to the high cost of living as previously mentioned. There needs to be better links between services and the housing department within the city. It would be a recommendation of this report that clear pathways are publicised more pro-actively amongst the drug treatment services to make them aware of the procedures and the processes that service users must do to gain access to housing provision. Service providers have also recommended that a dedicated housing worker is linked to the hostels to allow direct access in relation to advice and information for service users relating to access to housing in the city.

Families & Carers

Currently York DAT commission a Families and Carers service (FACs)which data shows is well utilised by carers and the range of services on offer within the service is extensive and to a high standard, however anecdotal evidence form both carers themselves and stakeholders all suggest that due to the geographical location of the service outside York has proven to be a barrier to people accessing the service, therefore the provision of a helpline for carers to access is vital to support the success of this project. Consultation with carers has requested a service that is not connected with substance misuse service and not solely a mainstream carer service as there was recognition that these services did not fulfil the need of carers of drug users, many carers do not wish to access these service due to stigma and shame and the perception by the carer of being a failure. It would be a recommendation of this report for the partnership to seek the feasibility of identifying neutral premises within York where a carer’s clinic could be run from making the service more accessible to the carers in

York. The service would provide counselling, support and advocacy. It is recognised by the FACs service that currently they are only seeing individual carers and are not providing interventions for the whole family. In line with the Think Family agenda in the new national drug strategy, links with and pathways into Children Services, Social Services and the Safeguarding agenda should be developed and maintained. Further exploration is needed on how the FACS can work in partnership with Children's Services more effectively and how the needs of children and young people should be met if help is sought from FACS.

It would also be a recommendation that the project begins to focus more on the outcomes of families and carers rather than the service outputs to inform future sustainability of the project, also more detailed data relating to York only clients would be more useful in outlining if the current needs of families and carers in York are being met.