

REVIEW OF EXECUTIVE EXPENDITURE ON TACKLING DRUG MISUSE

INTRODUCTION

Background

1. Tackling drugs is a key policy priority for Scottish Ministers. Substantial public expenditure is being channelled into drugs programmes across the departments and agencies of the Scottish Executive. Information on that expenditure is patchy, and Ministers have made clear their desire for a better understanding of current expenditure patterns, taking a cross-cutting approach to spending across all areas of activity. This in turn will allow Ministers to explore the scope for directing activity and expenditure in pursuit of their policy goals.

2. The Policy Unit was commissioned to carry out this work for the Ministerial Committee on Tackling Drug Misuse (MCTDM) and to report to Mr MacKay by the end of December 1999. The agreed aims of the project were as follows:

- to chart expenditure on drug misuse across the Executive;
- to analyse expenditure patterns in relation to stated policy objectives; and
- to explore the scope for directing activity and expenditure in pursuit of agreed policy goals.

3. It is hoped that the report will also prove useful as:

- An overview of current activity across the Executive;
- Source material for anticipated Parliamentary interest in the drugs field;
- The building blocks for the development of a drugs resource strategy within the Scottish Executive;
- A contribution to the development of guidance to local Drug Action Teams (DATs) on corporate budgets.

Approach

4. The project was developed in conjunction with all main spending departments and agencies. This was based upon a mixture of written material setting out information on current spend and interviews with key officials. We have in most instances not commissioned new work to determine precise levels of spend, although additional analysis has been provided in some policy areas (health service spend for example). The constraints on generating better information on drugs spend are set out more fully in para 25 below, and in Annex B.

5. Given the emphasis on Executive spend, the majority of interviews and discussions have been with Scottish Executive officials. Some officials within local authority departments were approached in relation to work they had undertaken on tracking drugs spend locally; their views are reflected in paras 39-40 below.

6. The report is broken down into 5 main sections:

- The problem: pulling together information on current levels of drugs misuse, social, health and economic consequences, interaction with other programmes and policies
- Activity: brief summary of current activity within context of agreed drugs strategy, what do we know about effectiveness, anticipated outcomes
- Expenditure: the main section of the report, pulling together information on spend across departments; funding mechanisms, budget allocations and control; development of corporate budgets at local level; role of DATs
- Making best use of resources: exploring options for a strategy to determine future expenditure levels, improving effectiveness, possible areas for further policy thinking
- Discussion and recommendations: taking the work forward

SECTION 2: THE PROBLEM

7. Drugs misuse and its attendant circumstances are a major problem for Scotland – although the definition of what constitutes ‘the problem’ varies according to perspective and policy interest. (Scotland is of course not unique in this regard and this is very much part of wider national and international picture.) It is a public health problem. It is a criminal justice problem. It is an economic problem – the Government estimates that drugs misuse costs £3-4 billion a year in social, economic, health and crime consequences.¹ It is a problem for communities – especially those often most vulnerable communities where drugs have taken their toll. And it is a problem – a personal tragedy - for those individuals and families who are most directly affected.

8. Some statistics serve as a useful reminder of the drugs impact in Scotland and the scale of the task²:

- 46% of S4 pupils have taken an illegal drug
- 15% of drug users said they were under 15 when their drug use became a problem
- Drug addicts are believed to be responsible for at least 30% of all crime
- 8,500 heroin injectors in Glasgow in 1996
- Committing an estimated 2.56 million offences a year
- Problem users average spend: £200 per week
- 87.7% of female prisoners admit to illegal drug use, before admission to prison.
- 263 drug deaths in 1997
- 2,000 admissions to general hospitals for drugs reasons in 1996-97
- 42% of AIDS and most Hepatitis C cases spread through shared needles
- 30,000 people in Scotland will face end-stage liver disease in the next 20 years as a consequence of Hepatitis C, spread through shared needles

¹ Tackling Drugs to Build a Better Britain, UK strategy, 1998

² Briefing paper on drug misuse in Scotland: head of PHPU 1999

9. Drugs cannot be considered or tackled in isolation. Failure to tackle the drugs problem will act as an impediment to the delivery of other policy objectives – on social justice or public health. Some examples of policy connections:

Children

The Executive (and HM Government) place significant emphasis on the need to give children opportunities to learn and thrive. Many children face early disadvantage as a consequence of drug related problems mainly through disruption to ‘normal’ family life. Around 30-40% of social work support to children and families is related to substance misuse. A snapshot of Child Protection Register cases suggested that over half of registrations were drug related.³ There are an estimated 7-10,000 children in Greater Glasgow whose parents are drug addicts.⁴ Research suggests that such children are often at a severe disadvantage and are at high risk of becoming drug users themselves. A very high proportion of looked after children have drug using parents.

Neighbourhood renewal

Drugs misuse – and drug dealing in particular – threatens communities and neighbourhood renewal. Anti-social behaviour, crime, intimidation, environmental degradation, and loss of community confidence can erode positive efforts to turn areas around – and quickly undermine communities and undo the benefits of housing investment.⁵

Homelessness

Drugs misuse is both a cause and a consequence of homelessness. Some of the most acute drug problems are faced by the homeless. A recent report showed that there had been 11 deaths in Glasgow hostels in 1999 with addicts just out of rehabilitation said to be ‘slipping back’ into hostels where drug and alcohol abuse, violence and theft are rife.⁶ Action to eradicate rough sleeping will need to be integrated with action on addiction.

Welfare to Work

One of the underlying themes of the Government – shared by the Scottish Executive – is to move people away from a dependency culture. Drug addicts however face particular difficulties entering and maintaining employment or even participating in training programmes. Many will face associated problems, such as homelessness, or a past criminal record. Evidence from the US suggests that employers are increasingly likely to ‘filter’ out potential employees with no educational qualifications, a criminal record or those who test positively for drugs.

³ Tackling drugs together in Greater Glasgow: Strategy 1999-2003

⁴ Ibid

⁵ “I think a lot of the difficulties we have in many of the schemes in the city can be traced almost directly to the vast amount of drug-related activity that is going on” – evidence by Glasgow City Council Director of Housing to Scottish Affairs Committee Enquiry into Housing and Anti-Social Behaviour, 1996

⁶ Glasgow City Council report, highlighted in Scotsman article 30 November 1999

Glasgow

Glasgow is a city of both opportunity and disadvantage. Public sector support of around £1.8bn goes into the city each year. The Glasgow Alliance – with the active support of the Scottish Executive – has developed a 5 year strategy to maximise the benefits of those resources, to tackle Glasgow’s problems, and to capitalise on its strengths. The drug problem in Glasgow must however be acknowledged as a threat to sustainable renewal – a drain on the resources of spending departments (health, social work and police in particular), and numerous knock-on social and economic consequences.

A safer Scotland

Drugs misuse has a huge negative impact on community safety – through specific drug related offences, theft to feed a habit, erosion of community confidence, and the tying up of significant resources within the criminal justice system (an estimated £1bn bill for the UK as a whole⁷). Drugs misuse was recently identified as the central problem facing the Scottish Prison Service⁸ with associated problems of suicides, and drug-debt related violence, undermining efforts to modernise prisons.

10. There is not universal agreement that drugs misuse is the most pressing substance abuse problem. Some in the health field argue that other equally if not more pressing problems (alcohol and tobacco for example) are disregarded because they lack the moral imperative of drug addiction with its associations of illegality. Some young people also criticise the double standards they believe some of their elders apply to drugs compared to alcohol and tobacco.

SECTION 3: ACTIVITY

11. Illegal drugs misuse is a multi-faceted problem. Tackling drugs misuse involves parents and families, local communities, police, courts, prison service, social work, teachers and peers, health education, GPs, specialist treatment services, the voluntary and private sectors. Action is now set within the context of the recently agreed drugs strategy *‘Tackling Drugs in Scotland: Action in Partnership’*. This in turn is related to the framework set out in the UK anti-drugs strategy. Multi-agency activity requires mechanisms for ‘joining it up’ – the responsibility of the Drug Action Teams (DATs) - one per health board area in Scotland.

12. It is not possible within the scope of this report to describe the full range of activity that is underway in Scotland (and other source materials do this). A short summary is however provided to give an overview of what is going on. Programmes are working towards the broad and essentially pragmatic objectives to:

- Disrupt trade
- Cut drugs deaths
- Reduce needle sharing
- Reduce drug-related crime
- Reduce drug use in prisons
- Raise age of experimentation by children
- Reduce use among young people

⁷ English drugs Comprehensive Spending Review (CSR)

⁸ HM Chief Inspector of Prisons for Scotland: report for 1998-99

Prevention

School education – drugs education within the context of health/social education, delivered in 98% of secondary schools and 61% of primary schools⁹. Work is underway to examine effectiveness of drug education, and to develop best practice guidance.

Health education and promotion – drugs programmes developed by Health Education Board for Scotland (HEBS), mass media campaigns (also HEBS); programmes run by health board health promotion departments

Informal education – provided by local authority youth and community services, voluntary agencies and Social Inclusion Partnerships

Diversion – drugs specific and more general approaches to developing local services for young people. Activities for children and young people in the evenings and school holidays, and sport and leisure initiatives may often feature within Social Inclusion Partnerships' strategies.

Treatment and Rehabilitation

Health service treatment – range of specialist treatment services provided by health boards, including needle exchanges and methadone (substitute prescribing) programmes.

Substance misuse – services provided by local authority social work departments, including community and residential services. Many services delivered through voluntary sector.

Community care – services provided by local authority social work departments, including mental health and HIV/AIDS programmes with a drug related element.

Criminal justice social work – interventions aimed at keeping people out of prison and supporting people in the criminal justice system – arrest referral scheme, Drug Testing and Treatment Orders (DTTOs) – still in its infancy. A growing area of interest.

Prisons: treatment and prevention – services delivered within Scottish prisons to prevent drugs misuse, and to offer treatment: within drugs strategy for SPS. Services primarily delivered by prison employees rather than external agencies. Growing efforts to link to community projects and other service providers to ensure effective through-care/after-care.

Enforcement

Police: specific areas of activity including the new Scottish Drugs Enforcement Agency (SDEA), National Criminal Intelligence System (NCIS), Scottish Crime Squad; significant element of police officer time is dedicated to drug-related crime and community safety.

Prisons: enforcement: action to reduce availability of drugs within prisons

⁹ HMI report [Drug & Nutrition Education 1999]

Legal remedies: confiscation of assets; exploration of options to pursue confiscation through civil courts

Wider Programmes

13. There are many programmes that are supportive of the overall anti-drugs effort and that will contribute towards the achievement of policy objectives. They include: services for children (childcare, Sure Start Scotland etc), New Community Schools, Social Inclusion Partnerships, action on homelessness, action programme for youth, community safety partnerships and more. Further details are set out in annex A.

Does it work?

14. There are many gaps in our current understanding of ‘what works’ and a good deal of effort is being put into improving our understanding of the effectiveness of different interventions. A summary of current thinking is set out below:

Prevention

15. Prevention programmes include a range of approaches reflecting different needs and requirements as children grow and develop (see also para 12 above). The broad objective of ‘prevention’ can be unpicked to reveal different objectives – early years programmes will assume that we want children to say no; programmes delivered to young people who already have exposure to and experience of drugs may be more about informed choices, reduction and alternatives. Firm validation for prevention measures is lacking, as it is for many areas of prevention in the social field. The new Effective Interventions Unit within the Scottish Executive should assist in the evaluation of impact and understanding of best practice (eg for/against the use of peer education).

Treatment and rehabilitation

16. There is strong evidence for the effectiveness of treatment in reducing crime and improving health. The methadone (substitute prescribing) programme has been described as a prevention measure, in that it has a dramatic impact on crime. A major study on treatment in England¹⁰ reported positive outcomes in terms of controlling and stabilising drug misuse.

17. For every extra £1 spent on drug misuse treatment, there is a return of more than 33 in terms of cost savings associated with victim costs, and reduced demands upon the criminal justice system. The increased expenditure of £1.6 million for treatment interventions yielded an immediate cost saving of £4.2 million in terms of the reduced victim costs of crime, as well as cost savings within the criminal justice system of about £1 million..¹¹

18. But treatment and rehabilitation is never going to be easy. It will include a lot of failures. “Drug misuse is a chronic relapsing condition and the difficulties in achieving successful outcomes in this area are considerable”¹². Many people are uncomfortable with the concept of the state maintaining people on methadone on a long-term basis. Methadone is itself a

¹⁰ National Treatment Outcome Research Study (NTORS) [detailed reference – and below]

¹¹ National Treatment Outcome Research Study (NTORS)

¹² Tackling Drugs in Scotland: Action in Partnership

dangerous drug and is responsible for a proportion of drug related deaths. Getting former or stabilised addicts back to normal lives and jobs – rehabilitation in the widest sense – is very hard.

19. Interventions within the criminal justice system – such as the new Drug Treatment and Testing Orders (DTTOs) – may have a positive long term impact by diverting people from the penal system (expensive to society, damaging to individual). The pilots are at an early stage and need to be tested in terms of the number of Orders made by the courts and compliance rates (as well as long term impact on drugs misuse).

Enforcement

20. Police activity has been successful in terms of hauls of illegal drugs: UK seizures rose from 30,466 in 1985 to 139,174 in 1997. This is in part a consequence of increased effort – but in part increased availability. Enforcement does not appear to have any significant impact on the availability of illegal drugs – except in terms of displacement (shifting use to alternative drugs). Despite police effort, drug prices on the street are not rising and indeed in many cases are less than the prices 5 years ago.¹³

21. This should not however be the only measure of success. Enforcement is also critical to maintaining (or rebuilding) community confidence in ‘the system’ to protect communities, individuals, families and children in particular from the threat of illegal drugs. Enforcement disrupts supply and the activities of dealers.

22. Many commentators have discussed the negative impact of imprisonment on addicts and the need to keep such people out of prison except where necessary for public protection. Imprisonment is expensive and may be liable to keep addicts in a treadmill of drugs – crime – imprisonment (the revolving door syndrome). Treatment programmes are of course available in prisons to offer support in breaking the cycle, but in many instances it may be more constructive to try and keep people away from custody.

What aren't we doing? Where are the gaps?

23. There are no significant areas of policy and practice where there is *no* activity. The question is essentially about areas where more could or should be done. This relates both to the extent to which provision is meeting demand and/or need; and the overall objective of directing activity (and spend) towards prevention rather than into reactive (and often more expensive) programmes. There is also an on-going need to develop a cross-disciplinary approach and understanding to ensure that activity is properly co-ordinated, opportunities identified, and gaps between programmes closed.

24. So where are the gaps? There is no easy answer to this question. We will not really be in a position to answer it properly until the strategic planning cycle is further underway (reporting progress against objectives) and more detailed information is available on the needs gap. Different commentators have however flagged up areas where more could or should be done:

- **Primary school drugs education** – currently only 61% of primary schools run programmes (98% in secondary schools)

¹³ eg heroin £80-£90 per gram 5 years ago; £60-80 per gram today. SEJD figures

But – competing pressures on teaching time; some philosophical reluctance to teaching drugs education at pre-secondary age, including possible reaction from parents of young children; limited information on effectiveness

- **Treatment and rehabilitation** – not sufficient to meet levels of demand; patchy provision across the country

Yes – good evidence about effectiveness of treatment/rehabilitation and impact on crime, **but** needs gap not yet quantified.

- **Treatment in prisons** – not sufficient to meet demand (around 15,000 presenting as drug misusers; only about 5,000 currently being assessed for treatment);

But – many prisoners only in for short periods; not all willing to address drugs problem – limiting chances of success; needs to be backed up with good aftercare

- **Aftercare and throughcare** – developing seamless support services through arrest – courts – prisons – release cycles: too many people still stepping through the gaps

But – even good service provision faces problem of getting clients to turn up following release: not a simple solution

- **Employment opportunities** – developing links with training and employment agencies, and private sector to ease access to labour market – important component of rehabilitation/stabilisation. Some early work underway through New Futures Fund

Yes – key element in long-term objective of moving off dependency, **but** not easy to achieve

- **Support for families** – often a neglected area with services for addicts tending to receive priority

SECTION 3: EXPENDITURE

25. Information has been gathered from across the Executive on spending programmes that tackle drug misuse. This material is set out in full in Annex B. The figures are as at February 2000. We must emphasise that there are significant limitations to our knowledge about spend – primarily because the bulk of it is spent locally, at local discretion. There are other caveats. Much of the information is based on assumptions about time spent on drug related problems – these assumptions may make a dramatic difference to the global costs. Some of the spend will be related to alcohol problems, given that most poly-drug users will misuse alcohol and drugs at the same time.

26. We have identified three main areas of spend: (a) drugs specific – targeted programmes and interventions (b) drugs generic – tackling drugs within mainstream programmes and (c) expenditure consequences – wider costs of drugs misuse to public services.

Drugs Specific Expenditure

27. The first section identifies those budgets that are most directly targeted at drugs misuse – a total of **£56.1m at the end of December 1999**. This is close to figures previously quoted – around £50m (although based on a different set of figures). The largest single funding element is £17.84m on health board treatment services. There is also significant spend through local authority community care budgets, on treatment and prevention via the Scottish Prison Service, and on drugs intelligence work.

Drugs Generic Expenditure

28. We have identified significant resource input from mainstream programmes: around **£85.4m**. These are primarily based on calculations of the contribution – mainly time – that is going into drugs related work. This includes teacher time on drugs education, an element of health board health promotion work, community education, community care services and criminal justice social work. The largest single element is police spend – estimated at around £42.9m – based on a 30% calculation of resources directly attributable to the investigation of crimes.

Total Programme Spend

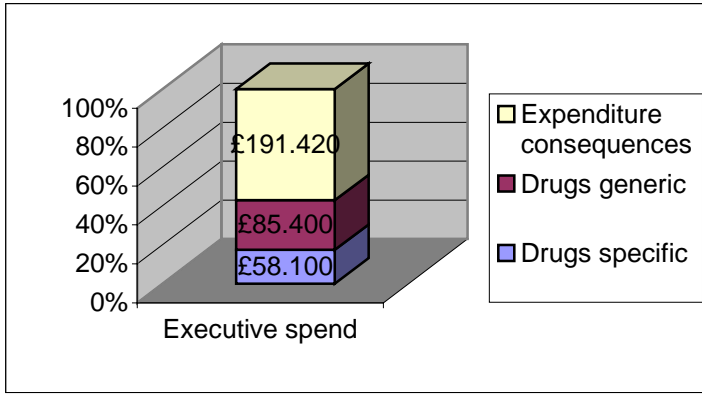
29. The total spend on drugs-related programmes, ie the sum of the above figures for specific and generic expenditure, is **£141.5m**. This is significantly higher than previously quoted figures. The apparent discrepancy is a consequence of additional spend in some areas (Scottish Drugs Enforcement Agency for example), better information on programme spend (in prisons for example), and the inclusion of mainstream programme spend. The results are similar to the approaches adopted in England. Treasury work in 1993-4 identified drugs spend as £500m; whereas the work for the English drugs Comprehensive Spending Review (CSR) in 1997 which included mainstream programme spend generated a figure of £1.4bn.

Expenditure Consequences

30. Annex B also contains estimates of the heavy costs of drug misuse to other programmes, picking up the consequences of addiction. These estimates are much less precise than the figures for specific or even generic expenditure. They are also snapshots at a specific point in time and will be influenced by external factors that have nothing to do with drugs issues. They are of interest nevertheless. An estimated 30% of children and family services are drug related: £84m. Health service costs have been estimated at just over £14m. Additional police costs of around £77m have been counted to reflect officer time spent on drugs related work. Court costs have been calculated at £16.2m. Identifiable expenditure consequences are therefore in the region of **£191.42m**.

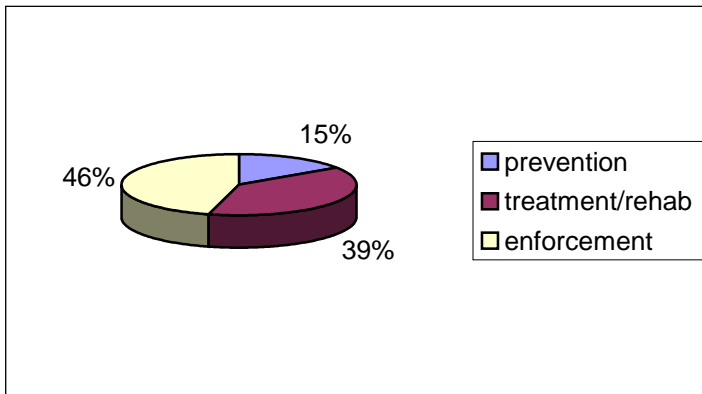
Overall Expenditure

31. Global expenditure on drugs misuse is therefore around **£332.92m**. The balance of spend between specific, generic and consequential spend is shown in the chart below. These figures echo the findings of the English drugs CSR that estimated costs of £4bn in social, economic, health and crime costs.

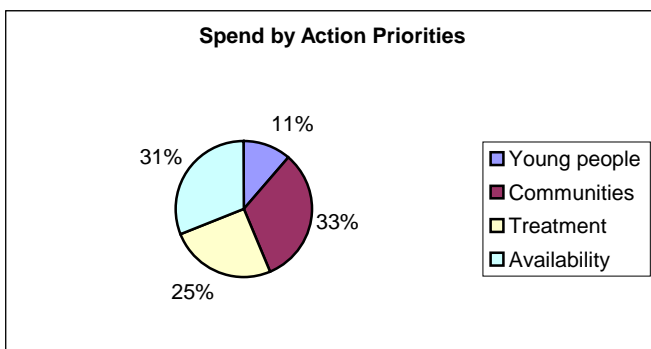


How is it spent?

32. Just under half (46%) of the £141.5m drugs spend (specific and generic programmes) is spent on enforcement. Over one-third (38%) goes on treatment/rehabilitation, and the remainder (16%) on prevention.



33. We also looked at the allocation of these resources in relation to the four themes of the drugs strategy. These calculations must be **treated with caution** as some fairly arbitrary allocations have been made to the four headings, (for detail see Annex B), but the overall picture suggests around £16m on young people, £45m on communities (including enforcement effort to create safe communities), £35m on treatment, and £44m on availability.

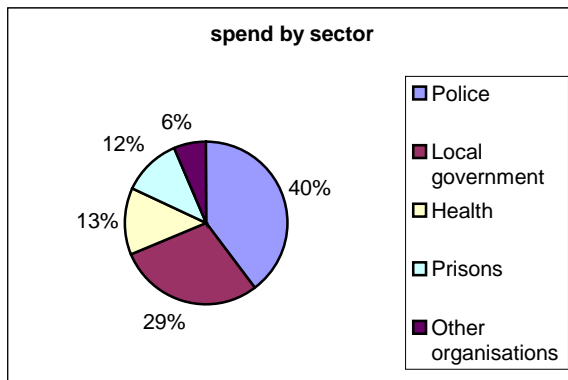


34. The main spenders are the police, local authorities – primarily social work departments - health boards, and the Scottish Prison Service.¹⁴ Relatively small elements of the overall

¹⁴ For details see Annex B. Sectoral analysis will be distorted by different counting methods used eg time is calculated for teacher/police spend, but not health service.

spend are directly funded by the Scottish Executive – health board treatment services, criminal justice social work initiatives, new resources for the Scottish Drugs Enforcement Agency and specific grants to voluntary sector and co-ordinating bodies. The bulk of the programme resources – community care, school education, community education, police – are allocated locally within budgets, primarily GAE, where drug-related expenditure is not ring-fenced.

- Police - £56.9m
- Local government - £41.74m
- Health - £18.96m
- Prisons - £16.9m
- Other organisations - £7m



35. This has significant implications for any attempt to develop a more corporate 'drugs budget'. Spending decisions are made at local level and therefore less subject to Ministerial influence than is the case with centrally-controlled expenditure plans. Local spending decisions are also being taken in the light of other priorities – including key Executive priorities like community care/care of the elderly, social inclusion, or lifelong learning. Ministerial encouragement to direct resources into the drugs effort does not necessarily help local authorities and other agencies to square their funding circles.

Allocating the Resources Locally: Role of DATs

36. Drug Action Teams were established to co-ordinate provision at local level in response to identified needs. This is based on a partnership approach: authority for spending decisions remains with individual agencies – health boards, local authorities etc. DATs are expected to deliver key elements of the drugs strategy – and there are performance mechanisms in place to monitor their progress – but at the same time individual agencies and departments have separate accountability frameworks for mainstream activity. **These issues are considered in more detail in the Policy Unit ‘Effective Implementation’ Study.**

37. We have identified a very wide range of funding streams that support drugs-related work, some mainstream, some ring-fenced, some time-limited. Co-ordination of those streams to best meet local needs requires considerable investments of time, trust and goodwill. DATs are being encouraged to develop ‘corporate budgets’, placing resources on the table for collective decision as to how they should be deployed to best effect. This makes good sense – but has limitations given that the bulk of spend is wrapped up in mainstream services.

38. DATs are aware of the need for the development of corporate budgets. Detailed information will be available shortly on spend on treatment services (primarily health and social work budgets). Work is underway in some areas to undertake a more comprehensive exercise in tracking spend and the Substance Misuse Division is considering how work in this area can be developed, which will include looking at the possibility of joint commissioning and issue of guidance to assist in this work. One approach is to get DATs to undertake a cross-cutting approach similar to this one, tracking spend in all departments. A similar exercise is underway in England.

39. Local authorities that have begun this work have identified difficulties in tracking spend. Outwith specific addiction services it is difficult to calculate spend other than making assumptions about activity levels. (Studies might be commissioned – for example diary surveys – but this would be resource intensive in terms of time and money and of questionable value.)

40. The quest for better information should not become an end in itself. The focus might be placed on information regarding **outputs**, not inputs. Thus, DATs while aware of the bigger picture on spend (police, prisons, education, etc) – and influencing those mainstream budgets as part of their work - should **not** have to involve themselves in complex and time-consuming form-filling exercises. This should be discussed further with DATs and local authorities before further work is commissioned.

SECTION 4: MAKING BEST USE OF RESOURCES

41. The Executive is channelling significant public resources into tackling drug misuse – over £56m. Much larger sums of money – around £85m - are spent through mainstream programmes. And even higher levels of resources are tied up dealing with the consequences of drugs misuse – over £190m. This section considers options for making better/best use of the resources that are currently tied up in drugs. This consideration is based on a key principle as expressed in the UK drugs strategy that **“drug related expenditure should shift over time away from reacting to the consequences of the drugs problem and towards positive investment in preventing and targeting it”**.

42. This option appraisal is broadly set within the context of the existing policy framework. Some commentators argue that a radically different approach is required, that the high costs of drug misuse are problems of our own making, that expenditure on police, customs and excise, courts, and prisons are a consequence of a societal decision to classify drug taking as an illegal activity, and that enforcement activity has little impact either on availability or demand. Decriminalisation, the argument goes, would have no impact on demand, and would free up resources for prevention/treatment. This argument begs a number of questions - the impact of decriminalisation on demand for drugs is **unknown** and untested. It is widely seen as a risk too far and at odds with helping young people to resist drug misuse in order to achieve their full potential in society.

43. We look instead therefore at options – not mutually exclusive - of:

- Shifting programme spend
- Streamlining resources
- Improving effectiveness – with a particular focus on delivery mechanisms
- Investing to save
- Making connections to other policies and programmes

Shifting Programme Spend

44. There is very little scope for achieving immediate change by direct shifts in programme spend. Given that the bulk of drugs spend is tied up in mainstream programmes it is hard to see how major shifts in spending patterns can be achieved quickly (at least not without inflicting pain in other areas). Although some streamlining could be undertaken (see below) the resources involved are limited compared to the major resources in say the police and prisons spend. This was the same conclusion reached in the English drugs CSR – that although much of the enforcement spend was reactive, it was not straightforwardly transferable to preventative programmes.

Streamlining Resources

45. This is primarily a job which has to be taken up by DATs – they are best placed to ensure that resources match need, and are joined up to greatest effect. This means pulling in both the drugs specific and mainstream programme resources as described within this report, and taking full advantage of any opportunities to tap into other funding sources – including lottery, charitable, private sector and European funds. This affects voluntary sector funding in particular (see below). **The Executive should however be ensuring that wherever possible its own resources are being channelled through DATs for planning purposes, and made as flexible as possible for them to use in pursuit of agreed policy objectives.** This could be done for example by making resources available to an individual agency for accounting purposes, but making payment conditional upon DAT agreement on spend.

46. The bulk of drug-specific resources have already been devolved to local level. Little remains by way of central spend. Some of that spend can only be deployed nationally, for example the SDEA, or resources for a national health promotion campaign. Other pockets of money – Social Inclusion Partnership Funding, New Futures Fund – could not be allocated to DATs without diminishing the impact of the host programme that is treating drugs misuse as part of a wider approach.

47. There may be scope to transfer responsibilities and funding (£1m rising to £1.5m) from Scotland Against Drugs (SAD) to DATs. SAD is now concentrating its effort into encouraging businesses to help local communities. Given the strategic role of DATs at local level it might make greater sense to co-ordinate help for communities through them. DATs might develop expertise in generating local business support for this and other roles, although some larger organisations may be less willing to support individual DATs rather than making contributions to high profile national initiatives. Further advice on the advantages/disadvantages of this approach should be brought forward.

48. Grants of just over £1m a year are made available to voluntary organisations from the Scottish Executive. This is primarily for projects of national significance, training initiatives, pilot programmes and so on. The sums involved are small but we should be ensuring that there is a shared awareness of who is funding what within the Executive. This should be aided by the establishment of an internal database containing ‘user friendly, current information at all times on all Scottish Executive funding to voluntary organisations’.¹⁵

49. The voluntary sector is also in receipt of resources from other sources. The National Lotteries Charities Board is supporting around £1m of drugs related projects. We recommend that the Executive (SMD and Voluntary Issues Unit) establish a dialogue with NLCB regarding (a) how best to tie their grant-making processes into the work of DATs and (b) how to ensure that knowledge about effectiveness and best practice emerging from NLCB sponsored projects can be fed into the policy making process.

50. The key role of the voluntary sector is in delivery of services at local level – a large chunk of the treatment resources are channelled into voluntary/community projects, and there are around 130 organisations in operation in Scotland providing drugs services of one form or another. This also includes central co-ordinating bodies such as Scottish Drugs Forum (SDF) and SAD. This can be seen two ways. Viewed positively, it is a sign of diversity, of support for local solutions and innovative approaches. Viewed negatively, it is a sign of an inchoate approach, an over-crowded playing field, with built-in inefficiencies. (This was the view expressed recently by Tom Wood in calling for a rationalisation of the ‘chaotic scene’ of 130 drug agencies.¹⁶) This is not however an issue which can be remedied by the Executive at its own hand – **it should be for DATs** to determine how best to use their resources, including delivery mechanisms, taking into account value for money, and achievement of policy objectives.

51. The establishment of the new Effective Interventions Unit should make an important contribution in the long term by providing information to help in the commissioning of high quality, cost-effective services and in the auditing of their success.

Improving Effectiveness through delivery mechanisms

52. The emphasis of this report has been on expenditure commitments. The financial inputs are only part of the equation though, we also need to get the *process* or delivery mechanisms

¹⁵ Recommendation (agreed) from MGSSU review of voluntary sector, 1999

¹⁶ Reported in the Scotsman 16/9/99

right. DATs are central to the delivery of the strategy, and their effectiveness (or otherwise) may be critical in achieving the desired outcomes. A good deal of effort is going on at official and ministerial level both to support the DATs, and to ginger up their performance. This should be continued.

53. Many of the problems reported/experienced by DATs – partnership fatigue, bureaucracy overload, difficulties establishing trust – are common to many if not all forms of partnership. Indeed, these problems should be seen within the context of the other partnerships/joint initiatives that are in existence, and the pressures this can place on participating agencies and departments. **Recommendations emerging from the Policy Unit’s ‘Effective Implementation’ study may be helpful in identifying ways of overcoming some of these problems.**¹⁷

54. There is a growing interest in the development of pooled budgets – bringing together resources from different departments and agencies – and the removal of (apparent) barriers to joined-up working locally.¹⁸ This has been mooted within the drugs context. This is however not a simple solution, and should be treated with some caution – we do not want to arrive at a situation where we have pooled budgets on for example drugs, social inclusion, lifelong learning and children – but have as many barriers to joined up working and thinking as there were previously between departmental/agency boundaries. This issue cannot be resolved for drugs in isolation. **Work on pooled budgets for DATs might therefore be taken forward within the wider context of the Policy Unit work on effective implementation.**

55. To reinforce the strategic role of DATs, and to emphasise corporate responsibilities, **any additional resources for service delivery should be made available to DATs**, for planning purposes, not individual agencies or departments. Teams should be asked to prepare plans setting out clearly what use would be made of additional resources, and what positive outcomes should be expected. This should be on the basis of firm commitment to spend, not a competitive bidding round.

56. More broadly, should we however be thinking about completely different ways of delivering the drugs strategy? Are new delivery mechanisms required? One option would be to create **a new agency** to deliver drugs education, treatment and rehabilitation services – initially at a local level but perhaps later expanded into a national federated structure. This agency would be given a budget – based on the existing budgets available in the locality - and then expected to deliver.

57. The advantages of this approach would be: clearer accountability lines (one identified responsible agency, direct link to Executive); less time wasted on bureaucracy/negotiating partnership agreements; more muscle to commission effective services; it would look and feel different.

58. The disadvantages would be: criticism from local government (eroding democratic accountability); possible hostility from other agencies; on-going need to build partnership networks with other structures (local government, health, police); adding an additional agency doesn’t equate with efficiency; creating a new drugs budget would mean re-directing

¹⁷ Policy Unit study on ‘Making a Difference: Effective Implementation of Cross-Cutting Policy’ –

¹⁸ See recommendation from Making It Happen Action Team: ‘we recommend that the Scottish Executive initiates a review of the financial and regulatory barriers to effective action in tackling social inclusion’ [

resources from other agencies-unpopular; the money transferred might prove insufficient(with the Executive held to account for the deficit);additional resources currently pumped in by partner agencies to supplement directly identifiable drugs spend might come to an end; there are dangers in treating drugs as a stand-alone issue – there are important links to be made to other policy/service areas. **On balance, we recommend maintaining the existing partnership approach, and making it work.**

Spend to Save

59. There are examples of interventions – in particular on the treatment side – that would generate long term savings. The English CSR in 1997 accepted the evidence of the NTORS¹⁹ study that £1 spent on treatment would equate to £3 saved in the long term, primarily in relation to police, prisons and the courts. So an injection of an additional £20m to support treatment services should generate long term savings of £60m. The justification for additional resources within the English CSR was based upon this argument – including the assumption that in the long term this would generate *cashable* savings.

60. There are some problems with this logic – once drug-related pressures on police, prisons or social work departments started to ease, activity is likely to expand to meet other demands. Cashable savings would not be easy to extricate. This replacement activity may well however be a positive in itself, in terms of delivering on other long term policy objectives, like community safety, and making more effective (less crisis driven) use of resources, compatible with objective around modernising government, and best value. **It would also reduce the likelihood of rising demand on criminal justice budgets in future years.**

61. Allocation of additional resources – targeted and focused – could make a positive impact on the drugs problem, generating both positive policy outcomes (reductions in drug related crime, improved support for vulnerable young people) and a reduction in reactive expenditure. There would also be a significant positive contribution towards the achievement of other policy objectives. **This should be considered further within the forthcoming expenditure review process.**

62. We are not yet in a position to quantify how much additional investment would be enough to make the critical difference. Analysis of DAT returns on needs assessment and service provision should provide some of the answers about the size of the funding gap.

63. It will be clear that this approach would require investment in one part of the government machine (health/community care) in order to generate savings in another (criminal justice). **This underlines the importance of the Executive adopting and maintaining a strong corporate approach to tackling drugs misuse, which must extend into decisions about resource allocation.**

¹⁹ National Treatment Outcome Research Study (NTORS)

Making Connections

64. As we have seen, the drugs problem impinges on a wide range of policy areas. There is often scope both for the development of innovative approaches and for making more efficient use of resources by looking at the margins of policy areas, where they bump up against each other. There are already positive examples of joined-up thinking, in particular about the ‘career’ of problem drug users through the criminal justice system. There are other areas however which are currently underdeveloped, and some early thoughts about policy connections are sketched out below:

65. *Welfare to work* – some early work is underway under the auspices of the New Futures Fund. It will be important to build on this thinking/expertise and look at ways of extending/developing. Look at ways of linking with ‘mainstream’ resources – New Deal, Employment Zone etc. Keep in touch with thinking emerging from DSS/Treasury/DfEE regarding on-going Welfare to Work agenda.

66. *Social inclusion* – continue to explore potential for better connections between drugs/social inclusion agendas; opportunities through area based Social Inclusion Partnerships to link with DAT work; linkages with people-based SIPs, in particular young people, care leavers, prostitution.

67. *Neighbourhoods* – continue to develop understanding of relationship between drugs, housing and neighbourhood dynamics; role of proactive housing management in dealing with drugs issues in communities.

68. *Families* – family/parenting services can make a contribution in a number of ways. In the long term, support for family networks will contribute towards resistance to drugs. Service providers may come into contact with families/parents with drug problems – work is already underway to develop training/best practice approaches.

69. *Children* – the problems facing children of drug using parents are cause for concern – injury from needles, methadone poisoning, neglect, early exposure, acceptance of drug misuse and balanced against the objective of keeping salvageable families intact. There is a need to look at the adequacy of ‘welfare’ responses from public sector agencies, and the consequences (human, social, economic) of getting the equation wrong.

70. There has been interest in support for grandparents and others who often step in to provide the main parenting role when families break down under the impact of chaotic lifestyles through drug misuse. This is often an alternative to placing children in care. A pilot approach was run by Glasgow City Council to provide a measure of income support for ‘caring’ grandparents, but it was withdrawn due to budget difficulties. The potential for some form of state support should however be explored further, possibly in conjunction with DSS.

Implications

71. There are already positive examples of ‘joined up’ working around drugs issues across the office, between justice/health and health/education in particular. Continued efforts need to be made however across the office (and not just in relation to drugs) to develop new, more flexible ways of working that facilitate networking and the open exchange of ideas. It also

emphasises the importance of carving out ‘spare’ capacity within the drugs misuse crosscutting team for policy development work.

72. In addition there are two broad policy areas, young people, and communities - both central to the drugs strategy – that remain somewhat fragmented in terms of office handling and understanding. A more corporate approach to the handling of these areas of the strategy needs to be developed.

73. *Young people* – the drugs strategy places significant emphasis on meeting the needs of young people. This includes the development of appropriate interventions/treatment services. The wider question relates to a positive agenda for young people – creating opportunities for them to fulfil their potential. This embraces health, education, lifelong learning, employment/training, leisure and recreation, arts, culture and sport. We should be treating this holistically – little point developing one approach for training, one for drugs, one for crime, one for healthy lifestyles. There is however little evidence as yet within the office of a corporate approach to dealing with issues facing young people. This should be looked at by the children and Young People Group with others concerned.

74. *Communities* – the drugs threat undermines communities – strong communities are also recognised as a key element of any strategy to withstand drug misuse. Again, community development approaches should not be designed in isolation from each other – little point designing an approach for drugs, another for public health, another for social inclusion. The issues and approaches tend to be the same; communities often view issues in a much more ‘joined up’ way than policy makers ever can; and a true development approach would have to be based on allowing communities to identify their own issues, rather than imposing an agenda from the start. Again, there is little sign of a corporate understanding of community issues. This should be looked at by Social inclusion Division with others concerned.

Conclusions

75. This paper has charted and analysed expenditure on drug misuse by the Executive. The summary of findings & recommendation at Annex A indicates matters to be considered as part of national and local drugs resource strategies. Annex A also indicates some policy connections to be explored further in the on-going development of the Executive’s overall drugs strategy.

ANNEX A

REVIEW OF EXECUTIVE EXPENDITURE ON TACKLING DRUG MISUSE**Summary of Findings and Recommendations**

1. Drug misuse remains a major problem: high cost and high impact on other policy objectives.
2. Strategic framework is in place plus delivery mechanisms through DATs.
3. Existing partnership approach should be maintained.
4. Activity already underway across a range of fronts.
5. More could be done – but no simple solutions, no magic bullets.
6. Significant resource inputs:
 - Drugs specific expenditure
 - Drugs generic expenditure (mainstream programme spend)
 - Expenditure consequences (costs of dealing with drugs)
7. Bulk of resources allocated locally – no simple shifts of expenditure possible.
8. Any additional resources should shift emphasis from reactive spend to positive, targeted investment.
9. Consider options for positive additional spend to tackle drugs misuse within forthcoming expenditure review.
10. Consider within *corporate* context – spend in one policy area to generate benefits/savings in another.
11. There are ways of improving effectiveness within existing resource envelope:

Streamline resources

12. Consider pros/cons of transferring SAD budget (and responsibilities) to DATs
13. Develop co-ordinated approach to funding of voluntary sector projects.
14. Engage in dialogue with NLCB re opportunities for joint working .

Support work of DATs

15. Continue process of support and encouragement.

16. Consider emerging recommendations from PU study on effective implementation for drugs policy.

17. Ensure that any additional resources for drugs work are made available to DATs for planning purposes in the first instance.

Develop corporate budgets at local level

18. Identify opportunities for pooled budgeting as part of PU effective implementation study.

19. Engage in open discussion with DATs (and constituent bodies, local authorities in particular) regarding pros/cons of more detailed work on departmental spend.

Policy connections

20. Develop thinking at official level in relation to linkages with the following policy areas. Papers to MCTDM over 6 – 9 month period. Some additional work may need to be commissioned in the long term (eg needs analysis):

- Welfare to work
- Social inclusion
- Neighbourhoods
- Family support
- Children

21. Develop corporate approach to handling of the drugs strategy relating to a) communities and b) young people within the Executive.

Policy Unit
February 2000

REVIEW OF EXECUTIVE EXPENDITURE ON TACKLING DRUG MISUSE

ANALYSIS OF SPEND

Introduction

1. This annex provides the detailed information on expenditure on tackling drug misuse across the Executive. This information is broken down into three main categories of spend, as explained below. The final sections include information on wider programme contributions, some analysis of the figures in relation to the strategic objectives, and comparison with previous studies.

2. The figures need to be considered with caution. There are a number of problems in trying to extrapolate out specific spend on drugs from what are in the main general programmes (health, social work, police etc). Many of the figures are based on *assumptions* about the amount of time/activity spent on drugs related work. In particular, the figure of 30% crime being drug-related has been used, although this is only based on anecdotal reporting. Different assumptions would generate a different set of figures. Some of the figures relate to drugs *and alcohol* related problems – although some are drugs specific. In the main, figures relate to 1999-2000 but this does not apply throughout and some averages have been used.

3. The analysis reflects Executive spend. This does not necessarily equate with local spend on drugs, which will include some additional resources – funding from mainstream budgets to supplement ring-fenced allocations, funding packages bringing in private sector, lottery, charitable and local authority project funding – and in some cases less spend on an actual basis than the averages that have been estimated nationally.

4. Spend is broken down as follows:

- **drugs specific expenditure**, where there are specific lines, grant programmes, or ring-fenced budgets, or where expenditure is closely and explicitly related to the drugs strategy
- **drugs generic expenditure**, mainly where a proportion of service time (police officer, teacher, social worker, prison officer etc) is related to drugs work
- **expenditure consequences** of the drugs problem – where agencies are having to deal with the effects of drugs misuse.

Drugs Specific Expenditure

Health education/health promotion

5. The majority of expenditure will be based within local health promotion activity (funded from within health board general allocations). In addition, the Health Education Board for Scotland (HEBS) fund some specific programmes, with projected programme expenditure this year of **£180k**. Additional funding was also provided this year for HEBS to undertake a heroin advertising campaign: cost **£80k**. HD provides funding of **£100k** pa for the National Drugs Helpline. Total **£360k**

Addiction services – community care

6. People with drug misuse problems are a community care group, and local authorities have a duty to assess their needs, and a power to provide for them. There is no specific 'line' for services. Funding comes from the unhypothecated £800m GAE for community care (ie authorities have discretion over spend). Local authorities spent about **£7m** on community care services for drug misusers in 1998/9 (estimated 2/3 of spend on substance misuse: balance spent on alcohol services). Most of this will be for community projects, often delivered by the voluntary sector. About a third of the total will be for day and residential projects.

Treatment – health service

7. A ring fenced allocation of **£11.3m** is made available to health boards. This budget is used to fund community initiatives (including voluntary sector projects and drug agencies), some prevention work, needle exchanges, and shared care/methadone programmes. This budget is managed through the Public Health Policy Unit. It was increased by £2m pa following the 1997 CSR. This ring-fenced budget may well be supplemented by spending by Health Boards from their general allocations. For example, GGHB reported expenditure of £2m in 1997/98 over and above their £3.4m ring fenced allocation.²⁰

8. In addition **£3.5m** was spent on reimbursing pharmacists for dispensing of methadone to drug abusers in 1998/99 (NB an increase of around 30% on previous years). This figure excludes the cost of methadone itself which amounted to **£2.04m**. Around **£1m** is spent on needle exchange schemes as part of drug-related prevention services within an allocation of £6m to health boards for HIV and AIDS work. Health service treatment costs therefore amount to **£17.84m**. Information on more general expenditure consequences within the health service is set out in paragraph 32.

Example: Methadone Programme costs

9. The annual costs to the health service of methadone prescribing have been estimated as **£1,150 per patient**, or £3.15 per patient per day.²¹ A study reported that £1.72m was spent on methadone prescribing by GPs and the Glasgow Drug Problem Service in the GGHB area (1995-96). This comprised methadone mixture (£482k, 28%), fees for dispensing controlled drugs (£1.05m, 61%), fees for GP participation (£138k, 8%), pharmacists' fees for supervision (£52k, 3%). In addition staffing costs of the Drug Problem Service amounted to £574k. An estimated 2,000 patients were being prescribed methadone at any one time. Costs do not take account of the full costs of GPs', pharmacists' and counsellors' time.

Training/Employment

²⁰ Tackling Drugs Together in Greater Glasgow: Strategy document 1999-2003

²¹ Gruer L. et al. General practitioner centred scheme for treatment of opiate dependent drug injectors in Glasgow. BMJ 1997.

10. As at February 2000 over **£1.5m** was committed to drugs related projects through the New Futures Fund, a relatively new initiative providing employment and training support for groups facing particular difficulties in joining the labour market (homelessness, prostitution etc as well as drugs).²² Over 50% of the drugs related spend was in Glasgow (£809k).

Social Inclusion Projects

11. Projects worth just over **£1.1m** were funded through the Social Inclusion Partnership Fund (formerly Urban Programme) in 1998-99. This supported a range of provision including detached drug workers, youth initiatives, and women's addiction projects. These projects are however time limited, and DATs will be expected to consider whether projects should be mainstreamed (if deemed effective) as and when the projects come to the end of their special programme funding.

12. One of the 'Working for Communities' pathfinders (Cultenhove, Stirling) has **£140k** in this year and the next two years to address community concerns on drugs and wider community safety issues. It is a community driven initiative and will test the value of the community more directly influencing the liaison between the Police and other agencies on drug related crime and support for families and drug users. Funding of **£48k** has recently been announced to support citizens' juries on drug misuse in Glasgow.

Total: **£1.29m**

Prisons – drugs strategy

13. The Scottish Prison Service has attempted to calculate spend on prevention, and care and treatment. This is not a ring-fenced budget, but is funded from within the overall SPS allocation. Additional figures on enforcement of anti-drugs measures are included below. The estimated spend on prevention is £1.4m (of which staffing costs are 78%); and on care and treatment £6.5m (of which staffing costs are 92%). Total spend on prevention, care and treatment is **£7.9m**. The SPS is hoping to inject an additional £850k in support of the drugs strategy.

Criminal Justice Social Work

14. A number of programmes are supported through criminal justice social work. These are ring fenced 100% funding arrangements, routed through local authorities in the first instance, and through them in some instances to voluntary sector partners. The budget of **£2m** this year is made up as follows:

- Drug Treatment and Testing Order pilot: £400k
- Specific intervention projects for addictions, including Turnaround project – £400k
- Probation orders with additional specific condition of drug treatment - £600k (estimate²³)
- Pilot diversion from prosecution schemes: estimated 50% of the 18 pilot schemes focus on the needs of drug misusing clientele. Element of costs associated with offender

²² This figure may rise/decrease in future years depending on projects put forward for funding, and allocation decisions

²³ Based on information from courts in Glasgow – applying a unit cost figure and applying across Scotland

accommodation and bail services can also be attributed to this group. Estimated £600k in total.

NB The budget will rise to £3m next year and beyond, reflecting the additional resources made available through the last CSR to fund the development of DTTOs (£3.1m over the 3 year CSR period).

Police: Drugs Enforcement Agency, Crime Squad etc

15. The budget for the SDEA is £10m covering this year and next. 90% of the work of the Scottish Crime Squad (total budget £7.5m) is estimated to be drugs-related. The figure for this work is therefore estimated at **£6.75m**. Similarly, 90% of Scotland's annual contribution to the UK body NCIS (National Criminal Intelligence Service) is drugs related, giving a figure of **£2.25m**.

Total: **£14m**

Grants to voluntary organisations

16. Total grants: **£576k**. Grants as follows:

Fast Forward Positive Lifestyles – voluntary organisation focused on combating drug, smoking and alcohol - misuse through peer group education: £50k from ED (relating to community education/youth work interests)

Crew 2000 – grant of £26k from Section 10 (HD)

Drug information and education initiatives: c£500k from HD

Co-ordination arrangements

17. Total: **£3.357m**. Funding as follows:

Support for Drug Action Teams (DATs) £1m (HD)²⁴

Scotland Against Drugs: annual grant of £1m (HD), to be increased to £1.5m in 1999/2000.²⁵

Paisley Centre for Alcohol and Drugs Training: annual grant of £35k (ED); support for training in substance misuse: £17.5k (ED); £91k from PHPU

Drugs Training (Stirling): £225k (HD), support for training in substance misuse £17.5k (ED)

Scottish Drugs Forum: core funding £150k (HD: PHPU) + £21,320 (HD)

Effective Interventions Unit: £300k (HD)

Research and Information

²⁴ (recently increased from £0.51m)

²⁵ Higher figure of £1.5m used

18. Total: **£265k**. Funding as follows:

GRO(S) – information on drug related deaths: £10k

Chief Scientist Office – research projects: c£225k

CRU criminology research – estimated £30k (will vary from year to year)²⁶

Education research - £12k²⁷

Total direct spend on tackling drugs misuse: £56.1m

General Programme Spend

19. A significant proportion of several mainstream budgets is spent on tackling drug misuse. This is less easily identifiable as it is often made up of officer time (which, in any given day, is also spent on a range of other duties). Included here is teacher time, spend within community education services, health promotion, community care services (excluding addiction services, counted above), criminal justice social work programmes, drugs related police activity, and drugs enforcement activity within prisons.

School based education

20. The estimated spend within schools is **£6.9m**. The bulk of this spend is on the proportion of *teacher time* that is spent on the delivery of drugs education within the curriculum. A small proportion is spent on materials, and teacher training.²⁸ The figure should be treated with caution. It is a “best guesstimate” only. The calculation is thought to be an underestimate of teaching time, but a more sophisticated estimate would require a special study.

Community education

21. The GAE line for community education is just over £100m. Provision by authorities varies, spanning community learning, adult education and youth work. A proportion of community based work will contribute to the general prevention effort, but it is youth work that is most closely connected to action on drugs. Some authorities for example support detached youth workers (street based), providing the opportunity to engage with young people who may be disconnected from other forms of service delivery (health and social work services, education) Rough estimates suggest that 10% of the global figure may involve work with individuals or groups where drugs is an issue. Programmes will, however, be aimed at empowering people to take control of their lives and experience positive development although specific drug education related work will feature from time to time – suggesting a contribution of some **£10m**.

Health promotion

²⁶ Other research projects across the Executive may well have a drugs dimension – social inclusion, children, social work projects for example. These have not been separately identified.

²⁷ Spend in 99-00. May be higher/lower in other years. This spend for example was part of a major research project evaluating drug education in Scotland, costing £163k over 3 years (1996-1999)

²⁸ Figures based on formula devised for Scottish Affairs Committee report in 1994-5, and updated

22. A recent study into DAT spend estimated that 5% of health promotion budgets would be drugs related (thought to be a realistic estimate). Health promotion departments in Scotland spend around £15m a year. On that basis an estimated **£760k** is going towards drug work (although clearly much of the general health promotion effort – in schools, communities, workplaces etc will have a beneficial impact)

Community Care

23. Direct spend by social work departments is within the context of substance misuse (see para 6 above, identifying around £7m on addiction services). Significant resources are also contributed by mental health programmes – an estimated **£4m** (calculated as 10% of estimated spend). A further 10% of HIV/AIDS services, **£200k** is thought to be drugs related²⁹. Total community care spend is **£4.2m** (excluding substance misuse) (and £11.2m including substance misuse).

24. This figure does not take into account more general expenditure within overall social work spend. The majority of community care spend (over 50% of the GAE line of £800m) is related to services for older people but a proportion of that overall spend (area teams and administration costs) will be drugs related. We do not have any estimates of the percentage of activity/spend that could be apportioned to substance misuse and this has not therefore been taken into the equation (explaining apparent discrepancy with costs identified within children and families expenditure, para 31 below).

Criminal Justice Social Work

25. Local authorities receive funding of £40.8m a year for criminal justice social work services (100% ring fenced funding). A significant proportion of this funding will be on drugs related work. The 1998 evaluation of DATs estimated 70% of time/spend, although this has not been tested, and is on the high side. [add reference to DAT study] Applying a 30% figure (reflecting estimate of 30% of crime being drug related) would suggest a figure of **£11.64m**.³⁰

Police

26. The overall GAE for police spend in 1999-2000 was £715m. Various estimates have been made of the proportion of this spend that is drugs related. One study in Strathclyde estimated that in an area with a notional population of 500,000, police costs on drug related work was likely to be in the region of £27.48 per head. Extrapolated, this becomes a national figure of £120M. This is lower than the anecdotal reports from the police that 30% of all recorded crime can be attributed to drug misuse – generating a figure of nearly £215m. Police Division recommends using the more conservative figure of **£120m**.

27. We have further split this figure of £120m between drugs generic spend, and wider expenditure consequences. Calculation of police spend in the English CSR was based upon a figure for the investigation of crime (20% of overall police spend). 30% of that spend was estimated to be drugs-related. Applying this formula to Scotland generates a figure of

²⁹ Based on the estimated proportion of spend not proportion of HIV/AIDS cases contracted through injecting drug misuse, which is estimated at around 40% of cases.

³⁰ Based on £38.8m total (£2m already counted as direct spend)

£42.9m³¹. The balance between this figure and the estimated £120m total has been counted as part of the expenditure consequences of drugs misuse (see para 34 below).

Prisons

28. Enforcement within prisons is estimated at just over **£9m** per annum. The bulk of this is officer time (c£7m). These figures should be treated with caution – they are ‘best guesstimates’ only. They are based on the rough proportion of time generic prison officer staff may be spending on drug related work (eg searching for drugs, picking up intelligence).

SUMMARY:

Drugs specific: £56.1m

Drugs generic: £85.4m

The combined spend – specific and generic programmes - is £141.5m

Expenditure consequences of the drugs problem

29. This section flags up key areas where drugs problems are hitting other service areas – in particular children and families, the health service and the criminal justice system.

Children and Families

30. The GAE line for children and families within social work spend is £220m. The estimated spend by local authorities (based on financial returns) is around £280m. An earlier study³² suggested that 60% of children and families spend was related to addiction work. This is generally considered to be too high; discussions with some of the urban authorities suggest figures of around 30-40% of activity (primarily social worker time). A recent ‘snapshot’ study from the Child Protection Register in Glasgow showed that alcohol or drug misuse were the underlying factors which led to registration in 52% of cases.³³ Glasgow faces particular problems given the scale of drugs use in the city, and spend may fluctuate according to current trends – the authority reporting for example a recent increase in resources to deal with young people entering the care system as a consequence of addiction problems.

31. Working on an assumption of 30% of spend, **£84m** is spent a year dealing with the consequences of drugs and alcohol misuse.

Health service

32. The health service has to pick up the costs of drug related health problems (although it should be noted that many in the health field regard alcohol as of equal if not greater

³¹ GAE £715m. 20% for investigation of crime = £143m. 30% drugs related = £42.9m

³² DAT evaluation

³³ Tackling Drugs Together in Greater Glasgow: Strategy document 1999-2003

importance in terms of demands on the service.) This impacts on level of demand for inpatient and outpatient services, psychiatric services, Accident and Emergency admissions, and GP time. Health economists have done some initial work identifying costs to the health service of drugs misuse, and the findings are set out below.³⁴ There are other costs to the system that have not been directly calculated, for example around 200 maternity cases a year with a drug diagnosis.

- Non-psychiatric inpatient costs: £2.8m
- Psychiatric inpatients (with drugs misuse diagnosis): £3.9m
- A & E: £0.7m
- Community mental health £1.5m
- GP time (based on sample study of consultations): £4.9m
- HIV/AIDS combination drug therapy dispensed from community care: £0.32m

TOTAL: £14.12m

33. This is similar to findings from an earlier study³⁵ which suggested that total UK health care costs were in the region of £100m.

Criminal Justice System – Police, Courts, Prisons

34. We have already highlighted the high levels of police activity that are related to tackling drugs (para 26 above). The overall cost of police effort in relation to drugs may be as much as £120m. Of this £42.9m has been attributed to generic costs. The balance of **£77.1m** is attributed to wider expenditure consequences.³⁶

35. Information has been provided on the costs of **court proceedings** – although it should be noted that this is based on cases where the *main* offence was a specific drugs offence – illegal supply, possession, importation etc. Many other cases may feature drugs as a secondary charge, and many more may be linked to drugs problems – housebreaking or shoplifting to feed a drugs habit for example. 1997/98 figures suggest costs in the region of **£16.2m** (figures based on average costs, so need to be treated with some caution).³⁷

Summary:

36. We have highlighted significant costs resulting from the drugs problem: over **£191m** supporting children and families, in the health service, and within the criminal justice system. This suggests that total Executive expenditure dealing with the problem of drugs misuse is in the region of **£332.92m**.

37. This does not sound unrealistic. The English drugs CSR estimated that the annual costs to the public purse arising from the most serious drug misusers alone are over **£4 billion** – taking into account social, economic, psychological, crime and health related costs.

³⁴ Estimating health spending on drug misuse in Scotland: SEHD paper December 1999

³⁵ 'Costing Problem Drug Use: A Discussion Paper'

³⁶ Based on £120m figure from Strathclyde study, less £42.9m estimated in relation to investigation of drugs related crime, see paras 25 and 26

³⁷ Figures provided by Justice Statistics Unit

Wider Expenditure Consequences

38. Some of the expenditure consequences may in fact go beyond the £191m figure. Some examples are considered below in relation to the criminal justice system and benefits system. These figures have *not* however been counted as part of figure for overall spend.

39. Figures were identified above for criminal justice spend both in the courts and through the use of police officer time. Some commentators suggest that even the global estimate of £120m may be an under-estimate, and that in fact as much as 30% of police activity may be drugs related. The true impact of drugs on police activity, time and money may therefore be as much as £215m.

40. The SPS estimate a budget of £16.9m in pursuit of their drugs strategy. The actual cost of drug misuse to the prison service may be much greater. Keeping people in prison is not cheap – an average bill of £26k to keep open each prisoner place across the service each year. Various estimates have been made of the size of the prison population that is a consequence of drug related problems.³⁸ Working on 30% of crime figures, an estimated £55m of the SPS total budget of £186m may be drugs related. That does not of course mean that £55m would be *realisable* by successful delivery of the drugs strategy, nor indeed that it is entirely attributable to drugs misuse – a high proportion of that section of the prison population might well be in prison for other reasons if not drug related activity.

41. Total costs to the criminal justice system in Scotland may be in the region of £191m (police time, court costs, global costs to the prison service³⁹). These figures are high – but probably not unrealistic. The preparatory work for the English drugs CSR estimated that the total cost of drug misuse to the criminal justice system was £1 billion, or 10% of the annual spend on the criminal justice system.

42. In addition there are costs to the victims of drug-related crime. There have been various attempts to calculate weekly spend by drug addicts, with figures ranging between £100 and £300 a week. Goods on average are fenced at around a third of their market value. A UK study estimated that around £650m a year was raised through acquisitive crime, with the value of goods stolen around £2bn. The majority of these costs are passed on to consumers (via organisations) rather than borne by individual victims. ‘Savings’ generated by better treatment would not be bankable by the state⁴⁰, although other costs to the public purse would diminish (contribution of Criminal Injuries Compensation Scheme for example, costs to NHS in treating health consequences of victimisation.)

Benefits Agency

43. The English Drugs CSR estimated that £16.4m pa was spent through DSS on Incapacity Benefit and Severe Disability Allowance Recipients where drugs are the main diagnosis. This would suggest a figure of £1.64m in Scotland. This estimate does not however take into account the wider picture. The vast majority of problem users are unemployed and claiming

³⁸ 50% of the male prison population current/former users; in Cornton Vale 80% of prisoners are from GGHB area, of them 90% have misused drugs (from Tackling Drugs Together in Greater Glasgow: Strategy document 1999-2003); SPS report figures of around 75% prison inmates showing signs of problem use

³⁹ £120m total police time, £55m total prison time, £16.2m courts – broad estimates

⁴⁰ From ‘Costing Problem Drug Use: A Discussion Paper’ by Mike Hough, Criminal Policy Research Unit, South Bank University. Paper prepared for work on English drugs CSR

benefit – estimated 80%. The majority will be claiming unemployment or sickness benefit, and many will be claiming housing benefit. One estimate placed this bill at £600m a year for problem users, or £60m in Scotland.⁴¹

44. It is of course unrealistic to attribute all this expenditure to problematic drug use. Indeed some people may have developed drug habits precisely because of the limited opportunities open to them for employment. Nevertheless, any interventions which enable a problem user to return to the workforce will yield a saving of £5,000 pa.⁴²

Wider Policy and Expenditure Framework

45. There are a number of programmes that are making an indirect contribution to the overall drugs agenda – these have not been costed but are included to demonstrate the context in which drugs specific programmes are being implemented.

We should also flag up that discussions are underway regarding the possibility of setting up a Scottish Confiscated Assets Fund to allow the Executive to channel assets into anti-drugs projects. If that scheme is set up we might expect to see funds channelled into anti-drugs projects annually.

Services for Children

Significant resources are being channelled by the Executive into services for children. (Childcare strategy, Sure Start Scotland, Family Centres, nursery and pre-school provision, etc). This is seen as a long-term investment with anticipated benefits across a range of policy areas in the future: educational achievement, improved health, reductions in youth crime for example, and should yield benefits in terms of improved resistance to drug-taking among young people. Many children's services are being developed to deliver better support for parents and families – and again, strengthened family/support networks should be seen as part of the wider drugs prevention agenda.

New Community Schools

46. 37 New Community Schools projects, involving around 150 schools, are already being supported in Scotland, and more are planned. These initiatives – following a range of different models – will integrate support services to better meet the needs of the pupil. This will include joint working between education, health, social work and police. Health education and health promotion will be integral to this initiative and the programmes delivered will include drugs issues, aiming to both raise awareness and develop and strengthen pupils' ability to make healthy choices.

Excellence Fund

47. There is a correlation between non-attendance at school (either through exclusion, or truancy) and increased risk of drug-taking and participation in other illegal activities.

⁴¹ From 'Costing Problem Drug Use: A Discussion Paper' by Mike Hough, Criminal Policy Research Unit, South Bank University. Paper prepared for work on English drugs CSR

⁴² Ibid. Savings would of course accrue to the DSS.

Through programmes such as the Alternatives to Exclusion (funded through the Excellence Fund) Scottish schools are working to improve attendance rates, and avoid exclusions wherever possible.

Social Inclusion

48. In addition to the drugs-specific projects highlighted above, a proportion of the Social Inclusion Partnership fund will be supporting work relevant to the drugs strategy – including activities supported by SIPs focused on specific groups (vulnerable young people, care leavers, prostitutes) and general preventive work underway in the area based partnerships.

49. New approaches to strengthening communities are being developed through the ‘Listening to Communities’ and ‘Working for Communities’ programmes. Some of the pilot work will have a specific drugs dimension (see para 12 above) but other pathfinders will touch on drugs related issues indirectly – improving neighbourhood management, addressing concerns in relation to youth crime etc.

50. Local authorities will also be supporting some ex-Urban Programme projects. This may be from central rather than social work budgets; for example in Glasgow (where some of the bigger projects are based) funding for ‘mainstreamed’ projects comes from a central social inclusion budget.

European Funds

51. The European Social Fund (ESF) provides significant resources for projects which address social exclusion, including the exclusion faced by drug users. A total of £71m was available this year. We do not have information on the proportion of spend allocated specifically to drug related work.

Action on homelessness

52. The Executive has allocated significant additional resources to tackling homelessness £20m both to deal with the immediate problem of rough sleeping, and to develop longer term preventive approaches. There are close connections between homelessness and drugs misuse (drugs being both cause and consequence) and agencies are being encouraged to develop joined up services and long term solutions.

New Deal, Training for Work, Employment Zone

53. There is a growing awareness of the importance of drugs issue within employment and training programmes. The New Futures Fund (see para 10 above) supports specific drugs related projects. Other programmes – the New Deal, Training for Work and the Employment Zone do not provide direct assistance, but pay for general confidence and self-esteem building programmes, and can link clients into support services (eg drugs rehabilitation).

Healthy Living Centres

54. £34.5m will be available over the next three years through the New Opportunities Fund to support the development of Healthy Living Centres. There is no prescriptive model for a

Centre. Some may have a drugs specific element, but all will contribute to improved health promotion at community level.

Comparison with Other Figures

55. Information on drugs spend within the then Scottish Office was pulled together for a Scottish Select Affairs Committee report in 1994, and the Drugs Task Force report of the same year. An estimated spend of £42m was identified at that time. Uprating of these figures gives a spend of some **£50m** and that is the figure the media/public are familiar with. The closest comparison is clearly with the drugs specific spend of £56.1m – although the figures are calculated on a different basis.

56. Information on spend within more general programmes has not previously been used – hence the apparent dramatic increase in overall spend. The results are similar to the approaches adopted in England. Treasury work in 1993-4 identified drugs spend as £500m; whereas the work for the English drugs CSR in 1997 which included mainstream programme spend generated a figure of £1.4bn.

57. The £141.5m figure is also closer to the notional spend calculated by consultants working with Scottish DATs on local spend – their analysis, although based on different calculations, generated a notional figure of £220m.

Sectoral Analysis

58. An analysis of the figures according to sector on the direct and general programme spend is set out below. There are inevitably some distortions in the picture this creates – in some instances (school education, police) officer time has been counted, in other areas (eg health service) it has not.

Police - £56.9m

Direct (SDEA, Crime Squad, NCIS) - £14m; police officers - £42.9m

Local government - £41.74m

Education - £6.9m; Substance misuse - £7m; Criminal Justice Social Work - £2m; Criminal Justice Social Work (general) - £11.64m; Community Care - £4.2m; Community education - £10m

Health - £18.96m

Treatment services - £17.84m; health promotion (direct) - £360k; health promotion (general) - £760k

Prisons - £16.9m

Prevention, care and treatment – £7.9m; enforcement - £9m

Other organisations - £6.93m

(voluntary sector, partnerships, training providers)

59. It is worth adding a short note about the **private and voluntary** sectors. The *private sector* clearly bears many of the costs of drugs (employee absence, reduced productivity,

drug-related crime). It is being encouraged to contribute to the effort to tackle drugs misuse through Scotland Against Drugs: contributions of £3m received to date.

60. The *voluntary sector* is a key player in the delivery of the drugs strategy. Over £1m of grant is provided direct by the Executive. Most of the projects funded by Social Inclusion and New Futures fund will be in the voluntary sector. A high proportion of the budgets allocated through local authorities in particular is directed towards voluntary sector projects. In addition, projects receive funding from charitable donations, and significant contributions from the National Lotteries Charity Board. Funding in the region of **£1.25m** has been provided by the NLCB to drugs-related projects since 1995.

Pattern of spend

61. How much of the spend goes on prevention, treatment and rehabilitation, and enforcement? Analysis of the *drugs specific* spend yields the following breakdown. The high proportion of spend going to treatment/rehabilitation is a reflection of the *ring-fenced* funding (£11.3m) going to health boards.

Prevention health education, grants, co-ordination and research	8%
Treatment/rehabilitation health board treatment, substance misuse, criminal justice, NFF, social inclusion, and prisons treatment	67%
Enforcement SDEA, NCIS, Drugs Squad	25%

62. The figures look very different however when based on the overall spend, including funds from mainstream/generic budgets.

Prevention schools and health education, grants, co-ordination and research; community education; health promotion/education	16%
Treatment/rehabilitation health board treatment, substance misuse, criminal justice, NFF, social inclusion, and prisons treatment; community care spend, general criminal justice social work	38%
Enforcement SDEA, NCIS, Drugs Squad; General police spend, prison enforcement	47%

63. This indicates a higher proportion of spend on treatment/rehabilitation in particular than the breakdown identified in the English drugs CSR: 62% enforcement, 13% international supply reduction (together: 75%), prevention/education 12%, treatment 13%.

64. Finally, we consider the pattern of spend in relation to the drugs strategy: *'Tackling Drugs in Scotland: Action in Partnership'*. The strategy identifies 4 action priorities: Young People; Communities; Treatment; Availability. There is no simple way of allocating spend against

each action priority, and some fairly arbitrary assessments have been made. Some lines have been split reflecting their different purposes – for example social inclusion resources contribute both to community support, and employment/training initiatives for young people within the treatment element of the strategy.

Young People: emphasis within the strategy on schools, community education, drug education (mass media), health promotion, and support for children and young people, including children of drug misusing families*.

We have attributed the following spend to this area: school drug education, health education, 80% of community education (youth work element), and 50% of voluntary sector grants.

We have not included a proportion of the children and families element, although that relates to the priority identified above*, since this figure has been counted within expenditure consequences.

Total spend: **£16.3m** (12%)

Communities: emphasis within the strategy on effective partnership, detection of drug related crime, referral of offenders to specialist agencies, alternatives to custody, joint working between prisons and agencies. Overall objectives to strengthen and protect communities from drug related crime (and fear of crime).

We have attributed the following spend to this area: 20% of community education (community learning); 50% of social inclusion resources; co-ordination, criminal justice, 50% of research, 50% of prevention/treatment in prisons, and *50% of general police effort*.

Total spend: **£45.176m** (32%)

Treatment: includes shared care arrangements, substitute prescribing, treatment for young people, links to education and employment, prison treatment programmes

We have attributed the following spend to this area: substance misuse; community care; health board treatment; New Futures Fund; 50% of social inclusion; 50% of research; 50% of voluntary sector grants; and 50% of prevention/treatment in prisons.

Total spend: **£35.567m** (25%)

Availability: includes enforcement activity by police, intelligence sharing, reducing availability of drugs in prisons

We have attributed the following spend to this area: police (SDEA, NCIS etc); 50% of general police spend; enforcement in prisons

Total spend: **£44.65m** (31%)

Policy Unit
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