

Derbyshire Drug Market Project

**Managing Local
Heroin-Crack
Problems:
Hard Lessons about
Policing Drug Markets
and Treating Problem
Users**

***Final Report from the
Derbyshire Drug Market Project***

Howard Parker and Roy Egginton

CONTENTS

	Page
ACKNOWLEDGEMENTS AND DEDICATION	1
EXECUTIVE SUMMARY	3
SECTION 1: DELIVERING THE UK ANTI-DRUGS STRATEGY AT THE LOCAL LEVEL	7
The Making of the UK Drugs Strategy	7
Delivering the Drugs Strategy at the Local Level	8
The Project's Structure and Staffing	10
The Project's Assumptions, Methods and Goals	11
Investing to Save: The Cost-Effectiveness Experiment	12
SECTION 2: DRUG MARKET MAPPING AND TARGETED ENFORCEMENT IN COMMUNITY LEVEL HEROIN-CRACK MARKETS	15
The DDMP Methodology	15
Evaluation Template for the Main Operations	18
Operation Quantum in Old Town	20
Operation Ultimate in Market Town	23
Operation York in Border Town	27
Operation Flavour in City	29
Operation Impact in Midshire Town	33
Learning Points. The Mapping and Enforcement Arm	34
SECTION 3: THE TREATMENT OUTREACH TEAM: AN EXPERIMENT IN DRUG TREATMENT DELIVERY	37
Recruitment and Development	37
The Outreach Team in Old Town	37
The Outreach Team in Market Town	40
The Rebadged Outreach Team in Border Town	42
The Outreach Team in City	45
The Outreach Team in Eastside Town	47
The Outreach Team: Perceptions of Service Users	51
The Overall Experience and Impact of the Outreach Team	53

SECTION 4:THE EFFECTIVENESS OF THE DDMP	55
Cost Effectiveness and Drugs Interventions	55
Funding the Derbyshire Drug Market Project	56
The Aspirational Goals of the DDMP	57
Views of the Key Players on the Effectiveness of the DDMP	64
SECTION 5:PARTNERSHIP VERSUS PERFORMANCE?: NEW LESSONS ABOUT THE MULTI-AGENCY MANAGEMENT OF LOCAL DRUG PROBLEMS	69
Introduction: Theory and Implementation Faultlines	69
Ineffective Strategic and Operational Management Systems	69
Finding New Ways of Integrating ‘Partnership’ and Performance	72
New Learning About Policing Drug Markets	72
Difficulties Harvesting the Potential Gains from Drug Treatment	74
Finally	77
REFERENCES	75
ANNEX 1:PROFILING AND ‘UNDERSTANDING’ LOCAL DRUG MARKETS AND HEROIN-CRACK USER POPULATIONS	79
Introduction	79
Jigsaw Epidemiology as a Backcloth	79
Estimating the Size of the Local Problem User Populations	84
Profiling Problem Users: Drugs Bills and Funding Strategies	88
Pricing and Sizing Local Heroin-Crack Markets	93
Conclusions	94

ACKNOWLEDGEMENTS AND DEDICATION

The DDMP would like to thank the large number of agencies and individuals who have facilitated our Project through their generous co-operation and partnership work. Without the help of DATs, community groups, schools, young person services, criminal justice agencies, drug treatment services and service users, local councils, etc. right across Derbyshire, our work would have been impossible.

The Project lost one of its keys movers in the summer of 2003 with the untimely death of (DCI) Mark Cheetham who chaired the Project Board. We miss you Mark.

EXECUTIVE SUMMARY

1. The Derbyshire Drug Market Project (DDMP) was a multi-agency action research project which aimed to deliver key components of the drug strategy at the local level in an innovative, cost-effective way. It brought together in one project the Police, Drug Treatment Services, local community stakeholders and professionals, Drug Action Teams and an evaluation team all co-ordinated by a multi-agency management board.

2. The Police led enforcement arm of the Project provided intelligence led drug market mapping/profiling leading to targeting each of 6 towns' known local heroin-crack dealers and subsequent mass arrests. Simultaneously an assertive Treatment Outreach Team was seconded to the town to provide immediate direct treatment access to local problem users, especially those whose heroin supplies were expected to be disrupted. The Outreach Team was also tasked to deliver drugs education and prevention programmes to young people, parents and stakeholders in each community to raise awareness of the local drugs problem and associated risks. A community development input was also to be delivered to enhance local resistance to hard drugs markets. Through this multi-dimensional project it was hoped to produce cost-effective outcomes in terms of reduced drug dealing, enhanced community safety and empowerment, reduced drug related crime and numerous gains associated with effective drugs treatment.

3. The detailed mapping and profiling of community (Level 1) heroin markets utilising police and public intelligence led to more effective targeting and, via undercover test purchasing, to successful arrests and convictions. Over 200 arrests mostly for heroin-crack related supply and possession offences were made in 6 communities. Almost all convictions led to imprisonment. Only one Drug Treatment and Testing Order was made. A significant minority of arrestees were already in drugs treatment. It proved possible to close open town centre heroin/crack markets in 2 towns. Local residents in such towns were generally appreciative of this co-ordinated enforcement.

4. However it was not possible, even in small rural towns, to create a supply 'drought' or prevent local users from accessing heroin. Many supply sources and dealers, outside intelligence, remained in place and the markets quickly reconfigured. Where very local supplies were temporarily disrupted, problem users simply travelled to nearby areas to score. The DDMP tested the hypothesis that in semi-rural small town settings enhanced enforcement could disrupt drug supplies. The notion proved 'null' – it was not possible to disrupt supplies.

5. The mass arrests in each Operation did not affect local recorded crime rates. Rates were monitored before, during and after enforcement. No crime categories were significantly reduced as a consequence of the Operations. Overdose ambulance call outs were similarly monitored. Operations did not have the adverse effect of increasing overdose incidents which might occur during periods of intermittent supply, varying purity and the use of diverted medications (e.g. benzodiazepines, methadone) as a heroin substitute. This was a positive outcome.

Derbyshire Drug Market Project

6. In terms of methodology it was found that Test Purchasing as a *modus operandi* whilst generally effective was unsuccessful in several closed markets and if over-used, recognised by some open market players. Processing mass arrests can also produce logistical problems particularly in respect of delivering arrest referral and managing court proceedings including overloading small town Probation Teams required to produce pre-sentence reports.

7. The Treatment Outreach Team was tasked to deliver a temporary direct access treatment service in each fieldwork area. Unfortunately overall only 73 problem drug users entered treatment against a target of 300. However of those that entered treatment most were dependent heroin users and with retention at about 60%, 39 were transferred to a mainstream drug service. The cost of delivering this service was probably 'repaid' in terms of reduced offending and social gains.

8. The main reasons for poor treatment uptake were:

(i) The belief amongst local heroin users that the Outreach Team were working in collaboration with the police and thus could not be trusted. This was an unintended consequence of the DDMP advertising itself as a partnership project.

(ii) Constant problems finding suitable premises/venues.

(iii) Difficulties recruiting sessional prescribing doctors and delivering a range of treatment regimes.

(iv) Temporary services do not have time to bed in and become known/recommended via drug user networks.

(v) Difficulties managing the Team effectively.

The notion that problem drug users can be drawn into treatment via attempts to disrupt their drugs supplies remains problematic. Motivation and timing for treatment entry is not easily manipulated through enforcement.

9. The DDMP's Outreach Team did not fully deliver the intended community development element of its portfolio nor did it attempt to target young people at risk of drug misuse as originally specified. Performance management proved difficult to deliver given the Project's multi-agency structure.

10. The Outreach Team successfully delivered its drugs awareness courses 30 times, engaging around 450 parents and teachers across 5 communities. Courses were evaluated positively. The team also delivered a club drug/health and safety/overdose prevention and response course 22 times mainly in City, engaging over 200 participants who rated the course positively. These were well executed low cost outputs.

11. The DDMP successfully developed new knowledge and understanding about local drug markets and problem user populations by sharing and collating data from multiple sources (e.g. Police records, treatment systems, needle exchanges). It was able to estimate the size of local heroin-crack user populations, providing ratios of those in treatment, with previous treatment experience and as yet 'untreated'. Forecasts of

future treatment demand were made. These findings are currently informing strategic planning and drugs service configuration across the county.

12. Profiles of the size of users' drugs habits and drugs bills have been produced, allowing the size of local heroin and crack markets to be estimated. Annual average heroin bills for problem users ranged between £8,000-£13,000, being lower in small towns and higher in urban/city environments. There are 9-10 thousand problem heroin/crack users in Derbyshire. Acquisitive crime, particularly shoplifting and theft is related to funding drug habits but problem users also rely on benefits, sex work, casual employment, 'sharing' and borrowing to finance their dependency.

13. A rough guide estimate for the value of the retail heroin market in Derbyshire is about £44 million a year in the county and £38 million in City. The crack market is difficult to estimate given a lack of data, but in City where crack use is most prevalent, the market is worth between £14 and 29 million.

14. The DDMP did not manage to generate the significant net gains it aimed for. However, it did produce sufficient positive outcomes to suggest the project paid for itself. Resources put in delivered results which justified the expenditure.

15. The DDMP as an evaluated experiment in delivering the drugs strategy locally has provided important new learning which should have national implications. The project embraced and enhanced inter-agency partnerships required by the drugs strategy. However its ambitious multi-faceted programme required sophisticated management which the partnership model *per se* was under-powered to deliver. With ever more multi-agency drugs interventions coming on line locally, the key message from the DDMP is that far more effective ways of creating unified performance and line management need developing and disseminating if the drugs strategy is to be delivered more successfully.

SECTION 1 DELIVERING THE UK ANTI-DRUGS STRATEGY AT THE LOCAL LEVEL

THE MAKING OF THE UK'S DRUGS STRATEGY

Street Heroin was barely available, outside London, during the 1970s and crack cocaine was yet to be processed and marketed. However during the 1980s the UK experienced its first heroin 'epidemic' when several large cities in England and Scotland became the sites for extensive heroin use. The new heroin users were primarily from the most deprived areas of urban conurbations although through time heroin use diffused to many more towns. By the end of the 1980s and in response to a decade of heroin use bedding-in, the nexus of a drugs discourse had evolved. Problem heroin users from the social exclusion zones, in order to fund expensive habits, became involved in or expanded their criminal activities, especially acquisitive crime such as burglary theft from vehicles and shoplifting. The first wave of problem users were also caught up in the HIV/AIDs 'panic' whereby intravenous injectors were identified as one conduit for the spread of HIV. A major public health programme involving the extension of drugs treatment provision, introducing Needle Exchanges and promoting outreach work was delivered in the affected areas. The linking of problem drug users with amplified crime rates and the delivery of health-harm reduction interventions was thus made.

Initially official attempts to develop an anti-drugs strategy leant heavily on the USA and the 'war on drugs'. Major concern about 'recreational' drug use amongst young people did briefly dominate the agenda during the early 1990s and led to a more complex debate about drugs and also prompted the first attempt at a coherent anti-drugs strategy *Tackling Drugs Together* (1995). This published strategy document was ground breaking in terms of bringing together several government departments signed up to one collective approach. The main pillars of this new approach were drugs prevention programmes, enhanced enforcement against cultivation, production and supply of all street drugs and the need for inter-agency corporate work. Uplifting treatment provision was not a priority in the early 1990s however, given heroin was for a brief period not being headlined as generating crime and social problems.

During the second half of the 1990s, however, evidence of the rapid spread of heroin into new regions of Britain and then crack into the old heroin cities revived the drugs-crime agenda. Thus the New Labour government which returned to power in 1997 quickly produced a revised national plan *Tackling Drugs to Build a Better Britain* (1998). This far more ambitious plan maintained the pillars of drugs prevention for young people, enforcement to reduce supply of street drugs and the inter-agency corporate approach but placed far greater emphasis on the expansion of drugs treatment. Between 1998 and 2008 the number of treatment places were targeted to double. The drugs-crime linkage was central to this revised national plan. The debate about the UK's drugs problem, because it attracts so much media attention and political debate, often becomes over-simplified. Complexities and caveats tend to be dumbed down and a set

of primary assumptions or beliefs tend to emerge. The result is a drugs 'discourse' whereby the political process in particular generates a sound bite approach to discussing a massively complex issue. This process is embedded in the current debate. The current essential message is that drug users become addicted to drugs and then commit enormous amounts of crime to fund their habits. Thus the way forward is to get problem drug users into treatment. The key assumption is – treatment works – and that investment in treatment will be highly cost effective bringing enormous gains in terms of reduced offending, safer communities and promoting healthier, more productive law abiding citizens.

All the key players and stakeholders centrally and at the local level have signed up to this ambitious drugs strategy and the mandatory inter-agency approach. The main irritation with the strategy amongst practitioners is its obsession with milestones and targets which have been wholly unrealistic in almost every arena from rapidly reducing young people's use of drugs by 25% to reducing drug related overdoses and deaths, to reducing the supply of drugs and so on.

These targets were quietly removed in 2002 through the *Updated Drugs Strategy*. This latest revision of the national plan shows an increasingly realistic and managerialist approach to tackling drugs problems. The war on drugs discourse is removed. The notion of preventing young people from trying drugs was implicitly abandoned. Enforcement goals are maintained but targets softened. However the drugs-crime-treatment agenda is given further emphasis. Heroin and cocaine become defined as the drugs which cause most harm and therefore ought to receive most enforcement and therapeutic interventions. A whole raft of youth and criminal justice drugs interventions have been introduced ranging from arrest referral schemes to coercive community treatment orders, to drugs treatment and prevention and treatment programmes in prisons to resettlement pathways now being integrated through 'CJIP' (Parker, 2004).

Since 1998 successive Labour governments have backed the drugs strategy with increased resources and a detailed modernisation plan. Enforcement and treatment services have been allocated ambitious and demanding modernisation targets designed to enhance their effectiveness. There can be no doubting the genuine commitment by government to making its anti-drug strategy work. Whether it is possible to produce the desired results at the local level remains a contested issue however.

DELIVERING THE DRUGS STRATEGY AT THE LOCAL LEVEL

Delivering a Demonstration Project

The Derbyshire Drug Market Project (DDMP) developed directly from the templates found in the national plan. The DDMP brought together the assumptions, priorities and methodologies advised in the UK strategy. The DDMP as a microcosm of the national plan, thus provides significant learning about the viability of the national strategy in delivering the goals it has set itself in terms of enforcement against drug supplying and local markets, the effectiveness of expanding drugs treatment to reduce drug related

crime and encourage citizenship and the viability of a corporate multi-agency delivery approach at the local level.

The project evolved from a degree of opportunistic networking and bidding between several key players in the county, in particular the Police and the two Drug Action Teams for City and the county. Firstly, Derbyshire Police Service through its drug squad was developing the idea of 'mapping' the county's drug markets. Their strategic thinking was that large amounts of intelligence about local drug markets were logged and available but not adequately collated and analysed. If this intelligence could be put together and enhanced by adding other, related, often public intelligence say from treatment agencies, community groups and other inter-agency stakeholders, then it should be possible to define and describe local drug markets. A detailed picture could be created of, for instance, how a town centre open heroin market was configured and supplied and by whom. From this picture more targeted and cost efficient enforcement could follow and further intelligence gleaned.

A Home Office funding stream *Targeted Policing* provided Derbyshire Police with the opportunity to operationalise this approach and a bid to set up a 'Mapping Team' was made in yr 2000. This bid for over £300,000 was eventually successful, fitting into both the specific criteria for the ring fenced funding about innovation and inter-agency work and clearly hitting the key requirements of the national drugs strategy. Targeting Level 1 community drugs markets, focusing on heroin and crack as drugs which cause the most harm, monitoring enforcement effectiveness and co-working with other local stakeholders were all features of this proposal and so matched almost perfectly the enforcement-supply disruption agenda in the national plan.

Riding directly on the back of this bid the City DAT, in collaboration with the county-wide DAT, put in a major request to the Treasury's *Investing to Save* fund for resources to link the Drug Mapping to a more ambitious and integrated project which twinned mapping and enforcement with drugs prevention and in particular assertive drugs treatment. This funding stream exists to identify innovative ways of delivering public services, to reduce the cost of delivering public services and improve their quality and effectiveness. The Treasury purposefully funded the DDMP as a 'high risk' experiment, recognising that at worst substantive learning about delivering the local drug strategy would flow. The Derbyshire bid was also successful, bringing in over £1.5 million for a two and a half year project.

From this networking and inter-agency collaboration to run a fully evaluated demonstration project was born the Derbyshire Drug Market Project. Could this project, showing firm commitment to delivering the national drugs strategy at the local level, demonstrate cost effectiveness against a clutch of clearly stated goals and required outcomes?

THE PROJECT'S STRUCTURE AND STAFFING

The DDMP was macro-managed by a Project Board (see Figure 1.1) which met monthly throughout. In theory, based on the original bid, the Board was in turn accountable to the 2 local DAATs (not shown). Whilst the make up of the Board changed slightly through time, it contained 3 police staff managers, namely the Drug Mapping Team co-ordinator and 2 senior members of the drugs squad, although divisional chief inspectors/superintendents also attended when their 'patch' was operationally involved. The Board was chaired by a chief inspector particularly committed to the project.

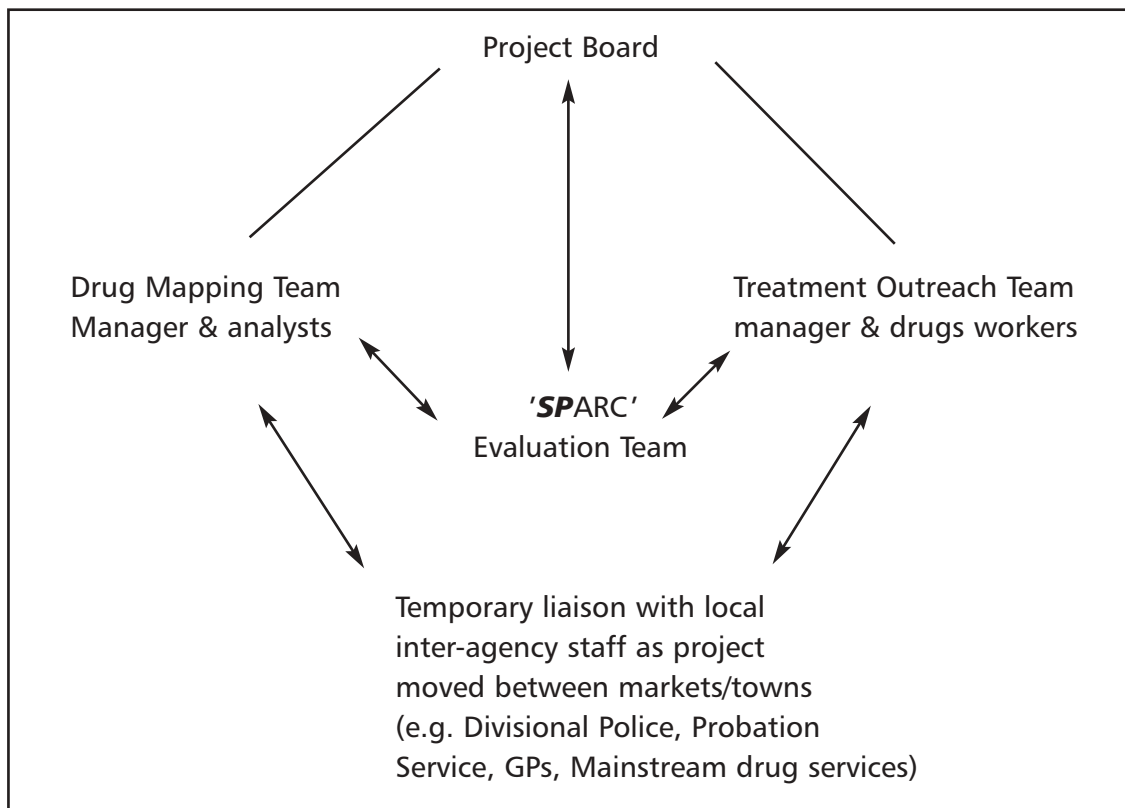
The Board also contained the county and city DAT co-ordinators and the Project's treatment/response team manager and employing drugs service regional manager, and the 2 evaluators. A regional government representative with a drugs brief also attended. A finance officer from a local health trust which monitored the overall finances, also often attended. A part-time 'chief executive' to the project was appointed after it had run for 6 months. He also attended the Board.

The Mapping Team was based in Derbyshire Police Headquarters and consisted of a male manager-co-ordinator, himself, a very experienced drugs squad sergeant and 4 female civilian analysts-researchers. The team had their own dedicated offices and state of the art IT/computing systems.

The Treatment Outreach Team were recruited and managed by 'Addaction', a national drugs treatment agency, which already ran the majority of the county's drugs services. There was a team manager and 5 workers with experience in community development, drugs prevention and mainstream Tier 2/3 drugs service provision. This team had an impressive administrative office base with secretarial support. Across the duration of the project they also worked from temporary accommodation in 5 areas (4 county towns and City).

As an action research project the DDMP was committed to reviewing performance and revising strategy and structure and the *Evaluation Team* worked within the project throughout making an active contribution to delivery as research findings emerged. Its first recommendation from the initial 6 month interim evaluation was that an overall co-ordinator was needed and a part-time Chief Executive was appointed. He was an ex police officer and was able to liaise and work with the police arm of the project very effectively although most of his working time was spent with the Treatment Outreach Team.

Figure 1.1: Structure of Derbyshire Drug Market Project



THE PROJECT'S ASSUMPTIONS, METHODS AND GOALS

The DDMP brought together several working **assumptions** found in the drugs strategy 'discourse'. In relation to enforcement, it pursued the assumption that drug supplying could be disrupted or 'stifled' through intelligence gathering and enforcement at Level 1 – the community or retailing level of the market. Heroin and crack cocaine were targeted as the drugs which cause most harm and are directly related to drug related crime, particularly acquisitive offending.

The project embraced the 'treatment works' presumption in the national plan and set itself the aspirational goal of producing enormous accumulated 'gains' from bringing 300 problem drug users into treatment in terms of reduction in local crime, reduced health care costs, reduced state benefit costs, etc. This was all situated in a project which embraced 'targeting' and all set within an inter-agency collaborative framework.

The overall methodology flowed from these related assumptions. The DDMP approach was:

1. To disrupt local 'Level 1' heroin/crack markets through intelligence led mapping, target hardening, test purchasing by undercover police officers and co-ordinated operations producing mass arrests in town level and especially visible or open markets.

Derbyshire Drug Market Project

2. That mass arrests are supported by strong evidence from test purchasing to produce convictions. Most offenders will be remanded in custody before receiving custodial sentences or, for a few, community supervision orders. This takes these local dealers, runners and user-dealers out of circulation (and offending). Thus local problem user-customers become 'drought' victims, unable to obtain immediate supplies, certainly in their local town. These users thus become susceptible to contemplating drug treatment entry.

3. The Treatment Outreach Team provides immediate-direct access to a drugs service which is locally based and heavily advertised, aiming to attract problem drug users into immediate treatment. This population is assessed, treated and supervised for an interim period before being transferred to the local mainstream service.

4. Simultaneously the Outreach Team provides support to the local community to 'resist' drug supplying/dealing and the local visible retail market. A targeted community group is given support to negotiate with the police and crime-disorder partnership to undermine the local drug market.

5. Local schools (teachers, parents, and young people) are given drugs awareness/prevention workshops to help reduce drug use and increase knowledge about problems associated with drug use. About 25 young people identified as most 'at risk' of drug misuse are targeted in each area for enhanced drugs prevention programmes. This is designed to prevent young people becoming 'new' problem drug users.

6. Inter-agency work and a sophisticated communications strategy involving local residents and young people as well as agency stakeholders is developed to enhance intelligence sharing and grassroots commitment to challenging drug markets and drug related crime. (This final goal was a requirement of *Investing to Save* wanting to promote 'ICT' type communications within the community).

7. The DDMP was also tasked to provide information and knowledge about local drug markets and problem user populations to improve strategic planning and 'understanding' of the local drug markets in the County.

INVESTING TO SAVE: THE COST-EFFECTIVENESS EXPERIMENT

One of the most innovative and compelling features of the DDMP was its overt commitment to external examination and an 'action research' perspective. From the outset the Project Board maintained its stated commitment to run a transparent project which would be continuously judged on its performance. The DDMP embraced outcomes rather than outputs and signed up to the evaluation task of ascertaining whether the overall approach was cost-effective. Essentially was this innovative corporate approach, costing £2 million over two and a half years, more productive than traditional and separate policing and treatment responses?

Initially, as we shall see, Project Board members were very optimistic about the programme proving highly cost-effective. It was believed that over several years the project's work would harvest gains priced at £30 million. It was argued that the mapping and enforcement strategy could indeed disrupt hard drug markets in small isolated 'greenfield' or semi rural towns (if not in urban conurbations). Reductions in drug related crime generated by local problem users entering treatment would save resources in police time, criminal justice interventions and via less victims of drug related crime. Problem users in treatment would no longer commit acquisitive crime. By entering treatment 'early' they would be more likely to have successful outcomes such as not contracting hepatitis, not requiring as much health care. In time they might find gainful employment thereby producing major savings in state benefits (e.g. incapacity benefit) whilst paying income tax. Whilst difficult to price, it was also felt that enhancing resistance to drug use and drug markets in local communities would also be a real gain.

SECTION 2

DRUG MARKET MAPPING AND TARGETED ENFORCEMENT IN COMMUNITY LEVEL HEROIN-CRACK MARKETS

THE DDMP METHODOLOGY

Mapping the Drugs Market

The DDMP, through its DAAT members and in consultation with Derbyshire Police, identified a list of county town markets and part of the capital city's drug markets to be mapped and targeted across the life of the project. The initial focus was on heroin markets. A focus on crack markets and their growing significance emerged during the project.

The Mapping Team's first task was to produce an initial outline and description of each market by seeking out and monitoring intelligence from the Force's data bases, direct contact with the Drugs Squad and local officers (e.g. beat officers) in the targeted town/community as well as information from 'CHIS' or informants. The Team also carefully collated 'public' intelligence from Crimestoppers but also from GPs, Needle Exchanges, local drug services, etc.

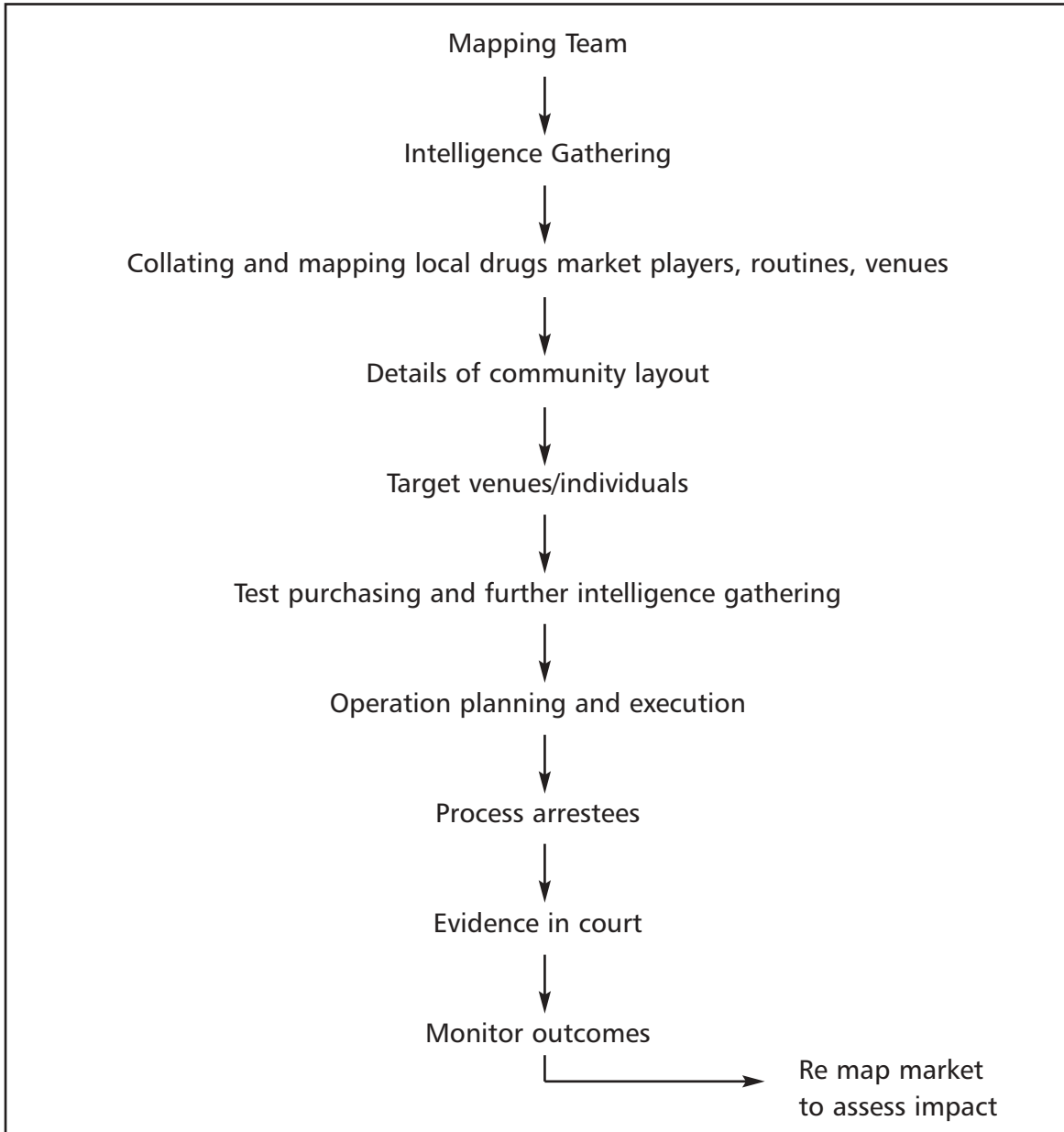
The outline was presented as an accessible and systematic confidential report. The community's population and demographics were introduced followed by detailed descriptions of the identified players in the local heroin/crack market and the results of previous operational work (e.g. seizures). Reports would sometimes contain aerial maps of key areas and always addresses and the personal details of key targets distinguishing between dealers, user-dealers, runners, etc. Details of pick up points, mobile phone numbers, car registrations, firearms were provided if available. These reports were 'innovatively' shared with all Project Board members.

Target Hardening and Test Purchasing

This scoping report also utilised formulae to estimate the size of the local drugs market (see Annex 1) based on recorded drug seizures, arrests and drug treatment data. This community profile formed the foundations for targeted enforcement beginning with the deployment of Test Purchase Officers (TPOs).

The exact details of how a Test Purchasing Team sets up, protects 'undercover' officers and gathers evidence must remain confidential. Very basically, especially trained and supervised officers were deployed 'cold' into the market to establish themselves as drug users and involve themselves with the targeted individuals and their associates. During their fieldwork TPOs are usually able to collect large amounts of new, high quality intelligence which is passed back to the Mapping Team and the Operational Team (usually made up of staff from the Division hosting the targeted community). TPOs attempt to make repeat drug purchases which are carefully 'recorded' as eventual warrant, arrest and prosecution evidence (see Figure 2.1).

Figure 2.1: Overview of Mapping, Intelligence Gathering and Operation



Enforcement Operations

The Operational-Enforcement Team move towards arresting key targets once the TPOs have withdrawn. In some towns the scale of arrests at 30-50 individuals requires extensive planning in respect of deploying officers, setting up increased capacity in custody suites, ensuring adequate Police Doctor and Arrest Referral capacity, etc. Early morning raids over several days were often required with uniform and plain-clothes officers in transit vans serving warrants and undertaking full house/premises searches as well as named arrests. Small amounts of drugs and stolen property were often recovered.

The mass arrests of individuals operating in the local heroin market were well-publicised and always attracted welcome, local, media interest (see Figure 2.2)

Re-Mapping and Evaluation to Assess Outcomes

The Mapping Team would revisit the intelligence on each market several weeks after enforcement operations. This allowed the DDMP to partly evaluate the effectiveness of the Operation. Did new intelligence suggest dealing had ceased say in an open town centre marketplace or were there signs of new dealers moving in or bailed original targets continuing to trade? Had hidden elements of a market previously unknown come to light?

The **SPARC** evaluation team also conducted fieldwork in the market area, interviewing users, dealers, stakeholders and local residents. Through time the Mapping Team began to utilise these findings as part of its data assessment and the Evaluation Team relied on the Mapping Team to provide key monitoring information.

Figure 2.2: Local Press Reports Regarding Operations and the Outreach Team



Operation Ibis in Big Town and Surrounds

One large operation which was the Mapping Team's first main project occurred before the DDMP got fully underway and the evaluation began. Ibis took place in the north of the county effectively being a Police Division-wide enforcement involving a large town, its small suburb and two other small towns nearby. Using the methodology described above the Mapping Team provided profiles and targets which led to a series of operations and 78 arrests in total. In Big Town itself 39 people were arrested with 22

being charged with heroin/crack supply/possession type offences. In Big Town Suburb six people were arrested for heroin/crack related offences. In one of the other towns 6 targets were arrested of which five were charged with heroin/crack related offences whilst in the other town all 17 arrestees were charged with heroin/crack related offences. Operation Ibis was conducted over a one week period and was heavily publicised in papers, on radio and regional television. The publicity highlighted the integrated multi-agency function of the DDMP.

In retrospect a number of early lessons might have been learnt from Ibis which could have improved and informed the performance of the new Project. Firstly, by compressing the arrests into a few days, the Police Divisional Operations Team, despite the contrary recommendations of the Mapping Team, 'overloaded' the processing system. On one of the strike days 22 arrestees were brought into police cells, overstressing the arrest referral system and local court remand hearings. Secondly, the treatment-enforcement multi-agency partnership highlighted in the media 'scared' local problem users making them fearful of walking out locally. Not only did the local mainstream drugs service (CDS) not receive any new referrals but many users already engaged in treatment failed to keep routine appointments. Friends and relatives were sent out to 'score' for local heroin users committed to keeping a low profile.

Ibis was highly successful in obtaining a large number of arrests which led to a high level of convictions and prison sentences. The confidence in the Mapping Team and its methodology was able to quickly bed-into the Force. However, the complexities of successfully managing many arrests where drug treatment entry was on the agenda were evident especially in respect of Arrest Referral and divisional police managers tendency to make unilateral decisions. Moreover the 'paranoia' created by Ibis had the unintended consequence of undermining local problem drug users' attendance with local drug treatment services and was an unrecognised warning that twinning and publicly linking enforcement and drugs treatment would be problematic for the DDMP.

EVALUATION TEMPLATE FOR THE MAIN OPERATIONS

Soon after Ibis the full DDMP went on line. The Mapping and Evaluation Teams collaborated in developing an evaluation template for each of the 4 main heroin-crack markets in which the DDMP operated both its enforcement and drugs treatment-prevention arms. These were:

1. **Operation Quantum and 'Old Town'**
2. **Operation Ultimate and 'Market Town'**
3. **Operation York and 'Border Town'**
4. **Operation Flavour and 'City'**

In this Section a brief description of each market, the operational process and impact on various measures are discussed.

The main evaluation measures from an enforcement effectiveness perspective were:

- *Changes in recorded crime rate.* These were monitored by comparing recorded crime in the Beats making up the drug market area for at least a month prior to the Operation, Operation week/fortnight and 4 weeks post operation on 9 or more categories most likely to be affected, mainly acquisitive crime categories such as theft and burglary but also violence offences which might flow from an unstable supply market or treatment entry reducing offending behaviour.
- *Changes in drug related overdoses.* Disrupting the supply of heroin to a town could lead to either unpredictable purity of bags/points sold at street level or to users taking other substitute drugs such as street methadone or benzodiazepines. One unintended consequence of this might be increases in drug related overdoses and even deaths. Consequently all ambulance call outs for drug related overdoses were monitored by street pick up in the market area for several months before, during strike week/fortnight and for 3 months post operation. Where possible call outs were categorized by substances involved.
- *Calls to National Drugs Helpline.* Calls to the National Drugs Helpline were monitored by primary postcodes so that all calls made from the market area could be identified again before, during and after each Operation. It was usually possible to identify which substance triggered a call and the basic demographics for each caller (e.g. parent, user, 'friend'). This indicator was used because it was hypothesised that a dependent drug user without his/her usual supplies or their parents might call the Helpline to get details of local drugs services.
- *Remapping with Post Strike Intelligence.* The Mapping Team reviewed all intelligence for the market several weeks after the Operation in an attempt to assess the impact in terms of arrests, dealing sites and activity and other intelligence. A Public Attitudes Survey was carried out in the first 3 market 'town centres' to obtain feedback from local residents.
- *SPARC Evaluation Fieldwork.* The Evaluation Team, as well as monitoring the enforcement operation arrests etc., conducted detailed fieldwork in each drugs market. This involved interviews with local drug users, drug dealers and local stakeholders (e.g. shop owners, pharmacists, residents' groups) and community activists. Local problem users were recruited voluntarily via the Project's Treatment Outreach Team and the local mainstream service. From these interviewees some 'snowballing' took place whereby other users and dealers not in treatment agreed to be interviewed. Interviews were confidential and involved a semi-structured schedule. A £30 music token was given as a thank you for interviews which on average lasted over an hour, usually taking place in the respondent's home.

SPARC also obtained feedback from the drugs and community development workers in the Treatment Outreach Team and observed many of their activities and meetings in each community. All their treatment entrants were case tracked and most independently interviewed.

OPERATION QUANTUM IN OLD TOWN

Operational Activity

Old Town was a sprawling set of discrete communities with an overall population of 15,000 residents. This was a mixed community in terms of housing stock and affluence, hosting some relatively deprived neighbourhoods. Drug dealing was perceived to be concentrated in a small number of locations.

The Mapping Team had originally identified about 250 people involved in the local drugs scene. About a third were identified as dealers, with the remainder being classified as runners/couriers, user-dealers and local problem users. Over half lived in the area but the remainder did not. Old Town had a long-established amphetamine market but interestingly there was no intelligence about crack being used or sold prior to the operation.

Quantum, in retrospect, proved to be the most successful of the 4 operations. It benefited from outstanding strategic and micro management and a high level of commitment from the large number of proactive and divisional officers involved. The Test Purchase Officers were particularly competent and their modus operandi was highly successful in gathering further intelligence and purchasing 'evidence' for eventual prosecution. Old Town drug dealers were successfully targeted by this methodology. Indeed, as we shall see, the police work was so successful that it produced major shock and subsequent 'paranoia' amongst those involved in the market and not arrested. This unintentionally undermined the Treatment Outreach Team's credibility (see Section 3).

Operation Quantum made 32 arrests. Of these, 27 were charged with supplying crack/heroin or both. One was charged with supplying Ecstasy, which he was selling to fund his heroin habit, and two (man and girlfriend) were charged with supplying amphetamine. This male amphetamine dealer had been a problem in the town for many years and his subsequent 4 year sentence reflected this, and his antecedent history.

The small Probation Service Office in Old Town, although briefed about the DDMP's presence, was not able to cope with the sudden demand for 27 Pre-Sentence Reports generated by Quantum. Extra officer time had to be brought in to mediate the temporary workload 'crisis'.

During the evidence gathering phase of the operation it became clear that crack was being sold at "introductory" prices of £6.50 and £7 a "rock" in an effort to create a market of users. The investigative team, the mapping team, and in fact the whole of the police division feel that an opportunity was missed when the only pro-active capability on the Division was scrapped once the operation ended. Since Operation Quantum there has been no concerted policing activity against dealers in the town, the only activity being sporadic responses to actionable intelligence.

Talking Heads in Old Town

“Loads of us were noid up with plain clothes coppers. Like there were new people around and it was hard to trust anyone”

(Male user, 18 years)

“The Bloke I score off told me loads of his lads got done”

(Male user, 20 years)

“I just know that it was supposed to be a big clampdown on Old Town but there still seems to be a big gang of them (dealers) at the moment”

(Male user, 39 years)

“Up until recently we’d always had the same dealer but there’s new runners now. The gear’s shit coz it doesn’t run properly and it’s gone up from £5 to £7.50 a point (0.1-0.2gm bag) and it’s really shit”

(Female user, 29 years)

Database Indicators: Crime, Overdose, Helpline Calls

In terms of recorded *crime rates*, once force wide trends, seasonal fluctuations and the direct impact of mass arrests driving up drug offence categories were controlled for, there were no significant changes which could be easily related to Operation Quantum. Similarly there were no changes in the rates of calls for service from the public which could be attributed to any impact from Quantum.

There were no discernable changes in the number of ambulance call outs for drug *related overdoses* in Old Town. If anything call out traffic was slightly lower in the post operational period based on 6 months data compared with the same period the previous year.

Calls from Old Town to the *National Drugs Helpline* were higher in the period after Quantum compared with the year before (38 up from 21). The vast majority were from women concerned about their own drug use and 3 were about crack use. This increased call traffic cannot be directly attributed to Quantum although an association seems likely. However it provides useful information for planning future treatment provision (see Annex).

Re-mapping and Assessing in Old Town

The Mapping Team's initial post operational assessment suggested that the scale of successful arrests had temporarily disrupted the Old Town heroin market. There was less visible dealing for a few weeks. However numerous dealing sites and activity continued and/or restarted. There was no evidence of a drought'. The main supply network into Old Town remained functional.

A review of Old Town's drug markets 18 months after Quantum showed no organised open markets were in situ. However some open dealing occurs. In general heroin availability in Old Town remains robust. The crack market remains in development but competing enforcement priorities has meant no further co-ordinated operations have taken place.

The main success of Quantum was the number of successful arrests and the removal of a large number of minor dealers and runners from the community. Drug seizures were small via Quantum which is usual for Level 1 enforcement. The longer term 'success' has been to reduce visible dealing rather than disrupt regular supply and distribution of heroin or crack.

Independent Evaluation in Old Town

Community stakeholders and residents welcomed Operation Quantum and were impressed by the scale of the highly publicised arrests. The Public Attitudes Survey interviewed 40 people. Three quarters had heard about the Operation confirming its significance in this small community. However several weeks after the Operation residents/stakeholders noted that many of the 'bigger' dealers continued to operate, that new dealing 'faces' and cars were being seen and that house dealers continued to trade. The Beat Officers echoed this perspective, finding increased disappointment through time and a request that enforcement be repeated.

Fieldwork interviews with a key local observer (former user/dealer now community worker) and 13 local problem users, 2 of whom had been arrested and bailed in the Operation, confirmed that the heroin market had recovered quickly in Old Town. Two town level dealers who supply the street level markets were continuing to operate. New operatives/runners were recruited and the market reconfigured within weeks. It was also apparent that Old Town users were able to travel to nearby towns or the main city to score without difficulty. Crack users remain the minority in Old Town but with trying and occasional use bedding-in.

In short, the qualitative fieldwork confirmed the Mapping Team's assessment. The Old Town market 'suffered' for a few weeks with heroin purity unpredictable but generally lower and good deals in short supply. Two important local dealers had been taken out but the remainder of the arrests were of user-dealers and runners who were quickly replaced. The market recovered but with lower visibility and more discrete retailing.

OPERATION ULTIMATE IN MARKET TOWN

Operational Activity

Market town is an ancient community with 3 main townships – Central, Dale and Hillside with an overall population of 22,000. Market town is relatively affluent, has a low crime rate and presents as a picturesque, old fashioned English town.

The Mapping Team's first scoping identified 148 individuals involved in the local drug scene, with the majority living locally. In particular Central, the town centre community, had a semi-visible heroin street market. Overall 80 individuals were thought to be dealing heroin with most being users themselves. Several dealing sites both in the town centre and more rural locations were identified. Whilst Market Town's Level 1 market was mostly populated by user-dealers, the town was supplied from at least 3 main out of area sources.

Operation Ultimate followed the methodology and format described earlier. From the scoping and mapping key targets were identified and Test Purchase Officers were deployed in both Central and Hillside. Ultimate, from a police perspective, was not as successful as Quantum and suffered from several challenges and contingencies. Firstly, the TPOs, whilst highly successful in penetrating and purchasing from the town centre open market, were unable to operate in the Hillside community. Whilst Hillside undoubtedly had both heroin users and user-dealers within it, the TPOs were viewed with suspicion and 'rumbled' as police officers and had to withdraw. Secondly, in the midst of the operational planning in Central and during pre-strike week, a main, outside heroin supplier came to Market Town seeking vengeance for the death of his brother (also a target) from a drugs overdose. Through a mixture of intimidation and violence, the Central market was seriously unsettled and normal activities disrupted. This unexpected instability in the market partly undermined Ultimate's effectiveness.

Despite these setbacks it was decided to complete the Operation and 16 warrants were executed in Market Town leading to 16 arrests and one further arrest in connection with the external supplier's network. Of the arrestees 11 were charged with supplying heroin and 3 with supply or being concerned in the supply of ecstasy and 4 with possession offences. There was no evidence of crack being available locally during this operation.

Database Indicators: Crime, Overdoses, Helpline Calls

In terms of recorded *crime rates*, the 8 weeks prior to Ultimate were compared with strike week itself and the subsequent 6 weeks using 9 recorded crime categories. Taking into account seasonal fluctuations, tourism months for Market Town and overall force crime trends, no significant effect on recorded crime could be attributed to Operation Ultimate. One possible fall in recorded shoplifting could be related to 5 arrestees being remanded in custody over the post strike period. However as there are only a handful of recorded offences each month, no significant positive outcome can be attributed.

Derbyshire Drug Market Project

In terms of *drug related overdoses*, aside from the dramatic overdose death of a target, there were some interesting findings when a year's call out data was analysed. December was the only month of 12 when no call outs were logged and this corresponded with the strike week. Thereafter overdose call outs returned to between 4-10 a month. A disproportionate number of call outs came from the Hillside area which had a closed drugs market.

The town's rate of calls to the *National Drugs Helpline* seemed unaffected by Ultimate but with a small downward trend after strike week confirming that users were not seeking help as a consequence of supply disruption. The calls from Market Town over a 12 month period totalled 38. Importantly half were from parents enquiring about their children's drug use – mainly heroin and cannabis. This, as we shall see, fits the profile of Market Town as hosting particularly young heroin users.

Remapping and Assessing in Market Town

The Mapping Team produced both their post-operational report and the re-scoping report a few months after Ultimate. From their intelligence sources the Team concluded that the open, semi-open street market dealing sites in the town centre had been disrupted and displaced. The majority of dealing activity has either moved or takes place from residential addresses. The supply of heroin to Market Town has been disrupted by other Level 2 enforcement activities, all making heroin hard to buy at street level. There were signs of new dealerships with outside connections setting up however. Hillside continues to be a closed market with almost no intelligence available. The buoyant pub/club drug scene in and around Market Town remains in place.

Further re-mapping over a year after Operation Ultimate confirmed that the Central open market remains displaced. This is a result of continued, primarily stop and search, enforcement by the Rural Crime Team. This on-going enforcement, lacking in the other small town markets, has sustained the 'gains' experienced by local Old Town residents in terms of public perceptions of street safety and the value of targeted enforcement.

Independent Evaluation in Market Town

Operation Ultimate was highly publicised in the local media. The police organized public attitudes survey undertaken in Central's town centre confirmed this. Of 19 respondents 13 had heard about police enforcement activities in Market Town via talking to other people in the town, newspapers, television and radio. The majority of the sample supported targeted enforcement against local drug markets although less than half felt their community was safer as a result of Operation Ultimate.

Interviews with local stakeholders were consistent. Most confirmed the semi-open market in the town centre had been disrupted/displaced and perceived this as a positive outcome as the town 'feels better' with problem users-dealers no longer visible at the rail station and other public areas.

Professional stakeholders (e.g. Homeless Team, Probation Service) were slightly more sceptical however. They had actively worked with several of the arrestees who had housing, mental health, 'offending' and social problems and whilst not denying their criminality and involvement with heroin felt that little would be achieved by simply imprisoning and then releasing these user-dealers. Half the arrestees were already in structured drugs treatment.

SPARC fieldwork involved in depth interviews with 11 dealers, user-dealers and local problem users variously connected to Market Town's hard drug market. These confirmed that the intimidation and violence meted out just before Ultimate had alarmed the local players. Ultimate had successfully 'entrapped' the town centre marketeers in that many of the user-dealer-runners had been arrested. However actual dealing activity was felt to have re-established itself within a few weeks albeit in new venues and in a re-configured internal network. No external suppliers/dealers had moved into Centre 3 months after enforcement.

Whilst obtaining heroin had been more difficult immediately after operational activity, several alternative 'strategies' had prevented a local 'drought'. Firstly, numerous house dealers and dealers outside the intelligence data continued to operate. A couple of bailed arrestees also returned to their dealing activities. However the main alternative approach from local problem users was to travel to nearby towns and follow up known contacts to obtain supplies. Interviewees also referred to a small diverted medications market operating in Old Town whereby methadone and benzodiazepines could be purchased as 'top up' or heroin substitute drugs.

SPARC's own scoping of Market Town's drug markets estimated that there were between 200-250 problem drug users in residence. However with heroin only bedding-in from the mid 1990s this user population was younger with smaller habits and generally less involved in offending (see Annex 1) than in the other markets. Most continued to live with parents/relatives and be more 'bonded' to conventional lifestyles than in Old Town for instance. Crack use was not evident in Market Town.

Talking Heads in Market Town

On the outside supplier coming to town:

"They busted into our flat and held a gun to my boyfriend's neck and told me to leave the room coz they were going to kneecap him. I refused to leave....we got talking about what they'd come for and it turned out they'd got their facts wrong"

(Female, 20 years, user-dealer)

On Operation Ultimate's impact:

"I think everyone's still a bit paranoid about it. But it settled down within a few days although I'd say it's all only been back to normal for a month or so"

(Male, 21 years, user)

"For about 2 days after the raids everyone was rattlin. I know some who left the area cuz they couldn't score"

(Male, 18 years, user)

"Me sister's ex-boyfriend was the top man. He's out on bail at the moment and he's started selling again"

(Female user, 29 years)

"Not much impact, they've just got users and one mainish dealer. It's made things worse coz people (users) are selling it now – just selling for their habit"

(Female, 21 years, user-dealer)

"I think there's only one dealer left. Sometimes we've been to 'Big Town' or 'Eastside'...and 'City' once or twice"

(Female, 21 years, user)

"Methadone [street purchased] lasts longer than heroin but since the busts it's been as rare as rockin horse shit"

(Female, 21 years, user-dealer)

OPERATION YORK IN BORDER TOWN

Operational Activity

Border town is found in a valley on the edges of Derbyshire and close to a large regional conurbation just across the county border (ie. Greater Manchester). This town of about 9,000 residents is a traditional 'white' community with a relatively low level of recorded crime. Border town is relatively impoverished compared with the Derbyshire average multi-deprivation score. Importantly the main road into Manchester out of Derbyshire runs by Border Town.

The Mapping Team's initial scoping of Border Town identified over 200 people involved in the local drug scene. Around 50 were believed to be dealers. Most users with intelligence against them were heroin users. Active club drugs and cannabis scenes were also identifiable from intelligence sources. Numerous dealing and using areas were identified in the initial mapping. The initial scoping prioritised 16 target dealers for Operation York to focus on and passed on the usual profiles, photographs and association/intelligence charts.

Two TPOs were deployed in the town centre of Border and quickly established contacts with a view to purchasing heroin. The TPOs also gathered a lot of high quality intelligence about 'new' dealers which the Mapping Team followed up and issued additional profiles via intelligence charts.

Operation York was delivered over a two-day strike period, a more concentrated period than for the other operations. Of 12 arrestees nine were charged with supplying heroin, two with possession of heroin and one for possession of cannabis. All were previously known to the police. Whilst these arrestees dealt several different drugs 10 were 'linked' to the heroin market. Three arrestees lived outside the town. Importantly again half were already receiving structured drugs treatment!

Database Indicators: Crime, Overdose, Helpline Calls

In respect of *recorded crime rates* these were very low in Border Town with some categories only registering single figure reports in any one month. The 4 weeks prior to strike week were compared with strike week and the post operational month on key offence categories. Taking into account seasonal fluctuations and force wide trends, there were initially no changes in reported offences which could be directly related to Operation York. The offence with the biggest atypical fluctuation was 'assaults' (+86%, comparing pre and post operational periods) but their reportage began increasing prior to strike week. Whilst recorded crime was higher in the post-enforcement period, so were divisional and force level figures.

Interestingly the length of custodial sentences given to most York arrestees was unusually severe and even surprised the Police. At time of sentencing, several months after the Operation, an unexplained fall in several assessed offending categories occurred. It is possible that these heavily advertised draconian sentences unnerved local offenders who either reduced their offending rates or travelled to commit crime.

Derbyshire Drug Market Project

In respect of *drug related overdoses* data analysis was problematic. Border Town often received ambulances from out of county (i.e. from Greater Manchester) but it was not possible to satisfactorily collate data from two ambulance services. Overall there was no evidence of an increase in call outs in the post-operational period and the number of callouts remained very low.

Border town residents very rarely call the *National Drugs Helpline* compared with other towns in the county. There were only 8 calls (2 unfinished) across the pre and post operational 6 months and no trend or 'blip' was identifiable.

Remapping and Assessing in Border Town

Initial re-mapping suggested the various town centre open dealing sites were no longer in use and this market had been successfully displaced or possibly eliminated. A year later this remained the case with no significant open dealing being recorded. Once again, certainly in terms of community safety and community perceptions, this is a long term operational success and identifiable positive outcome.

Independent Evaluation in Border Town

The Mapping Team had independently identified the significance for Border Town of being so close to Greater Manchester. They noted that the supply routes into Border Town were from towns and city estates across the border rather than from Derbyshire. Many of their targets' supplies had known addresses across the border.

The **SPARC** fieldwork included interviews with stakeholders and local professionals but most importantly 17 user-dealers, 'retired' suppliers and problem users both in and out of treatment. Two subjects had been arrested in Operation York but saw the evaluators as independent and agreed to interviews in their own homes. All concurred on several issues in relation to Border town's heroin-crack market. They confirmed that almost all arrestees were involved in the semi-open town centre market and were themselves dependent users 'grafting' to support their habits. (Indeed 6 of the arrestees were in structured drugs treatment and several used the local pharmacy needle exchange). It was widely agreed York further disrupted and undermined an already disorganised and variable open heroin market. It was also stated that their supplier was untouched by the enforcement and was still operating more discretely and re-recruiting runners or 'bagboys'.

Almost all the subjects identified the significance of the Greater Manchester's drug markets in servicing local problem users. It was felt that most 'organised' users in Border did not use the 'unreliable' town centre market anyway but went into Greater Manchester for their supplies. The main attractions of travelling were *regular robust availability, better deals* and the facility to *bulk buy*. The Border travelling users purchased from suppliers who dealt both heroin and crack and promoted the purchase of both with special offers and discounts.

In short, Operation York had further undermined the already unreliable town centre market and its clutch of customers. However, many users and user dealers were serviced

by the out of town cross border markets which were unaffected. It seems likely that low level dealing and purchasing has transferred to these out of town markets or dealerships outside intelligence.

Talking Heads in Border Town

On Operation York in the town's open market:

"Got the dealers? Yes in a way but a lot of them were ones who were getting their own (habits) sorted by buying in bulk (and selling on)"
(Male, 33 years)

"Most were junkies they arrested not drug dealers"
(Male, 32 years)

"They're faffing about, sometimes they have gear sometimes they don't"
(Female, 22 years)

"Those who do it now alternate so they don't get complacent, regularly swap about amongst themselves. One does it for a couple of days then they swap"
(Male, 35 years)

On buying drugs out of town:

"It costs too much around here so I buy it in Manchester. Can always get hold of heroin and crack as long as it's at a reasonable time"
(Male, 36 years)

"It's been more difficult but no really stopped anyone. A few will go into Manchester for better deals. In town you get about 3 times as much"
(Male, 35 years)

OPERATION FLAVOUR IN CITY

Introduction

The DDMP's original specification targeted 2 heroin/crack markets in City and its club drugs and the night-time economy. The debate about mapping and enforcing (and providing treatment) in respect of heroin and crack markets in the main city was one of the few major serious disagreements the Project Board and staff suffered. These politics of inter-agency partnerships and differing stakeholder priorities are discussed in Section 5. In the end deployment into 4 of City's heroin crack markets challenged both the Project's feasibility and the evaluation methodologies.

Operational Activity

City has a population of 222,000 residents and is the most multi-ethnic area of the county with 10% of the population being from visible ethnic minority groups. As with most cities deprivation is higher in many neighbourhoods than the county norm. The targeted hard drug markets were 4 inner city communities including one open heroin-crack market found in a 'notorious' area also hosting an open sex market.

With vast amounts of constantly evolving intelligence and continuous diverse enforcement the Mapping Team's scoping report identified nearly 900 individuals known to be connected to these markets, of whom 350 were dealers. This scoping illustrated the enormous complexity, diversity and dynamic nature of the inner city heroin/crack markets. With several discrete dealing 'gangs', numerous supply sources, ethnic minority involvement, a wide range of dealing and retailing techniques, even the 'known' picture was highly complex. From this scoping and several strategic confidential inter-agency meetings, it was 'agreed' that Flavour should go after at least a hundred arrestable targets.

Operation Flavour was somewhat buffeted and undermined by a whole set of complications and contingencies and illustrates the difficulties of 'delivering' in planned ways. Firstly, an expensive *Crimestoppers*' campaign encouraging anonymous information from the public about inner city drug markets was launched prior to operational deployment. Forty-one calls were made to *Crimestoppers* during this period. All were researched but very few contained actionable intelligence as there was little corroboration held or found during observations. As a result, only a very small number could be followed through with warrants because Magistrates will not issue warrants on anonymous information unless it is corroborated. Interestingly, one of the addresses mentioned in a call had featured in the last three *Crimestoppers* campaigns in the City, and yet the police had no other intelligence from any other source about it, and observations failed to give any corroboration.

Secondly, test purchasing was not successful in all the target neighbourhoods. Two areas with semi-closed heroin-crack markets could not be successfully penetrated. This put pressure on the timetable and slippage began to accumulate. Test purchasing was more successful in City's open drug heroin/crack market where user-dealers and small time retailers were more prevalent and transient. Flavour in fact revised the operational methodology and included surveillance tactics to identify home addresses and 'stash' which led to more drug recovery than in the other operations (£130,000 worth of seizures including much cannabis).

Flavour's planned strike fortnight in the end stretched to nearly 3 months. Further slippage was created by operational resource difficulties, difficulties finding targets and the need to abort certain strikes. In particular one planned raid involving a fully 'kitted' rapid entry team had to be aborted moments before entry to a hairdresser's shop because of the presence of children on half term break playing in the street!

In the end Flavour made 52 arrests, however only 22 were for heroin/crack supply type offences plus 6 for possession. Fourteen were arrested for cannabis supply / cultivation / possession offences and seven arrestees were not charged. Eight arrestees were regarded as more serious local dealers resting above Level 1. Flavour was the one operation that managed this.

Operation Flavour was not able to reach its original target of 100 heroin/crack dealers. Its difficulties must be understood in the context of much wider enforcement activities in City however. Flavour was one of several major operations against Level 1 and 2 markets undertaken over a 12 month period. Numerous important arrests were made through these operations and test purchasing had been extensively employed. Flavour's test purchasing difficulties were, in part, adversely affected by this *modus operandi* becoming known to drug market players. Test purchasing has poor outcomes in the better organised and cautious closed markets. There was perhaps also a sense that operational staff in the city were less enthusiastic about the DDMP approach than in the county town divisions. Flavour was also buffeted by shifting priorities in a busy inner city police division.

Database Indicators: Crime, Overdose and Helpline Calls

In relation to recorded *crime rates* it proved difficult to identify any effects of Flavour or indeed isolate them from other parallel enforcement activities. There were over 10,000 offences recorded in the market area in the 3 month period in which the operation occurred. The Mapping Team monitored recorded crime in 18 offence categories over a robust year long comparison period. Allowing for seasonal fluctuations there were no changes in overall offending rates attributable to Flavour. Increases in theft of cycles remained unexplained¹ but in general any changes in recording rates seemed independent of Operation Flavour.

In terms of *drug related overdoses* 18 months of ambulance call out data were examined in detail. In respect of heroin there are about a dozen cases a week first assessed as heroin related. These came disproportionately from the targeted drug market areas. There was a small increase in the post-operational period which could have been related to Flavour having an impact on purity levels or times of availability at the point of sale.

The *National Drugs Helpline* receives between 10-20 calls a week from City, almost all coming from the targeted market areas. There was no change during and immediately after the strike period. Most callers were given the contact details for local drug services.

Remapping and Assessing in City

All the arrestees in Flavour were already known to the police and whilst 15 of the 52 had no previous convictions most had multiple antecedents. The Mapping Team had difficulty in isolating the impact of Flavour from the extensive range of other enforcement operations whereby 158 people were arrested for drugs offences across the operational period.

¹ SPARC interviewed a prolific bicycle thief however who sold on to an organised fencing network in City to fund his drugs habit

The remapping suggested that some disruption had occurred that could be tracked to Flavour but that the general picture was of market replacement and reconfiguration. Open dealing in the 'notorious' market remains in place. Importantly the police were producing new intelligence about the increase of outside supply groups seeking business links with the internal market place and the increased incidence of firearms which the Mapping Team highlighted in their follow up reports.

It was always predicted that post-operational drug market mapping to assess impact would be problematic in a busy complex city market environment and this was the case. It was almost impossible to attribute cause and effect to one operation in a large complex drug market with numerous parallel enforcement activities being undertaken.

Talking Heads in City

On Enforcement:

"I think there's been one more bust but little evidence of it on the street...they're just catchin the wrong people – the junkies not the main ones"

(Male, 33 years)

"I think the police are trying but as soon as they take one out there's another one to replace them. I think heroin is the main drug round here. I'd say it was as available as cannabis was when I was 16"

(Female, 30 years)

"I heard there were some undercover police askin to score"

(Female, 24 years)

On ready availability of heroin/crack:

"I usually score from 2 regular dealers who would drop off at the supermarket or I'd go to [Other Dealer] to get it. If I was needin' more and couldn't arrange it with my regular dealers there's a few round here, one of them's a taxi driver but their stuff is not so good"

(Female, 30 years)

"On Giro day I'll buy a 1/16oz [1.75g] for £50, there's a group of us about 20-30 who'd all pitch in on this....it depends whose Giro day it is"

(Male, 29 years)

"In some places you can get a stone/crack for £10. You can get crack and heroin in the same bag for £20"

(Male, 29 years)

Independent Evaluation in City

The size of the market area made detailed observational and qualitative fieldwork in each neighbourhood impossible. Some public attitudes fieldwork was conducted by the DDMP treatment staff before and after Flavour in one neighbourhood. The first survey consulted 98 individuals. Most respondents wanted more drugs enforcement in the area.

SPARC obtained 22 interviews with drug market players including dealers, stashers, sex workers, runners, bulk buyers and prolific drug related offenders. Most saw police 'raids' and 'undercover work' as on-going and could not easily identify Flavour. Many noted that more 'intelligent' market players now understood the test purchasing methodology and will not sell to strangers. They recognised the impact of on-going enforcement on the markets but described a city with such a range of dealerships and supply networks that heroin and crack can almost always be sourced 24/7. Most cited the price reductions in crack and heroin over recent years and the tendency for both drugs to be marketed together. They described a wide range of deals to be valued by a price – weight – purity formula. More expensive £10 heroin deals were believed to weigh 0.2 gms and would usually be of higher quality and were provided with 'customer care'. Street level £5 deals would often be less pure, of varying weight and sold by less 'respectful' retailers.

This continuing ready supply at all hours from a wide range of outlets with some real price reduction indicates the 'impossibility' of enforcement seriously disrupting hard drug markets once they had bedded into a complex urban environment.

OPERATION IMPACT IN MIDSHIRE TOWN

As the main DDMP drew to a close the Mapping Team, prior to its redeployment, undertook a profiling of Midshire Town. The Outreach Team were not deployed in Midshire and thus Operation Impact was a discrete mainstream enforcement operation. Impact showed that detailed mapping and test purchasing led to more significant arrests around heroin than traditional police methods had done for several years in this area. Seventeen arrests – 16 for supplying heroin – were made over three days. Eleven arrestees received custodial sentences. Importantly, original intelligence from this operation that most dealing was within Midshire centre proved incomplete. It was found that dealers were spread throughout a number of neighbourhoods, small towns and villages loosely connected into the local heroin market. Users would visit whichever dealer had supplies at the time and travelled extensively sometimes across the border to sources in Nottinghamshire. This reinforces the general finding of the DDMP that it is not possible to create a drugs drought through even the most extensive enforcement because there are so many sources of retail supply which, themselves, continue to evolve and reconfigure often beyond the reach of localised police intelligence.

The arrests had the usual impact of closing down an open town centre market which has still not re-established itself. The moving of groups of users from the town centre

was again welcomed by locals and, particularly, shop-keepers. The arrests were given publicity in the local weekly newspaper, and there was a confidential briefing before the arrests started. This was followed by a presentation to the local Police Consultative Group, which met, by coincidence, a week after the arrests. Local officers also welcomed the arrests of this particularly troublesome group of dealers.

The fact that some of those arrested as dealers were also known persistent offenders meant that there was a small fall in crime during the arrest period, and may well have a cumulative effect on crime rates as they are sentenced.

LEARNING POINTS. THE MAPPING AND ENFORCEMENT ARM

Drug Market Mapping

The techniques utilised by the Mapping Team are being increasingly recognised as best practice around UK police services. What the DDMP demonstrated was how this methodology could be effectively employed at Level 1 community based drug markets. In particular drug market, intelligence-led, mapping seems a cost-effective approach to deploying limited police resources in towns. The scale of the arrests in each market suggests such an approach should become routine across all forces. The other particularly effective feature of the Mapping Team's methodology was the ability to re-map and re-scope a drug market after enforcement. This provides a useful outcome assessment and pointers to further enhancing effectiveness in future operations. Delivering follow up enforcement is another matter.

It must be said, however, that Drug Market Mapping based on 'intelligence' only captures elements of a local heroin/crack market structure for a particular area. The Mapping, however proficient, can only be as good as the information inputted and in practice police intelligence will always be incomplete. The level of resources and range of techniques which would be required to produce a comprehensive map will always prevent such a complete picture being produced.

Operational Success

Table 2.1 summarises the enforcement outcomes by operation. One hundred and forty seven heroin/crack related convictions were secured, the vast majority of which resulted in a custodial sentence.

Table 2.1: Summary of Operational Outcomes in Six Main Drug Markets

Market	Total Arrests	Heroin/Crack Arrests	Heroin/Crack Convictions	Custodial Sentences
<i>Operation Ibis</i> <i>Big Town & surrounds</i>	78	56	51	46
<i>Operation Quantum</i> <i>Old Town</i>	32	27	27	25
<i>Operation Ultimate</i> <i>Market Town</i>	16	11	9	9
<i>Operation York</i> <i>Border Town</i>	12	9	9	9
<i>Operation Flavour</i> <i>City</i>	51	28	23 (plus 2 trials pending)	21
<i>Operation Impact</i> <i>Midshire Town</i>	17	16	16 (8 sentencing pending)	7
Totals	206	147	135 (plus up to 2 more)	117 (plus up to 10 more)

The public attitudes surveys and evaluation fieldwork confirmed that community residents and stakeholders were very positive about these high profile mass arrests in drug markets, particularly where open dealing is prevented or displaced. The important reservation however is that the appreciation tended to be replaced by scepticism through time. A few weeks after one of the town operations the evaluation found concern amongst residents and community stakeholders that visible dealing had returned sometimes in new forms and with new faces. Beat officers bear the brunt of this scepticism, concern and demand for renewed enforcement. However in both Market and Border towns the open markets have been displaced for over a year.

The five police divisional managers in which town operations were undertaken all offered positive feedback about the mapping and scoping of the hard drug markets. In general the scale of arrests and the high rate of convictions and custodial sentences were perceived as excellent 'results'. Clearly this approach facilitates the delivery of annual enforcement targets. Level 1 enforcement does not produce extensive drugs seizures however. Apart from in City where the DDMP methodology was enhanced with surveillance, the DDMP operations found few drug stashes.

The heavy reliance of test purchasing in enforcement of Level 1 markets has, in general, proved appropriate. In Old Town and Border Town this modus operandi proved very effective. However in Market Town, the Hillside closed market and in City in two semi-closed neighbourhood markets the TPOs were completely unsuccessful. The regular repeat use of test purchasing in the same markets will produce diminishing returns through time except in very dynamic and cluttered, open drug markets where many 'disorganised' street retailers will remain susceptible (see also *May et al*, 2000). Wiser heads will simply not sell to strangers.

Limits of Disruption

The evaluation literature on drug market enforcement in the UK has concluded that even targeted major operations against city hard drug markets have little lasting impact on supply and retailing. The DDMP has tested the hypothesis that such enforcement might be more effective in small communities, especially rural towns. The conclusion after several market town operations is that even in such areas it is not possible to create a 'drought' or seriously disrupt dependent users' access to heroin and crack. In each of the three town markets dealers and users were able to access their supplies by finding new sources or recontacting old sources in new configurations/venues, etc. What the evaluation has noted is that open town centre type markets can be closed down and kept closed with quite basic policing responses at the first signs of re-emergence. Finally, the Mapping Team have regularly recommended follow up enforcement on the back of their post operational re-scoping but this has not been taken up. A further experiment is required to assess whether repeat targeting is cost-effective.

Unintended Consequences Averted

There were two potential unintended consequences of targeted enforcement in heroin/crack markets which have been monitored. Firstly, by disrupting Level 1 heroin supplies there is the danger of increasing drug related overdosing as a consequence of unpredictable purity levels and interrupted 'dosing' timetables when supplies are undermined. Moreover the use of substitute drugs such as 'diverted' benzodiazepines and street methadone, a common remedy when heroin cannot be obtained, is particularly associated with accidental overdosing. There was no evidence of overdosing increasing significantly directly after the four main Operations although in City a small increase was noted.

Secondly, in removing key local players from the Drug Market, arrests can destabilise the market and its internal equilibrium producing conflict about business, territory and 'staff', etc. Particularly where crack is concerned this may well promote intimidation, violence and firearms incidents. Whilst violence did descend on Market Town this was not directly related to enforcement. In City there is strong evidence of outside groups trying to move into the local heroin/crack markets, of inter-group conflict and several firearms incidents. It was difficult to identify any of this as being directly related to Operation Flavour however.

SECTION 3 THE TREATMENT OUTREACH TEAM: AN EXPERIMENT IN DRUG TREATMENT DELIVERY

RECRUITMENT AND DEVELOPMENT

The setting up of a fully staffed Treatment Outreach Team was not straightforward, there were difficulties in recruitment and considerable timetable slippage before a full complement of staff was in post. The complete team included a team leader with community development, training and networking skills and five drugs workers, one to focus on arrest referral and follow up work and four to provide assessment groupwork and key working. In theory an appropriate sessional doctor was to be sub contracted to the project as it moved around the county with 4-6 month placements in each market area. The team had an excellent administrative office base but obviously also had to find premises in each community they were seconded to. They located themselves in eight different venues over the life of the project.

These three issues of recruitment and retention of staff, especially managers, problems with obtaining prescribing doctor-clinical sessions and finding and retaining appropriate venues for delivery of a highly localised direct access service, challenged the Team throughout.

THE OUTREACH TEAM IN OLD TOWN

Advertising the Outreach Team

The Team set up with enthusiasm and apprehension in Old Town. Operation Quantum has been widely trailed as a 'partnership' approach between local agencies concerned about the local heroin problem, with the 'treatment outreach team' being introduced by police led press releases and media events. This advertising and the team's initial title of The Market Response Team were, in retrospect, ill-advised.

Direct Treatment Work in Old Town

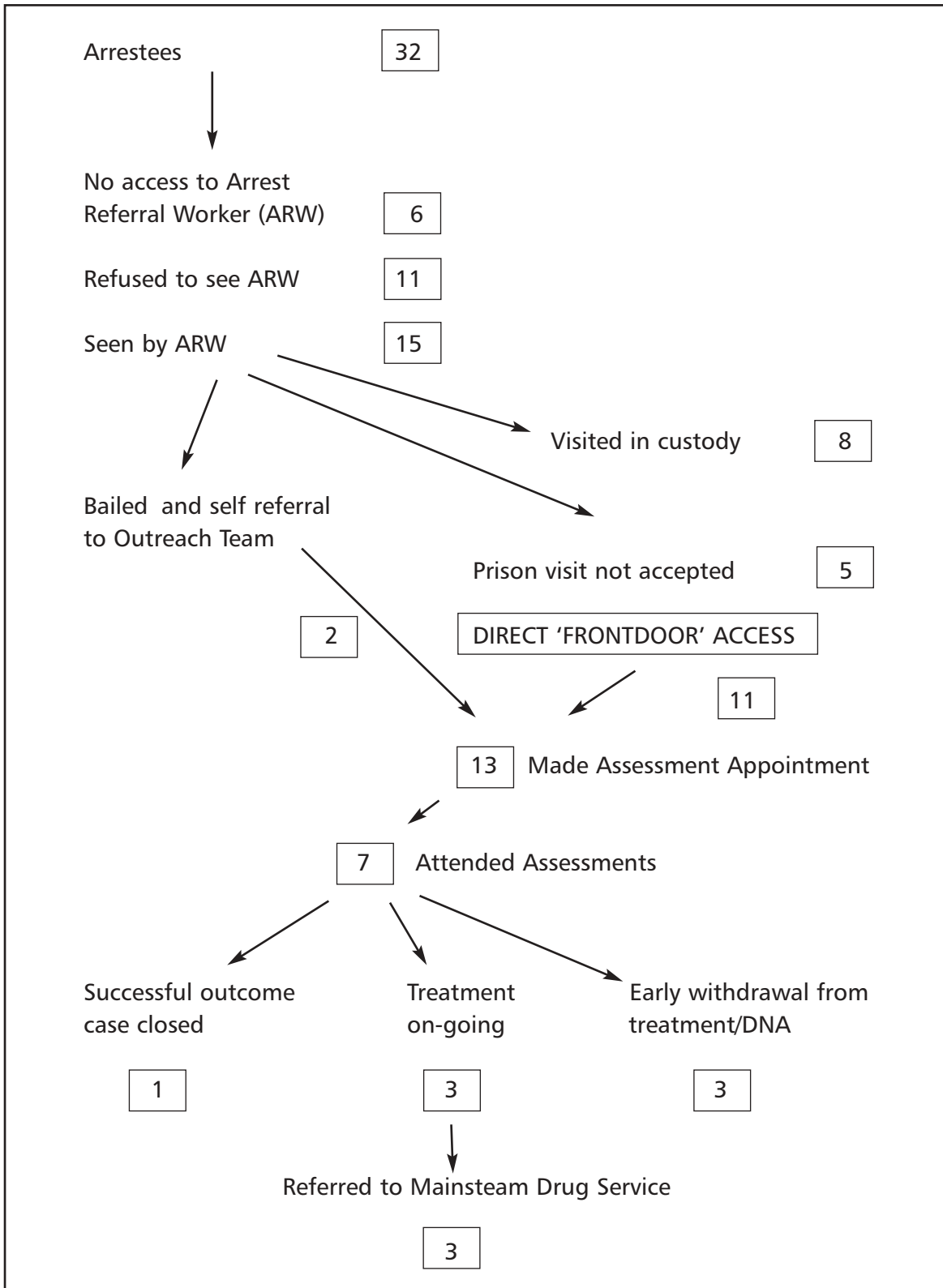
The 'Response Team's' primary task was to offer immediate direct access for local people to a broad range of treatment services from advice, harm reduction and information to full access to structured treatment. The initial goal was to provide an arrest referral for the Quantum arrests (n=32). The service was heavily advertised and set up in rooms in a thriving local community centre. In this secondment it also offered Hepatitis screening and vaccinations (a service seen to be highly cost-effective, over time, in the original planning).

Unfortunately only a small number of clients were picked up by the arrest referral process linked to Quantum and only 13 drug users made 'front door' access over the four months the Team was actually in place. Figure 3.1 provides an overview.

Derbyshire Drug Market Project

Arrest referral contact work was fairly successful if we include follow up work visiting arrestees remanded in custody. Of the eight visited in custody all eventually received custodial sentences however and were never able to become service users of the Outreach Team. Two bailed arrestees did self refer to the Outreach Team.

Figure 3.1: Outreach Team's Treatment Outcomes in Old Town



In terms of entry into structured treatment, 13 individuals made assessment appointments of which seven attended. Six were problem heroin users and one male adolescent 'petrol sniffer'. His case was successfully discharged. However 3 of the 6 heroin users quickly dropped out of treatment. The other 3 cases were transferred to the mainstream service at the end of the secondment.

Community Development in Old Town

A key goal for the DDMP was to help empower local, often relatively, deprived and insular communities to collectively organise against street level heroin and crack markets. The Outreach Team was very active organising and attending meetings with both statutory (e.g. Connexions, Probation, Housing) and voluntary services (e.g. Community Action Projects, Residents Groups). Overall this was the most successful delivery of community development across the whole project. There was a survey of local youths' views on drug problems. A community action group was encouraged into life and a county wide support group for parents with drug using family members was helped to set up in Old Town. Drugs awareness sessions were attended by about 20 local residents.

The Outreach Team did not attempt to target 25 'at risk' young people from Old Town to undertake preventive work in respect of drug use. The Project struggled to see how this could be delivered without running the risk of starting work with vulnerable young people it could not sustain. Nor did it provide drugs awareness sessions in local schools.

Conclusions and Learning Points from Old Town

It was clear from the **SPARC** fieldwork that the '*Market Response Team*' was suspected of co-working or being in collusion with the Police. Several interviewees suggested that local problem users would not attend the service because they could not be certain of its integrity and independence. The Outreach Team actually suffered from the success of Quantum in arresting so many local dealers and user-dealers. The evaluation team suggested a change in approach and the 're-badging' of the Outreach Service in future market areas.

The community development component of the team's work went very well and they made a credible and creditable impact in the local community during their stay. The parents' group was not sustained but the action group did continue to operate for over a year and now awaits suitable premises to be refurbished.

Although the arrest referral process went tolerably well we see the attrition of potential treatment cases throughout whereby problem drug users are not easily retained in treatment. Only 4 cases were either successfully closed or transferred. Prescribing primarily followed a detoxification approach.

There were some genuine leadership and micro-management problems for the Team and the Project Board accepted the evaluation recommendation that a Chief Executive be appointed.

Old Town showed that partnership and an inter-agency and community stakeholder involvement could be effective and that the Police and Treatment Services could share information and enjoy each other's growing trust. However an unintended consequence occurred at street level in that the local drug market and user fraternity saw 'partnership' as undermining the integrity and independence of drugs treatment. Importantly a new permanent 'Addaction' badged mainstream service satellite was set up in Old Town soon after the DDMP left and quickly attracted large numbers of local problem users, further confirming the reality of the 'noid up' effect. (See Figure 3.2)

THE OUTREACH TEAM IN MARKET TOWN

Advertising the Outreach Team

The Outreach Team, still struggling to find an appropriate management system, were slow in re-badging and went into Market Town continuing as the 'Market Response Team'. They advertised themselves extensively through the local media and writing to almost every relevant statutory and voluntary agency seeking referrals. The new premises were of high quality in a dedicated terraced house on a 'small business' row. Unfortunately the premises were only 3 doors away from the Police Station, again encouraging 'suspicion'.

"A lot of people think they're connected to the police. I mean they've set up a couple of doors away from the cop station....When I saw their ad in the local paper I thought it was really bad wording....'in conjunction with the police'"

(Male, 37 years)

Direct Treatment Work in Market Town

Given Operation Ultimate was a small enforcement most new cases had to be generated through front door access. Through poor strategic management at the time the Arrest Referral work was not undertaken by the Team. This custody suite work was undertaken by the county's main drug service. Of the 14 arrestees only 2 took up referral to the Outreach Team. Unfortunately in terms of several months open door access the same poor uptake re-occurred with only 9 service users coming in. However all were heroin/poly drug users. As Figure 3.3 shows one case was successfully treated and closed and 5 were retained in treatment across the secondment. However the same attrition was evident with only 3 transferring to the mainstream service.

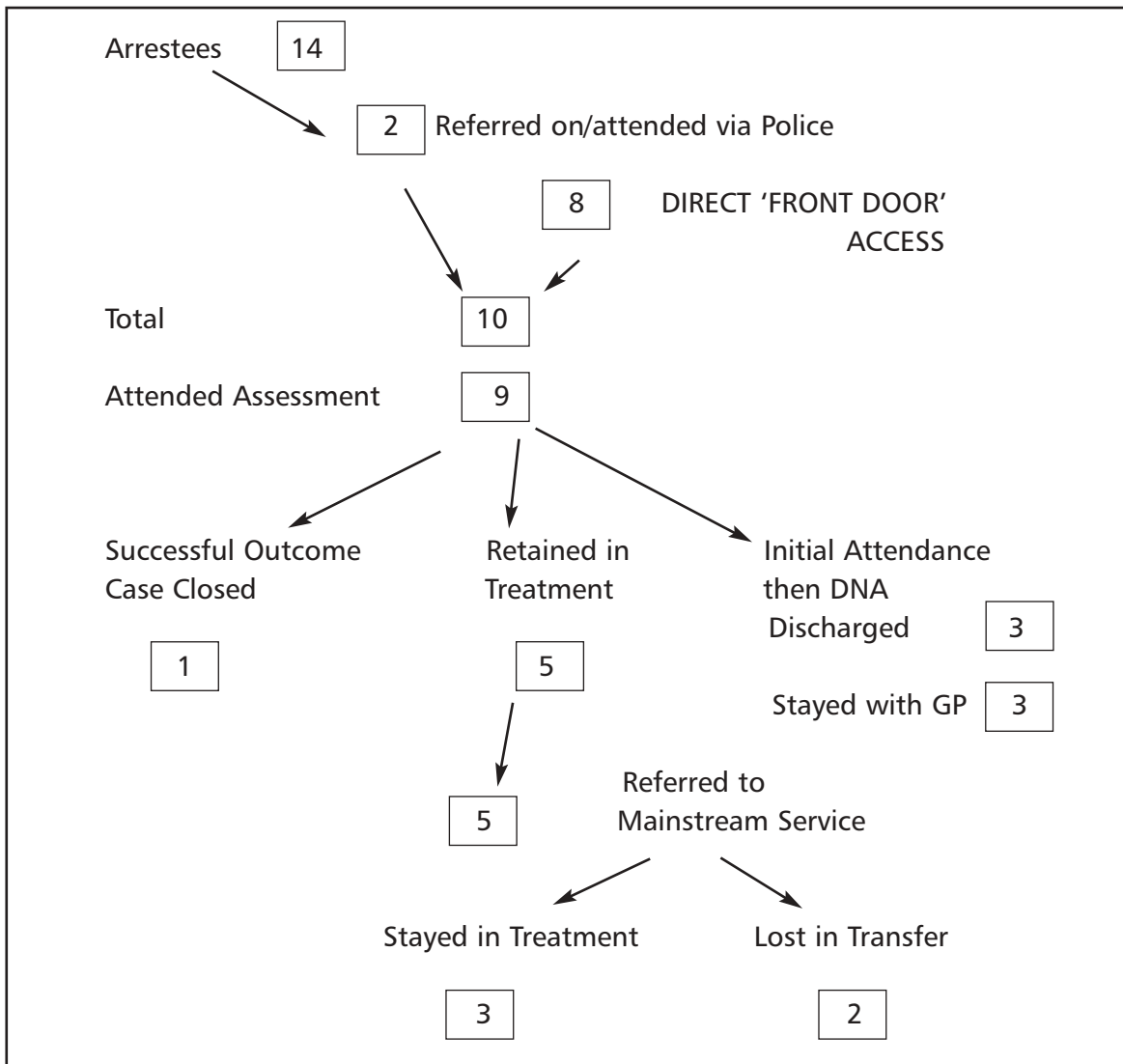
Community Development in Market Town

With continuing operational management difficulties (a new part-time Chief Executive was just coming into post), there was no properly planned community development work beyond extensive networking and 'talking'. The targeting of local 'at risk' young people was again neglected and basically disappeared off the Team's agenda for the rest of the Project. An impressive community survey about local drugs problems/issues was conducted in conjunction with a local community network however.

Figure 3.2: Local Press Reports Describing 'Partnership'



Figure 3.3: Outreach Team's Treatment Outcomes in Market Town



Drugs Awareness and Education Workshops

A clear element of the Team's work was developed in Market Town. All the area's primary and secondary schools were written to offering drug awareness events for governors, teachers and parents. Seven junior schools took up this offer. The Team delivered 6 parent information sessions covering basic information about different drugs, their effects and types of use. These interactive workshops also discussed 'what can parents do?' in respect of street drugs. An impressive delivery meant 150 attendees received these workshops which evaluated very positively.

Conclusions and Learning Points from Market Town

This was a disconcerting time for the Outreach Team. There were difficulties with the team's management and performance. It did not 'rebadge' as agreed. Finding a sessional doctor proved difficult and the local problem drug users, despite there being no drugs service in the town, did not present. In the Annex we describe Market Town's heroin history showing that most of its local problem users are younger than in Old Town and with less longstanding problem drugs careers. This implies an outreach strategy would have been required to bring in heroin-crack users 'early'.

The Outreach Team suffered from a lack of leadership and robust micro management. Despite being under-employed it lacked a proactive management system to test alternative approaches and indeed fulfil its key objectives. It did not undertake arrest referral work nor target local 'at risk' young people. There was very little community engagement. Despite this 'drift' the Team did deliver impressive, well attended drugs awareness events in local schools.

THE REBADGED OUTREACH TEAM IN BORDER TOWN

Rebadging for Border Town

The DDMP as an action research project was committed to learning from, on-going evaluation evidence. It thus dropped the 'Market Response Team' badge and became a 'Drugs Treatment Community Outreach Service' using the respected logo of its national mother service. A new management system was gradually developed with the incoming Chief Executive becoming operational as line manager but with supervisory team management being given to one of the team members. Team morale and performance probably 'peaked' in Border Team.

The Outreach Service did not get involved in the media promotion of Operation York and purposefully distributed its own drug treatment led publicity. Importantly more care and some luck led to 'ideal' premises being found in a detached office building in a discrete but accessible location. There were no difficulties with the local residents whom the Team purposefully liaised with.

Direct Treatment Work in Border Town

Although Operation York only arrested a dozen people the Arrest Referral work led by the Team did have contact with 8 including prison visits. Again many arrestees (n=6) were already in treatment with the county's Community Drug Service, so unsurprisingly arrest referral did not harvest many new clients (n=1).

Whilst at a senior level relationships between the DDMP and the county's mainstream drug service remained strained, the County Drug Service's peripatetic drugs worker servicing Border Town's shared care programme liaised effectively with the Outreach Team. She encouraged her clients to access the service for additional one to one support and acupuncture. Five service users took up this offer and received additional support through the Outreach Team's secondment to Border Town.

The acupuncture offered by the Outreach Team in fact attracted 16 regular attenders who rated the service positively and enjoyed the personal attention it offered. Several attendees were *not* in any structured treatment. This was a real 'gain' for the Outreach Team.

In terms of front door access (See Figure 3.4) 8 'new' problem users from the area attended, of whom 7 attended an assessment interview.

Six were heroin-crack users, of whom one dropped out (DNA) and 5 were retained and transferred to the main drug service. One problem drinker was successfully treated and the case discharged/closed.

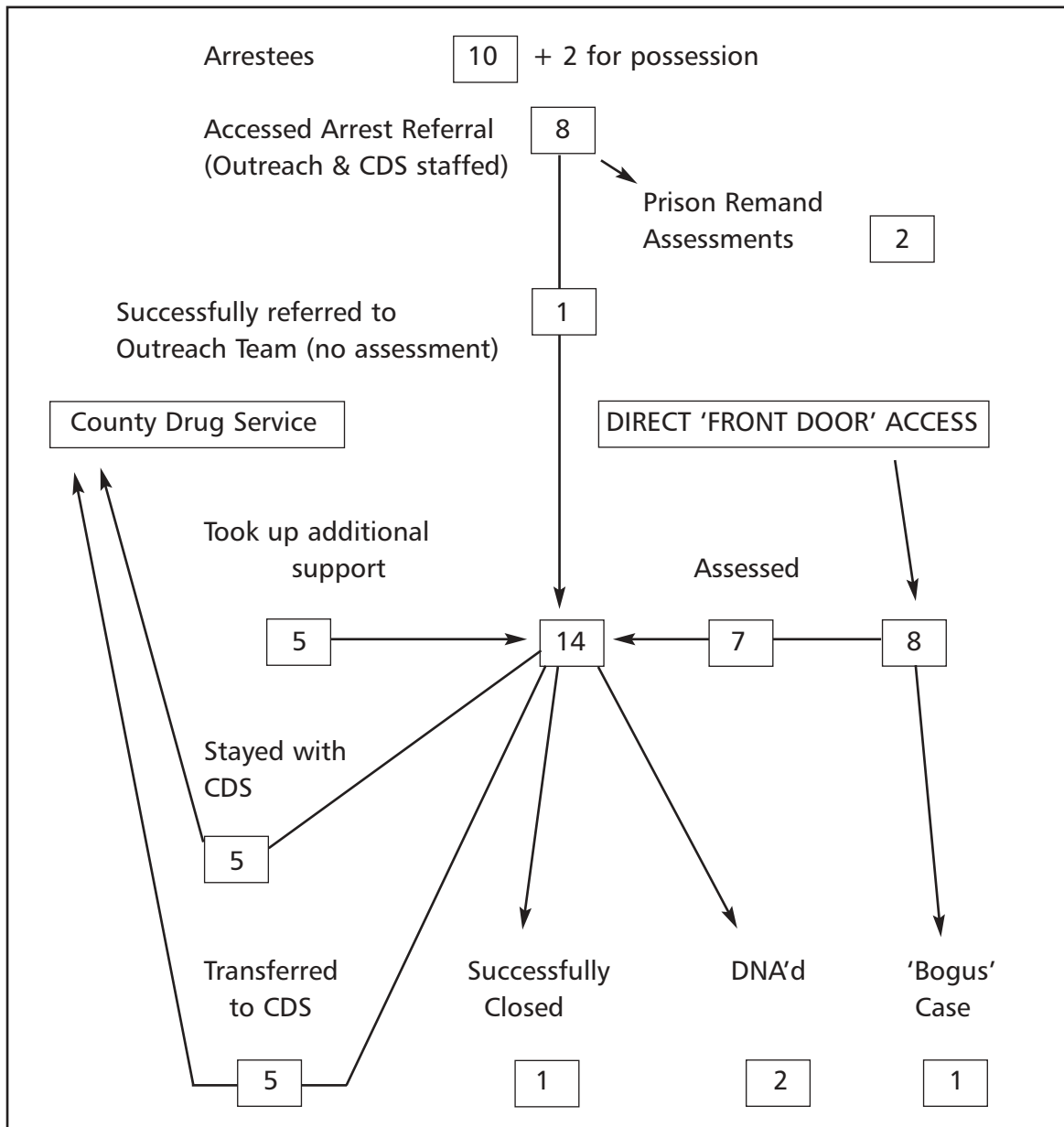
Outreach and Drugs Awareness Training

The on-going evaluation reports and Board discussions raised the issue of whether the Team rather than sitting in their venues waiting for drug users to walk in should be more proactive about making the service more accessible. Consequently staff took the 'unused' expensive DDMP mobile, walk-in trailer to the car parks of a local supermarket and leisure centre to advertise the service. They also held a public drugs awareness evening and set up a stall in an under 18s night at a local night club. Whilst there was 'interest' and lots of leaflets picked up, none of these events produced sustained interaction or contact and no referrals to the main treatment service.

The Team built on their Market Town experience of delivering local drugs awareness events via schools. They again approached all local schools and liaised successfully to deliver a series of events. Seventy four mainly parents and teachers received the drugs awareness package. A lunchtime 'drop in' at one secondary school attracted over 50 pupils during its week's presence. A full drug course was delivered to 13 'Year 12s' on becoming/acting as peer mentors in respect of drugs issues. Ten Year 11s received a similar half day course. In terms of primary schools, sessions were held in 6 and there were 80 participants, mainly parents, who again rated the session positively.

This was the most effective delivery of drugs awareness and drugs education agendas across the whole project. The direct work with young people was the closest the DDMP came to satisfying its aspirational goal of identifying young people at risk of drug involvement. There was however no community development work undertaken.

Figure 3.4: Overview of Outreach Team's Treatment Impact in Border Town



Conclusions and Learning Points from Border Town

Of the 4 areas the DDMP was fully operational in, this was the most successful for the Outreach Team. The Team's management dynamics had improved. The premises were 'ideal' for both staff and service users. The Team were busier in terms of new service users, the acupuncture groups and the shared care cases with the CDS worker. The drugs awareness delivery 'peaked' and engaged a large number of teachers, parents and young people. Importantly the re-badging and separation from the publicity of Operation York produced the desired results. There was no community level/drug user perception that the Outreach Team were connected to the police or undercover work. Neither clients nor **SPARC** fieldwork interviewees (n=17) made any connection between police enforcement and treatment provision nor mentioned the 'noid up' effect, so evident in Old and Market towns.

The key importance of working out of appropriate venues was illustrated in Border town. Finding such premises is far from straightforward but the gains in acquiring appropriate locations and facilities were evident. It was clear the Outreach Team responded well to improved management. It was also clear that through time their work agendas became shaped from the inside in the absence of strict higher management performance focused demands. We return to this issue in Section 5 when looking at the effectiveness of inter-agency partnerships in strategic and line management.

THE OUTREACH TEAM IN CITY

Introduction

The debate about which drug markets to prioritise 'peaked' with the targeting of 4 markets within City. The Project Board struggled with the politics of partnership before conceding that the project would operate in all City's key hard drug market areas. The Outreach Team were unhappy about this 'deviation' and were reluctant travellers.

A further complication driven by the City stakeholders on the Project Board was to utilise substantial funding from the core budget to help set up a network of Tier 2 Outreach Service venues across the city of which the DDMP Outreach Team would be a small temporary 'spoke'. This larger permanent service will be called the 'City Treatment Outreach Service' (CTOS).

Setting Up in City

The DDMP Outreach Team were to spend 6 months in City servicing two neighbourhood treatment venues and attempting to deliver their package of drugs awareness courses. By now the targeting of young people and community development roles had permanently slipped off the agenda. The Team continued to adapt the circumstances however and produced a health and safety/overdose prevention short course to be delivered in City and targeted at the bar/night club sector and other interested parties.

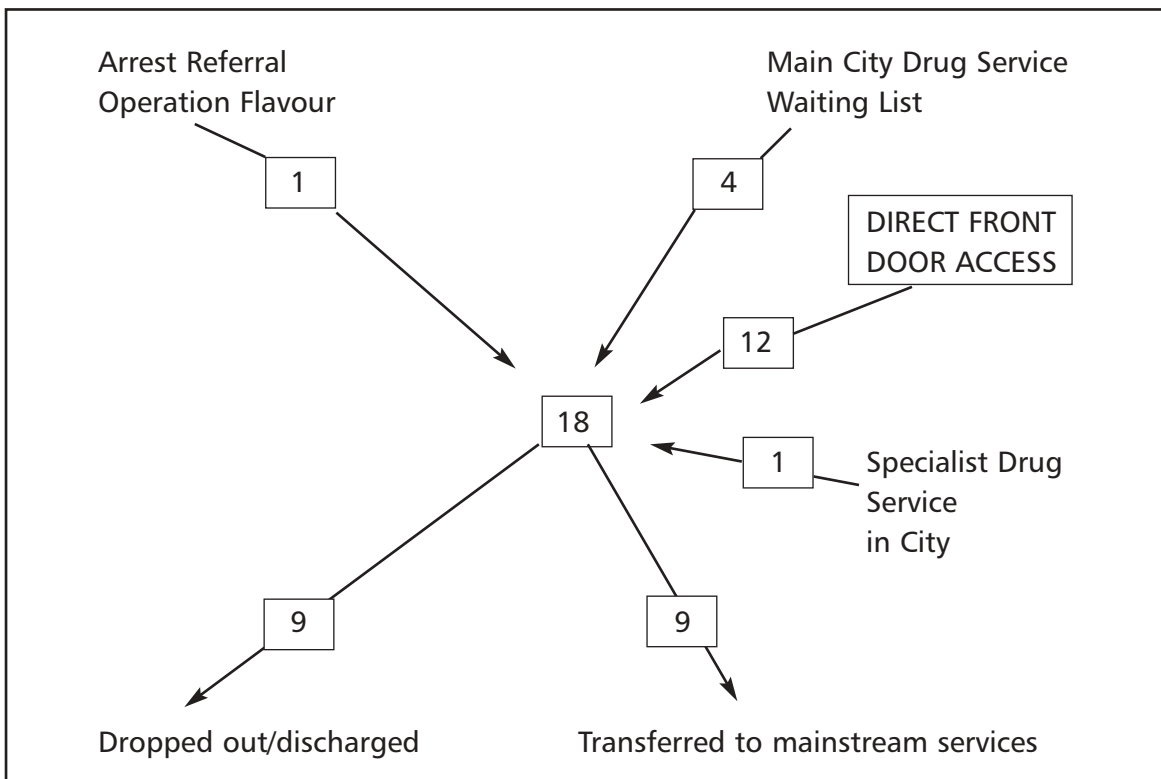
There were complex and contentious negotiations about the Team's deployment and siting. The 2 eventual venues were far from ideal. One direct access part-time service was delivered from a couple of rooms in a community centre at the edge of a new housing complex. This venue was difficult to find and access and only a handful of clients ever came in. The other venue was on an older residential estate in a terraced house already being used by a children's service. This accommodation was better sited and equipped but there were other problems. A posse of angry residents made it clear they didn't want a drugs service in their area and but for the temporary nature of the Outreach Team's presence this could have become a serious issue. The usual publicity, leafleting and networking was undertaken to advertise the service.

Direct Treatment Work in City

We noted in the last Section that Operation Flavour turned out to be a complex and elongated piece of enforcement with original strike timetabling being lost as the arrests spread over nearly 3 months. This did little to help co-ordination in respect of arrest referral which was to be delivered by the Outreach Team in conjunction with the full time City arrest referral worker (also employed by Addaction).

The level of mishap and the reasons for poor liaison remain contested but essentially of 52 arrests less than half had direct contact with the ARWs. Only one new treatment referral emanated from the work. The picture was of ARWs not being available at the time of re-scheduled arrests or during night shifts and weekends, plus some poor paperwork and cross-referencing between the police and the ARWs. Some deferred cautions were issued by the police without the required drugs worker session.

Figure 3.5: Outreach Team's Treatment Caseload in City



In terms of direct access to the Outreach Team's treatment programme, there were 18 case files opened (See Figure 3.5). Of these twelve cases were generated by direct access to the two satellite venues, with five other cases being referred off other City drug services' waiting lists. Of the 18 service users who attended, ten had heroin-crack problems, the other eight being primarily problem drinkers. Nine cases dropped out/DNA'd during the Outreach Team's six-month secondment but nine were transferred to mainstream services.

Drugs Awareness for City Schools

The Outreach Team delivered its now established programme of drugs awareness sessions targeted at pupils, school staff and parents in the 2 City neighbourhoods it was based in. Negotiations were time consuming and complex but eventually 11 workshops were delivered to junior school staff and parents. The Outreach Team co-worked with a City parents' support group in this delivery. Eighty six people attended and whilst the numbers were relatively low, despite extensive marketing, the sessions were, as always, positively evaluated. No events for young people were delivered however.

Drugs-Health and Safety Training Events

The Outreach Team tailored a new course targeted at the City's bar and night club staff. The effects of different drugs, the law, information updates about club drugs, the management of venues and overdose prevention/responses were included. There was excellent take-up and the course was delivered 22 times, being received by no less than 219 people. Seventy eight participants were from late bar/club staff, 46 were current/ex drug users, 52 were relatives of drug users and 46 were drugs workers/counsellors. The whole delivery was well organised, managed and executed. The course was positively evaluated by participants. Even after this extensive delivery unmet demand remained.

Conclusions and Learning Points from City

Essentially the Outreach Team were 'lost in the city'. Their secondment to 2 inner city neighbourhoods for several months produced small returns in terms of bringing problem drug users into treatment and retention was poor. Arrest Referral was particularly unproductive. The most effective intervention was the training programme on health-safety, drugs and overdose response which was delivered to over 200 people. However they also prepared a useful report on setting up a drug service for sex workers.

The recurring learning point about the importance of appropriate venues again emerged with one drop in being inaccessible and the other 'unwelcoming'. Team morale was understandably deflated as the staff spent many days in the satellites waiting for potential service users to appear. They were unable in such a short time to establish themselves as a viable alternative to the main city centre drugs service which as far as the heroin-crack user fraternity was concerned was 'where you went'.

THE OUTREACH TEAM IN EASTSIDE TOWN

Introduction

It was decided in mid project, in response to the difficulties of twinning the enforcement and treatment arms of the DDMP, that the Outreach Team's final secondment would be to a county town where no targeted enforcement ran in tandem. Eastside Town with a population of 11,000 was chosen as an area for the secondment. This town's drugs provision was delivered by the county's mainstream drug service via a peripatetic worker linked to a shared care programme with a specialist GP, but Eastside had no established

Derbyshire Drug Market Project

direct access premises. About 90 heroin users were in treatment with 17 using crack cocaine as a secondary drug in the Eastside and surrounding area. A voluntary parents' support group operated in this area.

The Mapping Team, by way of background information, scoped the area in and around Eastside and identified 75 nominals involved in the drug market. Several open dealing and using sites were identified in the town but most dealing appeared to be from residential addresses with a steady flow of customers and vehicles logged as part of local trade. Eastside's heroin and crack supplies came from outside the county given its proximity to Sheffield and Nottinghamshire.

The Outreach Team initially set up in adequate premises on an industrial estate close enough to the town centre to be accessible but discrete enough to maintain a degree of 'confidential' access.

A large amount of networking with the local council and general services was undertaken and an attempt was made to develop an exit strategy to transfer any clients to the mainstream service at the end of the secondment. The main CDS was not able to guarantee the absorption of many cases given its high caseloads and resource difficulties in this area. This difficulty remained unsolved for several months. As in Border Town the Outreach Team offered to provide additional support to local clients already in treatment with the main service although only 2 presented.

The Outreach Team began work in Eastside Town still in negotiation for a dedicated prescribing doctor. The new service was heavily advertised locally. This publicity created some complaints and the industrial estate's landlord, despite extensive discussions and reassurances and knowing the service was only temporary, moved towards evicting the Team. The Team were in the end required to depart and with the help of a local vicar relocated in a church hall on the other side of the town.

Once again the issue of finding suitable premises and venues militated against service delivery.

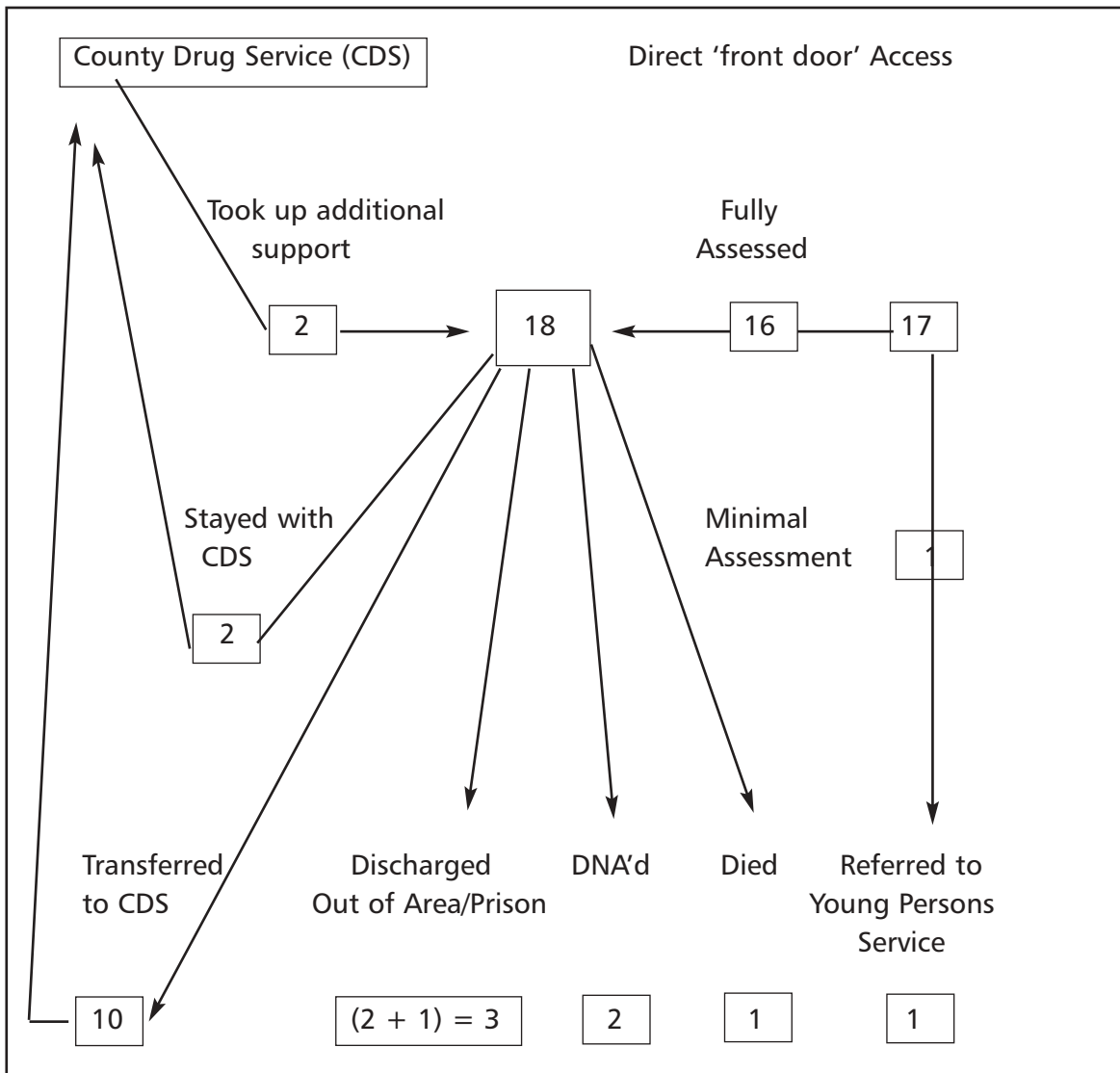
Direct Treatment Work in Eastside Town

There was obviously no arrest referral work on this secondment and few clients from the mainstream service engaged. In total 17 local drug users made front door access. The new entrants predominantly presented with longstanding moderate to heavy heroin use whilst crack cocaine was the drug of choice for one individual and alcohol the reason for accessing the service for another. Figure 3.6 illustrates their care pathways.

Eight individuals presented in the first 2 weeks and attended initial assessment. The delay in recruiting a prescribing doctor prompted several of these clients to begin missing key worker appointments. Importantly, however, once the doctor, a local GP (with Specialist Interest – in patients with addictions), began clinical sessions and the word got around, four of these clients 're-engaged' with the Outreach Team.

The main prescribing regime provided by this doctor, in line with provision in this part of the county, was, for the first time, methadone maintenance. Ten service users were treated with methadone (30-70ml daily) and one client commenced a Subutex detoxification. The Team’s key workers found the doctor to be flexible and knowledgeable about addictions and enjoyed working with him. More importantly this regime improved attendance and retention particularly compared with previous secondments. Most service users were urine testing negative for illicit substances by the end of this secondment.

Figure 3.6: Overview of Outreach Team’s Treatment Caseload in Eastside Town



Derbyshire Drug Market Project

One local heroin user who accessed the service in Eastside Town was impressed by the Outreach Team approach:

“First came here about 5 weeks ago. I’m now gettin’ methadone from the doctor here. I think the service is really good here and the workers are great...it’ll be a shame to see ‘em go.”

(Male, 34, Eastside Town)

Another client focused on the wider impact of the service’s presence in the area and their unwitting absorption of those responsible for a significant degree of acquisitive offences in the town:

“Most [Local heroin users] have gone to the ‘Outreach Service’. A third haven’t. Crime has reduced around here because they’re all at the ‘Outreach Service’.”

(Female, 33 years, Eastside Town)

Feedback from friends and relatives of the clients in treatment and the local parents’ group was very positive about the improvements observed in the client group.

Other Activities and Delivery in Eastside Town

The Outreach Team planned and delivered its established drugs awareness programmes to parents and teachers in four junior schools and one secondary in town. Attendance was poor however as only 34 people received the programme. As always, evaluations by participants were very positive.

Given the success of the overdose prevention-response workshops in City, an adapted programme was delivered for local professionals and stakeholders of whom 17 attended. Again evaluation feedback was very positive. A second workshop aimed at local drug users and clients in treatment despite detailed planning and prompting only attracted 1 participant.

The Outreach Team did not undertake any structured community development work although they created strong links with several groups and individuals in the community. They did not target any ‘at risk’ young people.

Conclusions and Learning Points from Eastside Town

The DDMP had already learnt that temporary satellite provision, even without the added problem of being ‘twinned’ with enforcement, cannot immediately attract large numbers of local problem substance users into treatment. Bringing in 10 new heroin users over this secondment was thus a reasonable performance. It was felt that had the service bedded-in and the original premises been maintained, that word of mouth would have increased the caseload given the positive experiences and views of clients and their families and friends. Eastside was similar to Border Town in this respect – a welcome extension of otherwise very basic service provision.

The delay in obtaining a clinician threatened retention but in fact the GP who did arrive was regarded as 'the best' across the whole project. His style of work with service users and willingness to prescribe methadone clearly improved not just retention but engagement with key working and actual progress in respect of abstaining from heroin use.

The transfer of these clients to the mainstream service was not straightforward however. As the Team left and the project ended both service users and the Outreach Team staff were apprehensive. Some additional funding was found to help their transfer and continued supervision within the mainstream service but negotiations were strained and difficult. There is no prospect of the transferred clients receiving the always accessible and high level of key worker support which they grew accustomed to from the 'time-and-resource-rich' Outreach Team. From the mainstream service point of view the DDMP unwittingly created problems – overloading an already stretched rural service with 10 new service users for whom there was no available doctor or key worker time. Moreover the mainstream County Drug Service could not provide the on-going level of supervision and care which these service users had become accustomed to. Their retention in treatment will remain a challenge. The difficulties across Health Trusts and services were again exposed as inter-agency structures struggled to deliver seamless care.

THE OUTREACH TEAM: PERCEPTIONS OF SERVICE USERS

From an evaluative perspective it is important to identify the 'causes' of the poor uptake of treatment and the poor retention of clients experienced by the DDMP. **SPARC** interviews were undertaken with 44 service users (6 of 11 in Old Town, 6 of 9 in Market Town, 14 of 14 in Border Town and 14 of 18 in City, plus ad hoc interviews with 4 of 18 in Eastside Town).

Several recurring themes were evident in the accounts of interviewees. Firstly, they welcomed the direct local neighbourhood access the Outreach Team provided.

"The [Outreach Team] system is good...better than [County Service]...there's no waiting lists. It's local and there's no travelling expenses..."

(Male, 34 years, Eastside Town)

Secondly, attendees were pleasantly surprised by the lack of waiting times for assessment particularly compared with the County's mainstream services. The 'delay', as most saw it, between assessment and getting a prescription (e.g. Subutex) for a particular treatment was regularly mentioned however. This relates to difficulties in contracting doctors into the Service.

"I struck up a deal to give up heroin and street methadone. I've kept my half of the deal and am now waiting for them to come up with their half"

(Male, 36 years, Border Town)

Derbyshire Drug Market Project

Thirdly, almost all the Outreach Team’s clients rated the Service positively. Table 3.1 below provides a more visual summary of client’s views and experiences of their involvement with the Outreach Team. The table shows that overall satisfaction with the Outreach Team was high particularly with regards to issues around efficiency, attitude and support.

Table 3.1: Client views/experiences of Outreach Team

Market		Old Town	Market Town	Border Town	City	Eastside Town	Total
	n size	6	5	10	14	4	39
	Column percentage	%	%	%	%	%	%
Efficiency	<i>No comment made</i>	33.3	0.0	10.0	7.1	0.0	10.3
	<i>Positive</i>	50.0	100.0	90.0	64.3	100.0	76.9
	<i>Mixed</i>	0.0	0.0	0.0	14.3	0.0	5.1
	<i>Negative</i>	16.7	0.0	0.0	14.3	0.0	7.7
Attitude	<i>No comment made</i>	33.3	0.0	0.0	7.1	0.0	7.7
	<i>Positive</i>	66.7	20.0	90.0	78.6	100.0	74.4
	<i>Mixed</i>	0.0	60.0	10.0	0.0	0.0	10.3
	<i>Negative</i>	0.0	20.0	0.0	14.3	0.0	7.7
Assessment	<i>No comment made</i>	66.7	0.0	30.0	7.1	0.0	20.5
	<i>Positive</i>	33.3	20.0	70.0	64.3	75.0	56.4
	<i>Mixed</i>	0.0	80.0	0.0	14.3	25.0	17.9
	<i>Negative</i>	0.0	0.0	0.0	14.3	0.0	5.1
Treatment	<i>No comment made</i>	50.0	0.0	0.0	0.0	0.0	7.7
	<i>Positive</i>	33.3	60.0	60.0	7.1	100.0	41.0
	<i>Mixed</i>	0.0	20.0	0.0	0.0	0.0	2.6
	<i>Negative</i>	16.7	20.0	0.0	14.3	0.0	10.3
	<i>Too early to say</i>	0.0	0.0	40.0	78.6	0.0	38.5
Support	<i>No comment made</i>	16.7	0.0	10.0	0.0	0.0	5.1
	<i>Positive</i>	66.7	60.0	90.0	78.6	100.0	79.5
	<i>Mixed</i>	16.7	0.0	0.0	0.0	0.0	2.6
	<i>Negative</i>	0.0	40.0	0.0	21.4	0.0	12.8

NB: A further 5 interviewees who had used Outreach Team service have missing data regarding these issues

The drugs workers routinely received praise from the interviewees.

“Brilliant, they’re really good. You feel at ease like a dead normal person”
(Male, 28 years, Border Town)

“I’ve told people I know about them. The workers are dead nice, not too intrusive, seem concerned about you. And they have that acupuncture”
(Female, 27 years, Border Town)

“....brilliant, better than other places I’ve been to”
(Male, 25 years, City)

The drop out from treatment was largely a product of the client's own decisions rather than 'falling out' with their key worker. However, several interviewees argued that the particular treatment regime most often offered by the Outreach Team and doctor was 'unforgiving'. The Outreach Team essentially delivered programmes to the protocols of their employing service and sessional GP which tend to be fairly high threshold detoxification oriented, for instance utilising urine testing to monitor non-compliance and discharging for repeat appointment breaking.

"He's a nice guy but I found him a bit pushy, you've got to be firm but I did feel a bit put down....I felt I had done well not having heroin for 5 days at a time. I've gone down from a hell of a lot a day to using nothing"

(Male, 33 years, Border Town)

These regimes explain the lower level of satisfaction with 'treatment' shown in Table 3.1.

THE OVERALL EXPERIENCE AND IMPACT OF THE OUTREACH TEAM

The Outreach Team were originally contracted to deliver 4 target 'services' in respect of providing arrest referral for the enforcement operations; being available to bring into treatment local problem drug users affected by a heroin-crack supply 'drought'; to provide a community development support to allow communities to resist visible drug markets and to target parents, teachers and also local young people 'at risk' of becoming problem drug users with drugs education inputs.

The *arrest referral work* was not very effective whereby the relatively successful performance in Old and Border Towns was not repeated in the other areas. Arrest referral nationally produces few referrals and even fewer successful treatment entries and this was replicated in Derbyshire. Liaison problems between the Police and Arrest Referral Workers were evident particularly in City.

The *community development work* in Old Town was in fact fairly effective but was surprisingly never re-delivered in the other 3 secondments.

The targeting of *at risk young people* simply never happened, given the worries about not being able to sustain any case work and was dropped from the portfolio with little detailed discussion. The alternative delivery was providing 'drugs awareness sessions' in each area. These were successfully delivered to teachers, school governors and parents in each market area. However, only in Border Town was there an effective programme for local young people. The innovation in City to deliver a drugs health and safety/awareness/overdosing response course proved highly successful, reaching over 200 people. Its success confirms the relative ignorance of 'lay people' in respect of understanding drugs issues.

Derbyshire Drug Market Project

The core activity of bringing *problem users into direct access treatment* was however a limited success. The target of 300 problem drug users to be brought into treatment was far from achieved as only around 70 were attracted with just over half successfully retained in treatment. We suggest that these disappointing outcomes were not a product of the Outreach Team's performance. There clearly were difficulties of micro management of the Service but service users were generally very positive about their personal treatment. The Outreach Team were always appropriately *in situ*, having fully advertised their service. They serviced their freephone contact line efficiently. Their approach to new clients was positive and professional. This leads us to look at more structural and methodological problems.

Even though in practice there was very little contact on the ground between the Outreach Team and the police, the perception of local problem users was that a partnership was in process. The difficulties over suitable venues and premises were also significant. Being only temporary in any area and constantly on the road with little time to acquire suitable venues, in terms of acceptability and accessibility, the Outreach Team were unable to control this agenda. Again it was the expectations built into the DDMP that were so challenging. New services must bed-in locally by word of mouth and temporary secondments to areas prevent this.

The difficulties of employing appropriate sessional doctors to supervise clinical work cannot be directly related to the Outreach Team either. This is a structural labour market problem which is also a problem for mainstream drug services across the county. The high threshold regimes the Team offered were the norm for Addaction Services in Derbyshire leading us back again to strategic and commissioning shortcomings rather than simple delivery issues.

Finally, there is a reasonable degree of agreement between the key players that Addaction never managed to appoint an appropriate Treatment Outreach Team manager. This post, which required a particularly experienced and innovative individual of high calibre, was never appropriately filled. Poor salary scales and poor advertising were part of the problem.

In the final section we will return to these 'difficulties' of delivery and consider why the Outreach Team failed to deliver all the components of its portfolio.

SECTION 4 THE EFFECTIVENESS OF THE DDMP

COST EFFECTIVENESS AND DRUGS INTERVENTION

Growing Interest in Cost Effectiveness

Alongside the steady growth in the drugs problem in the UK since the early 1980s and the parallel development of national anti-drug strategies, has been an increasing concern about the cost effectiveness of policies and initiatives to manage the problem. Driven by the North American literature numerous studies have been conducted in the UK over recent years attempting to identify 'what works' and whether the growing range of drugs interventions offers value for money.

Cost-effectiveness is variously defined. It can refer to a 'break even' process whereby positive outcomes, nominated a value, equal the cost of resources put in. The term is also used to discuss net gains over and above resource inputs (ie. cost-saving). The much quoted – for every £1 spent on drugs treatment £3 are saved in costs against offending, ill health, social problems – is a good example of this. The DDMP aspired to producing substantive accumulative net gains.

Enforcement and Supply Reduction

There is little evidence from the research literature that enforcement – targeted or otherwise – can significantly undermine the supply and availability of drugs like heroin and cocaine in urban settings. Numerous studies have reached similar conclusions (e.g. Best et al, 2001; Webster *et al*, 2001) noting there are too many retail outlets and options in a typical urban market to make specific targeting, however extensive, effective. There is evidence that residential dealing venues and open markets can be displaced but overall both specific studies and meta analyses of the international literature suggest supply reduction at the retail level is, given finite resources, impossible to routinely deliver (Scottish Executive, 2004; Mason and Bucke, 2003). This however does not mean resources and efforts to disrupt hard drug markets should be curtailed. We have to consider what level of further deterioration would occur in local communities if sustained anti-drug market enforcement was withdrawn.

The DDMP was well aware of these conclusions. Its task was to test the hypothesis that intense targeted enforcement of heroin markets in 'greenfield' towns in rural communities could be more successful because dealing outlets would be fewer and customer transfer more difficult.

Understanding and Pricing Drug Markets

A parallel new interest in demystifying the world of drugs and viewing drug markets as economic entities collectively worth several billion pounds a year (NCIS, 2001) has also developed. Studies have attempted to size and value the UK drugs market (e.g. Bramley-

Derbyshire Drug Market Project

Harker, 2001) suggesting heroin of the value of £2,300 million and crack to the value of £1,812 million are traded in the UK each year.

There are also case studies of local drug markets (e.g. May *et al*, 2000; Lupton *et al* 2002) producing very similar descriptions to the ones provided in this study as the DDMP mapped and priced drug markets across the county.

Drugs Bills and Drug Driven Offending

A further feature of understanding the 'costs' of heroin/crack problems has been the production of numerous assessments of the scale of problem drug users' daily habits, subsequent bills and funding strategies. Whilst drug-crime relationships are complex there is little doubt that problem drug use in the UK is strongly linked to acquisitive crime. The evidence comes from NEW-ADAM (Bennett and Holloway, 2004) and numerous empirical studies (e.g. Haracopos *et al*, 2003; Parker and Bottomley, 1997). These findings are the driver of the political and policy faith in drugs treatment as a lead priority. Reducing crime through encouraging and coercing problems users into treatment is a the primary goal of the drugs strategy.

The Cost Effectiveness of Drugs Treatment

Health economists in the UK are now following the lead from the USA (e.g. Cartwright, 2000) confirming that drug treatment can be highly cost effective in terms of reduced illicit drug use and drug related crime. The most impressive British study is the National Treatment Outcome Research Study (NTORS). Secondary analyses of the dataset shows there have been highly cost effective outcomes in respect of crime reduction whilst users are actually engaged in treatment. Whilst warning that different regimes produce varying levels of success and that because treatment retention is poor cost effectiveness is best generated through time by multiple treatment episodes, NTORS nevertheless provides the key plank in the 'treatment works' discourse (Godfrey *et al*, 2004a)

'Rough Guide' to the DDMP's Effectiveness

As an action research project the DDMP could not be configured to produce a scientific cost effectiveness analysis. The evaluation team were part of the process and tasked to suggest modifications along the way 'to improve economy and efficiency'. However, due regard was paid to assessing both outputs and outcomes and in this Section we consider the performance of the DDMP against its core objectives and targets. We thus call upon the monitoring and evaluation fieldwork undertaken throughout the project and the carefully recorded evolving views of the key stakeholders. In general terms we 'price' these outcomes against the financial and 'in-kind' costs of running the DDMP.

FUNDING THE DERBYSHIRE DRUG MARKET PROJECT

Overall direct funding for the DDMP ran to £1,836,000 to cover a 2 year period. The Home Office *Targeted Policing* programme contributed £311,000 and the Treasury's *Invest to Save* budget £1,163,500 conditional upon locally matched funding of £388,500 provided by Derbyshire sources mainly County and City Councils and local Health Trust contributions.

In reality the DDMP cost over £2 million to execute once we recognise the uncoded contributions of partner agencies. So, in respect of mapping and enforcement whilst the DDMP budget actually funded the operational costs of the enforcement the Police Service provided numerous uncoded inputs such as 'intelligence', administrative support, senior officer time to attend meetings, etc. Similarly, large amounts of Drug Action Team co-ordinator time were dedicated to the Project without direct payment; other partner agencies attended meetings and provided local information; the financial management for the Board was 'free'. The Treatment Outreach Team was sometimes provided premises free of charge or for a nominal rent; and, so on.

The main direct expenditure sectors were:

Derbyshire Police Mapping and Operational Cost at about	£846,000
Addaction: Drug Treatment and Outreach Team provider at about	£931,000

Other costs were for capital items such as a Minibus and mobile walk-in trailer and a Web Kiosk in addition to a range of exceptional items. The evaluation cost £150,000.

THE ASPIRATIONAL GOALS OF THE DDMP

The DDMP as described in Section 1 had an integrated set of objectives and desired outcomes which 'theoretically' provided a highly cost effective approach to delivering 'value for money joined-up' drugs interventions. The DDMP proposal legitimately borrowed the range of benefits attributed to delivering drugs interventions especially drugs treatment as celebrated in the national drugs strategy. It thus argued that targeted, enhanced, enforcement in County towns would lead to the arrest of large numbers of drug dealers. This would disrupt the local retail market ideally creating a 'drought' or at least stifling supply, making problem users susceptible to accessing treatment through the Treatment Outreach Team. This in turn would reduce local volume crime which would reduce routine divisional policing costs. The reduced acquisitive and other crime plus the absence of visible heroin/crack dealing would enhance community safety and feelings of well-being amongst local residents. Through delivering drugs awareness courses and stimulating community involvement in restricting drugs markets the gains build and become part of community regeneration. Targeting young people in general with drugs prevention inputs and especially those 'at risk' of drug misuse was the final component of local delivery.

By capturing a projected 300 problem drug users across the life of the project the aspirational goal was that many clients would be new to treatment and with less entrenched 'chaotic' lifestyles and health problems. Their retention in treatment as well as reducing crime would reduce accumulative costs the Health Service (e.g. mental health problems, overdosing, hepatitis, etc.). With successful outcomes some service users would come off state benefits and obtain employment and pay income tax. The gains were thus perceived to be cumulative and in the long run cost saving by several hundred per cent.

Derbyshire Drug Market Project

The Treasury's *Invest to Save* funding criteria, whilst generously flexible, did require its funded projects to implement an Information and Communication Technology thread to develop interactive IT communications between local communities/customers and professional service providers. Consequently the DDMP was obliged to utilise IT in its delivery.

Recognising the integrated nature of the Project goals it is nevertheless necessary to isolate the 5 key objectives in order to expose them to a basic assessment of outcome achievement.

Objectives

1. To utilise drug market mapping and targeting to enhance the effectiveness of enforcement against Level 1/Community retail drugs markets in the County's towns.
2. To provide rapid access to drugs treatment for local problem (heroin/crack) users affected by a 'drought' or shortage of supplies after town level enforcement. To harvest gains from treatment engagement.
3. To provide drugs prevention for local young people but especially a targeted group 'at risk' of drug misuse. To utilise interactive IT resources.
4. To provide drugs education and awareness for local adults in nominated communities especially teachers, stakeholders, parents and community activists. To utilise IT for interactive information sharing. To help improve community safety and build community resistance to local hard drug markets.
5. To provide improved information and 'understanding' of drug markets and local drug problems for those charged with delivering the drug strategy at the local level (e.g. DAATs, Crime and Disorder Reduction Partnerships, Treatment Services, Police, etc.).

We can now consider the extent to which the DDMP achieved its goals, delivered value for money and/or produced new learning about contingencies and problems which undermined effective delivery given the experimental nature of the Project.

Mapping and Targeting Local Hard Drugs Markets

The Market Mapping and Enforcement arm of the DDMP was the primary deliverer of *Objective 1* and key contributor to *Objectives 4 & 5*. In respect of demonstrating the value of drug market mapping to enhance the effectiveness of targeted enforcement against Level 1 or community level retail heroin and crack markets the Project has been a moderate success. The number of arrests and successful convictions of heroin dealers and user-dealers has been impressive. From a police perspective both the scale of arrests and the Court's recognition of the seriousness of supplying Class A drugs in utilising imprisonment indicates successful outcomes. At a police divisional level there was considerable satisfaction with the results. Moreover, the drug mapping methodology allows targeted areas to be revisited to assess the impact of targeted enforcement.

On the other hand, several specific objectives were not achieved. In particular the hypothesis that targeted enforcement of small towns hard-drug markets in semi-rural settings could create temporary heroin 'droughts' proved null. It was not possible to significantly disrupt supply even in the smallest most geographically isolated areas. This reality in turn impacted on the DDMP's methodological assumption that in drought conditions local problem drug users would seek treatment if it was directly locally accessible (*Objective 3*).

We have also seen that acquisitive and local volume crime were not obviously reduced by targeted enforcement thus undermining an anticipated cost-effective outcome in respect of savings in police time and resources. On the other hand, the unwanted negative impact of drug supply reductions in increasing drug-related overdoses as a consequence was not evident with any of the 4 main Operations. This is a gain in terms of cost-effectiveness as the economic cost to the Health Service (and indeed Coroners' work) is considerable for each overdose and in line with a drug strategy target. Operations did not stimulate violence within the market through destabilising it.

Few would contest the 'reality' that police led and collated intelligence only ever allows the partial mapping of drugs markets. It was thus unsurprising that post operational analyses, including **SPARC's** evaluation fieldwork, showed problem drug users immediately found other sources of drugs supply. In practice varying proportions of a local drug market are outside the scope of intelligence and so it was for the DDMP. In Derbyshire the main intelligence weakness has been in respect of the supplying and 'spread' of crack-cocaine. The main Operations have found crack where there was no prior intelligence of its availability. Moreover, the profiles of local users' drugs careers produced by the fieldwork and secondary analysis of drug treatment case files (see Annex) show that crack use is far more prevalent than the Police have thus far understood. A lack of 'good' crack seizures and failure to identify crack wash-houses or all the supply routes is consistent with this conclusion. This lesson is being learnt particularly in City.

In terms of combining enforcement and treatment under the banner of partnership the DDMP has learnt far more than it achieved. Arrest Referral work involving close efficient co-ordination between divisional police staff and local services, whilst probably no worse than elsewhere, did not always operate successfully leaving a proportion of targeted arrestees without the opportunity of speaking to an Arrest Referral Worker (ARW). More fundamentally, Operations Ibis, Quantum and Ultimate all demonstrated that when extensive orchestrated enforcement and mass arrests hit a small town in a blaze of publicity local drug market players become defensive and keep a very low profile for several weeks. Local problem users in each of the three towns did not seek immediate treatment entry. On the contrary those in treatment often missed appointments and those not in treatment did not use Helplines nor access the Treatment Outreach Team when badged as the Drug Market Response Team and advertised as working with the Police. The 'noid-up' effect of successful enforcement was not anticipated and unfortunately exposed a flaw in the assumptions within the DDMP methodology.

Two further issues relating to linking enforcement and treatment systems are worthy of comment. Firstly, from nearly 200 drug offence convictions only one offender had received a Drug Treatment and Testing Order (DTTO) at the end of the Project. So whilst arrest referral and deferred cautioning of arrestees with very minor drug offences led to criminal justice customers receiving drugs intervention across the Project, there was no evidence of DTTOs being regarded as suitable for Level 1 user-dealers and runners. This is in part to do with sentencing guidelines but also suggests a rather conservative viewpoint by both the Probation Service and Magistrates and Crown Courts.

Secondly, and somewhat ironically, a significant minority of the arrestees from the small town operations were already in voluntary structured treatment. This reality rather challenges the 'treatment-reduces-crime' mantra and perhaps unsurprisingly ignites a degree of scepticism amongst operational police officers about the efficacy and efficiency of local drug treatment services. However the general conclusions of the research literature must remain central – gains will accumulate through time if problem drug users can be retained/recaptured and provided appropriate treatment and clinical supervision.

Rapid Access Drugs Treatment

The Treatment arm of the DDMP represented by *Addaction* and the Treatment Outreach Team was primary deliverer of *Objective 3* in terms of providing immediate direct access to local problem drug users in the post-enforcement period. The aspirational goal of attracting 300 problem drug users into treatment over the five field-secondments to different areas was clearly within the capacity of the Team of five over a 2 year period and key worker resource could and would have been enhanced had caseloads become oversized. In practice however only around 73 service users entered structured treatment (see Table 4.1).

This poor take-up was the product of several processes and contingencies. The twinning of the 'Market Response Team' (later to be renamed Treatment Outreach Team) with enforcement was in retrospect a serious misjudgement. Secondly, the problem of finding suitable premises and venues dogged the Project even leading to an eviction in Eastside Town. Whilst there are successful 'mobile' drug services (e.g. converted coaches/minibuses to provide an outreach type service) and regular on-going part-time satellite clinics and drop-ins throughout the country *temporary* drug services appear seriously disadvantaged. This is primarily because services need to bed-in and become referred to and recommended amongst drug user networks and other professional/voluntary services in an area. The Treatment Outreach Team never fully benefited from the process being on the move to another town every 4-5 months. Again this was a flaw in the assumptions behind the methodology.

Table 4.1: Treatment Pathways and Outcomes

Market	Old Town	Market Town	Border Town	City	Eastside Town	<i>Total</i>
<i>Accessed Service</i>	13	10	14	18	18	<i>73</i>
<i>Completed Assessment</i>	7	9	7	12	16	<i>51</i>
<i>Case Closed with Successful Intervention</i>	1	1	1	0	0	<i>3</i>
<i>Client DNA'd Unplanned Discharge</i>	3	3	3	9	5	<i>23</i>
<i>Case Transferred to Main Drug Service</i>	3	5	10	9	12	<i>39</i>

NB: One client from Eastside Town died towards the end of the Outreach Team's secondment

The treatment completion and retention rates for the Treatment Outreach Team (3 successfully closed, 39 transferred to mainstream services) at around 60% was in fact slightly better than that of their mother service and the City's new outreach service (at around 50% over 6 months). The evidence we have based on research interviews with 44 clients of the Treatment Outreach Team was that whilst in treatment there was a reduction in illicit drug use (mainly heroin) and offending but especially in Eastside Town where the specialist trained GP applied a more sophisticated approach to patient care and utilised methadone maintenance alongside intensive keyworker monitoring. The research interviews suggested that outcomes in terms of treatment retention; reductions in heroin/crack use and self/family reports of reduced offending were excellent. Here, however, as the Project closed there were resource and co-operation difficulties in transferring a dozen active cases to the mainstream drug service which felt it did not have the capacity to absorb these users without additional resources being made available.

Finally, only in their first secondment to Old Town did the treatment arm of the DDMP provide Hepatitis screening and follow-up vaccination. Whilst the take-up was very small the original brief had been to provide this service in all five areas. Preventing hepatitis was a key goal in producing cost-effectiveness given that it cost approximately £12,000 a year to treat hepatitis-positive individuals displaying morbidity.

Even with relatively small numbers of problem heroin-crack users captured and retained in treatment, on balance, the data collected suggests the gains accumulated from crime reductions by those in treatment will at least have paid for the service. There were 45 heroin/crack users in the treatment cohort. Most had previous histories of acquisitive offending particularly shoplifting. Most of these clients were interviewed by **SPARC** and completed detailed 'drug diaries' linked to their methods of funding drugs bills.

Utilising Godfrey *et al's* 2004(a) and (b) findings from NTORS they estimate total 'social gains' (primarily offending) from entering treatment will be between £38,969 and £46,334 over 2 years for each client. To this can be added savings in criminal justice expenditure which Godfrey *et al* calculate to be over £7,000 per person entering treatment. Even if only half the net gains (of around £2 million) were generated, this pays for the delivery of the DDMP service. The first cautionary note here is that NTORS has been focusing on methadone reduction and maintenance treatment. The tendency for prescribing doctors attached to Addaction to use high threshold detoxification regimes may not produce the same level of social gains for as long. The second caveat is that post operation recorded crime rates for each of the first 4 markets showed no significant falls in acquisitive offending categories at the very time local problem users were in the care of the Treatment Outreach Team. Even in Eastside recorded crime rates did not show any reductions.

Drugs Awareness and Prevention with Local Young People

The Outreach Team were responsible for delivering *Objective 3* in providing drugs prevention inputs for local young people in each area. We have noted that the specific targeting of young people identified as 'at risk' of developing problem drugs careers slipped off the delivery agenda early in the Project's life. There was no specific sustained targeting, for instance, via Youth Offending Teams, Connexions, or Social Services child care/leaving care teams although the Team always 'networked' with these services during each deployment. The nearest the Team came to delivering these outputs was in Border Town with an impressive series of events for 50 secondary school children as well as a 'peer-mentoring' workshop for 15 adolescents via the local secondary school. A handful of Under 19 problem drug users did also enter treatment via the Outreach Team's treatment service.

Drugs Awareness and Community Development in Local Communities

The Treatment Outreach Team were primarily responsible for delivering *Objective 4* – drugs awareness programmes to local residents, parents, school staff and local community activists and related professionals in each fieldwork area. Here outputs were impressive in respect of drugs awareness workshops delivered via schools (mainly Junior (8-11 years) schools). Around 30 sessions were delivered engaging approximately 450 parents and teachers. In all cases participants made positive evaluations of the workshops in terms of increasing their knowledge about drugs, their effects, legal status and in understanding how to perhaps prevent and to deal with drugs incidents.

The modified course aimed at the bar/clubs scene developed for City was highly successful and economic to deliver with 22 sessions being run for over 200 participants. A further single delivery to 17 participants in Eastside Town was also undertaken. Thus large numbers of bar and club staff, parents, drug users and local stakeholders received up to date information about club drugs, overdose prevention and response as well as health and safety in the night-time economy. Whilst the outcomes of this programme cannot be assessed beyond highly positive participant evaluations the scale of output is impressive.

In terms of community development the DDMP's first secondment in Old Town was the only area where the community engagement role was fully delivered. In particular a series of community events and meetings, extensive networking and the setting-up of a community action group with a drugs focus left an effective legacy. At closure of the Project the community group had been suspended however awaiting refurbishment of premises in a local community centre. Unfortunately this element of the Outreach Team's work programme was never repeated and potential gains were not harvested. The reasons for this will be discussed in the final section.

Part of the community engagement brief for the DDMP was to enhance community involvement in resisting drug markets and engender a greater sense of community confidence and safety. Clearly the Police had an important role to play here. The Public Attitudes surveys, the SPARC fieldwork and feedback to local police officers all suggested the targeted enforcement against street level and open drugs markets was both expected and welcomed by local communities. Initial responses to the highly publicised operations were very positive. The closure of open town centre drugs markets, as in Market and Border Towns, was particularly praised by local residents and stakeholders.

There were signs however of scepticism developing through time as some markets re-configured or were unaffected by the Operations. It has been possible through routine policing to keep some of these markets displaced but the lack of systematic follow-up Operations shaped by re-mapping and re-targeting has been apparent. This is one of the great difficulties for drugs enforcement in a world of competing priorities, finite resources and performance targets across a full range of policing activities. Whilst the DDMP recommended follow-up enforcement in the same areas it was not able to get this delivered by busy divisional police staff.

Improving Information and Understanding of Local Drug Markets

Objective 5 was to collate data from multiple sources and create better information and understanding of local drug markets and problem user populations for dissemination to County and City DATs, Crime and Disorder Reduction Partnerships (CDRP), treatment services, etc. Thanks to excellent co-operation and information sharing (by all but one mainstream drugs service) this objective was largely achieved. The findings in the Annex illustrate how the new knowledge was produced in terms of pricing drug markets, profiling problem user populations and developing a dynamic 'model' of local drug problems and this report, in itself, is a further exemplar.

Several accessible reports and presentations to Regional Seminars and the City's CDRP were delivered. Feedback from all the stakeholders was positive about the added value produced by the DDMP's 'jigsaw' analyses. This was one of the advantages of having an evaluation/action research team as an integral part of the Project. On this objective the DDMP delivered effectively.

VIEWS OF THE KEY PLAYERS ON THE EFFECTIVENESS OF THE DDMP

As part of the evaluation all the members of the Project Board were asked to predict the likely outcomes of the DDMP at the outset in mid 2002. Nine members were interviewed (3 Police Managers, 2 DAT Co-ordinators, 2 Treatment Service Managers and 2 Regional Government Representatives). As part of the interview each was asked to score, on a Likert-type scale, on the likelihood of the DDMP delivering on its core objectives.

Two years later, near the end of the project, these key players were asked to utilise the same scoring system to represent their conclusions about outcome delivery. Two of the original Board members had left office but the part-time Chief Executive (not in post at the outset) was included in the follow-up. Figure 4.1 summarises views at the outset and conclusion at the end of the Project.

Figure 4.1: From Outset to Outcome: The Project Board's Assessment of the DDMP in 2002 and 2004

(i) The enforcement strategy of 'mapping' led targeting will substantially reduce the heroin/crack market in Derbyshire

	Very Likely	Likely	Not sure	Unlikely	Very unlikely
Outset	-	7	2	-	-
The enforcement strategy of 'mapping' led targeting has substantially reduced the heroin/crack market in Derbyshire over the life of the project					
	Very definitely	Largely	Partly	Not really	Not at all
Outcome	-	1	-	3	3

(ii) The Treatment Outreach Team will capture substantive numbers of drug users into treatment who would otherwise not be presenting

	Very Likely	Likely	Not sure	Unlikely	Very unlikely
Outset	1	4	2	1	1
Has the Treatment Outreach Team captured substantive numbers of drug users into treatment who would otherwise not be presenting?					
	Very definitely	Largely	Partly	Not really	Not at all
Outcome	-	-	-	8	1

(iii) A noticeable increase in community involvement and ownership of local hard drug scenes will be achieved

	Very Likely	Likely	Not sure	Unlikely	Very unlikely
Outset	2	4	3	-	-
The Project has noticeably increased community involvement and ownership of hard drug problems where it has operated					
	Very definitely	Largely	Partly	Not really	Not at all
Outcome	-	1	6	2	-

(iv) The project can be a model for effective partnership between enforcement and treatment/prevention strategies

	Very Likely	Likely	Not sure	Unlikely	Very unlikely
Outset	3	5	1	-	-
Has the project become a model of effective partnership between enforcement and treatment/prevention strategies?					
	Completely	Mostly	Partly	Marginally/hardly	Not at all
Outcome	1	5	2	1	-

(v) Overall the cost-benefit analysis at the end of this project will show real gains

	Very Likely	Likely	Not sure	Unlikely	Very unlikely
Outset	2	4	3	-	-
Given the resources utilised by the DDMP has it, overall, been cost-effective?					
	Completely	Mostly	Partly	Marginally/hardly	Not at all
Outcome	-	1	5	1	2

Derbyshire Drug Market Project

In respect of (i) creating local heroin/crack 'droughts' and reducing the operating size of Derbyshire's drug markets most players felt this would be likely at the outset but in 2004 the collective conclusion was that this had not been achieved. At the beginning of the DDMP there was moderate optimism that the (ii) Treatment arm of the Project would capture substantial numbers of drug users into treatment who would otherwise not be presenting. At the end of the Project and aware of the poor uptake Board members unanimously concluded that this outcome had not been achieved. In respect of (iii) enhancing community involvement and ownership of local hard drug problems in the targeted towns the moderate initial optimism was mediated with most respondents believing this goal had been only marginally achieved.

The experience of these players in respect of effective partnership (iv) was positive however and their initial expectations that their enhanced partnership working would be effective was, they felt, largely realised. However as their overall assessment (v) shows there was a collective recognition that the DDMP had not been cost effective in terms of delivering its aspirational goals and specific intended outcomes.

Discussion

In the final section we will discuss the lessons learnt from the DDMP. There are many and they produce added value particularly if they inform future local commissioning and practice in respect of delivering the drugs strategy at a local level.

From a cost effectiveness perspective the DDMP did not perform well across the board. It was moderately successful in respect of demonstrating that drug market mapping and targeted enforcement is more effective. The sheer scale of successful arrests and convictions of Level 1 and some Level 2 heroin/crack dealers is impressive. The Project enhanced feelings of community safety in respect of displacing open drug markets. The grander notions of creating local drug droughts, reducing volume crime and so on were not deliverable. Unwanted outcomes like drugs overdosing and violence in destabilised drug markets were avoided.

In respect of providing better information and understanding of local drug markets to enhance inter-agency work in the drugs field the DDMP also delivered effectively. Similarly, the delivery of drugs awareness programmes to local parents and stakeholders in 4 areas was successfully executed by the Project with the club drugs/overdose prevention courses being an additional highlight.

Where the DDMP struggled was in respect of delivering drugs treatment to problem drug users in each of the five communities. There was significant wastage of resources here with only around 70 clients engaged against the target of 300. The funds expended for this service in terms of opportunity costs could have provided major enhancement to mainstream services and starkly could have provided a robust mainstream service for around 400 problem drug users across the lifetime of the Project based on unit cost of a typical community drug service. Methadone maintenance would have improved crime reduction outcomes. This said, the treatment service probably more than paid for itself.

The DDMP also failed to remain focused on all its key delivery objectives. Thus the delivery of Hepatitis screening, the targeting of 'at risk' young people in of the five areas and the goal of enhancing community involvement in challenging hard drug markets all variously slipped-off the agenda. Whilst the impact of targeted drugs education and community development inputs are always hard to assess in terms of positive outcomes it must nevertheless be of concern that even as outputs these resourced strands of the Project were not appropriately delivered.

Finally, the *Invest to Save* requirement to utilise IT in communications at the local level proved highly problematic. The DDMP did not find a way of bringing interactive electronic communication to its drugs awareness/prevention or community development roles. The primary attempt to do this was to purchase an expensive Web Kiosk and write software so that it could be sited where local people could access the DDMP website and related links. The Kiosk was successfully set-up in a couple of locations but overall became something of a burden for a project regularly on the move.

The final section will consider the main learning points from the DDMP experiment. A great deal has been learnt which can inform policing and practice in the future and this can be credited as added value.

SECTION 5

PARTNERSHIP VERSUS PERFORMANCE?: NEW LESSONS ABOUT THE MULTI-AGENCY MANAGEMENT OF LOCAL DRUG PROBLEMS

INTRODUCTION: THEORY AND IMPLEMENTATION FAULTLINES

The DDMP partly achieved its goals in respect of drug market enforcement, community drugs awareness programmes and delivering better understanding of the complexities of managing drug markets and problem user populations and providing direct access treatment. As an action-research cum demonstration project it has also produced a lot of new knowledge about the difficulties of delivering the core goals of the national drugs strategy at the local level. This Section focuses on these lessons and so inevitably describes the difficulties and disappointments suffered by the Project. These are presented in order to encourage discussion and debate about how difficult it is, on the ground, to manage hard drug problems where delivery requires inputs from a complex configuration of key agencies in 'partnership' and delivery techniques which lack sophistication when held against ambitious goals requiring intense performance management.

The DDMP was built on several assumptions found in the drugs discourse. Its methodology assumed small semi-rural heroin/crack markets could be undermined to create a supply drought. The notion that drugs treatment is highly cost-effective especially in reducing crime was incorporated. The principle that delivering drugs interventions can be best achieved through multi-agency partnerships and co-working was also adopted.

If these assumptions/principles borrowed from the national drugs discourse are robust and veracious, then the non delivery of some of the DDMP's goals need to be framed as **implementation** failure. If the key assumptions are flawed and thus undermine effective delivery, then we can highlight **theory** failure.

In reality the DDMP struggled diligently with a complex set of 'faultlines' which become intertwined. Several of its conceptual assumptions proved unsound but its performance was further undermined by ineffective management structures and a lack of accountability in respect of delivering outputs and outcomes – suggesting a degree of implementation failure. Yet the inefficient delivery can also in part at least be traced back to the 'theory' assumption that inter-agency partnerships must be at the heart of local delivery.

INEFFECTIVE STRATEGIC AND OPERATIONAL MANAGEMENT SYSTEMS

In retrospect most Project Board members felt that the organisational structures for delivering such a complex and innovative project were inadequate. This conclusion coincides with the process assessment of the evaluation team. The DDMP was obliged to work as an inter-agency partnership to secure funding but anyway celebrated the

Derbyshire Drug Market Project

notion of partnership and merely extended its normalisation as the main vehicle for delivering the drugs strategy locally. Yet the project's management brought together quite different 'cultures'. The police culture focusing on enforcement was typically task centred and fairly bureaucratic. The drugs service-treatment culture is less focused on detail and deliverables and tends to live with inefficiencies and slippage in delivery, being far less accountable and rarely challenged by service users (problem drug users). Robust management of drugs services is not yet fully in place. The DATs tend to focus on commissioning and setting up services which they only monitor from a distance. DATs do not yet have effective performance-outcome assessment systems.

From the outset the Project Board was under-powered and poorly configured as a strategic and operational management system. Most Board Members now believe that more time should have been dedicated to setting up protocols and decision making systems which might have produced more effective line management. Accountability remained unclear throughout its life. The single biggest faultline or 'theory failure' in partnership delivery is its lack of a unified line management system. The Board either struggled with or retreated from key strategic and operational management decisions throughout its life. Its funding streams denied it a 'thin' low cost set up period where a development manager could create systems and protocols and devise organisational procedures. Thus with sudden 'full on' funding significant timetable slippage immediately set in in respect of recruiting the Treatment Outreach Team and devising an appropriate management system. Yet the Project Board had no mechanisms for rescuing this poor start beyond discussion and pleading between partners. The process of poor delivery from the treatment arm of the project was never resolved and there was little discussion at any time about the non delivery of community development, non targeting of young people in each field area and the lack of ICT in the delivery process. There were simply no rigorous reviews of performance against targets. In other organisational structures this performance management would be routine with, for instance, non-executive Board Directors demanding improvements from the executive teams.

In their retrospective reviews of performance Board Members accepted that their private disappointments and concerns about delivery were not often voiced because there were no 'safe' procedures in the Board to challenge colleagues and re-gear performance. In retrospect key players wished they had been more assertive with each-other about expressing their concerns about under performance.

"We didn't get full value from Mapping.....they utilised very little info outside police intelligence....and I'd hoped that the mapping would map all the markets in the county/City. I should have been more challenging."

"The Treatment Outreach Team's failure to target and I understand that people need to want treatment but I wanted to see us do more than just sit and wait for people. We should have tried to be more proactive."

“The inability to get away from politics...we must do the City market...when we would have had more impact elsewhere. However, I stand as guilty as anyone on this.”

“I found the experience of management and decision making through the Board structure debilitating and frustrating. The power to make operational decisions was severely restricted and in retrospect I should have worked harder in the early stages of the Board’s formation to establish more robust terms of reference”

Rows were occasionally had both in and outside the Board but as one police manager put it “who needs them...they don’t get you anywhere except upset”. So in the absence of protocols, for instance by taking a conclusive vote on a key decision, mini power struggles about priorities festered away. The non attendance of Board Members at monthly meetings only exacerbated this process and extended delay and slippage.

Two issues caused particular dissatisfaction. Firstly, there was much unhappiness in the Board and the staff about the re-defining of which drug market areas in the county should be targeted. Different stakeholders wanted to ensure the DDMP came to their area to satisfy the wider ‘political’ goals and justification for matched funding which they had to manage. The enormous scale of the ‘City’ secondment was the most contested and affected morale across the project particularly for the Treatment Outreach Team.

Secondly, almost all Project Board Members felt seriously unhappy with the financial and auditing systems. Several spoke of feeling ‘guilty’ about not being able to track funding streams and identify slippage and underspends effectively. A regional government officer Board representative who anyway felt “my role has never been clear” was appalled by the financial systems: “I felt a degree of culpability but the Board wasn’t strong enough to challenge....”.

The financial management difficulties of the project seem to stem from different professional/stakeholder understandings and approaches. The budget was set up with a ‘commissioning’ model but with split responsibility between Addaction as paymaster and a new Health Trust acting as administrator /auditor but with no real mechanism for monitoring expenditure to produce up-to-date accounts. Further complications occurred when different spending and accounting rules (e.g. the police) were incorporated. Too many funding streams further undermined robust accounting. There is important learning here for future ambitious multi-agency collaborations. It seems important that the ‘Board of Directors’ should be fully briefed and fully accountable for funding and expenditure decisions. The approach utilised by the DDMP undermined and exasperated a large group of experienced professionals regularly used to taking responsibility for budgets. Views about why financial management was ineffective still remain contested between the key players. As ever however the confusion over ‘accountability’ sources this problem.

The appointment of a part-time Chief Executive several months into the programme was a direct result of the recognition by stakeholders that the project was 'wandering'. This appointment helped considerably but only thanks to the CE's diplomatic and task centred approach. There was no revised accountability or line management review and the CE essentially lacked authority in tasking any delivery staff or the commissioning agencies. Accountability for performance and finances remained in the air. The Treatment Outreach Team undertook a retrospective review exercise for the evaluation. They too felt that their management had been problematic and inconsistent. Their collective view was:

"It's felt that effective, experienced management of a project of this design is paramount to its success. We needed managers with funding experience, person management skills and a sense of direction."

The Team admitted to feeling it was "headless" and "flapping around", "without any grounded reality" and on the fringes of both the Management of the Project Board and their mother organisation. The Team essentially fell down the accountability cracks between Addaction and the Project Board.

Finally, in respect of inter-agency fora, the DDMP never established effective communication and collaboration with one key mainstream drugs service. This produced problems for the evaluation and case tracking to assess treatment retention and outcomes. More importantly it led to weaknesses in case transfer and 'seamless' care management as East town demonstrated whereby 12 service users, doing well in treatment with the DDMP, could not be effectively transferred to the mainstream service.

Whilst one Board member noted " this Service and Trust were very difficult to engage and get good partnership working with. On reflection we should have brought them on to the Board at senior manager level from the beginning". Another argued that they had been invited but were poor attenders.

FINDING NEW WAYS OF INTEGRATING 'PARTNERSHIP' AND PERFORMANCE

Despite all these problems the DDMP stakeholders still sincerely believed, at the end of the project, that inter-agency work had been enhanced. This was because in working together so intensely and most often convivially, the enforcement, treatment and commissioning stakeholder groupings had all learnt a great deal about each others' cultures, priorities and ways of working. In particular trust of each other's agencies to maintain confidentiality and treat sensitive information with care was cemented and understanding of others' professional agendas was developed.

"We've all learnt to trust each other with confidential information"

"I've learnt a hell of a lot about how hard it is to make drugs treatment work"

The DDMP's ability to enhance understanding of how drug markets operate (see Annex) and configure and how local problem drug user profiles can be generated to inform strategic management also produced positive assessments of partnership work. Each stakeholder group recognised that this deeper understanding of drug problems on their patch was created by information and data sharing at an unprecedented level. New decision making and information sharing arrangements have been put in place within Drug Action Team structures as a consequence (e.g. assessing drug availability through multi-agency information sharing).

From an evaluative perspective and looking at the DDMP as an 'organisation' tasked to deliver a complex set of goals and targets, there is a tension between partnership and performance. Partnership made the DDMP possible and sustained it throughout yet relying on multi-agency partnerships, per se, to drive, monitor and review performance was the project's Achilles heel. There are other organisational structures which celebrate partnership and co-working but which embrace unified line management and more stringent accountability for 'Boards'. The Youth Justice Board-Youth Offending Team structure has managed to embrace multi-professionalism within a unified strategic operation and line management system.

Future developments and programmes in multi-agency working in the drugs field might be utilised to pilot different organisational structures. With the knowledge and experience gleaned from this experiment, all the key players in the DDMP agree they would set up a further similar project very differently. The case for experimenting with more unified projects, with secondees accountable to one managerial structure and with one operational budget, is a strong one.

NEW LEARNING ABOUT POLICING DRUG MARKETS

The DDMP tested the hypothesis that intelligence led targeting and mass arrests of Level 1 dealers and runners, etc. when applied in small rural towns can disrupt hard drug markets and create a temporary 'drought'. Whilst the poor results undermined the project's wider goals, the experiment was a success. It has demonstrated that even at small town level such disruption cannot be achieved. Small open markets can be closed but dealing can only be displaced. The wider local and regional markets reconfigure and maintain supplies. There were minor inefficiencies (implementation failure) in respect of the over reliance on Test Purchasing, effective operational delivery in busy police divisions and an inability to resource repeat enforcement, but essentially the Derbyshire operations were competently planned and executed. The reality is that intelligence about drug markets is only partial and that sufficient resources to maintain high level enforcement in any one area can never become available when set against the wide range of police priorities and performance targets.

For the police stakeholders the DDMP confirmed their suspicions that:

"All we can ever hope to achieve, no matter what efforts are put in – is to keep the lid on the availability of drugs – and that is an achievement in itself."

This is an important learning point. The accumulated evidence is that drug markets are too embedded in the wider community to be eradicated whether in urban or now semi-rural settings. However without on-going enforcement these markets would almost certainly produce further deterioration in community life, the number of new problem users and the scale of drug-related crime. In City, for instance, crack markets are becoming so problematic that with finite resources the debate is being had about whether the arrival of associated guns and violence has to be a greater enforcement priority than heavily policing the retail crack market. 'Keeping the lid on' drug markets becomes the more pragmatic and realistic goal rather than simply sweeping up the street level retailers for a period in custody in the vain attempt to close the market. However, this private discourse cannot be easily had with the public who expect all crime related problems affecting them to be prioritised.

DIFFICULTIES HARVESTING THE POTENTIAL GAINS FROM DRUG TREATMENT

The assumption that drugs treatment is highly cost effective where large problem user populations are in situ should be robust. The international literature repeatedly finds these gains but as always with caveats about the circumstances, settings and treatment regimes required. In truth the UK drugs treatment sector is not yet sufficiently powered to maximise gains and is several years away from being able to deliver effectively despite massive investment and the modernisation agenda. We have noted the DDMP's problems in recruiting and retaining competent experienced drugs service managers and staff, finding suitable premises, contracting appropriate doctors and offering a range of different treatment regimes to match diverse needs and stages of addiction and user lifestyles. This is a national structural problem and the DDMP had to operate against this challenging backcloth as best it could.

What compounded the delivery problems for the DDMP was related to methodology and implementation failure. The Treatment Outreach Team suffered from the unintended consequences of public partnership with the Police which undermined local user presentation. There were no heroin 'droughts' created believed to trigger early presentation. And finally temporary secondments to a new area prevented the genuinely good name of the service from bedding in and percolating through problem user networks. Local referral agencies also had no time to feel able to recommend the service to potential clients. Even if the Outreach Team had been competently performing and line managed, it is doubtful whether the treatment numbers and outcomes could have been significantly enhanced in all these circumstances. The motivational triggers which lead problem drug users into treatment are highly complex and not easily manipulated.

FINALLY

The government intends to increase scrutiny of the delivery of the national drugs strategy at the local level over the 2004-08 'Public Service Agreement' period. There will be more focus on the 'impact of our investment and programmes' with audits and inspections of drug services and hosting Trusts alongside the rapid increase in treatment places. An 'outcome based' approach to assessing supply reduction of illicit drugs through all levels of drug markets including local police enforcement will be prioritised. All this is still to be managed within the 'partnership' approach (see Public Services Agreements 2004).

Lessons from the DDMP suggest that there are major 'structural' difficulties with the current approach to local delivery. It is important to recognise and incorporate some of these lessons in the debate about 'effectiveness'. There are faultlines in the national strategy's assumptions which should be recognised at the centre. The conditions required to make treatment work are many and complex and a degree of patience is required to allow drugs services to become more effective. More attention to facilitating their improvement and less emphasis on collecting 'target' data and satisfying Whitehall's rather different agendas is required. As importantly the delivery model for the drugs strategy is inadequate whereby the inter-agency partnerships *per se* struggle to create the management processes required to deliver complex initiatives. A few will deliver well but most will not.

Further dialogue about both the theory and implementation shortcomings in the overall national drugs agenda, which the DDMP has illustrated as conspiring to make local delivery problematic, must be had. The next phase of national implementation might well turn the favoured 'traffic light' risk assessment from amber to red if outcome performance becomes the primary driver but the performance delivery is organisationally under-powered at the local level.

REFERENCES

Bennett, T. and Holloway, K. (2004) *Drug use and offending: summary results of the first two years of the NEW-ADAM programme* Findings 179, Home Office, London.

Best, D., Strang, J., Beswick, T. and Gossop, M. (2001) 'Assessment of a concentrated high-profile police operation: no discernible impact on drug availability, price or purity' *British Journal of Criminology* 41, pp. 738-745.

Bramley-Harker, E. (2001) *Sizing the UK Market for Illicit Drugs* RDS Paper 74, Home Office, London.

Cartwright, W. (2000) 'Cost-benefit analysis of drug treatment services: a review of the literature' *Journal of Mental Health Policy and Economics* 3, pp.11-26.

Godfrey, C., Stewart, D. and Gossop, M. (2004a) 'Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from NTORS' *Addiction* 99, pp. 697-707.

Godrey, C., Parrott, S., Eaton, G., Culyer, A. and McDougall, C. (2004b) 'Can we model the impact of increased drug treatment expenditure on the UK drug market?' Paper prepared for the 24th Arne Ryde Symposium, *Economics of Substance Use*, University of Lund, Sweden, 15th-16th August, 2004.

DDMP (2004) *Derby Drug Futures*, Derby City DAT, Derby.

Harocopos, A., Dezlee, D., Turnbull, P., Parsons, J. and Hough, M. (2003) *On the Rocks: A follow up study of crack users in London*, NTA, London.

Home Office (2000) *Drug Seizure and Offender Statistics, United Kingdom, 1998*, Home Office Statistical Bulletin 3/00, Research, Development and Statistics Directorate, London.

Lupton, R., Wilson, A., May, T., Warburton, H. and Turnbull, P. (2002) *A rock and a hard place: drug markets in deprived neighbourhoods* Home Office Research Study 240, Home Office, London.

Mason, M. and Bucke, T. (2002) 'Evaluating actions against local drug markets: a 'systematic' review of research' *The Police Journal* 75, pp. 15-30.

May, T., Harocopos, A., Turnbull, P. and Hough, M. (2000) *Serving Up: The impact of low level police enforcement on drug markets* Police Research Series 133, Home Office, London.

Millar, T., Gemmell, I., Hay, G. and Donmall, M. (2004) *The dynamics of drug misuse: assessing changes in prevalence* Home Office On line Report 35/04, London.

NCIS (2001) *The threat from serious and organised crime in the United Kingdom* National Criminal Intelligence Service, London.

Parker, H., Bakx, K. and Newcombe, R. (1988) *Living with Heroin: the impact of a heroin epidemic on an English community* Open University Press, Buckingham.

Parker, H. and Bottomley, T. (1997) *Evolving Crack Cocaine Careers: New Users, Quitters and Long Term Combination Drug Users in N.W. England* Home Office RSDR, Home Office, London.

Parker, H. (2004) 'The new drugs interventions industry: What outcomes can drugs-criminal justice-treatment programmes realistically deliver' *Probation Journal* Vol 51, No. 4, Special Issue 'Rethinking Drugs and Crime'.

Pearson, G. and Hobbs, D. (2001) *Middle Market Drug Distribution* Home Office Research Study 227, Home Office, London.

Public Services Agreements (2004) *Public Services Agreements*, Treasury, London.

Scottish Executive (2004) *Reducing the impact of local drug markets: a research review* Effective Interventions Unit, Scottish Executive.

Webster, R., Hough, M. and Clancy, A. (2001) *An Evaluation of the Impact of Operation Crackdown* Criminal Policy Reserch Unit, South Bank University, London.

ANNEX 1

PROFILING AND 'UNDERSTANDING' LOCAL DRUG MARKETS AND HEROIN-CRACK USER POPULATIONS

INTRODUCTION

This Annexed Section describes and illustrates the 'practice theory' developed by the DDMP in terms of profiling and mapping hard drug markets and understanding the history, epidemiology and characteristics of local level drugs problems and the indigenous problem user population. One of the positive outcomes of the Project has been the ability to bring together enforcement/police/crime data with profiles of local problem users and the performance and nature of drugs treatment regimes. By collating and pro-actively analysing these data it has proved possible to produce a dynamic model of the evolution, current status and future prospects of heroin-crack related problems at town and city level. This in turn can inform strategic planning for policing and drugs enforcement and the commissioning and configuring of drugs interventions especially Tier 2 and 3 mainstream drugs services.

The ability to do this rested within the DDMP's commitment to having an action research-evaluation team within the project. **SPARC** staff were able to apply social science and epidemiological techniques to 'understanding' drugs in Derbyshire. These methodologies are not new but have rarely been fully utilised in the drugs field beyond 'Needs Assessments' for local DAT areas and the application of crude formulae to estimate the size of problem user populations although there are clear signs of increased sophistication emerging (e.g. Miller *et al*, 2004)

In this section we briefly illustrate the kind of modelling which informed the DDMP by showing how bringing together police-stakeholder-treatment and primary research data can produce added value to delivering the drugs strategy at the local level. The key principle of this profiling/modelling is that only very partial pictures emerge from one source but through integrating 'theory', primary research, policing, treatment and general data sources (e.g. area demographics, housing, deprivation, service provision) these jigsaw pieces begin to describe a fuller picture.

JIGSAW ANALYSIS OF LOCAL DRUG PROBLEMS

Drugs Epidemiology as a Backcloth

There are recognisable timelines and diffusion patterns when heroin and crack arrive and bed into a local community and 'find out' a minority of residents who become regular and then problem drug users (Parker *et al*, 1988). Speaking very generally, some areas of the UK were affected across the 1980s by heroin outbreaks (e.g. Scottish cities, N.W. England and London), whilst other regions only saw heroin's full on arrival from the mid 1990s (e.g. East Midlands and Yorkshire). Crack has also arrived at different times in different regions, first bedding into the old heroin cities (e.g. London,

Derbyshire Drug Market Project

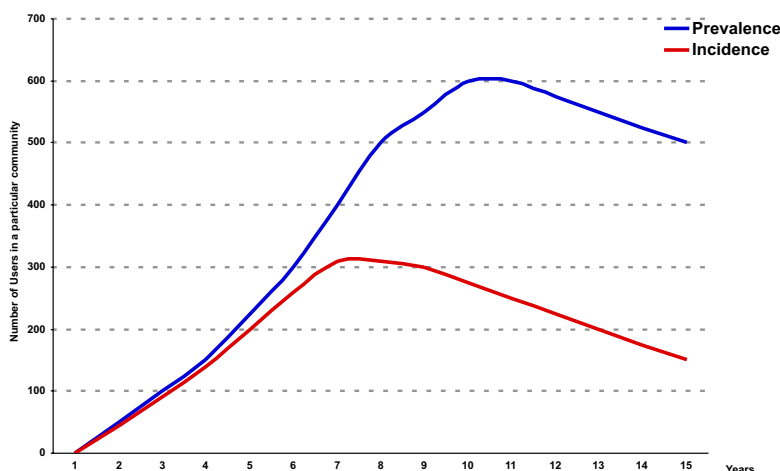
Manchester and Liverpool), sometimes making 'surprise' appearances (e.g. Nottingham) or very quickly following a heroin outbreak (e.g. Sheffield). Some cities with a heroin footprint from the 1980s have suffered a heroin and crack problem of particular intensity during the 1990s (e.g. Bristol and Bradford). Some cities have not yet had to confront a sustained major heroin-crack problem (e.g. Belfast).

This same complex pattern of diffusion and difference can be seen in towns across the country. It follows therefore that one shoe does not fit all and that the effective delivery of drugs interventions whether enforcement, prevention or treatment must be based on understanding or 'modelling' a discrete local community's drug problem.

Each community has its own heroin and, increasingly, crack history and it is important to understand this in order to produce a dynamic model. In particular we need to know when heroin first arrived in a town or city. This allows us to create a timeline (e.g. 1980-2004). We then need to estimate how many new users of say heroin there were in each year. This is the *incidence rate*. As each year passes from heroin's significant arrival the aggregate of new users (minus those who stop using, die or leave the area) is called the *prevalence rate*. This is the number of heroin users in the community at any one time.

Traditionally we were able to identify an epidemic model for heroin which had a natural life of 10-20 years. Today this is more difficult with such aggressive and effective heroin-crack marketing ensuring 'natural' macro diffusion between communities is undermined. This epidemic model must now be applied as a guide – a general principle worth applying – rather than a robust forecasting tool. As Figure 1 illustrates there is a period of several years when most people in a community who are going to take heroin do so. This incidence rate then tends to fall off at different rates in different communities (see Millar *et al*, 2004) making local plotting vital for sensible service planning. However because few heroin users give up their drug of choice quickly but embark on careers spanning a decade or more, then the total number of users in the community nearly always grows annually for many years.

Figure 1: Very Basic Outbreak Model for Heroin

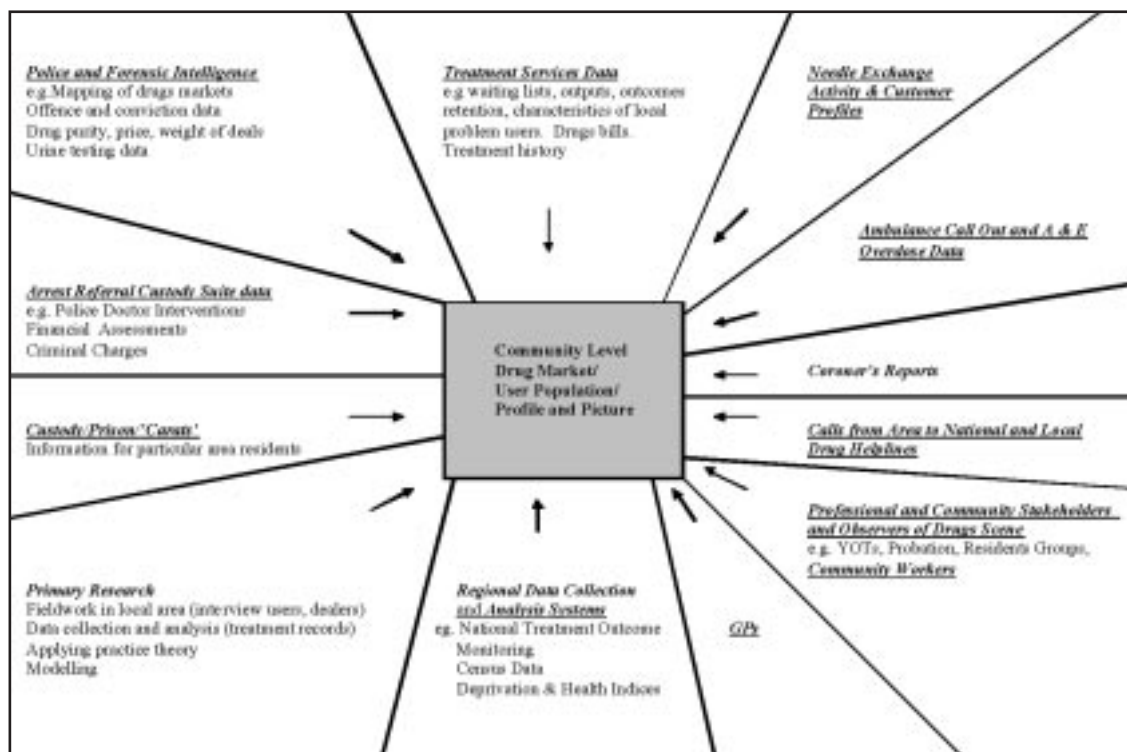


The heroin outbreak model has been further complicated by the bedding-in of crack and the development of heroin-crack drugs careers. In truth, research led epidemiology has been in short supply and we do not have robust modelling methodologies to utilise especially in relation to crack cocaine. In the DDMP this epidemiology was applied loosely and as no more than an aid to mapping and modelling.

The Jigsaw Pieces

Figure 2 illustrates how information and indeed 'ideas' from multiple sources are required to create a jigsaw 'rough guide' to a particular community's drugs profile and problem. The DDMP, as a multi-agency corporate programme with a research-evaluation arm to act as catalyst, was able to collate key data from all the sources shown and produce an outline model of town and small city level drugs 'problems'.

Figure 2: Jigsaw Analysis of Local Drug Markets and Problem User Populations



The Mapping Team had the capacity to provide detailed profiles of heroin and crack markets based on known intelligence and access all manner of information on drug prices, purity levels, 'deals', crime figures, urine testing results, custody suite records (e.g. medical interventions, financial assessments) and case tracking to conviction of arrestees. The Team also collated 'public' intelligence (e.g. needle finds, *Crimestopper* reports). The treatment services both produced activity reports and allowed ethically-approved, anonymised, secondary analysis of their data sets and case files. This generated a wealth of information which allowed the area's heroin and crack history to be outlined, the characteristics of local problem users, their drugs bills, previous

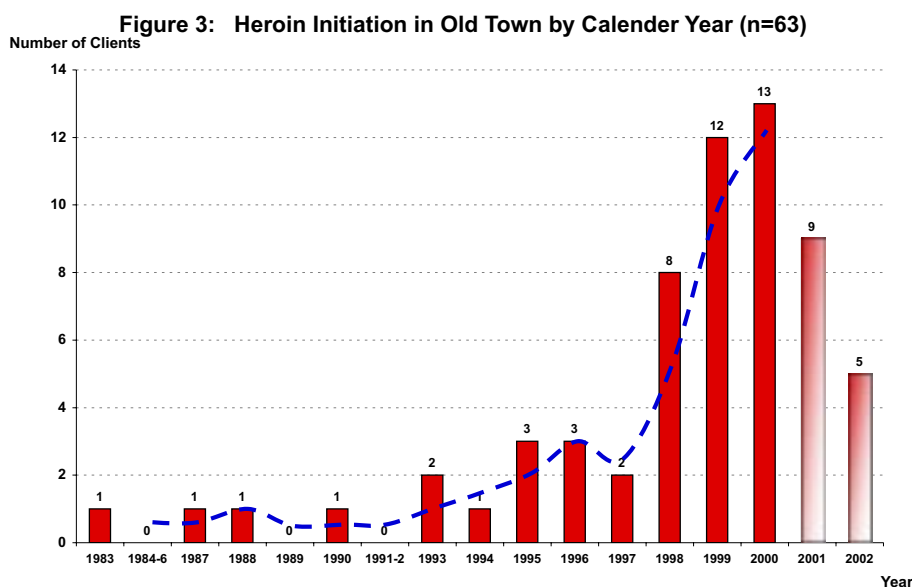
Derbyshire Drug Market Project

treatment episodes, etc. Needle Exchange data was also available for analysis. We saw in Section 2 how Helpline and ambulance call out data provide insights into local problem drug use. Accident and Emergency data was not but should ideally have been accessed and analysed in respect of accidental and deliberate overdoses and the substances involved. In Market and Border Towns the shared care GPs provided key information and important perspectives on the local problem user scene. Arrest referral logging can also provide insights.

Accessible regional data sets can provide a demographic profile for each area with housing, education and health indices creating a backcloth. A potentially key data set is the National Treatment Monitoring System although in reality this is poorly administered in some areas. The Home Office now provide information on prisoners and drug treatment interventions they receive in custody by area of residence. This information can be factored into the local profile.

Examples of 'Outbreak' Modelling in Derbyshire

If we can obtain accurate data on heroin initiation from a reliable sample of problem users in a community, we can begin to grasp the nature of the local epidemiology. Figure 3 for instance used heroin initiation year data from treatment cases (n=63) with Old Town addresses. From various sources the picture built up of Old Town was of a small heroin population from the end of the 1980s but with a growth of the problem from the mid 1990s. This was confirmed by analysing the incidence history. The steep climb from the mid 1990s is in part illustrated by those presenting for treatment.

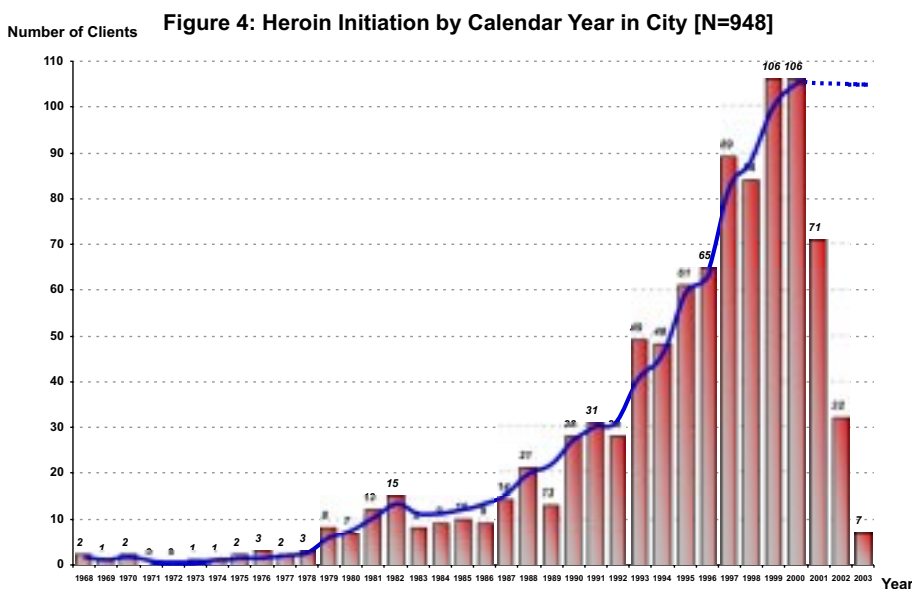


NB: A further 6 individuals had appropriate data missing

However in Derbyshire heroin users are taking an average of 6 years to first present. So presenters after 1999 are mainly 'early' presenters. This suggests the incidence curve is only now peaking in Old Town. This in turn suggests prevalence is yet to plateau and also that the rate of spontaneous presentation to treatment services will continue to grow and/or remain high for many years. Some validation of this modelling done in 2002 is now being found in the steady rate of presentation to a new permanent drugs service in Old Town. Ideally all the new cases should be analysed and the modelling updated and revised.

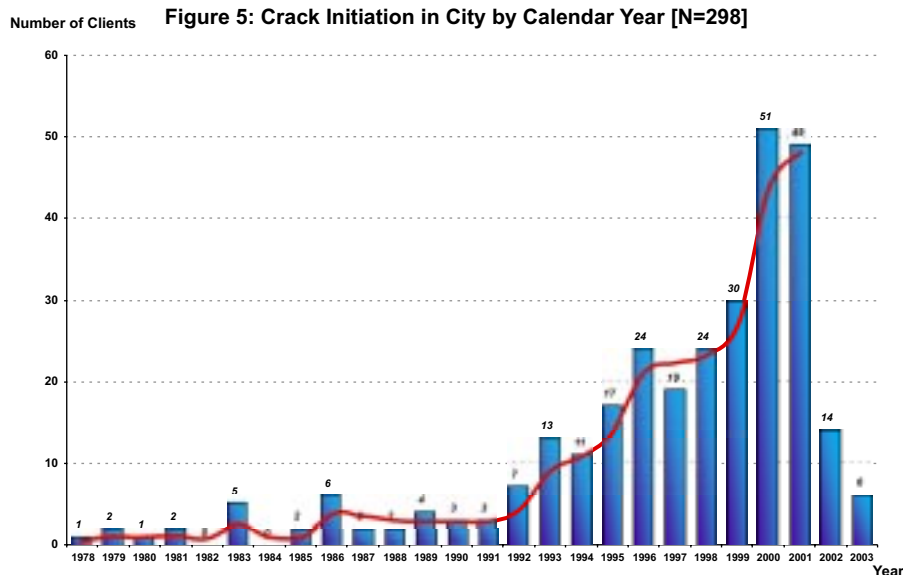
When we undertook this exercise for Market Town we found that heroin had only really arrived during the mid 1990s. In this locality users were younger and only initiated in the period from 1996. This suggests that spontaneous presentation will not peak for a few years in this area and that outreach work is required. Border Town, on the other hand, was affected by the far earlier heroin outbreaks of Greater Manchester and its user population is older and often very treatment experienced. Few young heroin users are likely to be *in situ* as the next birth cohorts in an 'old' heroin town tend to reject its use.

Turning to City where the most extensive modelling was undertaken based on a large sample of treatment cases of almost 1,000 local problem users with complete and valid data, Figure 4 below shows that City had a heroin problem from the 1980s 'wave' of outbreaks. Unfortunately this cannot be fully illustrated as no treatment data prior to 2000 is available. Nevertheless the second or extended incidence wave is clearly shown and given the presentation lag of 6 years, the incidence curve has yet to peak. This helps us plan a tailored long-term treatment strategy (see DDMP, 2004).



Derbyshire Drug Market Project

Turning to crack-cocaine in City all the jigsaw indicators point to a growing crack problem. Consistent with this is the initiation pattern for City crack users who have been in treatment (in fact mostly for heroin dependency). In Figure 5 below we can see that crack is only now bedding-in. We can reasonably predict that the incidence curve will continue to climb for some time. In the near future presentation for treatment will mostly be for heroin-crack/poly drug problems although a small primary stimulant problem user population is in the making according to treatment and direct fieldwork data. Again this allows commissioners to reconfigure future service delivery.



Having tried to understand a local area's heroin-crack history, the next key task undertaken was to size and profile the problem user population.

ESTIMATING THE SIZE OF LOCAL PROBLEM USER POPULATIONS

Methods for estimating the size of drug user populations range from expensive, longitudinal capture-recapture studies to applying unvalidated formulae without any substantive data collection. The DDMP, because it collected and shared multi-sourced drugs information and had the time and resources to undertake primary and secondary data collection, was able to produce fairly sophisticated calculations.

From drugs services' records it was possible to aggregate the number of people in treatment by primary drug of choice and undertake extensive secondary analysis of case files. Needle Exchange data was also collected. All this was supported by primary fieldwork in all 5 areas, interviewing dealers and users of heroin and crack.

This data richness allowed the application of several recognised techniques for estimating local, problem user population sizes. In Old Town we estimated there were around 350-400 heroin/crack users, in Market Town a small younger population of about 200 heroin users and in Border Town the population was about 150 heroin-crack

users. In City the estimate was 3,000-3,500 heroin/crack users with crack being a secondary drug for at least a third of the hosted population. We will utilise City to illustrate how these estimates are made using the available data. Four different estimator formulae were applied.

1. National Drug Strategy Formula.

This estimate should be based on the number of people in treatment in England in one year, the population of England and the population of City. The formula which utilises these data then calculates the size of City's problem user population as if City were at the mean/average for the country. The most recent estimate of problem users in England is about 500,000, the overall population based on 2001 census data was 52,455,300 and City's population of 221,708.

The formula is thus:

$$\frac{500,000}{52,455,300} \times 221,708 = 2,114$$

2. Bramley-Harker Estimator

This estimator involves applying an unvalidated formula which requires being 'fed' several enumerators from local arrest and imprisonment data and utilising findings based on the NEW-ADAM urine testing drug monitoring system. This approach appears to over-estimate numbers of heroin users in rural areas. It also has difficulty dealing with the reality of poly-drug use whereby it cannot calculate heroin-crack user populations but only 'single' drug populations.

So for heroin users in City the complex calculation looks as follows using a basic and advanced formula.

Table 1: Estimated number of heroin users in City based on Bramley-Harker formula

Formula	Description	Calculations and Estimates for Heroin
A	Annual number of persons arrested in City (excl. South Border Town)	10,165
B	Percentage of NEW-ADAM sample that are regular users	21.7
C = (AxB)	Number of regular users arrested	2,205
D	Probability user has been arrested in last 12 months	0.64
E = (C/D)	Estimated number of users	3,445
F	Probability user has been in prison in last 12 months	0.28
G	Number of individuals in prison	964
H	Mean number of months in prison	2.0
I	Number of 'whole time equivalents in prison'	160
J = (E-I)	Number of regular users in the community	3,285

Derbyshire Drug Market Project

The calculation for crack-cocaine users produces an estimate of 2,000 but we know that the vast majority of these are also heroin users from the treatment and fieldwork data analysis. We estimated about 350 primary crack users in City who may not use heroin.

From here it is reasonable to suggest this estimator falls in a range of 3,600-3,800 heroin/crack users.

3. Treatment Demographic Model

This estimator requires us to factor in the number of problem drug users in England and Wales taken to be 500,000 alongside local data about the number of clients new to treatment and the length of their use of, in this case, heroin, cocaine and crack prior to entering treatment. By extracting the key data from local treatment records for 3 recent years, we applied this formula as follows:

$$\begin{array}{rcl}
 \text{(a)} & = & \text{(b)} \quad \times \quad \text{(c)} \\
 \text{Number of problematic} & & \text{Number of opiate/crack} \\
 \text{drug users} & & \text{cocaine* users entering} \\
 & & \text{treatment in any given} \\
 & & \text{year for the first time} \\
 & & \text{Average duration of} \\
 & & \text{problematic drug use} \\
 & & \text{prior to entering} \\
 & & \text{treatment}
 \end{array}$$

Table 2: Treatment Demographic Model based on problem drug users on first presentation 2000-3

Year (October to September)	Clients new to treatment	Duration of use prior to first presentation (years)	Estimate
2000-01	456	6.70	3,055
2001-02	387	5.83	2,256
2002-03	281	5.39	1,515
<i>Average</i>	<i>374</i>	<i>5.97</i>	2,233

NB: Calculations performed on the basis of heroin, crack and cocaine users and excludes amphetamine injectors

Table 2 shows estimates employing the Treatment Demographic Model based on the equation above. The period 2000-01 provides the highest estimate by far of over 3,000 heroin, crack and cocaine users derived from 456 individuals entering treatment with an average of almost 6 years 9 months (6.70 years) of drug use prior to first presentation. In the following two years estimates for this population fall to 2,256 (2001-02) and 1,515 (2002-03). These decreases are explained by fewer first time presenters (387 and 281, respectively) with shorter duration of use prior to recorded date of first presentation (5.83 years and 5.39 years, respectively). We have also included an average calculation which shows the estimate for City's problematic drug user population to be 2,233.²

4. Treatment Coverage Model

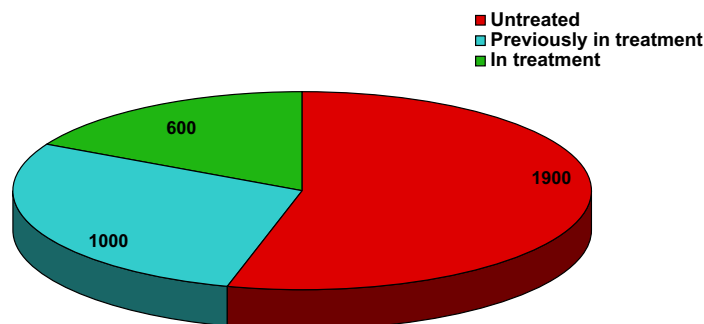
This formula requires the total number of heroin/problem users in treatment in any one year to be calculated. It is then assumed this in-treatment population is only a proportion of the overall problem user population. Based on the results of capture-recapture studies the ratios have been found to rest between 1 in 4 and 2 in 5. In areas where heroin outbreaks are recent, the hidden or out of treatment population tends to be far larger than the in-treatment population. Where heroin incidence has peaked and heroin use is endemic, studies tend to find a higher proportion in treatment. Clearly this formula can be undermined by different levels of local drugs treatment provision. For City, with 1,250 in recent treatment experience, the range falls between 5,000 and 3,125.

$$(a) \quad 1,250 \quad / \quad 1/4 (0.25) \quad = \quad 5,000$$

$$(b) \quad 1,250 \quad / \quad 2/5 (0.40) \quad = \quad 3,125$$

These four estimates produce a range around 2,200-5,000 but with 3,000+ being most often produced. By looking at this estimate range against other modelling data we can close down the range. In particular we can try and distinguish between the *in-treatment*, *previous treatment*, and *untreated* populations in City. The in-treatment population at any one time for City was 600. However with retention rates poor, at less than 50% a year, then even since yr 2000 we can count another 1,000 with previous treatment experience but not currently in treatment. Based on our 3,000-3,500 total problem user population estimate, this would mean about 1,400-1,900 as yet untreated. A useful way to validate these ratios over and above the treatment data is to look at Needle Exchange activity for the City. We were able to estimate that around 1,000 drug users access the 4 Pharmacy and 1 Agency Needle Exchanges over a year. However, looking at equipment distributed, a small number of steroid injectors are apparent in this population. Few of this large population of injectors were in treatment so giving further support to the presence of a large, as yet untreated, population. This fits the earlier treatment data analysis showing that users in city typically take 6 years to present (unless 'captured' early in the youth and criminal justice-child care systems) and that many are likely to have started using only recently according to the epidemiological forecasting.

Figure 6: Overview of City's Estimated Heroin/Crack User Population



PROFILING PROBLEM USERS: DRUGS BILLS AND FUNDING STRATEGIES

Heroin-Crack Consumption 'Bills' and 'Cheaper Deals'

There are numerous profiling dimensions that can be collated for problem user populations. Here we illustrate the process in respect of looking at the drugs consumption patterns of City's 'known' problem users and how they fund expensive habits.

The key data flowing from profiling those with treatment files and also conducting primary fieldwork interviewing local heroin-crack users allows us to price the average drugs bills for users in different towns and to collate self reports of methods of funding these large bills by a population generally not in legitimate employment. These rough estimates are as close as we can realistically get to 'the truth'. This is because, in reality, heroin and crack users do not always have uniform 'steady' weeks. Lack of resources, lack of supplies, 'giroday', a period in custody, a period in hospital, a need to 'rest' from crack cocaine and so on all impact on use patterns. Drugs workers tend to record one typical or recent assessment from their clients usually by number of deals or bags a day. Very often crack use has not been adequately discussed and assessed. There is also missing data and we cannot be sure service users want or feel able to be totally honest with drug treatment services. Finally, the price of heroin and crack is unstable and diverse in Derbyshire with many different deals available.

What drugs workers did record in City services however was disclosures during assessments with heroin users in which they state the use of 1.0g costing £50. Other disclosures show presentees paying £40 for four bags or weekly habits of 25 bags costing £250. The point at issue in this discussion is whether or not a 'bag' of heroin can be considered to contain 0.1g or 0.2g of 'substance'. A gram of heroin costing £50, a regularly quoted price, helps us to calculate the cost of other 'amounts scored'. There is no reason for us to believe that four or three bags will contain any less than 0.8g or 0.6g respectively with the former costing £40 and the latter £30. Furthermore, approximately one in ten assessments of heroin users attending Addaction in City who admitted using 1.0g per day also stated that they paid £50 for such an amount and significant proportions using 0.5g at a cost of between £25-30. The logical deduction from this evidence is that we cannot assume that 'a bag' contains only 0.1g. Our evidence from fieldwork interviews corroborates this view.

Table 3: Cost of heroin per gram (£) by average heroin use range up to 12 weeks prior to interview (n=56)

Use-period prior to interview		Average daily heroin use range (grams)					<i>All</i>
		Less than 0.30g	0.30g to 0.49g	0.50g to 0.99g	1.00g to 1.50g	Over 1.50g	
<i>7 days</i>	n size	23	7	8	0	1	39
	£ per gram	59.01	50.00	41.07	~	17.55	52.65
<i>1-4 weeks</i>	n size	24	8	14	0	1	47
	£ per gram	61.30	49.59	41.40	~	17.55	52.45
<i>5-8 weeks</i>	n size	19	10	15	4	2	50
	£ per gram	62.56	51.67	45.63	38.34	24.94	51.86
<i>9-12 weeks</i>	n size	22	11	14	7	2	56
	£ per gram	61.93	53.03	47.97	35.58	24.94	52.08

Table 3 shows that overall a gram of heroin costs on average between £51.86 and £52.65. Obvious differences do occur depending on the level of usage with average price per gram reported by lower level users costing significantly more than those with larger habits. We acknowledge that calculations of this nature are further complicated by the fact that experienced heroin users involved in high levels of use are more likely to obtain better 'discounted' deals than 'novice' users who are not fully appreciative or aware of the 'choice' of deals available in local drug markets. From our fieldwork in City it was also apparent that some experienced heroin users are also more discerning with regards to paying £10 for a 0.1g deal from dealers they know and trust to sell them 'bags' containing heroin in higher purity. With such caveats in mind it seems that although users with heavier habits are able to command relatively low costing grams, deals for those using less than 0.3g are paying more per gram *pro rata*. Perceptions amongst users with lower daily use as to what they are paying for may not always match what is actually contained in the 'bag'. A key point is that the price of heroin is falling and bulk buying is a key driver of this process.

Table 4 describes the results of treatment file data for Old and Market Towns and from two treatment data sources in City (a new outreach service, 'CTSOS', and the main central service). We were not given access to treatment data in Border Town or Eastside Town via the mainstream service. We can see how the differences in the nature and stage of heroin careers are reproduced in the size of habits and thus bills. In Old Town the older user population was typically using 0.62gms (3 x 0.2g bags) a day culminating in an average annual heroin bill of over £11,200. In Market Town with heroin only bedding-in during the mid 1990s and a younger, less entrenched population of users mean annual heroin bills were nearly £8,300. In City heroin bills for those attending the Tier 2/Outreach Service were an average £11,300 but when we drill into the large data base of the main service we find heroin bills at £12,700.

Derbyshire Drug Market Project

Table 4: Average heroin average bills in Old Town, Market Town and City

Location	Old Town	Market Town	City (via CTOS)	City (via Mainstream Service)
N size	69	37	88	841
<i>Average bills (£):</i>				
<i>Daily</i>	30.76	22.58	31.00	34.77
<i>Weekly</i>	215.34	158.06	217.00	243.39
<i>Monthly</i>	938.26	688.71	945.50	1,060.49
<i>Annually</i>	11,259.15	8,264.52	11,322.75	12,699.74

We must also make a calculation for crack use which treatment services are still not fully assessing and recording. In Derbyshire, thus far, only City hosts a large heroin/crack poly drug using population and we used treatment file data to calculate this major addition to overall drugs bills. Based on over 1,200 individuals on treatment service databases in City 409 were found to be involved in the use of crack. Of these only 224 had recorded data relating to expenditure on this drug. After calibrating averages to take into account the impact of frequency of use (i.e. daily, weekly and monthly) and as to whether crack has 'primary' or 'secondary' drug status it was found that average daily crack-cocaine expenditure was £39.55 (primary users £59.25; secondary users £34.32).

Funding Strategies

The only reliable source of information on how Derbyshire's problem users funded their drugs bills was gleaned from primary qualitative fieldwork. This reduces sample size (n=66) and veracity but is nevertheless worth calculating.

Table 5: Funding Drug Bills: Local Users' Self-reported levels of importance (Ranked)

Market		Old Town	Market Town	Border Town	City	Eastside Town	Total
n size		13	11	16	22	4	66
Column percentage		%	%	%	%	%	%
1	<i>Totally</i>	61.5	72.7	31.3	77.3	100.0	63.6
	<i>Mostly</i>	7.7	0.0	12.5	0.0	0.0	4.5
	<i>Partly</i>	7.7	9.1	6.3	13.6	0.0	9.1
	<i>Not at all</i>	23.1	18.2	50.0	9.1	0.0	22.7
2	<i>Totally</i>	38.5	9.1	23.5	36.4	100.0	32.8
	<i>Mostly</i>	15.4	27.3	0.0	0.0	0.0	7.5
	<i>Partly</i>	23.1	18.2	0.0	27.3	0.0	16.4
	<i>Not at all</i>	23.1	45.5	76.5	36.4	0.0	43.3
3	<i>Totally</i>	23.1	27.3	56.3	22.7	25.0	31.8
	<i>Mostly</i>	0.0	0.0	12.5	0.0	0.0	3.0
	<i>Partly</i>	0.0	9.1	6.3	13.6	0.0	7.6
	<i>Not at all</i>	76.9	63.6	25.0	63.6	75.0	57.6
4	<i>Totally</i>	7.7	18.2	37.5	0.0	75.0	18.2
	<i>Mostly</i>	0.0	0.0	18.8	4.5	0.0	6.1
	<i>Partly</i>	7.7	18.2	18.8	9.1	0.0	12.1
	<i>Not at all</i>	84.6	63.6	25.0	86.4	25.0	63.6
5	<i>Totally</i>	15.4	36.4	6.3	13.6	0.0	15.2
	<i>Mostly</i>	7.7	0.0	6.3	4.5	0.0	4.5
	<i>Partly</i>	7.7	36.4	37.5	0.0	50.0	19.7
	<i>Not at all</i>	69.2	27.3	50.0	81.8	50.0	60.6
6	<i>Totally</i>	0.0	36.4	25.0	0.0	0.0	12.1
	<i>Mostly</i>	0.0	0.0	6.3	0.0	0.0	1.5
	<i>Partly</i>	7.7	0.0	12.5	9.1	50.0	10.6
	<i>Not at all</i>	92.3	63.6	56.3	90.9	50.0	75.8
7	<i>Totally</i>	7.7	0.0	18.8	4.5	0.0	7.6
	<i>Mostly</i>	0.0	0.0	6.3	4.5	0.0	3.0
	<i>Partly</i>	30.8	9.1	18.8	0.0	25.0	13.6
	<i>Not at all</i>	61.5	90.9	56.3	90.9	75.0	75.8
8	<i>Totally</i>	30.8	0.0	6.3	4.5	50.0	12.1
	<i>Mostly</i>	7.7	0.0	0.0	0.0	0.0	1.5
	<i>Partly</i>	0.0	9.1	0.0	9.1	0.0	4.5
	<i>Not at all</i>	61.5	90.9	93.8	86.4	50.0	81.8
9	<i>Totally</i>	0.0	0.0	0.0	9.1	0.0	3.0
	<i>Mostly</i>	~	~	~	~	~	~
	<i>Partly</i>	0.0	0.0	0.0	13.6	0.0	4.5
	<i>Not at all</i>	100.0	100.0	100.0	77.3	100.0	92.4

Table 5 above describes in hierarchical order the importance of different strategies for funding large bills. State benefits are crucial sources of income. Unsurprisingly acquisitive crime is a key strategy for many users. In Derbyshire legitimate waged employment is important. Nor should we forget that heroin-crack users accumulate debt and share their drugs and resources. One person may be the income generator for a using partner for instance. Casual work and 'foreigners' also figure in some user's funding strategies with sex work being primarily a source of income only for City residents.

Derbyshire Drug Market Project

The DDMP, in line with the national drugs strategy, targeted drug using offending. So focusing on those subjects in the fieldwork sample who were largely dependent on acquisitive crime to fund drugs bills, Table 6 below describes with more precision the sorts of primary offences they regularly commit. In line with the wider picture we see the sheer dominance of shoplifting in offending profiles. Our fieldwork suggested that these drug dependent shoplifters, once they became known in their local area as offenders, travelled to large towns and local cities to conduct 'organised' shoplifting. Many were connected to 'fencing' or purchasing markets for stolen goods. This reliance on shoplifting by many problem users ensures that recorded crime figures do not reflect the scale of offending with so much theft activity simply accommodated in the retail trade's 'shrinkage' figures. Moreover, local problem users commit much crime off their residential patch. In the 1980s when domestic and commercial burglary was favoured by problem drug users, the consequences of heroin outbreaks were much more transparent and of even greater local concern (Parker *et al*, 1988).

Table 6: Types of Crime Involved in Local Users' Funding Strategies

Market	Old Town	Market Town	Border Town	City	Eastside Town	Total
n size	10	6	4	14	4	38
Column percentage	%	%	%	%	%	%
<i>Shoplifting</i>	100.0	83.3	75.0	71.4	75.0	81.6
<i>Thefts:</i>						
<i>from person</i>	0.0	16.7	25.0	0.0	0.0	5.3
<i>from vehicle</i>	0.0	0.0	0.0	7.1	25.0	5.3
<i>from other source</i>	10.0	33.3	50.0	21.4	25.0	23.7
<i>Burglary</i>	0.0	16.7	0.0	0.0	50.0	7.9
<i>Frauds/Deceptions</i>	0.0	33.3	25.0	35.7	25.0	23.7
<i>Other 'acquisitives'</i>	20.0	0.0	100.0	7.1	0.0	18.4

Criminal Careers

Table 7 describes the cautions and convictions accumulated by the interview sample by locality. Firstly, it is quite clear that the intensity and extent of offending careers, as measured by cautions and convictions, confirms that Derbyshire's problem users who do utilise acquisitive crime do fit the profile of 'prolific' offenders. Again we see the differences between Market and Border towns and City in particular. Our City interviewees with longer, more intense, problem drugs careers have accumulated 40 caution/conviction antecedents compared with only 7 in Border Town.

Looking at offence types excluding drugs possession/supply offences, we again see the dominance of acquisitive crime via shoplifting, theft and burglary. However the importance of 'cars' in the lives of this sample is also illustrated whether in 'Taking Without Owners Consent' (TWOCing) or traffic offences. Violent offences including assaults are more prevalent amongst City respondents consistent with the cultural

differences between small rural towns and the inner city. We would expect these differences to be statistically significant with a larger sample. The profile gleaned from our small sample is consistent with the picture generated by national research.

Table 7: Cautions and Convictions (non-alcohol/drug offences) against Local Users

Market	Old Town	Market Town	Border Town	City	Eastside Town	Total
n size	13	11	17	22	4	67
<i>Ever cautioned/convicted?</i>	%	%	%	%	%	%
<i>Males</i>	100.0	71.4	70.0	90.9	100.0	86.0
<i>Females</i>	100.0	50.0	42.9	90.9	100.0	70.8
<i>All</i>	100.0	63.6	58.8	90.9	100.0	80.6
<i>Mean number of cautions/convictions</i>	(n = 13)	(n = 7)	(n = 10)	(n = 20)	(n = 4)	(n = 54)
<i>Males</i>	10.8	11.2	7.0	24.4	40.0	16.2
<i>Females</i>	2.0	4.5	1.3	8.1	1.0	5.7
<i>All</i>	10.1	9.3	5.3	16.3	30.3	12.9
<i>Type of offence - Convictions only*</i>	(n = 13)	(n = 7)	(n = 10)	(n = 20)	(n = 4)	(n = 54)
<i>Shoplifting</i>	69.2	28.6	10.0	45.0	50.0	42.6
<i>Assault related</i>	23.1	14.3	11.1	40.0	0.0	24.6
<i>Traffic offences</i>	30.8	42.9	30.0	5.0	25.0	22.2
<i>Theft</i>	7.7	14.3	30.0	25.0	25.0	20.4
<i>Burglary</i>	0.0	14.3	10.0	30.0	25.0	16.7
<i>TWOCing</i>	0.0	14.3	0.0	10.0	25.0	7.4
<i>Other: thefts, frauds, etc.</i>	0.0	42.9	30.0	15.0	50.0	20.7
<i>Other: public order, violence, vandalism, etc</i>	7.7	28.6	20.0	15.0	0.0	15.0
<i>Other offences</i>	30.8	14.3	20.0	25.0	0.0	22.4

* Denotes inclusion of respondents who indicated both caution and conviction for same offence type

PRICING AND SIZING LOCAL HEROIN-CRACK MARKETS

We can further build the overall picture of a town's heroin-crack market by bringing together various data sources. The DDMP mapping profiles provide a basic picture of supply and dealing structures. Police and forensic information about price, purity levels and real weight of 0.1-0.2g deals demonstrates that in Derbyshire purity levels are within national norms but price is slightly lower than the national averages. From the primary research drugs diaries and the treatment data about the size of recent habits, we can estimate the amount and cost of a 'typical' heroin, heroin-crack habit. We can then produce estimates of the size of the local drugs market based on the estimates of the size of the problem user population.

In City the rough guide estimate to an annual heroin habit was £12,700. However with a third of the 3,000-3,500 users also using crack we must add a daily bill of at least £40 for 1,000 users. This suggests that the annual retail turnover for heroin in City was £38 million and for crack between £14-29 million. This in turn allows us to estimate that 712 kilograms³ of heroin and possibly around 200 kilograms of crack are distributed in City each year.

³ This corresponds to approximately 3.5 million 0.2 gram bags of heroin sold each year on City streets!

Derbyshire Drug Market Project

We estimated heroin bills for the 4 county towns profiled by the DDMP based on treatment and primary interview data. Our best guestimate is that the mean is about £8,400 a year. If an estimated 5,500 problem heroin users in the county (excluding City) consumed an average of £8,400 the total retail value of heroin bills is £44 million. We do not have sufficient data to calculate the county's crack market.

These estimates would not stand gold standard statistical review but at least start to define the general scale and size of hard drug markets in Derbyshire.

CONCLUSIONS

Using Derbyshire as the test bed, the profiling/modelling element of the DDMP has brought some gains and positive outcomes. The original goal of enhancing inter-agency communication and corporate work has been partly achieved by providing the key players with a more integrative 'understanding' of how their agencies and roles fit into and indeed impact on the area's evolving heroin-crack problem. This said, not all agencies associated with the DDMP were willingly co-opted partners and some important data was not made available at the right time in respect of treatment data from the north of the county.

Strategic planning for both policing drug markets and commissioning and reconfiguring drug services can and is being enhanced by this modelling. The main City analysis provides the lead for forecasting. In City we saw how heroin use had bedded-in during the 1980s with another incidence surge from the mid 1990s whereby around 3,500 heroin-crack users currently live in and around the city. They have daily habits of 0.65g a day leading to annual drug bills of approximately £12,000. Most service their bills from acquisitive crime, dealing, benefits and occasional employment. Around 712 kilos of heroin and between 145 and 290 kilos of crack/cocaine are retailed each year in the City.

This 'deterioration' associated with crack-cocaine will continue for many years because the user population is either still growing or just peaking. Most are not in treatment and a third have not yet ever presented, with the remainder mostly 'failing' earlier treatment experiences. Moreover with the growing tendency for problem drug users to be heroin/crack/poly drug users, the cost of habits will grow and treatment challenges become that much greater. The City provides the most 'extreme' model for Derbyshire with the night-time economy, the stolen goods fencing market, open sex markets, prolific offending and widespread drug selling, all inter-acting.

For the county towns their profile varies and responses need to be tailored as a consequence. Macro diffusion of heroin-crack drugs careers will variously affect these towns but the 'severity' of problems will be less. Old Town having been an amphetamine injecting and heroin site for decade is more likely to see crack spread in the next few years than Market Town, for instance, with later heroin supply and young users still only a few years into their heroin careers and in a quieter, more limited drug market. Similarly, in these rural communities the problem user population being often more bonded and bounded by family and community expectations will often have

smaller habits and be less likely to resort to extensive crime to fund their habits. Ideally both enforcement and treatment provision should be responsive to these differences. So in City in respect of enforcement and finite resources, the case for 'living with' heroin-crack markets and prioritising protecting the city from guns and gangs following the drugs trade is worthy of serious consideration. Similarly strategic planning of drugs services can be based on clearer evidence – that high demand for treatment will continue for many years, that retention is poor and that the heroin/crack/poly drug problem user will soon be the primary presenter. The need for a range of treatment regimes especially methadone maintenance is clear. Treatment gains will tend to accumulate as the problem user population not in treatment return for further episodes.

