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AN OVERVIEW OF THE UK DRUG STRATEGY WITH A FOCUS ON TREATMENT AND THE DEVELOPMENT OF DRUG INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM (ENGLAND AND WALES)

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I. INTRODUCTION

The overarching aim of the UK Government's drug policy is to reduce the harm that drugs cause to society - communities, individuals and their families. The key to delivering this aim is to reduce the number of people caught up in the chaotic lives of addiction and crime (problematic drug users) and to stop young people from entering their ranks. Tackling the enormous challenge of drug misuse is not a matter for Government or its agencies alone.

This paper reflects information provided in the Updated Drug Strategy's, Executive Summary and includes some of the current evidence, the progress so far and some of the next steps being undertaken to tackle drug misuse particularly in relation to treatment and the development of drug intervention in the Criminal Justice System in England and Wales.

II. TERMINOLOGY

To help set this work in context, this section of the paper will focus on some of the terms which will be used. The ongoing debate about terminology means that a number of different terms are used to describe drug taking behaviour. For the purposes of this paper the terms described below, have been adapted from previous definitions adopted by the Health Advisory Service (HAS), the Advisory Council on the Misuse of Drugs (ACMD) and the National Treatment Agency (NTA).

- *Drug Use* – illegal and illicit drug taking that does not cause any perceived immediate harm- even though it may carry some risk of harm e.g. health problems.
- *Drug Misuse* – illegal and illicit drug taking which leads a person to experience social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence.
- *Treatment* -describes a range of interventions which are intended to address an identified drug related problem or condition relating to a person's physical, psychological or social (including legal) well being. Structured treatment (evidence based) follows assessment and is delivered according to a care plan with clear goals regularly reviewed with the client. It may comprise a number of concurrent or sequential treatment interventions. Drug treatment can encompass a wide range of interventions / treatment modalities (types).
- *Problematic Drug User*: describes those drug users who experience social psychological or legal problems related to their drug use rather than those who use drugs casually or recreationally.

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The views expressed in this paper are those of the author, not necessarily those of the Home Office (nor do they reflect Government policy).

III. BRIEF OVERVIEW OF THE ENGLISH LEGAL FRAMEWORK AND ROLES OF CRIMINAL JUSTICE AGENCIES

To set the work being undertaken with drug users in the criminal justice system in context, in England and Wales, a very brief overview of the legal framework and the role of criminal justice agencies has been provided.

A. The Misuse of Drugs Act 1971

The main legislation controlling the misuse of drugs in Britain is the Misuse of Drugs Act 1971. It incorporates the relatively new system of licensing doctors to prescribe heroin and crack cocaine to drug users, the safe custody of drugs and national stop and search powers for the police. It also established the first statutory advisory body the Advisory Council on the Misuse of Drugs (ACMD).

The Act divides controlled drugs into three classes linked to maximum penalties in a descending order of severity from A to C. This three tier classification was designed to make it possible to control particular drugs according to their comparative harmfulness either to individuals or to society as a whole. (See Appendix A which outlines more details, including the proposals relating to cannabis)

B. The English Judiciary Process

The English legal system has been built around two distinct court processes:

- Civil Law and
- Criminal Law.

The procedures within the court systems vary greatly; it is the judicial process around the criminal court system which will need to be taken account of in delivery and planning of drug related criminal justice programmes to be described later.

The British Court System is known as adversarial which means that both the Defence and Prosecution try to persuade the bench or jury of either guilt or innocence.

The courts which deal with crime and related issues are the Magistrates Court and the Crown Court. Offences within the criminal judicial system fall into one of three categories. The category determines the court's power to deal with the offence. The categories are outlined in Appendix A.

C. The Magistrates Court

Magistrates Courts deal with Summary Offences and less serious Either-way offences. The Magistrates only have the power to sentence individuals to up to one years' imprisonment. There are two types of Magistrates in England and Wales, Lay Magistrates and Stipendiary Magistrates.

Lay Magistrates sit on a bench with usually two others. They are members of the local community who have been invited to sit on the 'bench'. They are not qualified in law and their role is voluntary.

Stipendiary Magistrates on the other hand are qualified solicitors. They are paid to undertake their duties and have the power to pass sentence by themselves.

Specialist Youth Courts form part of the Magistrates Court Structure. These courts deal with young offenders less than 18 years. Lay Magistrates who have had training in youth matters sit at these courts.

D. The Crown Court

The Crown Court is the higher of the two courts. This means that the most serious of offences with sentences up to life imprisonment are conducted within it.

Proceedings in the Crown Court are overseen by a Judge and take place before a jury. The jury consists of 12 members of the public who make a decision on the guilt of the defendant based upon the case presented.

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The judge is qualified in law and will have experience through being a barrister in the higher courts. The judge has the power to pass sentence on their own at the end of a trial.

E. Court Roles

1. The Clerk of the Court

The Clerk (Legal Advisor) is a qualified solicitor who is neutral in court proceedings. Their role is the day-to-day running of the court. The Clerk advises the Magistrate on points of law and they sit below the bench.

2. The Crown Prosecution Service (CPS)

The CPS has two roles: they prepare cases against defendants with information given by the police and also prosecute the case against the defendants if there is enough evidence. The CPS solicitor is commonly known or referred to as the Crown or Prosecution.

3. The Client's Solicitor

The clients' solicitor is also qualified in law like their CPS counterpart. Their role is to defend the client against the charges put forward by the CPS. The clients' solicitor is commonly known as their brief and is often referred to as 'The Defence' in court. In the Crown Court the clients' brief is known as the 'barrister'.

F. The Probation Service

The National Probation Service for England & Wales is part of the Home Office. There are 42 probation services across England & Wales matching police force geographical boundaries.

Their role is to supervise offenders in the community; in a court context they have two roles:

- To assist the court in making decisions about bail.
- When asked by the court, to prepare written reports on those who are found guilty of offences, the report known as a Pre-Sentence Report (PSR) is used.

G. The Prison Service

There are around 135 custodial institutions across England and Wales which comprise of a range of types from high secure, through to establishments for women and young offenders: The role of the prison service is to supervise offenders in custodial institutions.

The main aim of the Prison and Probation Services is to work together to deliver court sentences in order to reduce re-offending and protect the public.

H. The Police Service

There are 43 Police Forces across England & Wales, covering specific geographical areas which are coterminous with the Probation Service. The aim is to protect the public/community and prevent crime. For policing purposes each police force area will be divided into smaller geographic areas, which could be termed/Divisions or Basic Command Units, comprised of one or more 'police stations or custody suites. Each division will: operate to meet both the national objectives and targets for all police forces and the needs of its own local community.

IV. THE CURRENT POSITION - THE EXTENT OF DRUG USE IN ENGLAND AND WALES

In order to focus on what will really make a difference, it is important to understand the scale and nature of drug misuse in England and Wales and its consequences. The associated evidence base shows that drug misuse is a changing picture in England and Wales, which is difficult to assess and varies from area to area. As drug taking is an illicit activity reliable data on prevalence is hard to obtain.

The British Crime Survey (BCS 2000) provides the best available guide to changing patterns of drug use among the adult population in England and Wales. It is a large national survey and is designed to be representative of the population of adults. In addition to asking about their experiences of crime the BCS

also asks about a number of other crime related topics, since 1994 it has included a comparative module of questions on drug misuse.

The BCS indicates that in 2000, around one third of those aged 16 -59 yrs had taken illegal drugs at some time in their lives, Using this information it can be estimated that around 4 million people use at least one illicit drug each year, evidence suggests most of this drug use is cannabis.

Further information highlights around 1 million people use at least one of the most dangerous drugs (such as ecstasy, heroin and cocaine) classified as Class A. Many of these individuals will take drugs once, evidence suggests that for many of these individuals, drug use is experimental and use is limited.

A. Estimating the ‘In-Need Population’

Estimating the number of people who experience serious problems or dependence because of their drug misuse is in itself difficult and problematic.

Estimating the number of people who need drug treatment because of their problematic drug use is also not easy. Research suggests that there are around 250,000 problematic Class A drug users in England and Wales and the large majority of these individuals are engaged in criminal activity (whether or not it is related to their drug use). It is estimated on the basis of the NEW ADAM (New English and Welsh Drug Abuse Monitoring programme 2001) that there are around 180,000 problematic drug users who enter the criminal justice system through police custody suites each year. Of these only a minority (around 15 percent) are already in treatment, although a larger proportion has previously had a treatment episode.

Using the data from the National Drug Treatment Monitoring System (NDTMS) which reflects those seeking help, we can estimate that there are around 100,000 drug misusers in treatment.

These rough estimates highlight that the criminal justice system provides an important opportunity to identify and engage in treatment, problematic drug users who have not previously engaged with treatment services or for whom treatment has failed.

B. Evidence Base - Links between Drug Use and Crime

The evidence base has helped to inform and drive national policy and targeting work with problematic drug users. Recent research indicates that many drug misusers are also offenders though the relationship between drugs and crime is complex.

Research on offender populations in the UK suggests that acquisitive crimes such as shoplifting, burglary and fraud are the main methods to fund drug consumption (Bennett 2000).

A Home Office research study (New English and Welsh Drug Abuse Monitoring Programme Bennett 2001) involving the drug testing of arrestees irrespective of offence in 8 Police Custody suites found that:

- 65% of arrestees test positive for at least one illegal drug
- 30 % tested positive for two or more such substances
- 29% tested positive for heroin/cocaine
- users of both heroin/cocaine/crack commit between 5-10 as many offences as arrestees who do not use drugs
- 78% saw a connection between drug use and acquisitive crime

The National Treatment Outcome Research Study (Gossop 2001) – Prospective cohort study amongst 1075 drug misusers admitted to specialist drug treatment, found that amongst the treated population over half of those attending specialist treatment centres had some involvement in acquisitive crime (shoplifting was the most common offence).

Strategies aimed at reducing the demand for illicit drugs by breaking the link between drugs and crime have been an integral part of the UK Government’s anti-drug strategies since the mid-1990’s. The importance of this connection can be demonstrated through the recent estimations of the economic and social costs of Class A Drug use. These estimations were derived from a recent study undertaken by York

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University (Godfrey et al 2002) the main focus of which was to estimate the economic and social costs of Class A drug misuse. The study found that the total social and economic costs (including victim) of Class A drug use in England and Wales, was estimated to be between £10 billion and £18 billion per annum. Problem drug users account for almost all economic and social costs (99%) and drug related crime accounts for around 88% of total economic and social costs.

C. Evidence that Treatment Works

The National Treatment Outcome Research Study (NTORS) (Gossop et al, 2001) a 5 year prospective study following a cohort of drug misusers through different treatment modalities, has shown clear reductions in levels of drug use and acquisitive crime one year after treatment, which were maintained at five years. In cost-effectiveness terms, NTORS estimates that for every £1 spent on drug treatment, a concomitant saving of £3 is made on criminal justice and victim costs.

In addition a number of pilot programmes in the criminal justice system targeted at drug misusers (to be explained in a later paper) found that they could be effective in getting them into treatment. These programmes can deliver crime reduction outcomes as evidenced by the early arrest referral pilots which showed that of those interviewed:

- around 60% reported reductions in acquisitive crime
- 75% reduced their spending on drugs
- 31% said they had reduced their drug use
- 28% said they had stopped using heroin or other illicit opiates.

Although there is strong evidence on the efficacy of drug treatment services, evidence (Audit Commission, 2002; Hough, 1996) listed below points to a number of specific issues that need to be addressed if treatment is to work effectively amongst problem drug-using offenders entering the Criminal Justice System:

- Drug using offenders should have quick access and entry into treatment;
- They should be retained in continuous treatment for at least three months;
- They should have the option of methadone maintenance (and not rely on detoxification alone) and should be seen by high quality, committed staff;
- Comprehensive care management techniques are needed to deal with an individual's multiple needs; and
- There needs to be close co-ordination between specialist and generic services across a range of interventions.

V. OVERVIEW OF THE UK DRUG STRATEGY

The policy agenda in the UK for addressing drug misuse problems has been developing rapidly in recent years and has led to a stronger emphasis on drug treatment services.

In 1995 the Government white paper *Tackling Drugs Together* set out plans to tackle drug misuse over three years. Multi-agency Drug Action Teams were established at a local level with the remit of taking an overview of drug related issues, co-ordinating service planning and delivery and developing local action plans.

The publication of the Government's strategy for tackling drugs, *Tackling Drugs to Build a Better Britain* in 1998, was and still is a landmark: the UK's first cross cutting strategy across government departments to tackle drugs in an integrated way has four main strands:

Young People - to help young people resist drug misuse in order to achieve their full potential in society;

Communities - to protect our communities from drug-related anti-social and criminal behaviour;

Treatment - to enable people with drug problems to overcome them and live healthy and crime free lives; and

Availability - to stifle the availability of illegal drugs on our streets.

A. Overview of the Updated Drug Strategy

Over the last year, the 10 year Drug Strategy, was reviewed to sharpen its focus and improve effectiveness. The findings and recommendations of the Home Affairs Committee and the work of the Audit Commission, the Advisory Council for the Misuse of Drugs, the Health Advisory Service, the Police Foundation and others have also contributed to the review.

In December 2002 the updated Drug Strategy was published which built on the foundations laid before and took account of lessons learnt so far. The strategy also included the additional availability of resources to be made available and invested. Planned direct annual expenditure for tackling drugs will rise from £1026 million in this financial year 2003/04 to £1244 million in the next financial year; £1344 million in the year starting April 2004 to a total annual expenditure of nearly £1.5 billion in the year starting April 2005.

The overall aim of the updated strategy is: **Reducing the harm that drugs cause to society - communities, individuals and their families**

The updated strategy sets out a range of policies and interventions, which concentrate on the most dangerous drugs, the most damaged communities and the individuals whose addiction and chaotic lifestyles are most harmful, both to themselves and others.

The most effective way of reducing the harm drugs cause is to persuade all potential users, but particularly the young, not to use drugs. Success will only be achieved if there are strategies which stop young people from developing drug problems, reduce the prevalence of drugs on the streets and reduce the numbers of those with existing drug problems by getting them into effective treatment.

Preventing today's young people from becoming tomorrow's problematic drug users

The section relating to young people in the updated strategy highlights that all controlled drugs are dangerous and no one should take them. Universal programmes of education and information will provide all young people and their families the information and skills they need to protect themselves from the risks and harm of all drugs. The most vulnerable young people will get support before drug problems escalate.

Since 1998, universal programmes of education and information have been expanded. Substance misuse education is now part of the National Curriculum and 80% of primary and 96% of secondary schools have adopted drug education policies.

Much has also been done to improve how to identify and support the most vulnerable young people:

- 80% of England is covered by the new Connexions Service who identify young people with drug problems and arrange for specialist help as a part of their wider role to support all young people.
- All Youth Offending Teams (YOTs) have named drug workers who assess and arrange for support for young offenders with drug problems.
- Treatment services for young people, including detoxification and community prescribing are now provided in 80% of Drug Action Team (DAT) areas.
- Positive Futures - using sport and arts to engage the most vulnerable young people by developing skills to help them resist drugs and re-enter education and training - are available in 57 of our most disadvantaged communities.

16,000 young people currently receive support from local authority and health services, including 4,000 supported by drug treatment agencies and 3,000 by Positive Futures programmes.

By March 2006 young people will be discouraged from using drugs in the first place and support parents and family members who are worried about drugs by:

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- Expanding the provision and improving the quality of drug education so that by March 2004 all primary and secondary schools have drug education policies and further improve the quality so that by March 2006, no drug education lessons will be described as 'poor' by OFSTED.
- Launching in Spring 2003, a major new Communications Campaign driving home the risks of Class A drugs and encouraging young people and their parents to seek further advice and help. It is vital that the message to young people is open, honest and credible. The reclassification of cannabis will support this.
- Clamping down on dealers who prey on the young by increasing the penalties for dealing Class C drugs by July 2003 to match the already severe penalties for dealing Class A and B drugs.
- Expanding prevention programmes so that by March 2004 all young offenders and pupils attending Pupil Referral Units participate.
- Improving services for parents and carers by setting clear standards for the support offered to parents who are concerned about substance misuse or whose family members have a drug problem.

The provision of substance misuse treatment within the youth justice system will be expanded to:

- Introduce drug testing and referral of young people for treatment following arrest
- Give courts the power to include drugs treatment as part of community sentences
- Pilot and roll out new programmes of treatment and wider support for young offenders
- Provide drugs workers in all juvenile custodial establishments to organise programmes of prevention, treatment and support on release by December 2003.

There will also be investment to help local authorities support young people with drug problems. This will provide specialist support, outreach workers, training for professionals working with young people and an expansion of the Positive Futures programme. By March 2006 the number of young people with drug problems receiving support will include:

- 12,000 supported by YOTs and in juvenile custody
- 28,000 supported by local authorities, health services and Connexions
- 5,000 supported by Positive Futures programmes
- 5,200 supported by drug treatment agencies

This means that by March 2006, there will be the capacity to support 40-50,000 young people with drug problems every year. By 2008 this will have driven down the number of young people who go onto become future problematic drug users.

B. Reducing the Supply of Illegal Drugs

Reducing the supply of illegal drugs and tackling the trafficking of all drugs is key. Progress since 1998 includes:

- establishing the Concerted Inter-Agency Drugs Action Group (CIDA) to co-ordinate operational activity across all intelligence and enforcement agencies;
- increasing the number of drug seizures – the results for 2000 show a 53% rise in the number of cocaine seizures and a 30% increase in heroin seizures compared with 1997; the amount of drug-related assets recovered has also increased - £18.9 million from April 2001 to March 2002, almost 20% up on the previous year;
- establishing the National Crime Squad and the National Criminal Intelligence Service in April 1998, with key priorities of tackling hard drugs;

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- more than 60 drug liaison officers are now in post in key drug producing and transit countries, working to identify illicit drug movements, related financial activities, the structure of criminal organisations involved and providing hard intelligence for use in investigations;
- assisting EU candidate countries in their development of drug strategies and enforcement capabilities. The UK is a lead partner in a law enforcement project across 10 candidate countries and also involved in anti-drugs twinning projects in Bulgaria and the Czech Republic;
- the Proceeds of Crime Bill received Royal Assent in July 2002, strengthening investigation and confiscation powers, and the Recovered Assets Fund has been established;
- following the fall of the Taliban, the UK has led in the co-ordination of international efforts to help the Afghan Government counter narcotics production in Afghanistan.

There will be continuing focus on international trafficking, with a renewed focus on middle markets, local policing and tackling crack. New initiatives include:

- *Increasing co-operation with countries on key supply routes so as to increase the quantities of heroin and cocaine taken out en route, at the border and within the UK this includes:* setting up a joint investigation team with Spain to investigate organised crime networks associated with cocaine trafficking; working closely with the Jamaican Government to disrupt the supply of cocaine via Caribbean countries; in close touch with the Turkish authorities, both bilaterally and through the EU, on problems associated with heroin trafficking; and hosting a conference to address organised crime in the Balkans – including drug-related organised crime.
- *Working closely with the Afghan Government to reduce opium production with a view to eliminating production by 70% by 2008 and in full by 2013.* The initial focus will be the 2003 crop.
- *Enhancing intelligence capability and working in co-operation with EU partners* to tackle the secondary distribution of heroin and cocaine from the EU and to prevent the diversion of precursor chemicals used to make illicit drugs, such as Ecstasy.
- *Reviewing the impact of interventions on the drug supply chain from international production to distribution within the UK.* The Government's Strategy Unit working with the Home Office and other key departments will undertake a study.
- *Increasing the recovery of drug-related criminal assets.* The new Asset Recovery Agency will be established by February 2003.
- *Targeting the middle markets.* The police and other agencies are working together to tackle one of the most profitable parts of the supply chain – cross-regional markets. With close support from CIDA, this capacity is being built at a regional level. In addition to the existing team in the West Midlands, middle market capacity will be developed on Merseyside and in South and Mid Wales, before being spread across the rest of England and Wales.
- *Strengthening policing to better disrupt local supply markets.* Police performance is being strengthened through the work of the Home Office Drug Strategy Directorate and the Police Standards Unit. This involves guidance, sharing best practice, developing new targets and understanding drug markets. The Police Priority Area programme supports local policing strategies to better tackle multiple problems like drugs, addressing all aspects of policing.
- *Taking high profile action against suppliers in communities with particular problems.* Recent initiatives in Peterborough and Lambeth have shown how working closely with local partners and the community we can successfully deliver specialist action to tackle local drug markets and associated crime. For example, the Lambeth initiative saw over 100 crack house raids, 564 searches and over 90 people arrested.

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- *Tackling crack.* Policing to disrupt crack markets will be intensified in the areas most affected. Specialist treatment for crack addiction will also be increased and action taken to deter usage. Following a conference in June 2002, a National Crack Action Plan will be published before the end of December 2002.
- *Heavily penalising those caught dealing or drug trafficking* with maximum sentences ranging from 14 years (for Class B and C drugs) to life imprisonment (for Class A).

C. Reducing Drug Use and Drug Related Offending through Treatment and Support. Reducing Drug Related Death through Harm Minimisation.

Evidence shows us that treatment works. It is the key to reducing the harm drugs cause to users, family and communities and core to the delivery of the whole Drug Strategy. Problem drug misusers need a variety of interventions, it is not a case of one size fits all.

It is not possible within the scope of this paper to describe the full range of treatment available to 'treat' drug misusers. It is however important to recognise that a holistic approach is needed and which seeks to address the range of assessed needs, related to the individual's drug misuse and may include support with housing, family and finance issues. For this paper the delivery of 'specialist drug treatment' will be described across four main types/modalities these are:

- Community prescribing
- Care planned counselling including structured day programmes
- Inpatient programmes
- Residential rehabilitation

Specialist Drug Treatment is provided and delivered by a range of agencies which may include non-government organisations (known as the voluntary/independent sector), and statutory service providers, such as health and social services.

The availability and effectiveness of drug treatment (delivered by a range of providers) is variable across England and Wales. The Department of Health and Home Office jointly funded the National Treatment Agency (NTA), created in 2001 as a special Health Authority. The NTA's remit, covers England and it's current priorities are to ensure equality in drug treatment; increase the capacity and competence of the drug treatment workforce; increase quality and accountability at all levels of the drug treatment system; improve the availability and accessibility of drug treatment in all areas of the country; and increase the effectiveness of drug treatment.

The Department of Health commissioned the NTA to enhance planning, commissioning and provision of drug treatment services. This resulted in the development of Models of Care, a national framework (See Appendix B). Services for drug misusers can be grouped into four broad bands or tiers. Local areas covered by Drug Action Teams (see delivery section for explanation of DATs) will be expected to ensure that they provide the right balance of local drug treatment services to fit the needs of their local population and can provide access to the types of services outlined in the four tiers.

Models of Care is based on current evidence, quality standards and good practice in England and advocates a systems approach to meeting the multiple needs of drug misusers. It recognises the need for effective assessment which should be needs-led and seen as an on going process.

The three levels of assessment which should be available locally to provide access between the four tiers are:

- Level 1 Screening and referral assessment
- Level 2 Drug and alcohol misuse triage assessment
- Level 3 Comprehensive drug and alcohol misuse assessment

1. What is the Aim of Treatment?

For some years a range or hierarchy of goals of treatment have been identified in the UK (ACMD 1988 89, Task Force to Review Services for Drug Misusers 1996). These are

- Reduction of health, social and other problems directly related to drug misuse
- Reduction of harmful or risky behaviours associated with the misuse of drugs (e.g. sharing injecting equipment)
- Reduction of health, social or other problems not directly attributable to drug misuse
- Attainment of controlled non-dependent or non-problematic use
- Abstinence from main problem drugs
- Abstinence from all drugs

This hierarchy of drug treatment goals endorses the principle of harm minimisation, which refers to the reduction of the various forms of drug related harm until the drug misuser is both ready and able to come off drugs (Department of Health 1999). Harm minimisation strategies in the UK have achieved considerable success in preventing a more severe HIV epidemic (ACMD 1998).

2. Treatment – Overview from the Updated Strategy

The aim continues to be to increase the participation of problem drug users in the full range of treatment services and increase the proportion of users successfully sustaining or completing treatment by 2008. There has been good progress but much more needs to be done to ensure that treatment is readily available to those who need it. Through national and local action, this will be achieved by:

- *Investing in additional and better quality treatment services.* An expansion in treatment provision will take time to build – there is no quick fix solution. However, by 2008, capacity will have doubled so that 200,000 problematic drug users can be treated per year in the community or in a residential setting, as appropriate.
- *Filling the gaps in services.* Drug users have different treatment needs, it's not a case of one size fitting all. DATs and the NTA are committed to ensuring that all areas have access to an adequate range of services – including advice and harm reduction; GP and specialist prescribing; detoxification and rehabilitation, including residential services; and that new provision is evidence-based and effective.

Services for *crack* and *cocaine* users will be expanded from Spring 2003 with the development of new fast-track agencies - first in areas of greatest need and later across the country - along with new guidance, improved training and support for front line drugs workers.

All those who have a clinical need for *heroin* prescribing will have access to it under medical supervision, safeguarding against the risk of seepage into the wider community.

- *Reducing waiting times further.* The growth in treatment capacity and improved efficiency of services means that by the end of March 2004, maximum waiting times from referral to receipt of treatment should be no more than 2 weeks for in-patient detoxification and GP prescribing and 3 weeks for all other forms of treatment.
- *Improving the health of drug takers through the greater involvement of GPs.* We will increase the number of GPs / primary care professionals working with drug users and improve access to healthcare services for all problematic drug users, irrespective of prescribing needs.
- *More referrals from the Criminal Justice System.* There will be a focus to develop better links to treatment for drug offenders in the areas with the highest levels of crime.
- *Improving prison-based treatment provision.* An additional 2,000 intensive treatment programmes places will be created in prisons. New low intensity programmes will be introduced providing 17,000 places for those serving short sentences. The throughcare element of the system will be enhanced to ensure better continuity of treatment once prisoners leave custody.

D. Reducing Drug-Related Crime and its Impact on Communities

Nothing affects the well-being of local communities as much as drug misuse, drug-related crime and the fear of such crime. Where communities are strong, drugs do not take a hold. The highest incidences of drug-related crime, supply and drug-related nuisance occur in the communities that suffer most from social deprivation.

Since 1998 a number of criminal justice based drug initiatives have been introduced or piloted in England and Wales, designed to either facilitate the referral of drug misusing offenders into drug treatment or deliver treatment within the context of a community or custodial sentence. These initiatives provide access and engagement at key access points in the criminal justice system and have been listed in brief below:

1. Police Custody Suites

Arrest referral schemes now cover all 43 police forces in England and Wales. Drug testing pilots operate in one custody suite in nine police force areas and in additional custody suites covered by four police forces within the street crime areas.

2. Courts

All courts in the drug testing pilot/street crime areas have access to the results (positive/negative) of drug tests in police custody to inform bail/sentencing decisions: and power to order pre-sentence drug tests in the pilot areas. Arrest referral workers have a presence in some Magistrates Courts.

3. Community Sentence

Drug Treatment and Testing Orders were introduced to courts in all probation areas in England and Wales from October 2000. Drug Abstinence Orders/Requirements are being piloted in 9 probation areas since November 2001 (part of the Drug Test pilot programme).

4. Prison

Healthcare teams providing clinical services and detoxification for prisoners received into custody. Counselling, assessment, referral, advice and throughcare (CARAT) teams have operated in all prisons from September 1999. There are a range of structured drug treatment programmes and therapeutic communities available in selected prisons. Mandatory drug testing has been available since 1997, a significant number of prisons have chosen to give prisoners access to voluntary testing units.

5. Post-release

Currently there is no comprehensive aftercare provision for drug misusers returning to the community from custody. Initiatives have developed in an ad hoc manner and prisoners serving less than 12 months are not currently subject to statutory supervision and therefore particularly vulnerable following release. Drug testing as a licence condition is being piloted in the 9 drug testing pilot areas.

E. The Updated Drug Strategy Highlights in this Area

- New programmes have been established to get drug misusers off drugs and out of crime through effective treatment – the key to reducing offending. Each year, arrest referral schemes have picked up around 50,000 drug misusers at the point of arrest and referred them into treatment or other programmes of help. Drug treatment and testing orders have enabled around 6,000 offenders per year to address their problems through intensive community based programmes, and drug testing pilots have been introduced to test arrestees and better inform bail and sentencing decisions. Their drug misuse and related crime rates have dropped significantly as a result;
- The Jobcentre Plus initiative progress2work was launched in 2001 and the first participants started in 2002. It helps recovering drug users find and sustain jobs – a key way of returning to a more stable and constructive life;
- £100 million has already been made available through the new Communities Against Drugs fund to support targeted, locally determined measures designed to strengthen communities, disrupt the local drugs markets and tackle drugs and drug-related crime;

- Guidance, training, information and support have been provided on housing management, neighbourhood renewal, homelessness and dance club management to enable agencies and organisations to tackle drug misuse in the context of wider community problems.

To break the link between drugs and crime there will be investment in a major new programme of interventions for adults and young people, which will move offenders out of the criminal justice system and into treatment. Using every opportunity from arrest, to court, sentence and on release, this programme will include:

- making arrest referral schemes more proactive and effective;
- extending drug testing after charge to those local police force areas with the highest crime;
- piloting the introduction of presumption against bail where offenders test positive for drugs but refuse treatment;
- doubling the number of Drug Treatment and Testing Orders by March 2005;
- expanding treatment provision in prisons;
- providing comprehensive programmes of throughcare and aftercare for treated drug misusers returning to the community from prison, including post-release hostels, and for those leaving treatment programmes who have not been in prison; and
- a package of corresponding, but appropriate interventions for juveniles.

F. Delivery of the Updated Drug Strategy

The problems of drug misuse are complex and require integrated solutions and co-ordinated delivery of services involving education, intelligence and enforcement, social and economic policy, and health. Tackling drugs requires effective joint working between Government Departments at national level and similar partnership working between agencies at local level.

Delivering the Drug Strategy is a cross-government initiative. Following the 2001 General Election, the Home Secretary took over lead responsibility for driving forward delivery of the Drug Strategy, as Chair of the Cabinet Ministerial Sub-Committee on Drugs Policy. The committee includes ministers from the Department of Health, the Department for Education and Skills, the Office of the Deputy Prime Minister, the Cabinet Office, the Treasury and the Foreign and Commonwealth Office.

The Drug Strategy targets are expressed in departments' public service agreements listed below and supporting service delivery agreements. These are embedded in delivery plans which are drawn up in conjunction with the Prime Minister's delivery unit and kept under regular review by ministers and officials. The Public Service Agreements are to:

- Reduce the use of class A drugs and the frequent use of any illicit drug among all young people under the age of 25 especially by the most vulnerable young people;
- Reduce the availability of illegal drugs by increasing: the proportion of heroin and cocaine targeted on the UK which is taken out; the disruption / dismantling of those criminal groups responsible for supplying substantial quantities of Class A drugs to the UK market; and the recovery of drug-related criminal assets;
- Contribute to the reduction of opium production in Afghanistan, with poppy cultivation reduced by 70% within 5 years and elimination within 10 years;
- Reduce drug related crime, including as measured by the proportion of offenders testing positive at arrest; and

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- Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008, and increase year by year the proportion of users successfully sustaining or completing treatment programmes.

The Government set up the National Treatment Agency (NTA) as a Special Health Authority on 1 April 2001, although staff were not in place until the autumn of that year. The NTA's current priorities are to ensure equality in drug treatment; increase the capacity and competence of the drug treatment workforce; increase quality and accountability at all levels of the drug treatment system; improve the availability and accessibility of drug treatment in all areas of the country; and increase the effectiveness of drug treatment.

G. Regional and Local Delivery Mechanisms

The following mainly reflects delivery in England.

At a local level, agencies working in partnership through 149 Drug Action Teams (DATs) deliver the Drug Strategy. DATs were initially set up in 1995 and have been aligned with local authority boundaries since April 2001. They bring together representatives of key local agencies, such as health (Primary Care Trusts), social services, the police, probation, education, the Prison Service, and housing. Each DAT is supported by a co-ordinator and is accountable to the Home Secretary. Some include alcohol and solvent misuse within their remit. DATs are supported by one or more drug reference groups, whose membership includes key local professionals involved in the delivery of drug services.

DATs are supported at a regional level by Home Office drug teams (Regional Government Office Teams). There are nine in England. In recognition of the need to operate more effectively at regional level, Home Office teams, including the nine regional teams are being integrated into the regional Government Office structure. This will support closer links between those supporting regional activity on crime, drugs, community cohesion, racial equality, active communities and other Home Office priorities such as neighbourhood renewal, and the wider Government Office agenda.

H. Performance Management and Monitoring

Delivery of the Drug Strategy depends on agencies working effectively in partnership to make a real difference to local communities. Home Office teams support partnership working in a variety of ways, including setting and monitoring standards of performance, and assessment of partnerships' plans through a process which includes the NTA and other regional representatives (for example, the Youth Justice board, the Connexions Service and the Social Service Inspectorate).

Recommendations for action are then agreed between the DAT and the Home Office team; and progress is monitored and reported on a quarterly basis.

I. Annual Report

Each year DATs report on their work by providing statistical and qualitative data on young people, treatment, communities and supply. From April 2001 DATs have provided this information electronically. This in itself is a success story for the Government's e-business strategy and has generated a database, which includes the most comprehensive local information available to date on the delivery of the Drug Strategy and tracking of expenditure. The database allows comparison of DAT performance across "families" and regions, providing DATs with an opportunity to share good practice.

VI. WHAT NEXT FOR DEVELOPING DRUG INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM?

The updated Drug Strategy 2002 set out plans to break the link between drugs and crime by extending, enhancing and integrating a range of criminal justice interventions from arrest to court to sentence which are aimed at getting drug misusing offenders in to drug treatment and provide appropriate aftercare.

A new criminal justice interventions programme – drugs, has been introduced to integrate new and existing programmes. The aim of the new criminal justice intervention programme is to reduce drug related offending by moving drug misusing offenders through criminal justice interventions into and through the

drug treatment system. An integrated approach to delivering criminal justice based drug interventions is now being developed.

A range of different initiatives highlighted previously currently deals with drug misusing offenders as they are processed through the criminal justice system. such as Arrest Referral Schemes located in police custody suites, Drug Treatment and Testing Orders managed by the probation service and prison based CARAT schemes. In many instances, lack of co-ordination between these services has lead to inconsistency of care, inefficient working practices and failure to effectively engage and retain offenders in treatment. This is particularly true of offenders who are released from prison without adequate aftercare arrangements.

The updated drug strategy highlights the aim to join up initiatives in the criminal justice system more effectively and develop an 'end to end approach from arrest through to sentence and beyond. Under this new programme supported by the Home Office and NTA, 25 DATs covering areas with the highest levels of acquisitive crime have been asked to adopt a model of working delivered by a 'virtual or dedicated' community based criminal justice drug team for their area. This approach should where possible build on work and arrangements already in place using a combination of existing and new resources from the additional capacity building and aftercare funds.

In line with the Models of Care framework described in this paper, this approach adopts the principle of identifying an integrated care pathway which clearly maps the course of treatment for a drug misuser who is assessed and referred within the criminal justice system

This 'community based team' will accept referrals from police, courts, probation and prisons and their role will extend beyond assessment and referral. There is clear evidence from the arrest referral evaluation (July 2002) that delays between referral and accessing treatment are de-motivating and lead to a high proportion of offenders not engaging in treatment. This learning highlights the need for the community based team to be able to provide and/or access the full range of Tier 2 interventions, including case management and low threshold treatment interventions, to ensure that offenders are engaged and supported and to maximise the prospects of retaining them in treatment.

The new teams will undertake the following tasks:

- Drug and Alcohol triage assessment and referral into appropriate specialist treatment.
- Care planning and co-ordination function.
- Harm reduction advice and interventions.
- Immediate access to low threshold treatment – for instance, structured counselling/motivational interviewing and methadone prescribing.
- Appropriate interventions for crack and cocaine users.
- Work in partnership with probation and police in contributing to the delivery of DTTO, pre-arrest and prolific offender programmes.
- Provide a dedicated aftercare service for prisoners being released into the relevant DAT area to address their drug treatment needs and facilitate access to other services like housing, mental health, employment etc. This will include liaising with CARAT teams and probation staff to prepare jointly agreed release plans. Manage a team of volunteer mentors to provide practical support and encouragement for offenders.

There will also be similar initiatives aimed at young people in the youth justice system, starting with piloting Arrest Referral for under 18s in 10 of the 25 DATs from September 2003.

VII. CHANGES TO EXISTING LEGISLATION AND THE LEGAL FRAMEWORK

The Governments' White paper 'Justice for All', published in the summer of 2002 outlined a range of proposals to be taken forward subject to legislative changes. Some of these have been outlined in this paper.

The legislative process is under way and at the time of writing this paper these proposals amongst others are being considered under the current Criminal Justice Bill. The proposals include:

- extending drug testing provisions after charge with a 'trigger offence' under the Criminal Justice and Court Services Act 2000 to those under 18;
- piloting the introduction of presumption against bail where offenders 18 and over who test positive after being charged must agree to be assessed and/or access treatment or be refused court bail;
- introduction of a single generic community sentence made up of specific elements which will replace all existing community sentences including the DTTO;
- introduce a condition of treatment for young offenders as part of an Action Plan Order or Supervision Order; and
- under the Criminal Justice and Court Services Act 2000 provisions to extend drug testing as a condition after release on licence to include non-trigger offences.

VIII. CONCLUSION

This paper has provided a brief overview of the UK Updated Drug Strategy's, particularly in relation to treatment and the development of drug interventions in the Criminal Justice System in England and Wales. The overarching aim of the UK Government's drug policy is to reduce the harm that drugs cause to society - communities, individuals and their families. The key to delivering this aim is to reduce the number of people caught up in the chaotic lives of addiction and crime (problematic drug users) and to stop young people from entering their ranks. Tackling the enormous challenge of drug misuse is not a matter for Government or its agencies alone, partnership and collaborative approaches are needed from a national, regional and local level to tackle the complex issues raised through use and misuse of drugs across all aspects of the four areas outlined in the strategy. The development of drug interventions in the criminal justice system in conjunction with effective treatment has demonstrated the potential for reducing drug related offending, drug misuse and improving health can be achieved through moving drug misusing offenders through criminal justice interventions into and through the drug treatment system.

**APPENDIX A
THE LEGAL FRAMEWORK**

I. THE MISUSE OF DRUGS ACT 1971

Drug misuse is a huge global problem which poses a threat to people in many countries worldwide. In the early 1960s, the international community recognised that restricting the availability of drugs that are liable to misuse would require co-ordinated and universal action and, with this aim in view, has subsequently drawn up three United Nations Conventions on drugs.

The UN Conventions provide controls on several hundred narcotic drugs and psychotropic substances that are liable to misuse. They prohibit or restrict their use by means of a comprehensive range of control measures. The Conventions also recognise that some narcotic and psychotropic drugs have valuable medical and scientific uses. They make specific provision for the production and use of such drugs for legitimate pharmaceutical, medical and scientific purposes, but otherwise prohibit their use.

The UK is a party to these Conventions and has implemented their provisions into UK law by means of the Misuse of Drugs Act 1971 and its associated regulations. As a member state of the European Union (EU), the UK also works in close partnership with other member states to deliver the EU Drug Strategy (2000–2004). The strategy is wide-ranging, covering actions against supply and demand both within the EU and internationally, as well as the development of comprehensive evaluation mechanisms. It is practically implemented by means of the EU action plan on drugs (2000–2004). Subject to the scrutiny of Parliament, a number of elements of the EU strategy will be incorporated into UK law.

The Misuse of Drugs Act and regulations made under the Act establish the controlled status of drugs liable to be misused in the UK. They prohibit and make unlawful the importation, exportation, production, supply and possession of such drugs without authority. The regulations also provide for the legal production and distribution of controlled drugs for pharmaceutical and medicinal purposes.

The Misuse of Drugs Act 1971 also established the Advisory Council on the Misuse of Drugs (ACMD), an independent body of experts in the drugs field, to advise the Government on drug misuse issues. It is part of the ACMD's remit to consider and make recommendations on the classification of new drugs and for keeping the classification of existing drugs under review.

The drugs which are controlled under the Act are listed in Schedule 2 and are separated into Class A, Class B or Class C depending on their harmfulness. Class A drugs are the most harmful and Class C drugs are the least harmful. The Act provides penalties for drug offences. The highest penalties relate to trafficking offences, e.g. unlawfully supplying controlled drugs. Class A drugs attract the highest penalties and Class C drugs the least strict penalties, as shown in the table below.

Table 1. Misuse of Drugs Act 1971

Class A	Class B	Class C
Heroin	Amphetamines	Amphetamine related drugs
Morphine	Barbiturates	Buprenorphine
Methadone	Codeine	Most Benzodiazepines
Cocaine	Cannabis	Anabolic Steroids
LSD		(under certain circumstances)
Ecstasy		

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Table 2. Misuse of Drug Offences – Maximum Penalties

Offence	Class A	Class B	Class C
Production of a controlled drug	Life or a fine or both	14 years or a fine or both	<u>current</u> - 5 years or a fine or both <u>proposed</u> - 14 years or a fine or both
Supply of a controlled drug	Life or a fine or both	14 years or a fine or both	<u>current</u> - 5 years or a fine or both <u>proposed</u> - 14 years or a fine or both
Possession of a controlled drug	7 years or a fine or both	5 years or a fine or both	2 years or a fine or both

A. Reclassification of Cannabis

It is important that the UK Government's message to young people is open, honest and credible. Drug laws must accurately reflect the relative harms of different drugs if they are to be effective and credible in trying to persuade young people in particular of the dangers of misusing drugs. The police and other enforcement agencies need to focus their resources effectively on tackling the drugs which do the most harm.

To ensure that these aims are met, the Government has decided to bring forward proposals to Parliament to reclassify cannabis from Class B to Class C under the Misuse of Drugs Act 1971. Cannabis is illegal and will remain illegal.

Hard drugs like heroin and powder and crack cocaine destroy lives. They cause harm and misery to those who use them, their families and the communities they live in. The Drug Strategy will therefore concentrate on tackling these drugs. Efforts to reduce the supply of such drugs, and the approach to treatment and education, needs to reflect this priority.

The decision to reclassify cannabis is based on the advice of the Advisory Council on the Misuse of Drugs (ACMD). The Council advised that the classification of cannabis as a Class B drug was disproportionate in relation both to its inherent toxicity, and to that of other substances (such as amphetamines) that are currently within Class B. In making its recommendation, however, the Council made it clear that cannabis is unquestionably harmful.

The reclassification of cannabis will mean that the law is brought better into line with what actually happens in practice. The maximum penalty for the possession of cannabis will go down to two years' imprisonment. Most first offences of cannabis possession will be dealt with by the police by way of a warning and confiscation of the drug. The police will retain the power of arrest to be used where there are aggravating factors, such as flagrantly disregarding the law.

A new cannabis enforcement model being developed by the Association of Chief Police Officers (ACPO) will provide police with a clear and firm steer on dealing with cannabis possession, including any aggravating circumstances. Police time saved as a result can then be redeployed, supporting the wider strategy objective of refocusing efforts – including enforcement action – on the drugs that cause the most harm.

1. Supply Offences

The Government takes the supply and dealing of cannabis very seriously. It therefore intends, subject to Parliamentary approval, to increase the maximum penalty for supplying and dealing in Class C drugs from 5 to 14 years' imprisonment. This will maintain the maximum penalty for dealing in cannabis at its level as a Class B drug and will enable the courts to continue to impose substantial sentences for serious dealing offences involving cannabis.

II. THE ENGLISH JUDICIARY PROCESS

A. Brief Summary and Roles of Agencies

To help set the work being undertaken with drug users in the criminal justice system in context, in England and Wales a very brief overview of the legal system and the role of criminal justice agencies has been provided.

The English legal system has been built around two distinct court processes

- Civil Law and
- Criminal Law.

The procedures within the court systems vary greatly; it is the judicial process around the criminal court system which will need to be taken account of in delivery and planning of drug related criminal justice programmes to be described later.

The British Court System is known as adversarial which means that both the Defence and Prosecution try to persuade the bench or jury of either guilt or innocence.

The courts which deal with crime and related issues are the Magistrates Court and the Crown Court. Offences within the criminal judicial system fall into one of three categories. The category determines the court's power to deal with the offence. The categories are:

- Summary Offences (Magistrates Court)
- Either-way offences (Magistrates or Crown Court)
- Indictable offences (Crown Court)

1. Summary Offences

Summary offences carry a maximum prison sentence of six months; these are dealt with by the magistrates' court.

2. Either-Way Offences

Either-way offences can be tried in either the Magistrates Court or Crown Court. The transfer between courts is known as a committal. The reason for the transfer between the courts can be: the magistrates elect not to deal with the matter and transfer it to the higher court due to the serious nature of the offence; or the defendant elects for trial in the higher court.

3. Indictable offences

Indictable offences are the more serious and can only be tried in Crown Court. The procedure will commence in the Magistrates court being committed to the Crown Court.

B. Brief Overview of the Courts

1. The Magistrates Court

Magistrates Court deals with Summary Offences and less serious Either-way offences. The Magistrates only have the power to sentence individuals to up to one year's imprisonment. There are two types of Magistrates in England & Wales, Lay and Stipendiary Magistrates.

Lay Magistrates sit on a bench with usually two others. They are members of the local community who have been invited to sit on the 'bench'. They are not qualified in law and their role is voluntary.

Stipendiary Magistrates on the other hand are qualified solicitors. They are paid to undertake their duties and have the power to pass sentence by themselves.

Specialist Youth Courts form part of the Magistrates Court Structure. These courts deal with young offenders less than 18 years. Lay Magistrates who have had training in youth matters sit at these courts.

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2. The Crown Court

The Crown Court is the higher of the two courts. This means that the most serious of offences with sentences up to life imprisonment are conducted within it.

Proceedings in the Crown Court are overseen by a Judge and take the place before a jury. The jury consists of 12 members of the public who make a decision on the guilt of the defendant based upon the case presented.

The judge is qualified in law and will have experience through being a barrister in the higher court. The judge has the power to pass sentence on their own at the end of a trial.

C. Court Roles

1. The Clerk of the Court

The Clerk (Legal Advisor) is a qualified solicitor who is neutral in court proceedings. Their role is the day to day running of the court. The Clerk advises the Magistrate on points of law and they sit below the bench.

2. The Crown Prosecution Service (CPS)

The CPS has two roles. They prepare cases against defendants with information given by the police and also prosecute the case against the defendants if there is enough evidence. The CPS solicitor is commonly known or referred to as the Crown or Prosecution.

3. The Client's Solicitor

The clients' solicitor is also qualified in law like their CPPS counterpart. Their role is to defend the client against the charges put forward by CPS. The clients' solicitor is commonly known as their brief and is often referred to as 'The Defence' in court. In the Crown Court the clients' brief is known as the 'barrister'.

D. The Role of Criminal Justice Agencies

The Probation Service – Established in April 2001 the National Probation Service for England & Wales is part of the Home Office. There are 42 probation services across England & Wales matching police force geographical boundaries.

The Prison Service – There are 135 custodial institutions across England & Wales comprised of a mix of high secure, to establishments for young offenders. The role of the prison service is to supervise offenders in custodial institutions.

Prisons and probation services work together to execute court sentences to reduce re-offending and protect the public.

1. Role of the Probation Service

Primary role is to supervise offenders in the community who have received a community sentence or are released 'on licence' from prison (i.e. those adults who having received a sentence of more than a year, or a young person 18-21).

In a court context the probation service provides support in a number of ways.

The first of these is to:

- Assist the court in making decisions about bail. The Probation Officer (PO) or Probation Service Officer (PSO) may be asked to clarify bail addresses or employment circumstances of defendants. In some cases they provide a bail hostel placement for defendants who have no bail address or need a more secure community address.
- When asked by the court, prepare written reports on those who are found guilty of offences. The report known as a Pre-Sentence Report (PSR) is used by the Magistrate or Judge to assist in sentencing. It gives information on the offender's background and their view on their offence. The

PSR also recommends a sentence to the court and if necessary outlines a plan of action that will be used to rehabilitate the offender (as in the case of a Drug Treatment and Testing Order).

E. The Police Service

There are 43 Police Forces across England & Wales, covering specific geographical areas. The aim is to protect the public and prevent crime. For policing purposes each area may be broken down into smaller areas which could be termed / Divisions or Basic Command Units. Each division will operate to meet the needs of its own local community this will also include involvement with partnership work. To assist in understanding the arrest referral programme to be explained later, a brief explanation follows about the role of police custody:

To assist in understanding how arrest referral works within the custody suite, a brief overview of the management within the custody suite/office is given below:

The Custody Office is a secure restricted access area within a police station/custody suite which comprises of a prisoner reception area custody desk interview room medical examination room and cell area. Separate cell areas are provided for males and females. It is normally staffed by a sergeant and one or two constables. The custody sergeant has responsibility for the custody office and all persons in police detention. The constables provide support.

The position of the Custody Officer is unusual in that their role requirement is defined by statute and is a legislative requirement (Police and Criminal Evidence Act 1984).

Upon arrival at a police station a detainee is brought back to the custody desk, where the arresting officer will explain the circumstances leading to the arrest.

The custody sergeant will then consider whether they need to authorise detention. Once detention is authorised the custody officer will open a custody record and the detainee will be given their rights and entitlements in accordance with PACE. (Human Rights etc) It is at this stage that the opportunity to see an arrest referral worker may first be offered.

The detainee will be searched and their property retained by the custody officer in accordance with PACE. Custody offices in some force areas now have video camera systems installed which records all activity within the custody cells.

III. POLICE AND CRIMINAL EVIDENCE ACT 1984 (PACE) AND CODES OF PRACTICE (NOTE: PACE WITH NEW CODES OF PRACTICE TO BE INTRODUCED)

The Police must ensure that they act at all times in accordance with PACE and the codes of practice in relation to arrest referral.

Particular relevance for arrest referral includes the following key codes which relate to interviewing and questioning:

- 11.1 A of PACE Code C (Code of Practice relevant to the detention, treatment and questioning of persons by the police)
- 11.13 of PACE Code C (relating to keeping written record of any comments by a suspected person)
- 3.4 of PACE Code C prohibits Custody Officer from engaging in conversation with the suspect regarding anything to do with the offence
- Section 40 (1) and (2) of PACE – periodic review of need to be in police detention.

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APPENDIX B
MODELS OF CARE - FOUR TIER FRAMEWORK

Table 1. Drug Misuse Treatment Tiers and Commissioning Levels

Tier No.	Tier Title	Service Modality	Commissioning Level
1	Non-substance misuse specific services	For example: Personal/general medical services (primary care) Non-DM specific social services including children and family services; non-DM specific assessment and care management Housing and homelessness services Non-SM specific probation services Vaccination / communicable diseases Sexual health / health promotion Accident and emergency services General psychiatric services Vocational services	Local DAT*/ PCT/ PCG
2	Open access drug misuse services	Drug-related advice and information Open access or drop-in services Motivational interviewing/ brief interventions Needle exchange (pharmacy/service/outreach) Outreach services (detached/domiciliary/peripatetic) Low-threshold prescribing Liaison with drug misuse services for acute medical and psychiatric sector DM specific assessment and care management	Local DAT/ PCT/PCG
3	Structured community-based specialist drug misuse services	Drug specialist care planning and co-ordination Structured care planned counselling and therapy options Structured day programmes (urban and semi-urban) Community-based detoxification services Community-based prescribing stabilisation and maintenance prescribing Community-based drug treatment for offenders on DTTOs Other structured community-based drug treatment services targeting specific groups Structured aftercare programmes Liaison with drug treatment services	Local DAT*/ Multi-DAT
4a	Residential substance misuse specific services	Inpatient drug detoxification and stabilisation services Drug and alcohol residential rehabilitation services Residential drug and alcohol crisis centres Residential co-morbidity services Specialist drug and alcohol residential units targeting specific groups, e.g. mother and child units services	Multi-DAT/ Regional/ National
4b	Highly specialist non-substance misuse specific services	For example: Specialist liver disease units Forensic services Specialist psychiatric units including: personality disorder units; eating disorders units Terminal care services Young people's hospital and residential services providing drug and alcohol treatment services (16 to 21 years) HIV specialist units	Regional/ National

Source : Models of Care for Treatment of Adult Drug Misusers - Part 1 NTA
(Oct 2002)