

# **A BRIEF OVERVIEW OF DRUG INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM (ENGLAND AND WALES) WITH A FOCUS ON SPECIFIC INTERVENTIONS PROVIDED AT ARREST - ARREST REFERRAL AND AS A COMMUNITY SENTENCE - DRUG TREATMENT AND TESTING ORDERS**

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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.

The updated Drug Strategy, published in December 2002, sets out plans to break the link between drugs and crime through joining up drug interventions delivered in the criminal justice system more effectively and developing an 'end to end' approach from arrest through to sentence and beyond.

Evidence from early pilots and more extensive evaluation has highlighted that drug interventions in the criminal justice system offer an effective means of putting drug misusing offenders in touch with appropriate services locally where they can receive help to reduce their drug use.

To help provide an overview of the potential benefits and implications for implementation of these types of interventions, particularly at arrest and at the community sentence stage, this paper will outline a brief summary of evidence from early pilots and programmes relating to Arrest Referral and Drug Treatment and Testing Orders. It will include references to the models of delivery as the evidence base as well as practical implementation issues which may need to be considered for effective delivery.

### **A. Terminology**

To facilitate an understanding of assumptions which may be made in the paper, this section will seek to describe some of the terms used which have been adapted from definitions adopted by the Health Advisory Service (HAS) and the Advisory Council on the Misuse of Drugs (ACMD) National Treatment Agency and the Audit Commission.

- *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

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sequential treatment interventions. Drug treatment can encompass a wide range of interventions / treatment modalities (types).

- *Problematic Drug User*: describes those drug misusers who experience social, psychological or legal problems related to their drug misuse rather than those who use drugs casually or recreationally.
- *Polydrug user*: describes the pattern of drug misuse where the same person will use opiates particularly heroin as well as crack, cocaine, other stimulants and drugs such as benzodiazepines.

**B. The Legal Framework and the Roles of Criminal Justice Agencies**

In order to understand how drug interventions are delivered within the context of the criminal justice system in England and Wales there is a need to have some understanding of the legal framework and agencies involved, for the purposes of this paper this is very briefly covered in Appendix A of my first paper.

**II. EVIDENCE BASE – DRUGS AND CRIME**

The relationship between drugs and crime is complex, though not all drug users commit crime. Research has helped to quantify the potential demand for Arrest Referral and other programmes and provides a 'profile' of those offenders who would most benefit.

The New English and Welsh Drug Abuse Monitoring programme (NEW ADAM), aims to provide basic intelligence on: drug misuse at the point of entry into the criminal justice system and links between drugs and crime. The programme involved adult offenders who had been arrested and subsequently interviewed and drug tested (using urine samples) to check for drug presence, in 8 police custody suites. The study found the following:

- 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
- users of heroin and crack cocaine were also responsible for more than half, by value, of acquisitive crime

Most of the arrestee group described above were not in treatment. 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. There is strong evidence that for many problem drugs using offenders treatment can be a cost effective way of reducing their offending. The importance of this connection can be demonstrated through the recent estimations of the economic and social costs of Class A drug use by York University (Godfrey et al 2002). The study found that the total (including victim) social and economic cost 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.

**A. Evidence Base- Treatment and Estimating 'Demand'**

We know that treatment works. Appropriate treatment, can reduce both drug misuse and related offending. Evidence highlights that problem drug using offenders referred through the criminal justice system to treatment, and then retained in treatment, report significant reductions in drug related crime, spending on drugs and use of drugs (NTORS, Gossop 2001).

Findings from early pilots of arrest referral to engage drug misusing offenders in the criminal justice system highlighted that drug using offenders do take up and engage in programmes of help, more findings from these pilots will be outlined later in the paper (Edmunds et al 1998).

Evidence suggests that there are strong links between users of certain drugs and crime particularly acquisitive. It is therefore not surprising to find that problem drug users frequently turn up in the Criminal

Justice System. It is estimated that 180,000 problematic drug users enter the criminal justice system through police custody suites each year, of these only a minority are already in treatment (NEW ADAM). It is also estimated that there are around 250,000 problem Class A drug users in England and Wales (Godfrey et al), of whom 100,000 (NDTMS) may be in specialist treatment.

The brief information provided in this section demonstrates the potential size of the population of problematic drug users in and out of treatment and the criminal justice system as well as the importance and cost effectiveness of treatment.

### **III. DRUG INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM**

Drug interventions in the criminal justice system offer an effective means of putting offenders who are using illegal drugs in touch with appropriate services locally where they can receive help to reduce their drug use.

Since 1998 a range of criminal justice based drug interventions have been introduced or piloted in England and Wales, which were designed to either facilitate the referral of offenders into drug treatment, or deliver treatment within the context of a community or custodial sentence.

These interventions have been implemented to provide access and engagement at key points in the criminal justice system; these are listed, in brief, below:

*In police custody suites* – Proactive arrest referral schemes now cover all 43 police forces in England and Wales. Drug Testing Pilot Programme - Drug testing after charge under the provisions of the Criminal Justice and Court Services Act 2000 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.

*Courts* – All courts in the drug testing pilot programme /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.

*Probation* – 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 (part of the Drug Testing pilot programme).

*Prison* – Healthcare teams provide 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.

*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.

#### **A. Drug Treatment Services**

Interventions delivered in the criminal justice system will only be effective when associated with appropriate treatment interventions. Treatment and support needs to be accessible to those who need it regardless of origin, gender, sexual orientation or source of referral. Although waiting times to access specialist drug treatment is reducing there are still problems in some parts of the country (NTORS 2001).

The availability and effectiveness of drug treatment (delivered by a range of NGOs 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 its current priorities are to ensure equality in drug treatment; increase the capacity and competence of the

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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 National Treatment Agency (NTA) is currently taking forward a programme of work to improve accessibility and availability to treatment services, generally and is working with Drug Action Teams (DATs) to ensure that drug misusers in all areas (England) have access to the full range of 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 A). The range of interventions outlined in the framework are grouped into four broad bands or tiers, which range from the least specialist and intensive in Tier 1 to the most specialist and intensive in Tier 4. Local areas covered by Drug Action Teams (strategic local partnerships) 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

The following section on Arrest Referral will briefly describe the term and models, outline the evidence base and links with drugs and crime, from early pilots and programmes and briefly refer to the processes adopted, practical and implementation issues for 'effective delivery.

### **B. What is Arrest Referral?**

Arrest referral schemes are partnership initiatives between the police, local drug services (delivered by Non Government Organisations NGOs and Statutory Services) and Drug Action Teams (DAT)/Drug and Alcohol Action Teams (DAAT) that *use the point of arrest* within custody suites as an opportunity for independent drug workers to, to make contact with arrestees with drug problems while they are in police detention and *refer them to appropriate treatment* to address their drug use. The pro-active arrest referral initiative is one of a series of criminal justice interventions that seeks to identify problem drug-using offenders in the criminal justice system and refer them to treatment.

Arrest Referral Schemes are not alternatives to prosecution or due process but provide a direct route from the custody suite to drug treatment or other programmes of help.

Evidence has suggested that the proactive approach is (Edmunds et al 1998) most effective. This is where a dedicated drugs worker, independent of the police, based in or on call to a police custody suite, makes contact with problem drug-using arrestees and refers them to appropriate treatment: with the aim of reducing their drug use and drug-related offending. The evidence provided to date supports the recommendation that all those arrested regardless of alleged offence should be introduced and/or informed of the scheme i.e. 'blanket coverage'.

Involvement with arrest referral is voluntary and is not an alternative to prosecution or due process. Focused on the point of entry to the criminal justice system, this initiative aims to identify and help problem drug-using offenders break their cycle of drug use and crime as early as possible.

Arrest referral schemes have been in operation in various forms since the 1980s. Three main models of delivery have been identified in earlier research: (Edmunds et al 1998, 1999).

- Information model. This approach involves the provision of basic information (such as leaflets) about local drug treatment services that can be delivered by police custody staff. Problem drug-using offenders will be expected to contact treatment services through their own volition.

- Proactive model. In this model, a dedicated and independent drug worker based in the custody suite or on-call, assesses problem drug-using offenders and refers them to an appropriate treatment service.
- Incentive or coercive model. This model can provide incentives to seek help. 'Caution Plus' schemes involve cautioning a problem drug-using offender arrested for possession of illicit drugs with the specific requirement to seek advice from a drugs worker. 'Deferred Caution' schemes delay the decision to issue a caution following attendance at a drug service within, for example, 30 days. If a positive report is recorded no further action will be taken.

### 1. Evidence Base - Arrest Referral

The evidence base for developing arrest referral initiatives consist of three strands of research which demonstrate:

- strong links between drug use and offending behaviour;
- high numbers of potentially problematic drug users entering the criminal justice system; and
- the (cost) effectiveness of treatment in achieving sustained reductions in drug use and related offending.

Evidence already exists which demonstrates the potential of arrest referral schemes to deliver reductions in drug use and offending behaviour. Three demonstration arrest referral schemes in Southwark, Derby and Brighton, were evaluated (Edmunds et al 1998) each adopting the 'proactive' model. Findings showed these pilots addressed an unmet need; whilst offenders had on average 21 previous convictions, previous arrest had not deterred them from drugs/crime; they were poly drug users, injectors with lengthy drug using careers which started when they were young. Only a quarter seen at arrest were in touch with drug services and a third had never been in contact.

At the six month follow up, large reductions were noted in self-reported drug use, rates of injecting were also reduced, average expenditure (median) on drugs fell from £400 per week to £70 per week (six months). The total number of criminal offences committed per month was also reduced from 10,800 in the month before contact with a scheme to 2,200.

The research concluded that the proactive model could be successful by identifying and targeting criminally active drug users who may benefit from treatment, referring this group to specialist drug treatment services and helping to ensure that referrals enter treatment programmes.

### 2. Expansion of Arrest Referral Schemes through the Joint Funding Initiative

The Home Office Crime Reduction Programme (CRP) was a three-year, evidence-based initiative costing £420 million, aimed at achieving a sustained reduction in crime, improving and mainstreaming knowledge of best practice and implementing cost-effective crime reduction activity. The programme included burglary reduction, targeted policing, violence against women, use of Close Circuit Television (CCTV), sentencing and treatment of offenders, early interventions, youth inclusion and arrest referral.

Encouraged by the evidence from early pilots for arrest referral, the Home Office agreed in summer 1999 to contribute £20 million over three years, from the Crime Reduction Programme (CRP). It is important to note that at the time a Key Performance Target for all Police Forces in England & Wales had been set out in the 10 year U.K Drug Strategy (1998),- to double by 1999 the number of 'proactive schemes in their force, and have full coverage by March 2002.

The Joint Funding Initiative (JFI) was established to help accelerate the development of arrest referral schemes across England and Wales and to learn more about how to maximise the effectiveness of this initiative. Funding was made available from December 1999 until March 2002. Following an invitation to all Police Forces in England and Wales, 41 out of 43 police forces applied for funding under the arrangements set out in the Home Office Circular 41/1999. Forces working in partnership with the DAT and local agencies were asked to identify the number of workers, and associated funding, with a view that police forces would continue funding schemes after 2003. The JFI provided funding for arrest referral workers which had to be 'matched' locally by the relevant police force, DAT or other partnership arrangement (based on prior

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research a unit cost of £40,000 per worker was used including 'on costs') the JFI would contribute a maximum of up to £20,000 per worker.

An additional year's central funding (up to Spring 2003) was subsequently provided by the Home Office. This initial investment from central government funded the establishment of schemes and arrest referral workers as well as contributing to the funding of local drug treatment services.

The majority of arrest referral schemes became operational from April 1st 2000. By the end of April 2002, all Police Forces in England and Wales were operating pro-active schemes (either funded by the Home Office or by police force funding schemes locally), employing approximately 400 workers. Central funding is now available to sustain delivery of drugs work in custody suites and court cells (as appropriate) over the next three years,

### 3. Monitoring and Evaluation of the Joint Funding Initiative

A key objective of the CRP and JFI was to obtain evidence of 'what works' with regard to crime reduction initiatives. To build on the existing evidence base from the previous DPI research (Edmunds et al, 1998), research was commissioned to assess how effective arrest referral schemes were by determining whether:

- arrest referral schemes are successful in targeting the key group of problem drug-using arrestees and ensuring their entry into specialist drug treatment services and;
- whether engagement with specialist drug treatment facilitates reductions in levels of crime (through self-reported offending and in police arrest figures).

A three-year programme of monitoring and evaluation was commissioned comprising two main elements:

- a national monitoring system to collect basic epidemiological information in the number, characteristics and referral outcomes of problem drug-using offenders screened by arrest referral workers (this is ongoing); and
- a programme of area-based research and evaluation studies to provide an assessment of the behavioural outcomes of arrest referral and how these can be maximised (this completes in summer 2003).

We know that arrest referral and treatment are inextricably linked. This programme would build on the work of the earlier pilot programmes and improve both knowledge and understanding of evidence based practice, to do the right things, right.

The Evaluation programme seeks to explore and demonstrate the combination and type of relationships needed to achieve the desired reductions in drug use and crime and improvements in health and social outcomes. This will be undertaken through a range of approaches including:

- Validation of monitoring
- In-depth, qualitative process and non-engagement studies
- Outcome assessments
- Re-arrest and reconviction studies
- Testing veracity of self-reported data
- Economic cost benefit analyses
- Examination of the efficacy of different treatment modalities

### 4. The National Monitoring System

The National Arrest Referral Monitoring System (NARMS) collates information on all arrestees screened, assessed and referred by the worker, this data is then linked to the National Drug Treatment Monitoring System (NDTMS) to identify uptake into specialist drug treatment. A generic monitoring form used across England & Wales (NARMS). See Appendix B.

Data is collected locally by the National Drug Treatment Monitoring System (NDTMS) and allows the anonymous follow-up of arrestees into treatment. One-year follow-up of those in treatment (client review).

### C. How Does Arrest Referral Work?

The arrest referral process can simply be broken down into a number of key stages:

- 'booking in' to police custody and initial offer of referral by the police
- subsequent contact with arrest referral worker to provide more information on the scheme and encourage participation.

In Appendix A of my first paper, the final section on the Police Service, briefly outlines the process undertaken known as 'booking in' of the detainee by the arresting officer and custody sergeant, irrespective of whether the detainee is seeing an arrest referral worker.

- All those at the 'booking in' stage are informed by the police that a scheme operates at the police station as the Custody Officer brings arrest referral to the attention of detainees as part of the booking-in procedure
- However the introduction by the police must comply with PACE
- The introduction must be restricted to a statement of factual information

The following statement is the one which is usually read out to the detainee

*'A drug referral scheme operates at this police station.  
If you are interested, I can arrange for you to see an  
Independent drugs worker in due course.  
Are you interested'?*

- Those who wish to know more are offered an opportunity to see an Arrest Referral Worker who explains how the scheme works, contact is made with the worker according to the arrangements drawn up between the police and the provider agency of arrest referral, it could be the cell or some other venue (see working protocols).
- Workers (according to local agreements may also be permitted by the Custody Officer to 'cold call', that is talk to the detainee directly in the cell. Evidence suggests not all detainees agree to see a worker at the initial stage of booking in, however on reflection in the cells and/or meeting a worker in the cells their perspective may change.
- If the detainee agrees, a screening interview and assessment is undertaken to identify a programme of help.
- The arrest referral worker arranges for client 'entry' or *referral* into treatment or arranges further follow-up.
- The client then attends the first appointment for treatment or is provided with the opportunity of carrying on seeing the arrest referral worker until a treatment place becomes available.

There are a range of practical considerations to be aware of in terms of implementing such a scheme the following lists briefly a few key issues for further consideration:

#### 1. Starting from 'Scratch' in the Community

Need the right people at the 'right level' to be part of a strategic working group of players including Police, Health, NGO's and DAT.

- Identify treatment availability capacity and appropriateness
- Custody suites – how many, throughput of arrestees, other initiatives at arrest
- Agree model and service specification (based on local picture including coverage of custody suites)
- Draw up and monitor Service Level Agreements with providers of arrest referral services
- Agree recruitment, Job Descriptions and CRO (crime) checks
- Agree local monitoring and evaluation
- Manage external and internal promotion - community
- Ensure development of working protocols

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2. Starting from Scratch in the Community - Working Protocols
  - Need agreed terminology and definitions
  - Operation - how it works, who does what, do's and don't's for 'workers'
  - Confidentiality and rules of disclosure
  - Agreed hours of cover for workers
  - Identification and passes in the custody suites
  - Health and safety in the custody environment
  - Monitoring responsibilities
  - *Where to see arrestees:*
    - The custody area
    - Client's own cell, Solicitors Consultation room, Doctors' consultation room, Police interview room, designated AR office, unoccupied areas of the custody suite.
    - venues outside the police custody area  
Group 4 custody area (private company), locations within magistrate's courts, Probation office, drugs agency.
3. Establishing Arrest Referral - A Typical Service Provider may Include the Following
  - Non government organisation (NGO) or state health provider providing community based drop in, practical advice information, advice and counselling and support
  - Provide access to prescribing treatment based on philosophy of harm reduction through GP liaison
  - Will cover e.g. 6 custody suites at the times when they are 'busy' and review with police to ensure this is appropriate
  - Employ trained drug workers, supervised by a manager
  - Provide training (focus work in criminal justice system)
  - Participate in the local 'steering group'
  - Agree risk assessment/referral protocols/information sharing/confidentiality agreements with steering group/police and other stakeholders
  - Ensure national and local monitoring arrangements implemented and that forms/data are fully completed where possible and returned appropriately (include analysis).
4. Role of the Arrest Referral Drug Worker

Recommendations are raised later in the emerging findings, but basic responsibilities would include:

  - Promoting/explaining scheme to detainees
  - Undertaking screening interview and comprehensive assessment to inform referral
  - Refer onto other services
  - Monitoring client progress
  - Development work with police and service deliverers
  - Training/inducting police and service deliverers
  - Liaison and work with colleagues involved at other points of contact with criminal justice system
  - Record-keeping to inform police and agency key performance indicators

#### **D. National Implementation -Findings from the National Monitoring and Evaluation Programme**

##### 1. The National Monitoring System

Published evidence from the NARMS shows that between October 2000 and September 2001, 48,810 arrestees were screened and interviewed, over half interviewed (58%) were referred to specialist drug treatment, over half (51%) were not currently engaged in treatment. Of those referred 22% made a demand for treatment, but there was variation in treatment take up across England & Wales. The findings from the monitoring system are explored more fully in the analysis of the emerging findings published in July 2002.

##### 2. The National Evaluation Programme- Emerging Findings

In July 2002, a summary of the emerging findings, from the research programmes at 18 months (Sondhi et al, 2002), was published July 2002.

The main findings are listed below; many are being taken forward from 2003/04:

- Proactive arrest referral schemes provide an effective way of reaching problem drug-using prolific offenders and referring them to drug treatment and other appropriate services. (48,810 individuals were screened between October 2000 and September 2001 in England and Wales, of whom over half were voluntarily referred to a specialist drug treatment service).
- Workers had some success in getting problem drug-using offenders into treatment. Of those referred, a quarter made a demand for treatment (or 5,520 individuals), however some were significantly more likely to drop-out of treatment once engaged compared to self or GP referred drug users to the same service. Further evidence provided more information about this group who had difficulties engaging in treatment.
- Black and Asian drug users; older poly-drug users with negative previous experiences of treatment; young crack-using street robbers and female crack-using sex workers were all less likely to engage with treatment than other groups.
- Contact with an arrest referral worker lead to a reduction in re-arrest rates, self-reported drug use and offending. The level of police re-arrest rates significantly declined six months after contact with an arrest referral worker compared to the six months before contact. Two thirds (67 per cent) were arrested less often following referral than before.
- Preliminary analyses suggests that arrest referral schemes can provide significant economic and social benefits analyses suggest that the economic and social benefits of the arrest referral initiative are around £4.4 billion over an eight year period.
- Significant reductions were also reported in secondary indicators such as physical and psychological health.
- Treatment retention has been identified as an important predictor of a successful outcome. It is likely that there is a combined effect of initial contact with an arrest referral worker, impact of community or custodial sentencing and treatment engagement that contributes towards a successful outcome.
- Self-reported drug use was validated by biological assay screening (saliva sampling) and the concordance was high, suggesting that problem drug-using offenders provide accurate information on their drug-using habits.
- The evaluation report also described the process and delivery of arrest referral schemes and presented some recommendations as to how the full potential of such schemes could be maximised. For example, schemes should:
  - remain independent from the police
  - offer harm reduction advice where appropriate
  - provide low threshold treatment interventions through a case managed approach to retention and engagement into treatment
  - develop integrated care pathways consistent with the Models of Care approach (NTA 2002)
  - be extended to juveniles, alcohol users and detainees in Magistrates' courts as appropriate.

### 3. Involvement at a Strategic Level and Partnership Working

Partnerships are key and need ongoing development at both strategic and operational levels. Strategically- the DAT should work with the police and other stakeholders to ensure that there is a clear strategic direction with shared aims and objectives for this work which integrates with other criminal justice interventions. Arrest referral should be considered as part of the overall delivery of local drug service provision. In England it should be considered as an integral part of the Models of Care framework for the commissioning and provision of specialist drug treatment services. (From July 2002, Models of Care had the same status as a national service framework for drug treatment.)

Arrest referral workers need to have knowledge of all available local treatment options including waiting times and be able to contribute to the planning and delivery of drug treatment services. Workers should be

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represented on DAT/DAAT treatment planning forums and have information which can contribute to the development and planning of treatment services.

4. Throughcare and Aftercare

Some problem drug-using offenders fail to engage with community-based treatment because they are retained in the criminal justice system. A number of arrest referral workers have used this knowledge to develop appropriate links – for example, with probation services when a Drug Treatment and Testing Order (DTTO is considered) and also with providers of treatment services in prisons. Integrated links are needed to ensure that the substance misuse needs identified at arrest continue to be addressed elsewhere in the criminal justice system, DATs/DAATs should continue to engage with relevant stakeholders to identify how this should be progressed.

5. Accredited Training

The development of accredited training was a key recommendation and will contribute towards recruitment and retention of workers. Work is being taken forward to ensure that arrest referral workers are included within the development of a national workforce and training strategy being taken forward in England by the NTA. The implementation of the National Occupational Standards for Drugs and Alcohol (DANOS) will be an ideal opportunity to develop practitioner competency. This will include standards working with a more diverse range of problem drug-using offenders (including crack users and black and other ethnic minorities).

Police custody staff should also be provided with routine training on drug awareness issues (including key harm reduction messages).

6. Next Steps Enhanced Arrest Referral and Integration

The recent emerging findings from the national evaluation and monitoring programme (DPAS Paper 18) published in July 2002 identified a number of recommendations, including operational enhancements which would maximise effectiveness of delivery at arrest and minimise non-engagement of drug misusing offenders particularly when referred to specialist treatment interventions.

The evidence base supported by feedback from workers, police, and treatment providers and service users over the last year have contributed to informing the interventions which contribute to the delivery of enhanced arrest referral. It was recognised that many schemes and workers had moved beyond assessment and referral in order to retain and engage drug misusing offenders until structured treatment became available.

Using the sustainable resources and evidence now available those involved in planning and delivering drugs work in custody suites can build on and further extend the role and interventions currently provided by drug workers in a custody suite/magistrates court. Moving beyond assessment and referral, the additional resources and evidence seeks to now enhance delivery to include interventions such as harm reduction advice, caseload management, care planning and delivery of low threshold treatment interventions. These types of services reflect the level of delivery of a Tier 2 type service.

This focus seeks to apply the recommendations and align the work delivered in criminal justice settings more closely with the Models of Care approach but also recognises the expertise of delivery of drug work within a criminal justice setting.

It is recognised that drug workers working within a criminal justice setting such as a police custody suite or magistrates court should be appropriately supported, supervised and skilled to deliver Tier 2 type interventions (at a minimum level). This includes drug advice, information, harm reduction information (including managing overdose), screening and specialist drug assessment, referral, care planning and case management and delivery of low threshold treatment interventions such as motivational engagement.

**E. Requirements of Enhanced Arrest Referral**

Using the existing knowledge gained through local commissioning and delivery of arrest referral, commissioners, Police and other stakeholders within the DAT should seek to apply the recent evidence base

and recommendations when commissioning criminal justice related drug interventions in police custody suites/magistrates courts in order that workers:

- can deliver drug-and alcohol-related advice, and identify how the offender may access information and referral services (and their families)
- know where and how to access services which reduce risks caused by injecting drug misuse, including needle exchange facilities (in drug treatment services and pharmacy-based schemes)
- deliver and also know where to access services that minimise the spread of blood-borne diseases to drug misusers
- deliver advice and know where to access services that minimise the risk of overdose and other drug-and alcohol-related harm
- as part of local arrangements (i.e. agreed with police, DATs) target high-risk and local priority groups
- undertake specialist drug and alcohol screening and assessment within a criminal context (Triage assessment - level 2)
- initiate care planning and case management in line with Models of Care and which reflects local DAT treatment arrangements
- deliver motivational and cognitive based interventions (drugs)
- access as appropriate community-based, low-threshold prescribing services to sustain engagement of offenders whilst waiting for Tier 3 services

All of these enhancements build on work already being delivered across many of the police forces in England and Wales. Previous Home Office reports have shown, there is much variety between schemes, a basic core set of skills and competences is being developed to inform training and support delivery.

#### **F. Partnership between Agencies**

The DAT/DAATs and Police should ensure with other key stakeholders that there are planning and monitoring arrangements which address both strategic and operational issues. Best practice has highlighted the value of a local steering group, which takes on operational responsibility and ensures the development and delivery of local procedures, protocols and day to day working arrangements. Recognition that information and feedback from workers could inform current delivery of treatment interventions and future commissioning of services. Strategically DATs need to ensure that there are appropriate mechanisms to have feedback from workers such as those working in Criminal Justice settings to inform current and future delivery of interventions.

The following section will now focus on Drug Treatment and Testing Orders briefly describing outcomes from the early pilots, the purpose and methods of delivery.

### **IV. Drug Treatment and Testing Orders**

#### **A. What is the Drug Treatment and Testing Order?**

Drug Treatment and Testing Orders, usually referred to as DTTOs, are a sentence of the court and implicitly a punishment for a crime. They were introduced under the Crime and Disorder Act 1998 in the pilot areas and rolled out to courts in England and Wales from October 2000.

#### **B. Background**

The DTTO was introduced as a response to the growing evidence of links between problem drug use and persistent acquisitive offending; it was a government manifesto, to break this link. , Drug Treatment and Testing Orders (DTTOs) replaced the power to add a requirement for drug treatment to a probation order. There had been low use of earlier legislation and it replaced the provision in the 1991 Criminal Justice Act for offenders to undergo treatment as a condition of a probation order (contained in paragraph 6 of Schedule 1A of the Act.). Lessons learnt and the experiences from USA drugs courts particularly relating to the close involvement of Sentencers in sentence review and management and lastly the ongoing evidence that treatment works and can reduce crime (NTORS), and that coercion could also be as effective (Hearnden et al 2000).

The purpose of the Drug Treatment and Testing Order is to break the link between drug use and crime. It is:

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- a sentence of the court
- a punishment for crime
- in place to prevent future crime
- an integral part of the UK Drug Strategy
- a key component of the crime reduction strategy

It can be imposed on any offender over 16 who has a dependency on or propensity to misuse drugs and for whom treatment may be helpful. The order is available in both the Crown and Magistrates' Courts, so that it has the broadest possible application, within its established targeting criteria.

It obliges the offender to:

- undergo treatment as specified for a set period of between six months and three years
- be tested regularly for drug use
- attend regular court review hearings at which progress under the Order will be reviewed.

Uniquely, in English and Welsh Law, courts have a vital role to play throughout the currency of the order and through the regular court reviews an offender's motivation and progress on the order can be monitored. The conditions of the Order may also be amended if required at the review hearing.

Regular drug testing provides an important reality check. Drug testing is mandatory and courts regularly review the offender's progress. The aim of testing is to help in monitoring the offender's compliance and progress with treatment. If testing requirements are not met and/or attendance at mandatory treatment is not adhered to, the court can 'revoke' a DTTO and re-sentence the offender. DTTOs cannot be imposed without the consent of the offender.

DTTOs aim to bring persistent and dependent drug-misusing offenders into a closely supervised programme of treatment in order to effectively break the links between their drug misuse and their offending.

DTTOs were implemented nationally in October 2000 following pilot schemes in Croydon, Gloucester and Liverpool. The pilot sites were independently evaluated by the Criminal Policy Research Unit at South Bank University. The pilot sites demonstrated the following areas of impact (through self-report interviews with offenders):

- reductions in drug use and offending at the start of the order
- fall in average weekly amount spent on drugs
- reduction in levels of polydrug use
- six-monthly interviews with offenders demonstrated that these reductions were sustained over time

Evidence suggested that drug dependent offenders can be successfully coerced into treatment as they pass through the criminal process (Turnbull et al. 2000).

**C. Key Elements of the DTTO are:**

- Assessment
- Treatment
- Testing
- Enforcement
- Court Review

**D. Assessment**

Home Office National Standards expects suitability for a DTTO to be assessed according to four main criteria:

- type and seriousness of offence
- seriousness of drug problem and susceptibility to treatment
- motivation to change
- volume of drug-related offending.

One key area of learning from the early pilots was the importance of getting the referral and assessment procedures right. With experience now broadening in the supervision of DTTOs what is being found is that an offender's capacity to manage being on a DTTO is a critical factor in assessment.

An initial assessment or screening may also occur in a variety of settings, for example an arrest referral scheme, the probation service or a drug service. The purpose of the initial assessment is to explore the possibility of a DTTO with the offender and to make a decision about whether to proceed to a full assessment. The screener will need to consider the pattern of the offender's drug misuse and nature and volume of their offending, as well as their motivation to undertake drug treatment. The court may receive information about drug related offending from an arrest referral worker, drugs worker in an approved hostel or a probation officer.

However an initial screening assessment will not be sufficient basis for a DTTO recommendation to the court. A full assessment as part of the pre-sentence report (PSR) should always be undertaken. This may either be carried out by the probation area themselves or by a drug treatment service purchased to provide the treatment aspect of the DTTO. The decision to impose a DTTO, whilst ultimately being made by the court, will nevertheless involve all of the stakeholders, the court, the probation service, the drug service, and the offender.

A Specific Sentence Report may provide information that leads to a request for assessment. Once the decision to adjourn for this special assessment is made the court will adjourn to a court date which fits best with the 15 day adjournment.

A question raised early on by some Sentencers was how were they supposed to know who will succeed under this Order - they are not experts?

The answer would be, they are not expected to be. Sentencing is, and will remain, a matter for the court. But the initial assessment of the offender by the probation service and treatment providers will be crucial in identifying and targeting the new Order at those who are causing a disproportionate level of disruption to their community and are most susceptible to treatment. Sentencers should be able to work with and consider the advice of the experts in order to make an appropriate sentencing decision on the basis of all the facts, including the advice of the probation service about what community interventions are available and might be appropriate.

#### 1. Assessment and Pre-Sentence Report

The assessment is usually provided within a pre-sentence report but is undertaken jointly by probation and treatment staff. It should include the following:

- a statement that the offender has been assessed by probation and treatment staff, is dependent upon or having a propensity to misuse drugs and as being susceptible to the kind of treatment being proposed
- a treatment plan, including the name and address of the treatment provider, and whether the treatment will be residential or non-residential
- confirmation that arrangements for this treatment are in place
- the suggested length of the order
- a signed statement from the offender that the requirements of the order and the consequences of a failure to comply have been fully explained by the responsible officer and confirming that the offender is willing to comply with the order
- a proposal for the minimum frequency of drug testing and of court review hearings to be specified in the order
- where there is a need for a residence requirement (other than for residential treatment) a proposal that a probation order be made alongside the DTTO and an explanation of the reasons why this residence requirement is deemed necessary.

#### **E. Treatment and Enforcement through DTTO National Standards**

Home Office guidance (PC43/2000) says that individual treatment programmes should be developed at a local level on the basis of the range of treatment available locally and the individual's need.

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Subsequently Home Office National Standards determined that the contract requirement was:

Commencement of treatment within 2 working days and  
Contact of 20 (now reduced to 15hrs) over 5 days for the first 13 weeks  
then 12 hrs per week for 3 days if progress is being made.

The range of treatment should include:

1. Treatment Related

- In patient detoxification
- Community detoxification
- Structured programmes
- Health Assessment/Education
- Relapse Prevention
- Residential rehabilitation
- Hepatitis test & vaccination
- Counseling

2. Offence Focused Work

- Supervision plan & reviews
- Accredited programmes 1:1 or group
- Victim awareness
- Relapse prevention

3. Lifestyles Packages

- Social skills
- Training
- Pre-employment work
- Basic literacy skills
- Use of leisure
- Housing
- Family support

- The first appointment with the probation service to take place within one working day of the order being made and contact with the treatment provider shall be arranged to take place within two working days of the order.
- Contact, including treatment, across all the requirements of the order to be on five days per week, for a total of 20 hours a week, for the first 13 weeks of the order. There is discretion for this to be reduced to a minimum of three days a week and 12 hours a week thereafter, if the offender is responding well. The minimum for the first 13 weeks of the order shall be 15 hours a week and nine hours a week thereafter.
- Contact with the offender to include provision for treatment, offence focused work and lifestyle programmes.
- It is anticipated that the offender will not usually be employed at the commencement of the order. If the offender obtains employment the probation service and treatment provider shall consider if the treatment and contact requirements shall be reduced to facilitate this and an early review hearing arranged for this to be considered by the court. Nevertheless, the minimum treatment and contact requirements shall be met in all cases.
- Treatment provided under the order must comply with co-existing national standards, such as those that will be introduced through the DH Models of Care.

**F. Testing**

The purpose of regular testing is to provide supervising officers, treatment providers and the courts with an objective measure of the offender's progress towards becoming drug free. The supervising officer must put these results into the context of the offender's overall progress on the order when reporting to the sentencing court for each review hearing.

Offenders should be tested at least twice a week for the first 13 weeks of the order with discretion for this to be reduced to a minimum of once a week thereafter depending upon progress.

## **G. Court Reviews**

### **1. What is the Purpose of the Court Reviews?**

The purpose of the Court Review is to enable the Court to monitor the offenders progress in treatment and to decide whether any changes to the conditions including treatment need to be made. Preferably held by the same sentencer or specialist bench. Courts can already ask for progress reports on offenders but now the review process is 'designed-in'. The court receives a written report from the probation officer including drug test results. The review hearing provides an opportunity to encourage and support progress, if the court is not happy with the offenders' progress, the offender can be required to explain themselves. If the order is really not working, the court may also amend the Order. Normally the offender attends with a member of the DTTO staff team. Courts have the option of waiving the requirement for an offender to attend the court in person if they are making satisfactory progress as long as this is confirmed by the written reports from the Probation Officer/Treatment Provider. The style of the review hearing may be less formal. The outcomes of the court review hearing could include: amendments to the Order, progress expected before next review and whether breach proceedings are justified.

## **V. SUMMARY**

Evidence from early pilots and more extensive evaluation has highlighted that drug interventions in the criminal justice system offer an effective means of putting drug misusing offenders in touch with appropriate services locally where they can receive help to reduce their drug use.

Interventions particularly at arrest and at the community sentence stage provide opportunities to engage but need to be part of a wider package of interventions across the criminal justice system.

### **Why deliver drug interventions in the Criminal Justice System?**

Because they have the potential:

- to reduce drug related crime
- to reduce drug misuse
- to improve health of drug misusers and
- to assist social reintegration of drug misusers.

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**APPENDIX A**  
**MODELS OF CARE - FOUR TIER FRAMEWORK**

**Table 1. Drug Misuse Treatment Tiers and Commissioning Levels**

<b>Tier No.</b>	<b>Tier Title</b>	<b>Service Modality</b>	<b>Commissioning Level</b>
1	<b>Non-substance misuse specific services</b>	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	<b>Open access drug misuse services</b>	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	<b>Structured community-based specialist drug misuse services</b>	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	<b>Residential substance misuse specific services</b>	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	<b>Highly specialist non-substance misuse specific services</b>	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

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APPENDIX B

TELEPHONE ENQUIRIES:  
020 7273 4045

ARREST REFERRAL MONITORING FORM

PLEASE SEND THIS COPY TO YOUR  
LOCAL NDTMS

<b>1. CONTACT DETAILS:</b>			
Where was contact made (✓ one)		Date of contact (4 digit year):	
Police	<input type="checkbox"/>	/ /	
Court	<input type="checkbox"/>	Police station:	
Other	<input type="checkbox"/>	Drug Action Team area:	
		Drug worker's code/name:	
<b>2. DETAILS OF CLIENT: Full name, address and postcode are NOT required</b>			
First initial		Date of birth (4 digit year):	
Surname initial		/ /	
Gender M/F		Local authority/ council of residence	
		(✓) if NFA <input type="checkbox"/>	
Ethnic group: Which of the following groups do you belong to? (✓ one)			
<b>WHITE:</b>	White British <input type="checkbox"/>	White Irish <input type="checkbox"/>	White Other <input type="checkbox"/>
<b>MIXED:</b>	White/Black Caribbean <input type="checkbox"/>	White/Black African <input type="checkbox"/>	White/Asian <input type="checkbox"/>
<b>BLACK:</b>	Caribbean <input type="checkbox"/>	African <input type="checkbox"/>	Black Other <input type="checkbox"/>
<b>ASIAN:</b>	Indian <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>
<b>OTHER:</b>	Chinese <input type="checkbox"/>	Other <input type="checkbox"/>	Asian Other <input type="checkbox"/>
Please specify:			
<b>Offence:</b> What alleged offence have you been arrested for? (✓ one) <b>If more than one offence tick the most serious</b>			
Shoplifting	<input type="checkbox"/>	Street robbery	<input type="checkbox"/>
Fraud	<input type="checkbox"/>	Other theft	<input type="checkbox"/>
Auto-crime	<input type="checkbox"/>	Soliciting	<input type="checkbox"/>
Selling/possession of drugs	<input type="checkbox"/>	Handling stolen goods	<input type="checkbox"/>
		Burglary	<input type="checkbox"/>
		Wounding/assault	<input type="checkbox"/>
		Other	<input type="checkbox"/>
		Please specify	
<b>3. TREATMENT HISTORY:</b>			
Have you ever received treatment for a drug problem?		Y/N	<input type="checkbox"/>
If yes, are you still receiving treatment for your drug problem?		Y/N	<input type="checkbox"/>
<b>4. DRUG AND ALCOHOL PROFILE: Drugs used in the last month? (Include alcohol as main drug if appropriate)</b>			
<b>Main problem drug</b>	<input type="text"/>	Injected Y/N	<input type="checkbox"/>
<b>Drugs used in the last month</b>	<input type="text"/>	Injected Y/N	<input type="checkbox"/>
	<input type="text"/>	Injected Y/N	<input type="checkbox"/>
<b>Alcohol units</b>	<input type="text"/>	Injected Y/N	<input type="checkbox"/>
<b>Per week</b>	<input type="text"/>	Injected Y/N	<input type="checkbox"/>
On average (to the nearest £), how much do you spend on illicit drugs per week?		£	<input type="text"/>
<b>5. INCOME AND OFFENDING BEHAVIOUR:</b>			
What are your <b>three</b> main sources of income? (please ✓ three options that apply)			
Legitimate paid work	<input type="checkbox"/>	Selling drugs	<input type="checkbox"/>
Benefits	<input type="checkbox"/>	Street robbery	<input type="checkbox"/>
Shoplifting	<input type="checkbox"/>	Auto-crime	<input type="checkbox"/>
Fraud	<input type="checkbox"/>	Handling stolen goods	<input type="checkbox"/>
		Other	<input type="checkbox"/>
		Specify	
		Burglary	<input type="checkbox"/>
		Sex work	<input type="checkbox"/>
		Begging	<input type="checkbox"/>
		Do you have any previous convictions?	
		Y/N	<input type="checkbox"/>
<b>6. SUMMARY: Initial assessment recommendation</b>			
<b>Initial assessment recommendation: Complete after discussing and agreeing the recommendation with the client (please ✓ all that apply)</b>			
No further intervention required <input type="checkbox"/>		Referral refused (by client) <input type="checkbox"/>	
<b>Referral to specialist drug treatment</b>			
Continue in treatment	<input type="checkbox"/>	→	Agency name
Referral to specialist drug agency	<input type="checkbox"/>	→	Agency name
<b>Caseload/case management</b>			
Scheduled for further appointment	<input type="checkbox"/>		
<b>Other referrals</b>			
Alcohol service	<input type="checkbox"/>	Referral to mental health service	<input type="checkbox"/>
GP/GP liaison or Primary Care	<input type="checkbox"/>	Referral to CARATs or Prison Healthcare	<input type="checkbox"/>
DTTO teams	<input type="checkbox"/>	Referral to housing agency	<input type="checkbox"/>
Other	<input type="checkbox"/>	→	specify:

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**GUIDANCE NOTES:**

The National Arrest Referral Monitoring System collects routine information on the number and characteristics of problem drug-using offenders who report a demand for treatment. The data collected forms a module with the National Drug Treatment Monitoring (NDTMS). All the information collected is anonymous and confidential (initials, date of birth and gender are used to calculate the number of individuals). See Informed Consent sheet for more details. DETACH THE CARBON COPY AND RETURN TO YOUR LOCAL NDTMS.

**PLEASE COMPLETE THIS FORM:**

- On all arrestees with whom you have a face-to-face contact. This may lead to a further detailed assessment of clinical or other treatment needs that may lead to a referral to a drugs service.
- For all face-to-face contacts, regardless of whether you have seen the arrestee before.
- Do not complete this form for all contacts such as brief personal interactions, letter or telephone contacts.

**1. CONTACT DETAILS**

- **Contact** Tick Police if seen in a custody suite; Tick Other for gateway agencies.
- **Drug worker's code/name:** This is used to allow local feedback. Include a code if it has been agreed locally with your NDTMS manager.

**2. DETAILS OF CLIENT**

- **Initials, date of birth and gender** No names and addresses are required.
- **Local authority of residence** This is the client's Unitary or County of residence
- **NFA** If the client has No Fixed Abode tick this box. This may include living in a hostel, B&B etc.
- **Ethnic group** Please use the client's own definition and select from the list provided
- **Offence** Please tick one option only. If the client has committed several offences then please enter the most serious. If a client has been arrested on a WARRANT then please tick the original offence.

**3. TREATMENT HISTORY**

- **Ever treated** Include if client has ever accessed treatment for a drug problem, including GPs and generic services.
- **Current treatment** Include if client is currently accessing treatment, including GP services.

**4. DRUG AND ALCOHOL PROFILE**

- **Main problem drug** Write in the drug that is the main problem for the client. Include alcohol here if appropriate.
- **Drugs used in the last month** Please WRITE in all illicit and licit drugs used in the last month.
- **Alcohol units per week** The number of units of alcohol the client is estimated to use per week.
- **Illicit drugs spend** Include estimates of client's spend per week. If drugs are not directly purchased, enter "0".

**5. INCOME AND OFFENDING BEHAVIOUR**

- **Sources of income** Please include client's three main sources of income from list.

**6. SUMMARY Initial Assessment Recommendation**

- Complete any assessment recommendations (tick all that apply).
- If the client refuses a referral following an assessment, please tick REFERRAL REFUSED (BY CLIENT)
- **Caseload/case management** Tick this box if, after assessment, you arrange to meet the client again at another venue.