

# The Criminal Justice Substance Misuse Pathway Needs Assessment.

January 2014.

## Contents

<b>Executive summary.....</b>	<b>Page 4</b>
<b>1. Introduction.....</b>	<b>Page 12</b>
1.1 Moving Forwards.....	Page 13
1.2 Aim.....	Page 13
1.3 Objectives.....	Page 13
1.4 Methodology.....	Page 13
<b>2. Background to the Criminal Justice Intervention Team.....</b>	<b>Page 15</b>
2.1 Custody Suites.....	Page 15
2.2 Custody Suites: Current context.....	Page 16
2.2.1 Alcohol in the custody suite.....	Page 17
2.2.1.1 Report against the findings from two evaluations of Home Office Alcohol Arrest Referral Schemes (Research Report 60)	Page 18
2.2.2 Target Testing.....	Page 25
2.3 CJIT role in the custody suite.....	Page 26
2.4 CJIT role in the courts.....	Page 28
2.5 CJIT Prison in-reach.....	Page 29
2.6 CJIT outreach.....	Page 30
2.7 CJIT and Integrated Offender Management.....	Page 27
2.8 CJIT core functions.....	Page 31
2.9 Police task Force.....	Page 33
2.10 Transitional Work.....	Page 33
2.11 Transforming Rehabilitation.....	Page 33
<b>3. Substance Misuse Team Background.....</b>	<b>Page 38</b>
3.1 Community Orders.....	Page 38
3.2 Current context.....	Page 38
3.2.1 SMT and Alcohol Interventions.....	Page 40

<b>4. Rapid Access Team.....</b>	<b>Page 42</b>
4.1 Rapid Access Team in the context of DIP.....	Page 42
4.2 Current context.....	Page 42
<b>5 The Adult Offender Building (AOB).....</b>	<b>Page 45</b>
5.1 Background.....	Page 45
5.2 Current Context.....	Page 45
5.2.1 Saturday Morning Surgeries.....	Page 45
5.2.2 The Diverse Therapy Support Group (DTSG).....	Page 46
5.2.3 Fit for Work.....	Page 47
5.2.4 ETE/ Employment Services.....	Page 48
5.2.5 Welfare Advice Clinics.....	Page 48
5.2.6 BBV and Vaccination.....	Page 48
5.2.7 Alternative Therapies.....	Page 48
5.2.8 Caring for Kids.....	Page 48
5.2.9 Social Skills and Social Skills Events.....	Page 48
<b>6 Service User Feed-Back.....</b>	<b>Page 50</b>
6.1 Methodology.....	Page 50
6.2 What does recovery look/feel like to you?.....	Page 53
6.3 Observation of the DTSG.....	Page 54
<b>Appendices:</b>	
<b>1. Service User Questionnaire.....</b>	<b>Page 55</b>
<b>2. Case Study.....</b>	<b>Page 62</b>
<b>3. Service User Letter.....</b>	<b>Page 64</b>

## Executive Summary

**Caveat: Throughout this needs assessment the use of the acronym “DIP” refers to the function rather than the financial pathway.**

### Introduction

The Drugs Intervention Programme (DIP) in its current form was devised in 2005 to deliver interventions to those individuals who committed acquisitive crime that was informed by their drug taking. DIP concentrated on the two class A drugs that were associated with the majority of drug related crime; heroin and crack cocaine. The aim was to increase the number of heroin and crack cocaine users into treatment and to greatly reduce the re-offending rate of this cohort of offenders. To this end DIP has been very successful; from its height in 2007 when there was an average of 200 positive tests per month in Nottingham City to the present day when the average monthly presentation of positive tests is below 100.

For a large number of offenders DIP and the use of coercive engagement via required assessments and community orders has been their first experience of treatment. To this end DIP has been very successful in engaging clients in effective treatment once they have got them through the door. This success can be measured against the reduced numbers of Opiate and Crack users (OCU) that now present in the criminal Justice system. It is also well documented that there are few young people presenting with heroin and crack cocaine problems and naïve presentations are also falling for this type of substance misuse. It is also well documented that the cohort of OCU is getting older and those that are still presenting in the custody suites are the most chaotic and least motivated to change.

However; caution should be applied to the sense of success associated with DIP, they have been successful in the delivery of interventions aimed at the cohort of OCU, the legislative sanctions that direct drug using offenders into treatment and away from their criminal activities has not kept abreast of recent drugs trends or the associated offending.

The number of Drug Rehabilitation Requirement (DRR) orders within a community order or suspended prison sentence has dramatically reduced since 2008. The decrease is partially due to the focus of diverting from charge and a reduction in the number of community orders issued by magistrates; primarily though it is due to the reduction in the numbers of positive tests for opiates and crack cocaine via test on arrest.

DIP remains the primary method of engaging drug misusing offenders in effective treatment. The effective process needs to be focussed to engage offenders who use drugs other than the two class A drugs that DIP have historically targeted; it also needs to offer interventions for those who offend due to the misuse of alcohol. Identifying substance misuse related crime is vital to ensure that the right approaches to reduce re-offending are targeted and effective. Substance misuse informed offenders are often the most prolific re-offenders; by identifying their prevalence and coercing them into effective treatment DIP can contribute to a safer Nottingham. Whether they are class A drug users or violent alcohol and/or cocaine fuelled offenders in the night time economy.

## Key Findings

The development of the Drugs Intervention Programme (DIP) since its conception in 2005 has been dramatic in engaging some of the hardest to motivate clients in the treatment system. It has offered an end-to-end approach; from arrest, through sentencing and beyond to those who's offending has been informed by their substance misuse. The emphasis for DIP has always been to reduce the number of individuals caught up in chaotic lives of addiction and crime and to stop young people from following this pattern of behaviour.

DIP concentrated on the two class A drugs that were associated with the majority of drug related crime; heroin and crack cocaine. The aim was to increase the number of heroin and crack cocaine users into treatment and to greatly reduce the re-offending rate of this cohort of offenders. To this end DIP has been very successful; from its height in 2007 when there was an average of 200 positive tests per month in Nottingham City to the present day when the average monthly presentation of positive tests is below 100.

### *The current treatment system:*

The service is currently divided into two distinct parts; the Criminal Justice Intervention Team (CJIT) who mainly deal with non-statutory offenders and those who commit acquisitive crimes to support their substance misuse. This division is supported by Nottinghamshire Healthcare Trust via the Rapid Access Team (RAT); who provide substitute prescribing and support for those clients with complex needs. The second division is the Substance Misuse Team (SMT) who deliver interventions for those clients on Drugs Rehabilitation Requirements (DRR) and engage with statutory clients with complex needs. Both of the divisions provide support and interventions for those clients who are engaging with the Integrated Offender Management (IOM) approach to reducing offending.

Caution has to be applied when one considers the success of DIP; whilst effective inroads have been made in engaging the cohort of offenders that DIP was commissioned to work with, we have seen a change in the offending nature attached to the current trends in drug taking. We have also seen an increase in alcohol/ poly substance misuse in informing offending, especially violent crime and there is little or no interventions available in the criminal justice pathway to engage this cohort in effective treatment.

The current drug trends and the increase in alcohol/poly substance misuse is having an adverse effect on the number of DRR being awarded through the courts. The majority of DRR are being applied to the most chaotic of service users which has an adverse effect on the number of successful completions.

### *"Transforming Rehabilitation: A Revolution in the Way we Manage Offenders"*<sup>1</sup>

In January 2013 the Government published a consultation paper entitled *"Transforming Rehabilitation: A Revolution in the Way we Manage Offenders"*. The paper laid out the government's plans to reduce the rate of re-offending by extending rehabilitation services to offenders released from short term custodial sentences where no provision had previously existed. The paper also commits to the previous

---

<sup>1</sup> Ministry of Justice. 2013.

proposals for the reforms laid out in “*Transforming Rehabilitation – A Strategy for Reform*” At the heart of the reform is the dissolution of the National Probation Trusts into one National Probation Service (NPS) and an introduction of Community Rehabilitative Companies (CRC) which will see public, private and voluntary sector organisations competing for Probation services in twenty-one package areas across England and Wales.

The effect of these reforms for Nottingham City is that Nottinghamshire Probation Trust currently delivers all the functions of DIP supported by Nottinghamshire Healthcare Trust. This delivery; according to the guidelines of the reforms, will have to cease in April 2014, although Nottinghamshire Probation Trust have negotiated with the Ministry of Justice an extension till September 30<sup>th</sup> 2014. This will allow enough time to complete a re-procurement process to allow for a new provider.

The main clauses included in the Reform Bill are as follows:

- Provide a mandatory period of no less than twelve months for the rehabilitation and support of short term offenders serving custodial sentences of less than two years
- Creates a new court process and sanctions for breach of supervision requirements for offenders serving less than two years
- Powers will be granted to allow for the testing of drugs on offenders under supervision to now include both Class A and B
- Introduces a flexible set of sanctions for the Magistrates’ Court to utilise should the offender breach conditions
- Introduces a Rehabilitation Activity Requirement for community sentences which will provide a wider flexibility for Probation Workers to instruct offenders to take part in accredited programmes and activities conducive to their rehabilitation
- A requirement by the offender to obtain permission from their responsible probation officer or Court before changing residence.

Whilst the provision of interventions for drug misusing supervision and the twelve month licence period is welcome the bill makes little indication of the provision of alcohol interventions for reducing re-offending amongst this cohort.

### *The Adult Offender Building (AOB).*

The co-location of all the Criminal Justice services within the AOB has created the provision for a recovery focussed service that has the provision of access to all the recovery capital to ensure a service user’s journey has all the individual’s needs met. The AOB houses all the substance misuse services; offender managers and the police, ensuring offending/re-offending concerns are dealt with alongside treatment and health provisions.

In October 2012 the Labour Peer, Baroness Massey of Darwen visited the AOB in her capacity as the chair of the then NTA. Baroness Massey was so impressed by the facilities and the success of the interventions contained within the AOB that she volunteered her views to raise the building as an area of good practice with the Chief

Executive designate of Public Health England, Duncan Selbie and the Junior Health Minister, Anna Soubry.

The AOB facilitates the delivery of social and health interventions from numerous third sector and voluntary services. Debt and welfare benefits advice are provided; as are education, training and employment access. Health advice includes BBV interventions; wound dressing and healthy living advice. Social skills and social events are very popular amongst the service users. Alternative therapies also offer spiritual interventions for the recipients.

*Gaps, risks and recommendations:*

Throughout the needs assessment it has become obvious that there is a lack of a comprehensive criminal justice alcohol pathway that engages those with sole or primary alcohol problems. At the present moment Alcohol Treatment Requirements (ATR) are delivered within the community pathway and there exists an alcohol diversion scheme that addresses the needs of those who may be subject to an alcohol informed fixed penalty notice. There are obvious risks with both of these pathways; the delivery of ATR in the community pathway means that recipients have to endure waiting times and are not seen as a priority by the community providers. Those individuals who are offered a chance to engage with the alcohol diversion scheme do so voluntarily and are rightly diverted away from the criminal justice pathway; but the scheme is limited to addressing the needs of those who commit offences that are classed as drunk and disorderly.

**The recommendations concerning alcohol interventions would be as follows using the existing infrastructure that exists for primary drug interventions;**

**To liaise with the custody staff and the arresting officers to engage all those detainees who appear to have committed an alcohol informed offence.**

**To conduct an assessment and deliver Identified Brief Advice (IBA) to all those detained with an alcohol informed offence.**

**To liaise with custody staff and police officers to ensure that all those who may be subject to a fixed penalty notice are made aware of the alcohol diversion scheme and offered the chance of engaging with the service.**

**To increase the use of conditional cautions to cover alcohol informed offences to coercively engage offenders in treatment within the AOB.**

**To explore the use Of Restrictions on Bail (RoB) to align alcohol informed offending with that associated with drug use.**

**To utilise the same pathway for ATR as is used for DRR; ensuring that recipients are seen in a timely manner by both the offender manager and the substance misuse worker.**

**To use the courts to report back on the delivery and engagement of those who are awarded an ATR in the same manner as DRR.**

**To engage offenders in Extended Brief Advice (EBA) at the AOB.**

**To offer all those with sole and primary alcohol informed offending the same opportunity to engage in the suite of recovery capital that is available at the AOB.**

**Explore the pathways between the criminal justice services and community services to manage alcohol detoxification for those service users who require this intervention.**

**To liaise closely with the substance misuse team in HMP Nottingham to refer offenders who may have alcohol problems to enable early interventions upon reception at the prison.**

Since 2007 there has been an obvious decline in the number of individuals who are using the two main target drugs; heroin and crack cocaine, but there has not been a corresponding reduction in the number of acquisitive crimes committed. According to the National Crime Survey for England and Wales (September 2013) there has been a 4% increase in shoplifting and 7% increase in personal theft. Nottingham police currently has data quality concerns around the effective use of "Alcohol" tags when recording offence details – a situation the Force is looking to rectify during the course of the current year. The information from a recent CJIT custody suite survey and from detainees volunteering information upon arrest suggest that there is still a problem with the use of drugs other than heroin and crack cocaine and alcohol. Cannabis, cocaine hydrochloride and alcohol all feature highly in the substances that detainees admit to using and also admit to being under the influence of when committing their respective offences. There is also anecdotal evidence that suggests an increasing number who are using New/Novel Psychoactive Substances (NPS). All this suggests that there are a substantial number of offenders who are passing through the custody suites, courts and prison without being offered or having the opportunity to engage in interventions aimed at their substance misuse and by definition their re-offending risks.

**Recommendations to consider concerning the current trends in substance misuse that informs offending.**

**To explore the feasibility of testing for a wider range of drugs at the point of arrest and to use the existing referral pathway to the custody suite drug workers upon a positive test. Early indications from "Transforming Rehabilitation A Strategy for Reform" suggest that those offenders who use drugs to inform their offending will be tested on a frequent basis for all class A and B drugs.**

**To explore the use of breathalyser kits where there is an indication that alcohol has informed the offending and to use the existing drug pathway to refer to the custody suite drug worker.**

**To develop the use of the existing paperwork [Drug Test 1 (DT1)] to inform the courts that a substance, other than heroin or crack cocaine, has been used to inform the current offence. This will allow the court to be more informed when considering awarding a RoB, DRR, or ATR in respect of the offence.**

**To increase the use of conditional cautions to coercively engage offenders at the AOB.**

**To use the existing referral pathway to the custody suite drug workers when a detainee admits to use of substances other than class A drugs upon arrest.**

**To liaise closely with the substance misuse team in HMP Nottingham to refer offenders who may have substance misuse problems to enable early interventions upon reception at the prison.**

There is considerable evidence to demonstrate that violence in the night-time economy is affected by the use of alcohol and stimulants; especially cocaine hydrochloride. The metabolite cocaethylene forms in the body when cocaine and alcohol are consumed this is a proven driver of violence. Drinking alongside the use of stimulants enables individuals to continue to drink to extremely harmful levels whilst remaining lively and alert. Whilst cocaine hydrochloride is one of the drugs that would give a positive response when tested for; the machine makes no distinction between Cocaine hydrochloride and crack cocaine, other stimulants including some of the NPS have the same euphoric effect as cocaine hydrochloride when combined with alcohol. However violent crimes are not part of the suite of trigger offences that would elicit a drug test on arrest and we are reliant on an Inspector's authorisation to make that test.

**Recommendations to consider when addressing non-trigger offences.**

**To explore the feasibility of up-dating the suite of trigger offences to include violence including domestic violence.**

**To increase the use of Inspector's authority tests with an emphasis on violent crimes, including domestic violence.**

**To consider the use of "test on charge" when an offender is considered a risk to self or others at the point of arrest.**

For obvious reasons the courts play a major part in identifying the client group that CJIT and SMT will work with. CJIT currently have workers based in the courts to monitor and track all those offenders who have tested positive and may be made subject to a community order or have a RoB applied to monitor motivation. Having completed a required assessment and a required follow-up assessment CJIT has the relevant information to inform a pre-sentence report or to advise a magistrate if a DRR or RoB is appropriate for individual offenders.

All offenders who test positive in the custody suite at the test on arrest stage have a Drugs Test 1 (DT1) to inform the court of the outcome of that test; it is not always obvious if the DT1 is used at sentencing stage.

**Recommendations to consider when liaising with the courts to ensure that the courts are informed of any substance misuse problem that may have contributed to the offending behaviour.**

**A process needs to be developed to indicate to the court clerk and the magistrate that a DT1 is included in the sentencing report. CJIT do not have the resources to attend all the courts for all the offenders who appear, so a simple indicator may suffice.**

**To explore the possibility of developing the above in respect of alcohol informed offending.**

**All Pre-Sentence Report (PSR) and Fast Track Report (FTR) writers to engage with the CJIT worker to assess the suitability for applying a DRR or ATR.**

**To explore the possibility of the application of RoB on those whose offending is linked to alcohol use.**

The application of *“Transforming Rehabilitation: A Revolution in the Way we Manage Offenders”* will have a profound effect on the caseload of DIP clientele. Currently the majority of CJIT caseload is made up of non-statutory offenders who have little or no intervention from offender managers; whilst some of these offenders may be identified as Integrated Offender Management (IOM) nominals they are still currently entering treatment on a voluntary basis. *“Transforming Rehabilitation: A Revolution in the Way we Manage Offenders”* will ensure that all prison releases; including those who have served a sentence of under twelve months will be subject to a “licence condition” of twelve months to address their substance misuse problems and to counter any further re-offending. This will also be applied to some community orders to ensure compliance from this offending cohort. The result will be a major increase in the number of individuals who have to engage with DIP (see **section 2.9** of the main text). It is not clear how the delivery of *“Transforming Rehabilitation: A Revolution in the Way we Manage Offenders”* will be applied to offenders who are IOM nominals after the bill is implanted; because seemingly it appears that all offenders will be dealt with under the ethos of IOM.

**Recommendations to consider concerning the application of *“Transforming Rehabilitation: A Revolution in the Way we Manage Offenders”***

**Currently there are a large number of clients who drop out of treatment after completing their required assessments or period of RoB; there is also a proportion of clients who only access the Rapid Access Team (RAT) to obtain their substitute prescribing. *“Transforming Rehabilitation: A Revolution in the Way we Manage Offenders”* will ensure that all these clients will have to engage to address their substance misuse problems or face sanctions. A consequence of this is that the number of DIP clients in effective treatment will increase. DIP will have to develop slicker, more effective and cost effective ways of working with this client cohort. Resources may be stretched to accommodate the increase in the client group; therefore interventions delivered in group-work may have to be considered.**

Whilst the Adult Offender Building is held up as a shining example of good practice by co-locating all the aspects of criminal justice interventions and the resource to offer the service user group access to all the elements of recovery capital there is an element of the service user group having a fractured recovery journey. Feed back from the service users that were interviewed suggests that for some service users there is a disappointment that they may have to engage with different recovery key workers throughout their recovery journey. The interviews suggest that those service users who benefit the most from the criminal justice pathway are those that volunteer to carry on engaging with CJIT after their required assessments.

For those service users who may face the full gambit of community awards the recovery journey can appear extremely fractured and confusing. Those who engage with CJIT who also have a prescription manager through RAT may be awarded a DRR which would entail moving recovery worker through to SMT and then having their substitute prescribing managed by SMT; should the courts also award a ATR the service user would be engaged in a community Alcohol service. At the completion of their community orders the service user may be referred back to a CJIT worker and also back to a RAT worker. This pathway is not conducive to recovery.

Those service users who engage with SMT on a community DRR are more likely to drop out at the end of their order than continue working to address any on-going issues.

**Recommendations to consider concerning the service user's recovery journey.**

**To redesign the service into one integrated criminal justice recovery service.**

**To allocate a recovery worker straight after the assessment process is completed; and that recovery worker to support the service user throughout their recovery journey. Training may be required to upgrade CJIT workers to deliver DRR**

**To deliver ATR within the AOB; alongside any other order.**

**To pro-actively encourage and motivate engagement beyond the coercive element of the criminal justice pathway.**

**To work on behavioural issues and make access to recovery capital available to all service users.**

## 1. Introduction

The overarching aims of the UK Government's (past and present) drugs policies has been to reduce the harm that drugs cause to societies; communities, individuals and their families. The emphasis has been to reduce the number of individuals caught up in chaotic lives of addiction and crime and to stop young people from following this pattern of behaviour.

Throughout the history of criminal justice drugs interventions there has always been the goal of breaking the link between drugs and crime through Joined up interventions which offer an "end to end" approach from arrest through to sentence and beyond.

The Drugs Intervention Programme (DIP) in its current form was devised in 2005 to deliver interventions to those individuals who committed acquisitive crime that was informed by their drug taking. DIP concentrated on the two class A drugs that were associated with the majority of drug related crime; heroin and crack cocaine. The aim was to increase the number of heroin and crack cocaine users into treatment and to greatly reduce the re-offending rate of this cohort of offenders. To this end DIP has been very successful; from its height in 2007 when there was an average of 200 positive tests per month in Nottingham City to the present day when the average monthly presentation of positive tests is below 100.

There is a case to argue that DIP has been restricted in keeping up with the times; the custody suite, testing and types of crime (trigger offences) have never been updated to keep abreast of the changing drug trends and the type of crime that these new drugs inform.

Currently the Criminal Justice service for drugs interventions in Nottingham City is part of the Nottinghamshire Probation Trust; supported by Nottinghamshire Health Trust. This service is comprised of two distinct parts; the Criminal Justice Interventions Team (CJIT), which mainly deals with non-statutory offenders via the custody suites through Test on Arrest (ToA), the courts via Restriction on Bail (RoB), and prison releases, and the Substance Misuse Team (SMT) who deliver community orders via Drug Rehabilitation Requirements (DRR). Both of these services are also employed to support the drugs pathway out of offending for the Integrated Offender Management scheme (IOM).

Supporting CJIT we have the Rapid Access Team (RAT), part of Nottinghamshire Health Trust, who deliver the prescribing of opiate substitutes and manage clients with complex needs via a number of GPs. SMT is also supported by the same GPs but under a different funding arrangement.

All the above drugs services alongside the Police come under the umbrella of the Drugs Intervention Programme (DIP) which, until recently, was a national programme designed to reduce drug related offending.

The whole of the Nottingham City DIP service is co-located in the Adult Offender Building (AOB) to ensure best practice.

From April 1<sup>st</sup> 2013 DIP was discontinued as a national programme and the choice of how to run DIP was handed over to local areas to run in accordance to the Police

and Crime Commissioner's guidance. Nottingham has chosen to continue with the ethos but has changed some of the delivery methods; trigger offence testing has been replaced by target testing to reduce the number of negative tests. CJIT have more of a say in who is tested. There is also a plan to increase the number of Inspector's authority tests for other crimes, mainly aimed at violence in the night time economy.

### **1.1. Moving Forwards:**

There are two challenges that we are faced with over the near future; firstly a complete review of DIP working on the hypotheses that;

- 1) Heroin and crack cocaine are having a smaller impact on informing offending
- 2) Other drugs are having a larger impact on informing offending
- 3) Alcohol is having a larger impact on informing offending.

To this extent we will conduct the needs assessment on the whole system with a view to integrating the service to enable it to offer interventions for all substances of misuse and to increase the reduction in re-offending amongst those whose offending is informed by substance misuse.

Secondly the recently published consultation response to **Transforming Rehabilitation A Strategy for Reform** highlights the fact that Probation will only have direct responsibility for high risk offenders; therefore the DIP service would have to be de-commissioned and may be re-commissioned into the Third sector, this would have to be completed in a very short time scale (before April 2014).

With all the above in mind; and dependent on the findings of the needs assessment, this might be the opportunity to streamline and integrate all the services into one single service to maximise offender contact and achieve value for money.

### **1.2. Aim:**

The aim of this needs assessment is to systematically assess the prevalence and level of crime that is informed by substance misuse and the intervention needs of the said offenders; the needs assessment will consider the effectiveness of the current provision in order to identify the gaps in the current treatment/intervention service and to make recommendations to address the needs identified.

### **1.3. Objectives:**

- To identify the level of need amongst those offenders in the criminal justice system
- To assess the current needs of those offenders in the criminal justice system
- To establish an overview of the current substance misuse services.
- To recognise the gaps in the current substance misuse interventions service
- To review the effectiveness of current provision
- To explore the views of key stakeholders and service users to identify attitudes and beliefs regarding needs and service provision.
- To make recommendations according to the needs of the service users.

### **1.4. Methodology:**

This substance misuse needs assessment will use a combination of two approaches.

- Epidemiological
- Corporate.

#### **1.4.1. Epidemiological:**

This information is based on the available data and analytical sources including, but not limited to:

- The mapping and evaluation of the current treatment/intervention provision.
- Service user profiles
- Service user questionnaires
- Non-service user questionnaires
- Custody suite data from DIRweb reports from the Home Office
- Exception reports against the DIRweb figures from CJIT
- Custody Suite data from the Police.
- Costing of the current provision.

#### **1.4.2. Corporate:**

To consult with and elicit the views of key stakeholders via the criminal justice commissioning group. To consider the recommendations within publications including, but not limited to:

- The National Drug Strategy
- The National Alcohol Strategy
- Clinical Guidelines on Drug Misuse and Dependency
- Clinical Guidelines on Alcohol Misuse and Dependency.

## **2. Background to the Criminal Justice Intervention Team.**

### **2.1. Custody Suites:**

Arrest Referral: Arrest referral schemes have been in operation in various guises since the mid 1980s; originally they existed to supply information in the form of literature, about local drug treatment services. This literature was usually supplied by police or detention officers with an expectation that the offenders would contact these local services through their own volition. By the mid 1990s proactive arrest referral schemes had been initiated; whereby a dedicated worker, independent of the police but based in the custody suites, made contact with the offenders and if they admitted a drugs problem they were referred into appropriate treatment. Three pilot schemes (Southwark, Derby and Brighton) for proactive arrest referral were evaluated in 1998 with quite positive results. This demonstrated a reduction in crime, a reduction in the quantity of drugs used by these individuals and a reduction in injecting behaviour amongst this cohort. The findings concluded that arrest referral met an unmet need. Funding was then made available, alongside key performance targets, to all police forces in England and Wales to set up proactive arrest referral schemes. The funding was available until March 2002. The Joint funding Initiative was established to accelerate the development of arrest referral and was matched locally by the relevant police forces and the Drug Action Teams. The majority of schemes were up and running by April 2000.

In 2001 drug testing on charge was piloted to identify Problematic Drug Users (PDU); those drug users who use Opiates and/or cocaine/crack cocaine. Around this time the development of the Drug Intervention Programme (DIP) was conducted, this came to full fruition in 2003 whereby DIP was established across the country with the Criminal Justice Intervention Programme (CJIP) delivering on DIP' s behalf. CJIP was replaced by the Criminal Justice Intervention Team (CJIT) in 2005 as the criminal justice service provider; performance managed by DIP but run by a variety of service providers. CJIT, in Nottingham City, came under the umbrella of Nottinghamshire probation service.

In 2005 new measures were introduced under the Drug Act 2005 in respect of those individuals aged 18 or over. The additional measures were aligned to help DIP by identifying more problematic drug users and encouraging more people who test positive into treatment; this process came under the banner of "Tough Choices" The act included a provision to move the point of drug testing from post charge to post arrest.

The criteria was established; such as the list of trigger offences or an Inspector's authority whereby an individual could be tested at the point of arrest. This was limited to those areas classified as intensive DIP areas; it was still illegal to drug test in non-intensive DIP areas. Greater Manchester, south Yorkshire and Nottinghamshire were the first three pilot areas to have test on arrest. In 2011 the police were given new directives to allow testing at all custody suites.; this move was to allow non-intensive DIP areas to come more in line with the intensive DIP areas, it also cut out some of the bureaucracy associated with random drug tests.

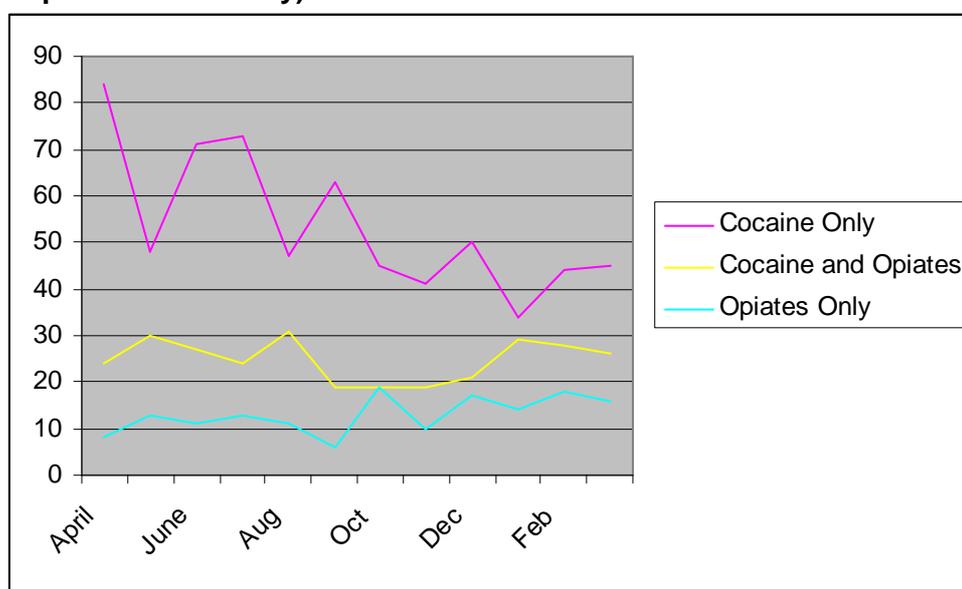
With the Tough Choices project came required assessments; whereby anyone who tests positive for a class A drug on arrest would be required, by law, to see a drugs worker either on site or at a designated destination. Failure to do so would be a breach of the Drug Act 2005 and the individual could face up to 3 months in prison or

a £2,500 fine. Attached to the required assessment was the provision of a required follow up assessment which also carried the same penalties as the required assessment. The Follow up assessment was not fully implemented until 2007.

## 2.2. Custody Suite; current context:

Whilst the figures for the number of acquisitive crimes has remained fairly constant since 2006 the figures for positive tests for opiates and cocaine has dropped by approximately 50%. The opiate and cocaine user (OCU) cohort does not appear to be increasing significantly; the cohort is getting older and very few young or naïve users are coming into the treatment system. There has been a movement away from crack cocaine to cocaine hydrochloride; but this cohort tends to commit crimes other than those of an acquisitive nature which then relies on a test via an inspector's authority. However the figures from the custody suite for 2012 - 13 suggest that cocaine hydrochloride use, which informs acquisitive crime, is also decreasing.

**Figure 1: Comparison of positive test results for 2012 – 13 (including Inspector's Authority)**



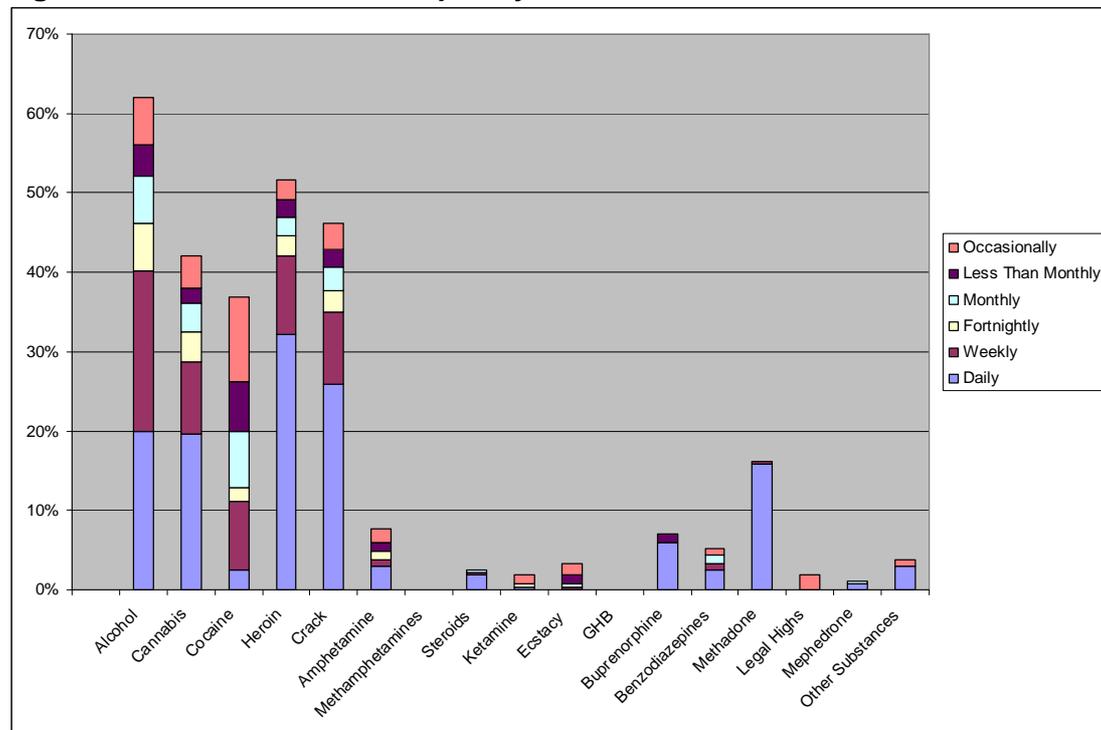
However caution should be applied when reading **figure 1**; during 2012 – 13 only 170 inspector's authority tests were granted, also cocaine hydrochloride users tend to commit crimes in the night time economy, usually violent crimes that are also linked to alcohol, so the figure for cocaine hydrochloride may be higher.

Caution should also be applied when we consider the number of new (novel) psychoactive substances (NPS) now available; some deliver the same euphoric state as cocaine hydrochloride, most are better value for money than cocaine hydrochloride and a certain number of users are buying white powder without knowing what the substance is or assuming it to be cocaine hydrochloride. None of the NPS are tested for at the custody suites which may suggest that drug informed crime may not have fallen but it is now informed by other substances.

**Figure 2** is taken from a questionnaire used by CJIT in the custody suite to demonstrate the identification and frequency of other drugs used by detainees who committed acquisitive crime but tested negative or were not tested for Class A

substances. The questionnaire was available for a six month period and was responded to by 270 detainees in the Bridewell custody suite.

**Figure 2. Identification and frequency of substance misuse.**



The graphic illustration above indicates that heroin and crack cocaine are still, as expected, prevalent amongst those who commit acquisitive crime. Alcohol and cannabis also appear to influence acquisitive crime. Surprisingly other drugs across the range do not feature very highly in informing this cohort's criminality; but may feature more highly in non-acquisitive offending. To try and engage this cohort CJIT pro-actively cold call the cells offering interventions for those who see substance misuse as problematic. In 2012 – 13 CJIT engaged 165 individuals into treatment via the voluntary route.

### 2.2.1. Alcohol in the custody suite.

Since the demise of the alcohol arrest referral scheme in 2008 there has been no alcohol specific interventions offered in the Bridewell custody suite. For those detainees who may be eligible for a fixed penalty notice there is a referral to the alcohol diversion scheme, run by Framework. Other detainees may have to request to see a drugs worker to get sign-posted to community services.

Detainees who have a poly substance misuse problem (Class A drugs and Alcohol) will be processed through the required assessment pathway and engaged by CJIT. Of those approached to answer the CJIT custody suite questionnaire 54 (20%) said they used alcohol on a daily basis; only 2 reported that alcohol was their sole substance of misuse. Of the 54 arrested 33 (61%) reported that they were under the influence when they committed their crime.

The partnership uses a proxy measure for the impact of city centre alcohol related offending, namely violence against the person (VAP) with or without injury across

four city beats between the hours of 18.00 and 06.00. The year to date figure (April - September 2013) indicate that 83% of City centre violence is Night Time Economy (NTE) related and that 20% of violence across the division (City) is NTE related.

Research and existing evidence indicates a link between VAP and the use of alcohol and cocaine hydrochloride. Unfortunately VAP is not a trigger offence that would elicit a drugs test so a test would be reliant on an inspector's authorisation. The table below indicates that 41% of VAP offenders are actually under the influence of cocaine or they admit to using it.

**Figure 3: Violence against the person test on arrest.**

VAP (1st April 2012-31st July 2013)	n	%
All non-trigger offences	281	
VAP non-trigger offences	111	40%
Tested +ive for cocaine	27	24%
Tested -ive for cocaine but admitted cocaine	15	14%
Tested -ive for cocaine but admitted amphetamine	3	3%
All cocaine and amphetamine (+ive and admit)	45	41%

### 2.2.1.1. Report against the summary of findings from two evaluations of Home Office Alcohol Arrest Referral Schemes. (Research Report 60)<sup>2</sup>

In March 2012 a report was published against the findings of two pilot Alcohol Arrest Referral Schemes; a summary and two full reports was published together. The summary; if read on it's own was lacking in detail and concentrated on the use of IBA as a tool to reduce re-offending rather than looking at the overall picture, the full reports was more detailed and reflected a level of success above and beyond the limitations of IBA. Below is the response that I produced at the time which is pertinent to this needs assessment.

Caution should be taken when making assumptions from the summary report as it gives a generalisation of two phases of alcohol arrest referral pilots without going into the detail of delivery; the reports themselves are far more self critical of the restrictions applied to the pilot schemes. They also consider the level of interventions delivered; the extremely high level of voluntary engagement and the limitations of applying a screening tool as an intervention.

Because of the complex nature of the actual report I will break my critique into looking at the data from individual phases, offer an opinion on the limitations and make a comparison with a recognised intervention process; namely DIP.

We also must consider that when DIP first started as an arrest referral scheme; rather than a test on arrest scheme, that this too was very limited in success and retention in treatment during it's early days.

<sup>2</sup> Home Office Occasional Paper March 2012.

## Phase 1 Scheme.

Phase 1 scheme. October 2007 – October 2008.	Comment	Learning from DIP
The original target group for the scheme was harmful and hazardous drinkers.	Over half the respondents were either dependent or “no risk” drinkers.	Some issues exist with the screening tool being used as an intervention; and the level of referral to the alcohol workers.
The study found that dependent drinkers reported a greater willingness to change than other groups and showed a slightly greater reduction in their level of alcohol consumption than harmful and hazardous drinkers.	The suggestion seems to be, from reading the client comments, that dependent drinkers accept that alcohol informs their offending and lifestyles. Harmful and hazardous drinkers had problems identifying that their offending was linked to alcohol.	Motivational Interviewing techniques alongside harm reduction were proven to be more successful in engaging clients in the early days of DIP.
Clients were generally content for the alcohol intervention to occur in the custody suite and there was no evidence that these were any less memorable or effective than community-based interventions.	The report suggests that it is not the venue that is at question, but the content of the interventions. Observed interventions identified that the concentration was fixed on units of alcohol consumed and health issues	DIP practice has suggested that some of the best interventions concentrate on relationships, family and social functioning alongside health issues. Again it appears that the screening tool is being used as an intervention rather than an indicator of the interventions needed
At all four sites, interactions with the CPS proved to be more problematic than with their police colleagues. The difficulties were strongly linked to perceptions about the practicality of using conditional cautions and conditional bail as referral routes. A number	In the early days of conditional cautioning (this pilot was conducted in 2007-8) links with the CPS were always problematic (in the majority of police areas) and were usually avoided by issuing a standard caution. Issues always existed around dealing quickly with clients	Other tools are available; such as representation at court and the application of restriction on bail, whereby a client has to attend treatment before sentencing. This has proven reliable in DIP.

<p>of interviewees referred to the need to „seek out“ the CPS as one of the barriers to using these routes. This was particularly so for conditional cautions, as a standard caution does not require CPS involvement and can be completed more quickly. However, the CPS did not regard this as a key issue and two interviewees noted that CPS Direct can be contacted at any time – one stating that a conditional caution can be set up in the course of a 45-minute phone call.</p>	<p>in a busy custody suite; the majority of these clients would be seen late on a week-end night</p>	
<p>All four schemes planned to refer between 20 per cent and 25 per cent of clients by conditional cautions but this route was rarely used because it was viewed by many stakeholders as being overly onerous in terms of paperwork. Conditional bail was used extensively by scheme D and, to a lesser extent, by scheme C, but other schemes had concerns about enforcing a breach of the bail condition. As a result, over 80 per cent of interventions were as a result of voluntary referrals and most of these occurred in the custody suite before clients had been discharged. This model ensured higher numbers of interventions delivered but some stakeholders expressed concerns about whether the interventions would be as effective</p>	<p>As above</p>	<p>DIP clients, in the days of arrest referral, were very hard to engage on a voluntary basis. The introduction of required assessments and required follow up assessment ensured that the client s attended at least two sessions, and if the worker applied themselves clients would attend for further interventions. The latest figures for successful completions and retention in treatment is testament to the success of effective treatment.</p>
<p>Despite worries about initial liaison between</p>	<p>For the pilots to work, delivery organisations</p>	<p>In the early days of DIP; training sessions were</p>

<p>police and alcohol workers, it was generally felt that close partnerships were developed as the schemes became established. This may in part have been facilitated by the fact that the Drug Interventions Programme (DIP) has established the role of substance misuse workers in the custody suite and the principle that the custody suite can act as the point for referral into assessment and treatment. The relationship between DIP and alcohol pilots is a point that warrants further consideration. In scheme A DIP and AAR overlapped, to a large degree, with the DIP worker also providing the alcohol interventions. However, in the other schemes DIP provision was kept separate.</p>	<p>needed to establish good working relationships between the police in the custody suites and the intervention workers. While police staff were given briefings about the AAR pilots, there was a feeling that this could usefully have been done at an earlier stage, rather than when all the details were in place and the pilots were about to go live. In schemes A and C in particular, some custody-suite-based officers were not informed about the scheme until alcohol workers were already in place. While this was not felt to have affected the long-term functioning of the pilots it was an issue that was seen to contribute to a slow start</p>	<p>facilitated by DIP workers for the detention staff, this established a good working relationship between the intervention workers and the custody staff. It explained and clarified the role that the detention officers had to play in reducing re-offending rates and gave them some ownership of their own contribution to interventions.</p>
<p>It is not possible to reliably identify alcohol-related offences from police arrest data unless an offence is specifically drink-related (such as being drunk and disorderly). As a result, there is limited information available about alcohol-related offenders and this evaluation has provided valuable information on the demographics and drinking behaviour of this group.</p>	<p>The data has been reliant on the referral from the detention officers to the intervention workers, so the data could be construed as being very subjective to who or what offence would be considered to be alcohol related. As evidenced above a considerable number of refers were for non problematic drinkers.</p>	<p>Things to consider would be testing (breathalysing offenders) and a suite of trigger offences.</p>
<p>Given the criminal justice focus of the initiative, assessing whether there is evidence that alcohol interventions had an effect on arrest rates is of particular interest. Arrest rates were used as a proxy measure for re-</p>	<p>An important finding was that 61 per cent of people in the Intervention and Control Groups had not been arrested in the six months before or after the „index arrest“ (i.e. the arrest resulting in the</p>	<p>The majority of interventions involved voluntary referrals so we must question whether those who have offended more would volunteer for the scheme. Police area data does not always contain an alcohol</p>

offending.	alcohol intervention and its equivalent for the Control Group). This confirms the findings from previous research (Donkin and Birks, 2007) and means that, if the arrest rates are low, any change in the arrest rates will be too.	flag, so it is not reliably possible to identify previous or past alcohol related offences. Violence (including domestic violence) is also affected by other issues such as situational placement; was a six month period enough to evaluate the data.
------------	---	--

Overall the evaluation is more positive than appears in the summary; like the foundation of DIP test on arrest the original arrest referral scheme was set up without laying down the fundamental infrastructure. A suite of trigger offences to consider those most likely to have alcohol informed offending; a robust referral pathway that had a coercive element to ensure compliance (required assessments etc), the need to have everyone on board including magistrates to ensure that the level of sentencing is fit for purpose and prior training for all those involved.

Schemes that demonstrated the most success were those that used more conditional cautions or used the DIP team to deliver the interventions.

There was no mention, within phase one, of the possibility of alcohol and cocaine being involved in the incidents of violence (violence was by far the most prevalent of offences representing 34% of all those seen).

It is also acknowledged in the document that hazardous and harmful drinkers do not consider their drinking as problematic and as such were less likely to attend a voluntary follow up assessment.

## **Phase 2 Scheme.**

A second phase of pilot arrest referral schemes was introduced in November 2008 with funding till September 2010; on the evidence from healthcare settings that brief interventions reduced alcohol consumption. The aim was to see if the same benefits could be applied to the criminal justice setting to reduce re-offending rates. The phase 2 scheme included drink driving offences and self reported offending. 8 police areas were used in the 2<sup>nd</sup> scheme and each service was given a certain amount of autonomy in how they set up and run their schemes. Throughout the majority of referrals were voluntary (75%). The scheme addressed issues around the night time economy such as drunk and disorderly behaviour and alcohol related violence. The most common offence being violence (36%) and the client group was overwhelmingly white (92%), male (86%) and under 29 (62%).

Phase 2 scheme. November 2008 – September 2010.	Comment	Learning from DIP
<p>A history of previous arrest (for any offence type) was strongly associated with a probability of re-arrest, regardless of clients' AUDIT or SIP scores, scheme area or any demographic variable. The odds of re-arrest increased by approximately 80 per cent for every additional offence in a client's six-month previous history. Re-arrest was also strongly positively correlated with AUDIT scores at baseline.</p>	<p>These figures and the analysis is consistent with the drugs world</p>	<p>This client group of top testers require a greater level of intervention than IBA. The DIP world would engage these clients in effective tier 3 treatment to consider a bigger picture than just the alcohol or drug use. Effective care planning would involve interventions for substance misuse, criminality, health and social functioning.</p>
<p>When AUDIT scores were split into four categories of increasing risk, those in the highest risk category (dependent drinkers scoring 20-plus) had 2.34 times greater odds of re-arrest than those in the no risk category (scoring 0–7), even after adjusting for the relative impacts of age, gender, index offence type and scheme area. Figure 4 shows the odds of re-arrest for each AUDIT score category, using those in the lowest risk as the reference group.</p>	<p>As above</p>	<p>As above.</p>
<p>20 Clients who were unemployed were almost twice as likely to be re-arrested as those who were in employment (38 per cent compared with 20 per cent) overall. After adjusting for differences in age, sex, offending</p>	<p>As above</p>	<p>Again; this group requires a higher level of intervention than IBA to have any effect on re-offending rates.</p>

<p>history, index offence types and scheme area, the odds of re-arrest increased to around 77 per cent for those who were unemployed.</p>		
<p>Simple analysis of client motivation to reduce alcohol consumption and re-arrest shows that clients with higher levels of motivation were also more likely to be rearrested. However, clients who were more motivated to reduce their consumption tended to have more severe alcohol-related problems, meaning that they were also at higher risk of offending.</p>	<p>The window of opportunity to engage a client when he/she is motivated is very small and is usually lost before the follow up assessment.</p>	<p>Coercive engagement usually ensures a client will attend an appointment and effective interventions can ensure that motivation to change is maximised.</p>
<p>As was the case in phase one, many schemes experienced difficulties in implementing mandatory conditional caution and conditional bail routes. Local resistance from the Crown Prosecution Service (CPS) and to a lesser extent, the police, was cited as problematic and this was linked to concerns about the enforceability of conditions. Despite these concerns, schemes succeeded in meeting the prescribed numbers of mandatory referrals outlined in service level agreements<sup>2</sup>. Where conditional bail or conditional cautions were the main referral processes, the police in these areas were closely involved in the scheme's development from the schemes' inception, including the appointment of a police scheme lead.</p>	<p>As identified in scheme 1 the success of these schemes relies on the whole of the criminal justice system buying in to the scheme. Coercive engagement as been proven to work across test on arrest, but it has to be linked to more than just IBA.</p>	<p>Other tools are available; such as representation at court and the application of restriction on bail, whereby a client has to attend treatment before sentencing. This has proven reliable in DIP.</p>

Generally, across all eight schemes, attendance at appointments outside of custody was low unless it was through a mandatory type route.		
--	--	--

Both schemes suggest that voluntary engagement is likely to be less effective amongst a cohort of offenders who do not associate their alcohol consumption with their offending. The DIP world has proven that coercive engagements get the client through the door and a failure to attend will result in another arrest and further charges.

Whilst IBA (Identified Brief Advice) may have benefits from a health perspective it is insufficient to reduce offending rates because it tackles the effect not the cause. Effective treatment, even extended Brief Advice would be more effective in reducing offending.

Scheme 2 seemed destined to be less effective in its goals because it limited itself to one tool (IBA) to tackle a large problem. The DIP world has proven that effective treatment is only effective if it is modelled on the clients needs with an eventual goal of abstinence or in the case of alcohol a goal of responsible drinking.

The summary of the two pilot schemes does not do justice to the work that was involved in the schemes. A lot of progress was made in getting police and detention officer support for the schemes. Both schemes suggested that there was a reduction in the AUDIT scores for those clients who responded to follow up assessments

“Alcohol-related offending is a seriously harmful problem for both society and individuals, and the principle of basing an intervention in custody settings appears to be supported through the experience of the AAR programme. Whilst the overall direction of the evidence does not support the continuation of the AAR process in its current form or for the current outcome measures, the research presents arguments for custody-based interventions that screen for alcohol needs and refer clients to appropriate support.”

Areas of consideration that were arrived at was the use of DIP and the DIP infrastructure to deliver alcohol interventions within the custody suites and possibly deliver the follow up interventions

**2.2.2. Target Testing.**

From April 1<sup>st</sup> 2013 DIP was discontinued as a national programme and the choice of how to run DIP was handed over to local areas to run in accordance to the Police and Crime Commissioner’s guidance. Nottingham has chosen to continue with the ethos but has changed some of the delivery methods; trigger offence testing has been replaced by target testing to reduce the number of negative tests. CJIT have more of a say in who is tested. There is also a plan to increase the number of Inspector’s authority tests for other crimes, mainly aimed at violence in the night time economy.

Target testing is now used as a result of the cost of financing testing moving from the Home Office to the local police authority. A pilot scheme, run in Yorkshire and Lancashire, found that by using a comprehensive screening tool on arrest a profile could be obtained which alerted the detention officers to deliver a drugs test. The reasoning behind this scheme is to reduce the unnecessary testing of negative testers and the retesting of known users. The adult detainee drug testing profile considers the following criteria;

- Is the detainee on a prison production? If yes does not require a test.
- Is the detainee subject of a DRR? If yes does not require a test.
- Is the arrest in relation to heroin, cocaine or crack?
- Has this detainee tested positive for heroin, cocaine or crack in the last 12 months?
- Has this detainee disclosed in custody to using heroin, cocaine or crack?
- Is there a PNC warning marker or a conviction for possession of heroin, cocaine or crack in the last 12 months?
- Has the person requested medical attention for heroin, cocaine or crack withdrawal or is on prescribed medication for withdrawal?
- Is this the detainee's first arrest for a trigger offence as an adult aged 18 or over?
- Does the CJIT drugs worker request a test or seek an inspector's authority if not a trigger offence?

The expectation of target testing is that the number of tests initiated will drop without a major drop in the number of positive tests.

**Figure 4: comparison of Test on Arrest data and Target Test data**

Month	2012 - 13		2013 - 14	
	Successful tests	Positive tests	Successful tests	Positive tests
April	418	116 (28%)	236	60 (25%)
May	524	91 (17%)	217	72 (33%)
June	454	107 (23%)	204	75 (36%)
July	453	97 (21%)	187	82 (44%)
Aug	392	89 (23%)	168	77 (46%)
Total	2241	500 (22%)	1202	366 (30%)

Whilst the figures for the same period in 2012 – 13 appear to be a lot higher for positive tests the average for the five month period just prior to the introduction of trigger testing indicate an average monthly figure of 88. This is compatible with the current recording.

CJIT drugs workers now have access to the police NSPIS log which now gives them access to offender's demographics and offending behaviour; which enables the drugs workers to make a more informed judgement on who should be tested.

### **2.3. CJIT role in the custody suite.**

CJIT drugs workers are on duty within the custody suite 365(6) days a year from 08.00 to 20.00. The original remit was to work from 08.00 to 22.00 but research and

evidence based data informed the service that it was rare to get a referral between 20.00 and 22.00. Extra staff cover is made available should the police have an operation that is likely to lead to more drug using offenders attending the Bridewell in any one shift.

CJIT ensure that every detainee that tests positive for a class A drug is given a required assessment and an appointment for a follow-up required assessment in line with Home Office guidelines. If an offender is tested and proves positive out of hours then the police will book an appointment for the initial required assessment on the CJIT electronic diary this appointment will be made for within 5 – 8 working days. Similarly if a detainee disputes the test then appointment will be made for 10 working days to allow time for the test results to be processed. All out of hour required assessments, disputes and follow-up assessments will be made at the Adult Offender Team building (AOT).

The success of coercive treatment is well documented; for a large number of the cohort accessing treatment through the criminal Justice system it is the first time that they have entered treatment. The coercive element means that as a minimum they have to be assessed and will be given a follow-up appointment to discuss all their needs. RoB and DRR mean that the coercive element is longer lived ensuring that the service user attends weekly appointments or completes the order. Unfortunately the coercive element is still limited to class A drugs ignoring all other substances of misuse including alcohol.

CJIT pro-actively try to engage all those detainees who commit trigger offences but test negative by cold calling the custody cells. They will also see and engage any detainee who expresses a desire to see a drugs worker or who exhibits any withdrawal symptoms.

CJIT work via A Single Point of Contact (SPoC) which is used take referrals for all required assessments and to facilitate those required assessments from out of area forces.

CJIT, at present, do not target alcohol only clients but will see them on request and signpost them into the triage service.

Detainees who use drugs other than class A drugs are problematic to engage in treatment, they are usually identified by cold calling the cells and have to be motivated to change to engage in interventions. However if a detainee has been arrested for possession of other drugs or admits to being under the influence of drugs then other tools are available to the police to refer the detainee to CJIT and to ensure coercive engagement; such as conditional cautioning, all CJIT workers have been trained in how to apply conditional cautions for treatment.

<b>Gap/Risk</b>	<b>Recommendations</b>
The criminal justice system, specifically DIP, is still almost entirely focussed on the use of cocaine and opiates. Public Health England have documented that this cohort is decreasing.	To broaden the range of drugs that are targeted by DIP; whether this is achieved by increasing the range of drugs that are tested for, which would have to be achieved by legislation, or by applying coercive treatment to those who admit the use of drugs other than opioids or cocaine.

<p>The range of trigger offences that elicit a drugs test are firmly linked to the use of opiates and crack cocaine.</p>	<p>The movement away from Opiate and crack cocaine use and the increasing use of cocaine hydrochloride, strong strains of cannabis and the emergence of New / Novel Psychoactive Substances (NPS) have demonstrated the movement away from acquisitive crime to violence and anti-social behaviour. We are now reliant on Inspector's authorities to test for this new range of offending, but are still limited on the drugs they test for. Ideally it would be useful to review the whole of the testing regime but in the interim coercive treatment should be applied for an admittance or possession of other drugs or their use.</p>
<p>There are no alcohol specific interventions offered via the custody suites.</p>	<p>The experience and the infrastructure that DIP offers is ideally situated to offer alcohol interventions within the custody suite and, with coercive measures attached, to continue to offer these interventions as part of an order, RoB or a condition of a caution.</p>

## 2.4 CJIT Role in the Courts

The main function of CJIT drugs workers in the courts is to track and monitor any individual that has tested positive to a class A drug in the custody suite. CJIT offers coverage Monday to Friday and has a referral process in place for Saturday. The team liaise with the CPS and the court ushers to ensure the magistrates are made aware of drug test outcomes and any recommendations from the required assessments.

CJIT ensure that all individuals who are given a Restriction on Bail (RoB) requirement are given the appropriate assessment within three working days of the requirement being delivered. All clients who are awarded a RoB requirement are seen once a week until they next appear in court where a report on the individual's engagement is provided for the magistrate.

Restrictions on Bail were introduced under the criminal justice act 2003 by reversing the presumption of bail to anyone who had tested positive for a class A drug; instead the individual will be asked to attend an assessment for their drugs problem and agree to attend any follow up recommendations by the assessor. This resource was piloted and extended to all Local Justice Areas in 2006. The figures for the number of offenders who are awarded RoB are relatively low compared with the numbers who appear in court for drug related offences. The Drug Test 1 (DT1), the police paperwork that indicates that an offender has tested positive, is always included in the presentation to the magistrate but this is not always made obvious and is not always considered in the sentencing.

When an individual is remanded into custody the CJIT worker will ensure that details and copies of the assessment are relayed to the receiving prison within 24 hours of remand.

Having completed the required assessments, and possibly engaged with a client, CJIT have the relevant information to inform a pre-sentence report which may consider a Drugs Rehabilitation Requirement (DRR). It is felt that CJIT are not employed often enough to provide this facility. During 2012 – 13 there were 269 instances of RoB being applied.

**Figure 5: The more recent figures for the application of RoB in October 2013 are as follows:**

Results for RoB eligible for first court hearings					
	RoB applied	Case disposed	Remanded in custody	Non-RoB bail	Total
NMC	17	14	4	5	40

Gap/Risk	Recommendations
It is evident that the paperwork indicative of a positive test (DT1) is not always considered at the sentencing stage.	A process needs to be developed to indicate to the court clerk and magistrate that a DT1 is included in the sentencing report. CJIT do not have the resources to attend court for all the offenders who appear, so a simple indicator on the front of the file would be useful.
The offender managers who are writing PRE-Sentence Reports (PSR) or Fast Track Reports (FTR) are not using the information that CJIT have on their client to influence sentencing.	All PSR and FTR writers should engage with the CJIT key-worker to assess motivation to change and suitability for a DRR.
RoB is only applied to those who have a drugs problem	Explore the possibility of the application of RoB on those whose offending is linked to alcohol.

## 2.5 CJIT Prison In-Reach

CJIT currently have two in-reach workers who hold weekly surgeries within HMP Nottingham offering interventions and release planning for all those prisoners who are on short sentences, remand or are due for imminent release. They liaise closely with the prison drug workers and healthcare to ensure a continuity of care for all clients. The CDP have commissioned an integrated IT system, Illy Carepath, to ensure robust communication with regard to client's interventions from community to prison and back out again.

CJIT also work closely with the drug workers in Peterborough Prison, our local remand prison for women, they offer in-reach work for imminent releases on a monthly basis or as necessary.

It is envisaged that the Transforming Rehabilitation agenda will increase the number of prison releases that have to engage with CJIT because all short term sentenced prisoners will have a requirement upon release to address their offending.

Figures from HMP Nottingham indicate that approximately 1200 prisoners with substance misuse problems are released each year; around 28% are Nottingham City clients (336n). This figure does not include those who have not engaged with the integrated substance misuse team in HMP Nottingham. The figure is likely to rise with the advent of Transforming Rehabilitation as HMP Nottingham will be designated a resettlement prison; the consequence of this is that all sentenced prisoners that live in the Prison's catchment area will be transferred back to HMP Nottingham.

<b>Gap/Risk</b>	<b>Recommendations</b>
The projected increase in the number of prisoners who are released with conditions to address their substance misuse (Transforming Rehabilitation) will mean that CJIT will have to be more proactive in engaging offenders in the prisons.	This will obviously be a resource issue that can only be overcome by working very closely with the prisons to ensure that pre-releases are prioritised. It may be worthwhile using mentors to pick releases up at the gate and ensure they attend their appointments.

## **2.6 CJIT Outreach**

CJIT provides outreach cover across a number of services; they engage individuals at probation field teams, approved premises, and the Women's centre. All of these facilities hold surgeries to encourage new clients into the CJIT service. There is scope however for CJIT to offer more outreach to try and engage clients who have dropped out of treatment. CJIT also offer monthly clinics at the two main homelessness projects to either encourage clients into treatment or to encourage re-engagement with those who may have dropped out.

<b>Gap/Risk</b>	<b>Recommendations</b>
As above; Transforming Rehabilitation will mean that more offenders will have conditions to engage in interventions for their substance misuse.	Again this is a resource issue that will have to be managed efficiently to ensure all those on extended orders get the interventions they are due.

## **2.7 CJIT and Integrated Offender Management**

Integrated Offender Management (IOM) is the most developed attempt to operationalise the concept of end to end offender management. An IOM approach aimed to co-ordinate all relevant agencies to deliver interventions for offenders identified as warranting intensive engagement, whatever their statutory status. At the core of IOM was the delivery of a managed set of interventions, sequenced and tailored to respond to the risks and needs of the individual. These interventions had

the key aim of disrupting the offender’s criminal activity and thereby reducing their re-offending. IOM is specifically aimed at serious acquisitive crime and comprises the delivery of interventions through the main partnership of Police, Probation and the Drugs Intervention Programme (DIP) with other partnership agencies delivering interventions on a needs basis. IOM is also currently identifying and starting deliveries of interventions within HMP Nottingham; this offers an end to end service to reduce re-offending.

The Drug Intervention Programme (DIP) is widely considered as being mainstream IOM, when in fact both DIP and IOM work are strongly aligned and co-supportive. The DIP provides a nationally recognised proven method of diverting offenders who have a drug or alcohol dependency, at point of arrest, into treatment. ‘Top testers’ are considered as part of the nominal selection process for the IOM framework and are prioritised accordingly.

The Prolific and Other Priority Offender units were set up in 2004 to tackle a hard core of individuals that were considered to commit a large amount of serious acquisitive crime. The premise was to manage this group through rehabilitation or through custodial sentencing. A large proportion of this group were identified as having drug related offending needs so the links between the PPO scheme and the DIP teams were created to offer multi agency case management approaches to tackle the rehabilitation issues.

Currently the IOM scheme is considering all acquisitive crime, rather than just serious acquisitive crime as a bench mark for IOM nominals; projects like Operation Dormice that focuses on retail shop theft is applying the IOM ethos to the way it interacts with offenders.

CJIT are employed to apply the interventions that consider the drug related pathway out of re-offending. There is no robust pathway for alcohol only clients other than a referral to community providers.

<b>Gap/Risk</b>	<b>Recommendations</b>
Currently all IOM nominals, including PPO nominals are prioritised for treatment interventions; with the advent of Transforming Rehabilitation and the indication that all prison releases including less than twelve month sentences will receive an order that they will all have “licence conditions” to address their substance misuse issues. Essentially this will mean that the IOM ethos will apply to all offenders.	Clarity is needed on how Transforming Rehabilitation will be applied in the case of IOM nominals; the implication is that the Criminal Justice caseload will increase dramatically (see 2.9)

## 2.8 CJIT Core Functions

CJIT core functions are primarily and specifically focussed on primary drug use and have been especially focussed on class A drugs. The functions are aimed at

implementing the recovery agenda alongside the aim of reducing the re-offending rate of this cohort. The functions consist of the following;

- Complete an initial/triage assessment for all service users, including a risk assessment at first contact.
- Complete a Child and Family support form; liaise with social services with regard to completing a Known Person Check and make appropriate referrals as deemed necessary.
- Produce an initial recovery care-plan for all service users
- A joint assessment with the Rapid Access Team will take place with all new referrals at the required assessment or follow up stage
- Ensure that service users who have received a comprehensive assessment and are engaged in Tier three treatment have a full recovery care-plan
- Identify a named recovery care co-ordinator for each service
- Ensure that recovery care co-ordinators contact service users a minimum of once per week until the service user has completed 12 consecutive weeks of treatment or the service user has completed his/her treatment.
- Provide appropriate psychosocial interventions with an emphasis on motivational techniques
- Provide appropriate information, advice and harm reduction interventions.
- Ensure appropriate referrals are made to structured treatment services
- Refer into, and co-ordinate the delivery of, other structured services (housing, education, training, finances) within two weeks of an identified need.
- Review recovery care-plans in accordance with individual milestones, at a minimum of every three months, and at every key event e.g. arrest, breach, and disengagement.
- Ensure that Treatment Outcome Profiles (TOP) are completed at modality start, review and treatment completion
- Complete NDTMS information as appropriate.
- 24/7 phone line offering advice, guidance and support for service users and their families.

<b>Gap/Risk</b>	<b>Recommendations</b>
Currently the majority of CJIT clients are non-statutory offenders or are not subject to IOM and are not obliged to engage with their key-worker beyond the required assessment or RoB compliance. This is indicated in the large number of clients	We are reliant on the motivational skills of the CJIT workers to engage clients in effective treatment; however Transforming Rehabilitation will give more powers to engage clients in effective treatment.

who drop out of treatment or who just access Rapid Prescribing to maintain their substitute prescribing.	
CJIT are not supported by offender managers when addressing the offending behaviour of non-statutory clients.	Transforming Rehabilitation will give more powers to engage clients in effective treatment and will have the necessary support to address offending behaviour.

### **2.9 Police Task Force:**

A CJIT worker pro-actively works with the Police Community Support Officers (PCSO) to engage sex workers into treatment. They operate the service on a monthly basis patrolling the streets of “red light areas” between midnight and 02.00 hours.

### **2.10. Transitional Work:**

CJIT workers engage with the clients at NGY to provide support to young adults with substance misuse problems who will be entering adult supervision

### **2.11. Transforming Rehabilitation:**

The potential increase in service users accessing the criminal justice substance misuse pathway post implementation of the Transforming Rehabilitation could be quite dramatic; if we consider the criminal justice service as one provider instead of three and base the data on quarter 2 NDTMS reports (Sept 2013) we can predict an educated estimate for the increase in the case load.

The effect of Transforming Rehabilitation will be that all prison release, including those serving under 12 months, will be given a 12 month condition to address their re-offending which will mean that those offenders who have a substance misuse problem will be given orders to address said substance misuse issues. HMP Nottingham has been designated a resettlement prison so all male prisoner releases to Nottingham City will come from HMP Nottingham. Young Adults (18 – 21) will serve their sentence in adult prisons (this is still out for consultation, but HMP Nottingham already houses young adults on remand). Community orders will apply to all those who are not given custodial sentences.

The current figures are as follows:

Current Criminal Justice case load engaging in tier 3 interventions	263
Current Criminal Justice case load engaging in tier 2 interventions	123
The number of Criminal Justice clients who do not accept interventions	143

The potential is that a large proportion of the tier 2 clients will have to engage in effective treatment and the clients who do not accept treatment after their Required Assessments will be on community orders to address their substance misuse. This potentially equates to a working case load of:

Community case load	529
% increase	100%

The current figures for HMP Nottingham at quarter 2 are as follows:

<b>A</b>	New receptions at quarter 2	1598
<b>B</b>	Prediction for 2013 - 14	6392
<b>C</b>	New receptions starting drug treatment	333
<b>D</b>	Prediction for 2013 - 14	1332
<b>E</b>	Primary alcohol use	62
<b>F</b>	Prediction for 2013 - 14	248
<b>G</b>	<b>D + F</b>	1580
<b>H</b>	Average release to Nottingham City 28%	442

The potential for the Criminal Justice caseload is as follows:

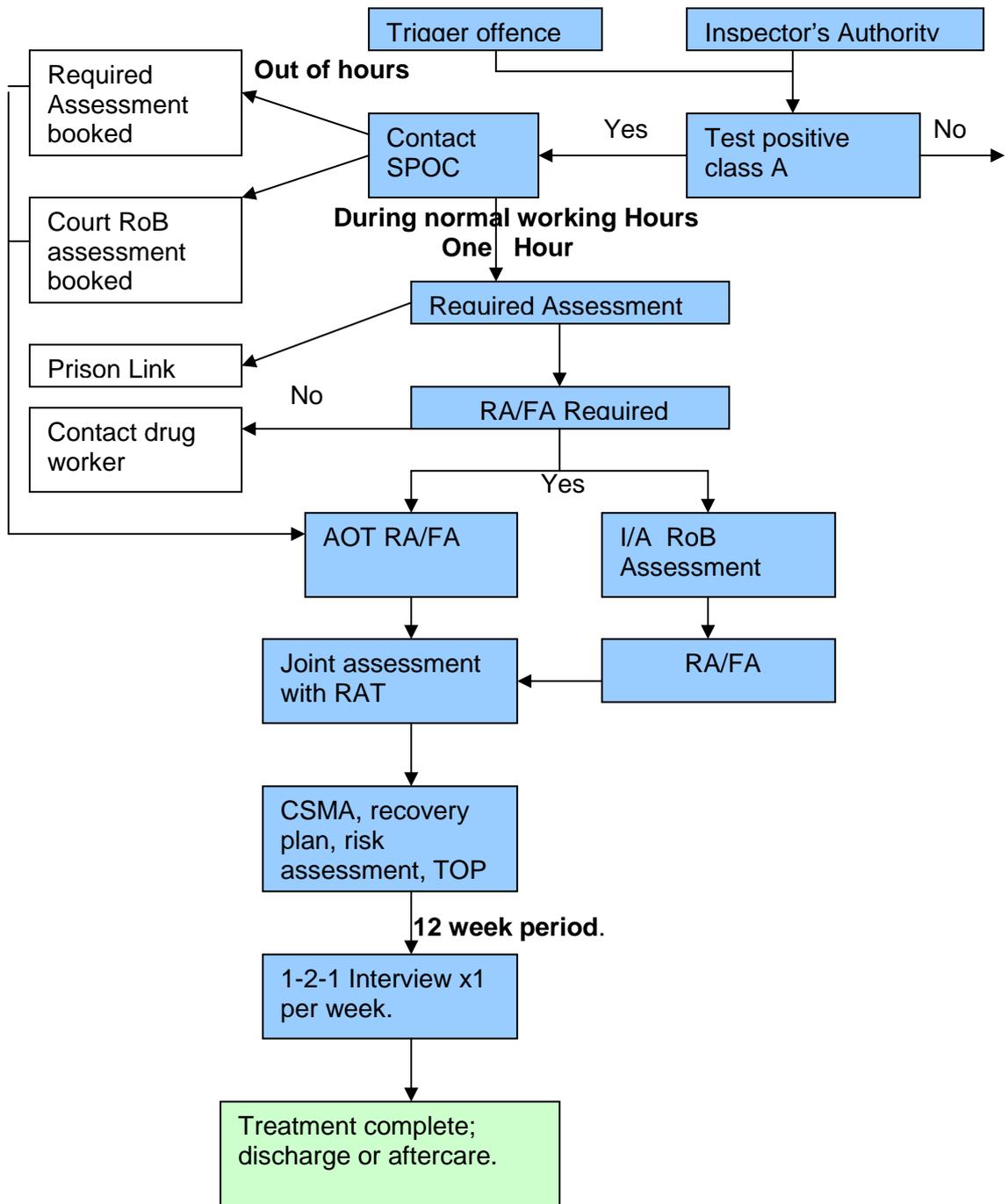
Community case load	529
Prison releases	442
Total	971
% increase	230%

This figure contains all those who are trapped in the revolving door of entering and leaving prison on a regular basis; who may be counted twice.

However it does not include the small number of female prisoners who are released to Nottingham City, nor does it include any individuals who have a substance misuse problems who have not engaged with prison interventions.

<b>Gap/Risk</b>	<b>Recommendations</b>
Any potential gaps are reliant on more explicit information around the implementation of Transforming Rehabilitation.	

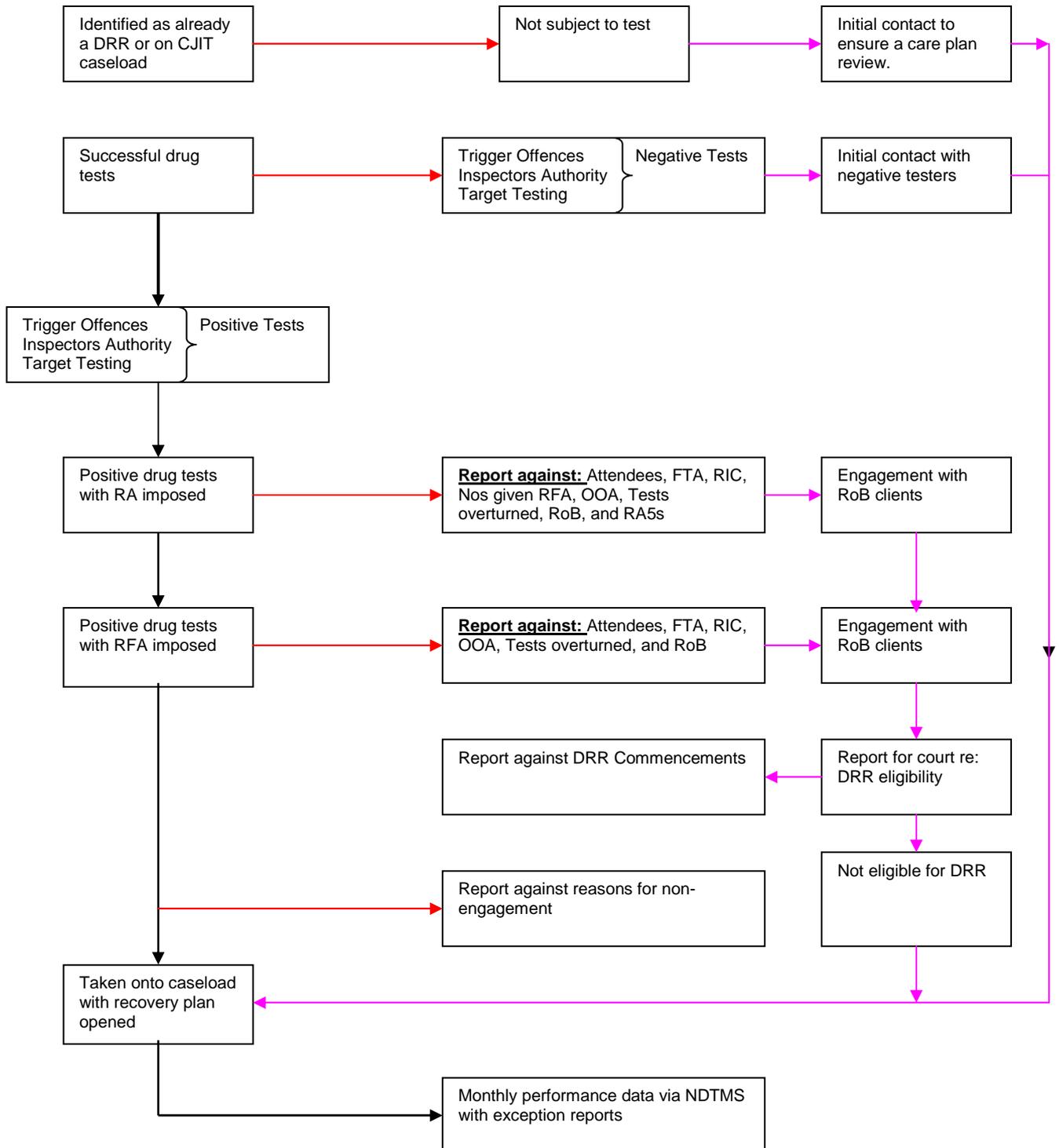
**CJIT Pathway.**



**Glossary**  
**SPOC.** Single Point of Access  
**RA/FA.** Follow-up assessment  
**RoB.** Restrictions on Bail  
**AOT.** Adult Offender Team  
**RAT.** Rapid Access Team  
**CSMA.** Comprehensive Substance Misuse Assessment  
**TOP.** Treatment Outcome Profile

**Recording: Custody Suite Post DIP.**

**Pathway** **Indicators**





### **3. Substance Misuse Team Background.**

#### **3.1 Community Orders.**

Drug Treatment and Testing Orders (DTTO) were introduced as a pilot in 1998; they were designed as a response to the growing evidence of links between drug use and persistent acquisitive crimes. The order was originally piloted at three sites; Croydon, Gloucestershire and Liverpool, over an 18 month period eventually being released nation wide in 2000. The order replaced the existing 1A(6) probation order, which was less effective and had a higher re-offending rate. The DTTO differed from the 1A(6) order in that the sentencing court checked progress periodically throughout the order. DTTO was replaced in April 2005 by the Drugs Rehabilitation Requirement (DRR) which differed again in that it offered an order that was person centred, dependent on the needs of the individual. The delivery of treatment and interventions is part of the DIP remit.

Currently the delivery of DRR is performed by Offender managers and the Substance Misuse Team (SMT). SMT deliver psychosocial interventions to aid recovery, they manage the substitute prescribing and the offender managers manage the offending behaviour. The SMT deliver reports back to the court monthly to demonstrate individual client's progress.

SMT also work with IOM and PPO to deliver interventions on the drugs pathway out of re-offending.

#### **3.2. SMT Current context.**

Interventions such as test on arrest and RoB are being used increasingly to identify offenders who are suitable to be sentenced to DRR; as such good working protocols exist between SMT and CJIT. Currently the interventions that CJIT deliver are used to prepare offenders for the delivery of DRR.

When an offender is on the CJIT caseload the CJIT drug worker will normally suspend the case during the period of the DRR. When the order is due for completion the SMT worker will liaise with the CJIT worker to continue to offer support beyond the order or the client may be referred on to Community services if the offending behaviour has been successfully addressed. However, as most DRR finish before the community order has finished it is advisable that the offender takes up the continued support available within the AOT.

In certain cases the CJIT worker will continue to deliver tier 2 interventions during the lifespan of the DRR.

SMT are currently delivering specified activities to National Standards where offenders who are being engaged in the probation trust field teams are identified as having substance misuse problems.

Figure 6: DRR Presentations 2012 – 13.

Month Started	Total	% by month
April	11	11.7%
May	10	10.5%
June	3	3.1%
July	6	6.3%
August	7	7.3%
September	10	10.5%
October	14	14.8%
November	16	16.9%
December	4	4.2%
January	4	4.2%
February	4	4.2%
March	6	6.3%
Grand Total	95	100%
Carried over from 11 - 12	18	
Overall total	113	

Figure 7: Discharge of clients 2012 – 13

Overall discharge reason	Total	Percentage
Incomplete – Treatment withdrawn by provider	1	1%
Transferred – not in custody	44	39%
Transferred – in custody	1	1%
Incomplete – retained in custody	47	42%
Incomplete – dropped out	4	4%
Treatment complete – drug free	14	12%
Treatment complete – occasional user	2	2%
Grand total	113	100%

Transfer Destination	Total	Percentage
CJIT Only	6	
Curfew Order	1	
Dovegate House	1	
Haven House	1	
Other Probation	1	
RiN	23	
Ley	1	
Primary care	7	
POW	1	
Direct Access	1	
Script ends.	1	
Total	44	



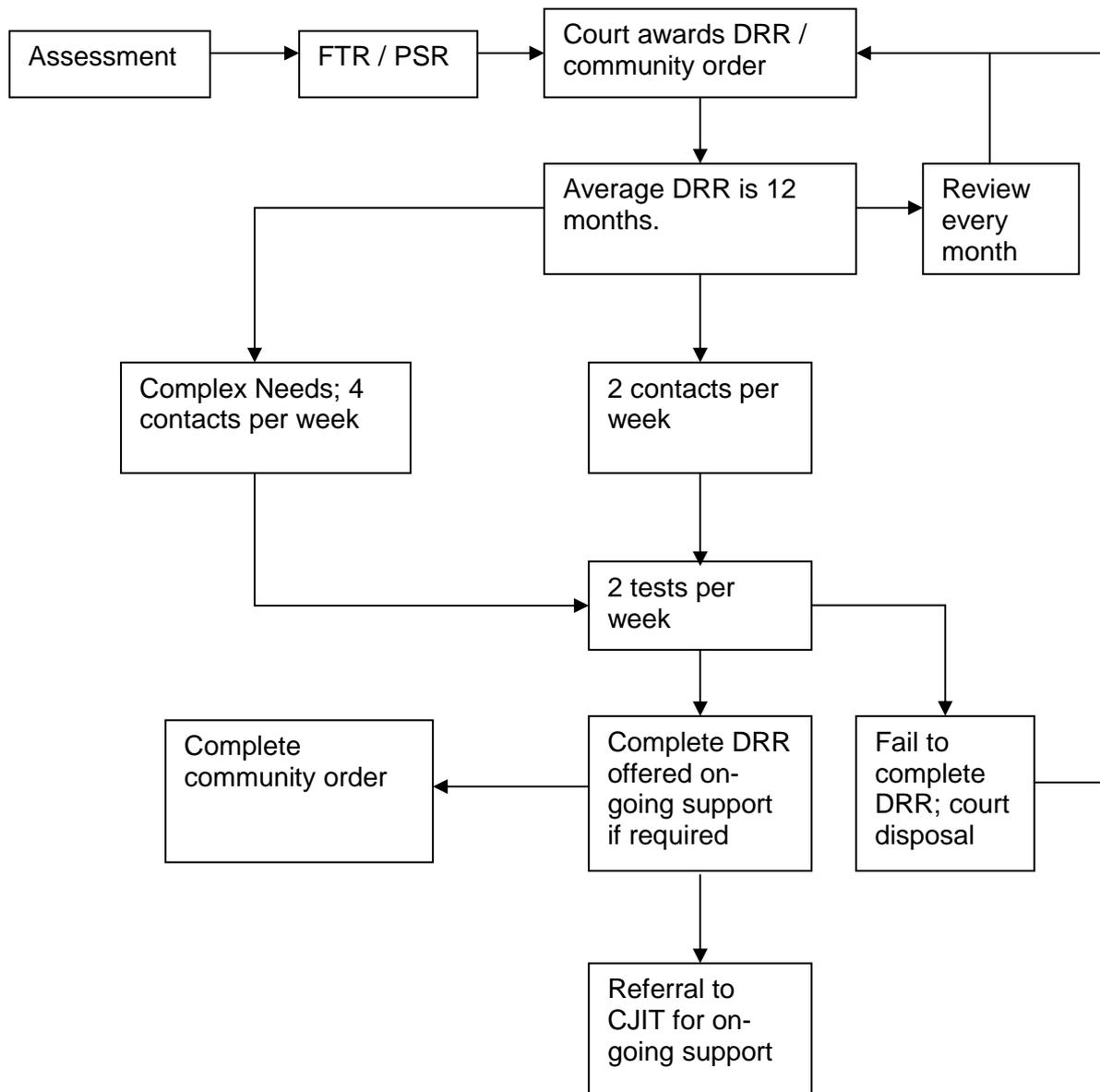
Gap/Risk	Recommendations
<p>There is a lack of consistency for service users in the number of potential key workers that they may have throughout a DRR. There is a potential to have up to 5 workers during a service users experience of the criminal justice journey which can be confusing for the recipient</p>	<p>SMT and CJIT workers both have the skills to deliver a DRR and this would stop the transfer of service users from one service to another. The scripting could be delivered by one set of GP supporting the Adult offender team rather than for SMT or Rapid Access.</p>

### 3.2.1 SMT and Alcohol Interventions.

Currently SMT are expected to address their service users' secondary alcohol use as part of a holistic package of substance misuse treatment. Where a service user presents with dependent alcohol use or where additional support, not delivered by this service, is required to address problematic alcohol use a referral into the local community alcohol treatment system is offered. Service users who present with alcohol only problems are not currently eligible for treatment within this service and will be referred into the local community alcohol treatment system for further assessment. Service users who are sentenced to community orders with both a DRR and an Alcohol Treatment Requirement (ATR) have the interventions for both delivered within the Adult Offender Building by the SMT practitioners.

Gap/Risk	Recommendations
<p>The delivery of ATR by community services does not address the related offending. Service user feedback suggests they are not happy having to go to one service for interventions and then visit another for their offending behaviour. The DIP pathway has proven value in addressing substance misuse and offending and should be applied for alcohol.</p>	<p>SMT and CJIT both work with alcohol problems when alcohol is the secondary substance of misuse or when the service user has transferred their primary drug to alcohol. A pathway needs to be planned to align alcohol Treatment and drug treatment especially when that is part of an order.</p>

**SMT Pathway:**



## 4. Rapid Access Team

### 4.1 Rapid Access Team in the context of DIP.

The Rapid Access Team (RAT) was devised in 2005 to offer support for the CJIT team by offering the management of substitute prescribing for opiate use and to offer interventions for those service users with complex needs. The function is currently provided by Nottinghamshire Healthcare Trust.

CJIT and RAT were originally collocated in the Waverley St Clinic, Radford; service users were assessed by CJIT workers and then referred to RAT for their prescribing needs. This usually resulted in multiple assessments taking place before the needs of the client were identified.

### 4.2 Current context.

RAT are currently collocated within the Adult Offender Building (AOB); alongside the rest of DIP and IOM. They still are commissioned to deliver the substitute prescribing service on behalf of CJIT clients and to deliver interventions for those with complex needs. RAT also pick up the prison releases that require on-going substitute prescribing needs. RAT is supported by a team of sessional general practitioners who issue the substitute prescribing; these are mainly the same GP who manage the prescriptions for SMT.

The referral process from CJIT to Rat has been simplified to reduce the number of assessments that service users have to be subject to. Service users who enter the AOB for an initial assessment or a follow-up required assessment are given either a joint assessment with RAT and CJIT or a dialogue takes place before the assessment between CJIT and RAT to discuss if a referral is necessary.

The dual working between RAT and CJIT encompasses, but is not limited to the following;

- A joint assessment on all service users within the criminal Justice System
- The provision of substitute prescribing and 'script management.
- To take the lead in the recovery plan for service users with more complicated needs.
- To hold joint recovery plan reviews with CJIT Drug Workers.
- To ensure that there is a continuity of substitute prescribing available for those leaving prison by liaison with the Prison health teams.
- To ensure that there is a continuity of substitute prescribing available for those who are attending court and may be leaving prison by liaison with the Prison health teams.
- To meet with CJIT team leaders on a regular basis to discuss and manage those who are leaving prison.
- To agree the discharge process with CJIT
- To agree with CJIT a process to ensure TOP completions.

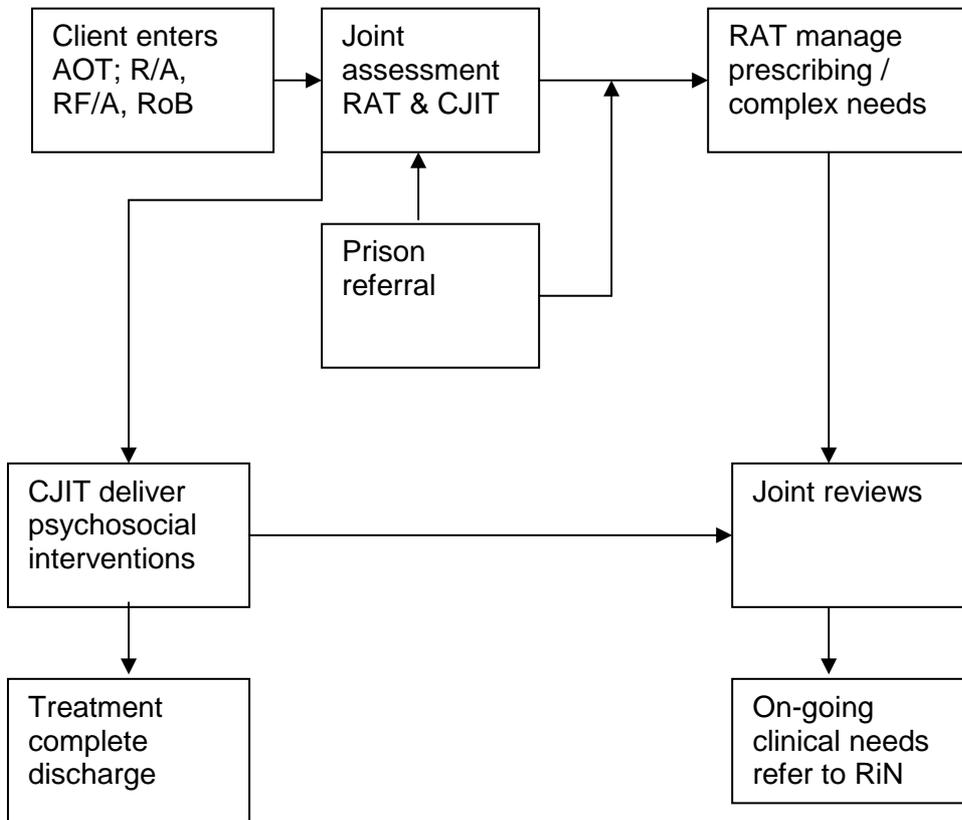
All service users who receive clinical interventions should be getting psychosocial interventions as well, in line with the NICE clinical guidelines. In essence all service users should have both a RAT key-worker and a CJIT key-worker. However,

because the majority of CJIT service users are non-statutory offenders their engagement with CJIT is voluntary and a number are choosing just to access substitute prescribing without the in depth psychosocial interventions or the access to recovery capital that CJIT can offer.

The ethos within the AOB is primarily to reduce the re-offending rate of the service users who engage therein. Health issues and recovery capital are also considered as important factors in the ultimate goal of reducing re-offending. The success of the AOB relies on partnership working across all the criminal justice services who are housed there. This has not always been the case with RAT buy in to the criminal justice ethos; patient confidentiality has offered barriers to the delivery of the reducing re-offending agenda. This has been obvious when RAT have not liaised with the police regarding service users who have outstanding warrants.

<b>Gap/Risk</b>	<b>Recommendations</b>
Service users choosing clinical interventions and refusing psychosocial interventions.	RAT and CJIT to work closely together to ensure a full compliance to all interventions.
Duplication of GP substitute prescribing to CJIT clients and SMT clients in two separate funding pathways.	GP to offer all sessions to all AOB clients regardless of who they are registered with.
Information sharing across all the parts of DIP	Information sharing protocols to be drawn up and agreed by all parties.

## Rapid Access Team Pathway.



### Glossary

**R/A** Required Assessment

**RF/A** Required Follow-up Assessment

**RiN** Recovery in Nottingham

## **5. The Adult Offender Building (AOB).**

### **5.1 Background**

The CDP commissioned the Renovation of 24-30 Castle Gate, Nottingham in 2006 for the purpose of collocating CJIT, RAT, and the Substance misuse team who deliver DRR, IOM (including the police pathways officers and PPO team) and the offender managers. The building ensures integrated work across all the teams and has the facilities to offer working space for third sector workers to deliver recovery capital interventions on site; i.e. housing, benefits and debt advice, education and general health awareness and improvement.

The building allows for the provision of group-work, BBV interventions and drug testing. It has a suite of interview rooms allowing for full confidential assessments. It also has the facilities to allow for "fit for work" interventions as part of recovery capital. The AOB has been offered as an example of good practice across the country and has been copied in a number of areas.

### **5.2 Current Context.**

The Adult Offender Building offers a comprehensive range of interventions and access to recovery capital for all Adult offenders with substance misuse problems (including secondary alcohol problems). The collocation of all the services that are involved in the criminal justice pathway ensures that a service user could, potentially, start and finish his/her treatment successfully; having had all his/her needs addressed without having to be referred on. The range of interventions and access to recovery capital has developed, and essentially is still developing to meet all the client's needs to ensure that this cohort has the potential to move away from a life entrenched in dependency and crime to a life that contributes to the greater good of society.

The main components of DIP; namely CJIT, RAT and SMT have been discussed in detail above, however it is worth discussing the delivery of other interventions and adjunct services that are available via the AOB and how they compliment the work delivered by DIP.

#### **5.2.1. Saturday Morning Surgeries.**

The changing substance misuse trends and associated offending meant that the AOB teams had to evaluate the new cohort of offenders and offer assessments and interventions to match their needs. This new cohort are taking different types of drugs, mainly cocaine or similar stimulants and tend to be committing crimes that are normally associated within the night time economy; namely violent or anti-social crimes. The majority of this cohort are socio-economically viable, in full time work with families and mortgages and do not correlate their behaviour as being linked to their substance misuse. For this reason Saturday morning surgeries were deemed to meet this cohort's needs; they could be assessed without having to take time off work or to be exposed to cross contamination from the usual client group. The surgeries could be focussed to offer interventions for stimulant use and could be tailored to offer brief advice around health risks and the risks to re-offending.

The Saturday morning surgeries also offer a peripheral service that developed almost by accident; Clients who had not been able to pick up their opiate substitute

prescriptions now had the chance to access them on a Saturday morning, rather than having to go the whole week-end without.

<b>Gap/ Risk</b>	<b>Recommendations</b>
Alcohol only clients are not being able to access the same level of intervention that focuses on health and offending.	That alcohol only clients who are committing crimes in the night-time economy are offered extended brief advice at similar Saturday morning surgeries.

### 5.2.2 The Diverse Therapy Support Group (DTSG).

The DTSG remains the intellectual property of Paul Berry, one of the practitioners employed by SMT. Currently he is delivering the group to clients in the AOB but wants to expand the delivery training to staff in the AOB and beyond.

The DTSG is a two stage, highly focussed, fast track training system that illuminates the way individuals think. The group runs in two stages of eight week per stage offering 2 hours per week; although this can be adjusted to take into account the group's intellectual ability. Each stage offers interventions for a maximum of eight attendees and stage 2 should immediately follow stage one. It is influenced by a Gestalt Psychotherapy approach drawing on cognitive and behavioural knowledge but drawing on a humanistic approach

The purpose of the DTSG training is to teach the recipients that their responses to situations are often based on a misconception, and that the misconception causes emotional and behavioural responses to stimuli that have to be acted upon with little understanding of the root cause. The DTSG lends itself to a number of behavioural response problems and is easily applied to substance misuse. The group the author attended had service users attending who used a variety of substances; however none were alcohol only users, it is suggested that if we can elicit problem alcohol only users into the AOB then this would be an ideal intervention.

**Figure 8: Attendance at DTSG 2012 – 13**

<b>Attendance</b>	<b>Total</b>	<b>%</b>
<b>Attended</b>	<b>102</b>	<b>53%</b>
<b>Client cancelled</b>	<b>9</b>	<b>5%</b>
<b>Did not attend</b>	<b>40</b>	<b>20%</b>
<b>Did not attend ( Probation authorised)</b>	<b>20</b>	<b>10%</b>
<b>Client in custody</b>	<b>4</b>	<b>2%</b>
<b>Not stated</b>	<b>15</b>	<b>7%</b>
<b>Key worker cancelled</b>	<b>5</b>	<b>3%</b>
<b>Grand Total</b>	<b>195</b>	<b>100%</b>

### 5.2.3. Fit for Work.

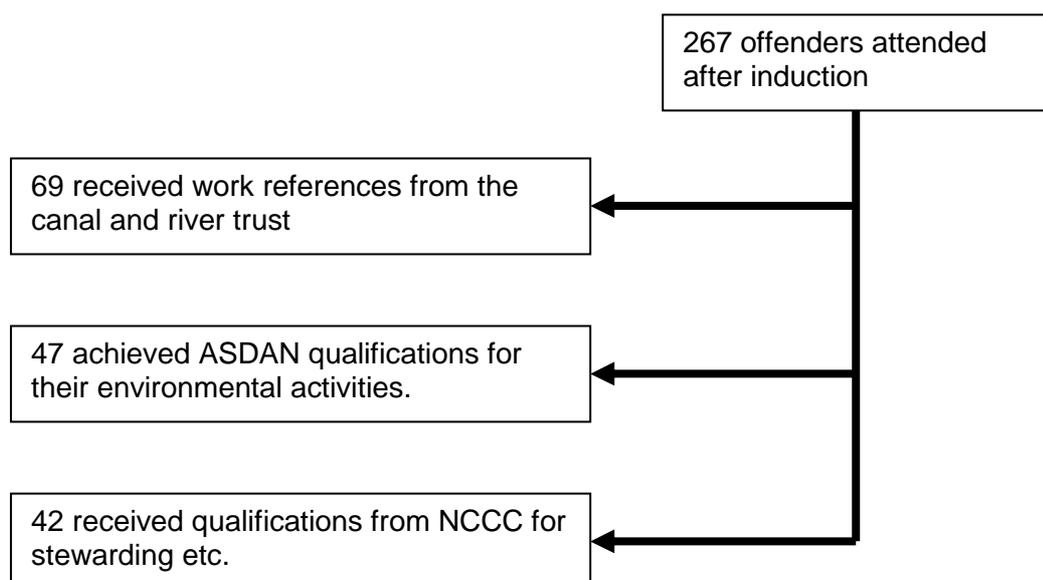
Fit for Work is a programme that primarily targets substance misusing offenders by addressing healthy lifestyles and physical and mental fitness through a weekly programme of physical activities such as gym sessions; climbing, canoeing, orienteering, boxing and hiking. The programme is designed to improve skills such as: team working, communication, trust, self-exploration and is proving to enhance employability skills and is contributing to motivate offenders into gaining and sustaining employment.

The concept for Fit for Work is that it will change offender's addictions and their view of themselves by encouraging and motivating a more stable lifestyle and reducing the need to re-offend. Simplistically Fit for Work aim to replace the high that is achieved from substance misuse with one based on fitness and exercise creating an understanding that the feel good factor can be achieved without drugs.

Fit for Work helps to break the cycle of substance misuse and re-offending by offering the support networks and the opportunities to take steps to attain employment. Participants take part in voluntary projects such as; the canal and river trust and the Forestry commission. They also have access to complete level 2 stewarding qualifications via Nottinghamshire County Cricket Club and Level 3 mentoring qualifications via Care Training.

Fit for Work are also working with the Reach 2 Project which offers offenders with dual diagnosis or mental health problems to be referred directly from prison; extra support is offered upon release to help them participate in Fit for Work. Fit for Work are also looking at increasing their interventions for offenders with ADHD or those who have problems concentrating and focussing on certain aspects of their lives. Fit for Work are looking to develop angling classes as this has proven worth with this group.

**Figure 9: Qualifications and references from Fit for Work.**



Qualifications were still ongoing and some offenders were working towards their NVQ3 Advice and Guidance Certificate and their references with the Forestry Commission.

#### **5.2.4. ETE / Employment Services:**

This service is provided by the REACH project and offers access to a variety of skills to improve the client’s employability. Clients can access direct training for specific employment or generic skills that are transferable to a variety of roles. REACH can also offer support and finances to access the correct paperwork to allow a client to work in certain situations i.e. CSC cards to enable clients to work on building sites.

#### **5.2.5. Welfare Advice Clinic.**

Weekly surgeries are held in the AOB to offer all benefits and debt advice for clients. Changes caused by the welfare reform will make this work more complex.

#### **5.2.6. BBV testing and Vaccination.**

Weekly surgeries are held at the AOB to offer BBV testing and Hep B vaccinations; wound dressing is also available via the same surgery.

#### **5.2.7. Alternative therapies.**

Alternative therapies including auricular acupuncture, Reiki, and hypnotherapy are available twice a week; surgeries are also available on Saturday mornings.

#### **5.2.8. “Caring for Kids” and Family Support workers.**

Workshops are held to help service users and their families to raise their awareness of substance misuse and to help service users develop their parenting skills and be aware of hidden harm issues.

#### **5.2.9. Social skills and social skills events.**

These workshops provide a range of courses designed to help with budgeting, healthy eating and living on limited resources. The events are designed to promote alternative interests and encourage engagement; they include visits to the theatre and local art galleries. These events are supported by the create groups which encourage art and literacy groups and the music groups which move service users on to college groups.

<b>Gap/ Risk</b>	<b>Recommendations</b>
The AOB offers the full gambit of recovery capital for all the service users who use the building; these facilities need extending to include those clients who have alcohol problems.	Those offenders who commit crime that is informed by alcohol should be referred into the AOB.
The potential increase in client numbers due to Transforming Rehabilitation may bar staff from delivering some of these	Interventions for service users may well have to be delivered in group-work to allow for recovery capital workshops to

groups and workshops because of increased client case-loads.	continue.
DTSG and Fit For Work may be affected by funding cutbacks	To promote the DTSG and Fit for Work into the CRC.
The forthcoming welfare reforms will impact on service user's benefits	To mitigate against all changes that will impact on service users caused by the welfare reforms.

## 6. Service User Feed-Back.

## 6.1. Methodology.

The author spent three days in the reception at the AOB soliciting interviews with service users; I also attended one two hour session with the attendees at the DTSG and interviewed some of the attendants of Fit for Work. In total 30 service users granted me interviews which lasted between 20 – 30 minutes; unsurprisingly none of the service users who were attending for Initial Assessments (IA) or Follow-up Assessments (RFA) agreed to be interviewed. All cited that they “hadn’t been coming to the building long enough” or that they “hadn’t got the time”.

The questionnaire, which is anonymous, asked 16 basic questions; finishing with the question “what does recovery look/feel like to you?”

**Figure 10: Age of interviewees.**

Age groups	Number	%
18 - 21	0	0%
22 - 24	1	3%
25 - 34	4	13%
35 - 44	23	78%
45 – 55	1	3%
55 +	1	3%
<b>Total</b>	<b>30</b>	<b>100%</b>

100% of the interviewees were White British.

**Figure 11: Are you on a probation order?**

Order	Number	%
DRR	12	41%
ATR	1	3%
Licence	1	3%
Voluntary	16	53%
<b>Total</b>	<b>30</b>	<b>100%</b>

The individual on the ATR was given the order a month previously and was waiting for his first appointment; he was voluntarily accessing the AOB via CJIT to address his drug use.

**Figure 12: How long have you been with the Adult Offender Team?**

Length	Number	%
Less than 1 month	10	33%
1 – 3 months	8	27%
3 – 6 months	6	20%
6 months +	6	20%
<b>Total</b>	<b>30</b>	<b>100%</b>

**Figure 13: How often do you see your Drugs Worker?**

Frequency	Number	%
Daily	4	13%
Weekly	26	87%
Fortnightly	0	0%
Monthly	0	0%
Longer	0	0%
Total	30	100%

Of those that see their drugs worker on a weekly basis 8 came in twice per week.

All the sessions were of a 30 minute – 1 hour duration although all the service users agreed that they would be given more time if they needed it.

All those interviewed were asked if they were on an opiate substitute prescription; 60% (18) said they were accessing a script 40% (12) said they were not. Of those who said yes 2 had reduced their dosage to a level that they felt they were ready to come off. Of the 12 who said no 4 had detoxed from their script. All those who said yes were being prescribed methadone.

**Figure 14: Is this your first time at the AOB?**

Response	Number	%
Yes	8	27%
No	22	73%
Total	30	100%

**Figure 15: What went wrong last time?**

Response	Number	%
Remanded	10	45%
Recalled	1	5%
Dropped out	9	41%
Finished Order	2	9%
Total	22	100%

Of the 22 who cited that they had previously been at the AOB 19 said they had made bad decisions about their drug use and their re-offending. The 2 that had finished their order and the one who was recalled said they felt that they were being told what to do rather than having their needs met; retrospectively all three felt that the workers were there to help but they were in denial about their needs. All those who were remanded returned to CJIT on a voluntary basis and all feel they are having their needs met.

**Figure 16; have you ever been in community treatment?**

<b>Response</b>	<b>Number</b>	<b>%</b>
<b>Yes</b>	<b>22</b>	<b>73%</b>
<b>No</b>	<b>8</b>	<b>27%</b>
<b>Total</b>	<b>30</b>	<b>100%</b>

Of the 22 who responded with a yes the majority (19) said they felt that their community treatment was OK. 3 felt that their interventions were just about injecting safely. All 22 said that there was more to offer in recovery capital at the AOB.

**Figure 17: Has your drug use changed since engaging at the AOB this time?**

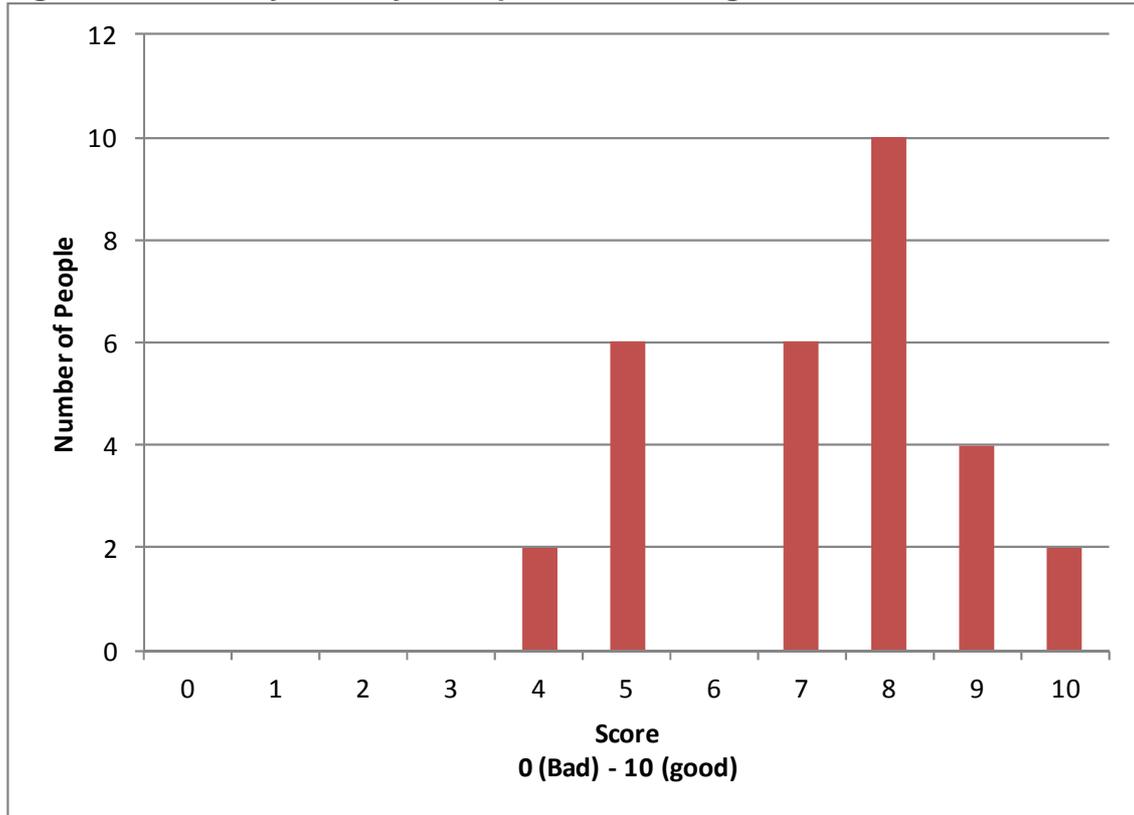
<b>Response</b>	<b>Number</b>	<b>%</b>
<b>Stopped</b>	<b>16</b>	<b>53%</b>
<b>Reduced</b>	<b>6</b>	<b>20%</b>
<b>Reduced considerably</b>	<b>6</b>	<b>20%</b>
<b>No change</b>	<b>2</b>	<b>7%</b>
<b>Total</b>	<b>30</b>	<b>100%</b>

**Figure 18: Has your offending changed since engaging at the AOB this time?**

<b>Response</b>	<b>Number</b>	<b>%</b>
<b>Stopped</b>	<b>20</b>	<b>67%</b>
<b>Reduced</b>	<b>4</b>	<b>13%</b>
<b>Reduced considerably</b>	<b>4</b>	<b>13%</b>
<b>No change</b>	<b>2</b>	<b>7%</b>
<b>Total</b>	<b>30</b>	<b>100%</b>

There was a direct correlation between the 2 interviewees that reported no change in their drug use and no change in their offending. The majority of interviewees said that their drug use had reduced or stopped sufficiently for them not to need to offend. Two interviewees who said their drug use had reduced said they were now “only using cannabis”

**Figure 19: How do you rate your experience of being at the AOB.**



## **6.2. What does recovery look/feel like to you?**

All the service users that were interviewed agreed that recovery would consist of:

- Stable housing.
- Employment.
- Relationships.
- In touch with their families.
- Health.
- To feel normal.
- Not having to offend.

However the majority agreed that this presents a dichotomy; if all or some of the above was in place getting off drugs would follow, but the majority agreed that if they were still on drugs then none of the above could be achieved. It was felt by most that the balance of drugs interventions and recovery capital was about right.

None of those interviewed felt that being on a script was a barrier to achieving recovery; although all felt that they would eventually like to be free of their script. A few added that they had detoxed too quickly in the past and this had led to a relapse.

All those interviewed were asked if they were on an opiate substitute prescription; 60% (18) said they were accessing a script 40% (12) said they were not. Of those who said yes 2 had reduced their dosage to a level that they felt they were ready to come off. Of the 12 who said no 4 had detoxed from their script.

The level of success amongst the thirty that agreed to be interviewed was quite high.

- 4 individuals were waiting to get their Construction safety certificates; 2 having been offered work on the new tram line.
- 1 individual was going on a three week training course in Tamworth to work for Railtrack.
- 2 individuals had obtained NVQ in mentoring, 1 is working as a mentor at the Youth Offending Team
- 1 individual, a single parent, had been offered plumbing work that fitted around his child care needs.
- 1 said he was now having regular contact with his child
- 2 said they were having contact with their families.
- 29 of the 30 were now in stable accommodation.
- 2 mentioned that they had opened bank accounts for the first time in their lives.

All but 2 agreed that recovery was achievable if they were prepared to work at it.

“They are willing to help you as much as you are willing to help yourself”

“This order is the best thing that has happened to me. I did try to engage when my licence was complete but could not access treatment here, I felt like I had to commit crime to get into the building”

All but 1 agreed that all their needs were being met within the AOB; this individual wanted a driving licence and felt that probation should pay for lessons and the test.

## **6.2 Observation of the Diverse Therapy Support Group (DTSG).**

The DTSG works on challenging behaviours that are related to the mismanagement of emotional and cognitive processes. Individuals are assessed on a continuous basis within a group setting; and are mentored through modelled behavioural techniques and cognitive methodologies that will reduce or eliminate problematic thinking techniques.

The session I sat in was well attended by a well informed and enthusiastic group of individuals. Various scenarios were set up and the group members applied themselves to consider emotional responses and how those responses could be kept under control and better choices can be made. All the participants were able to apply the scenario to their own problems with substances and offending.

The entire group were eager to share their own experiences and apply the group learning to inform better behaviour in the future. The group was prepared to challenge each other about their own behaviours.

## Appendix 1

### DIP Service User Questionnaire.

**This questionnaire is anonymous.**

Why is the questionnaire being conducted?

The Crime and Drugs Partnership is reviewing the delivery of interventions within the Adult Offender Building and would like to know if those interventions are meeting your needs.

This is your opportunity to help shape the way interventions are delivered. By taking part you will be helping us find out what is done well and where improvements can be made to ensure your needs are met.

If you answer the questionnaire and then think of a question that you would like answering then please ask a staff member to contact Ian Bentley at the CDP and I will respond to your question.

#### Question 1.

How old are you?

18 – 21

22 – 24

25 – 34

35 – 44

45 – 55

55 +

#### Question 2.

Ethnicity.

White.

Black or Black British

White British

Black or Black British Caribbean

White Irish

Black or Black British African

White European

Black or Black British Other

Asian or Asian British

Chinese or other ethnic group

Asian or Asian British Indian

Chinese

Asian or Asian British Pakistani

Other ethnic group

Asian or Asian British Bangladeshi

Asian or Asian Other

Prefer not to say

**Question 3**

Are you subject to a probation order? Yes  No

**Question 4.**

How long have you been with the Adult Offender Team?

Less than a month

1 – 3 months

3 – 6 months

6 months +

**Question 5.**

How often do you see your drug worker?

Daily

Weekly

Fortnightly

Monthly

Longer

How long are your sessions?

**Question 6.**

Are you accessing substitute prescribing?                      Yes                         No  

Methadone                     

Subutex                     

**Question 7.**

Is this your first time in the Adult Offender Building? Yes                         No  

**Question 8.**

If no to Question 7; what went wrong / right the last time?

**Question 9**

Would you have entered treatment voluntarily?    Yes        No   

**Question 10.**

Have you ever been in community treatment?    Yes        No   

**Question 11**

If yes to question 10: what went wrong / right the last time?

**Question 12.**

Has your substance misuse changed since engaging here?

Yes  No

**Question 13.**

Has your offending changed since engaging here?

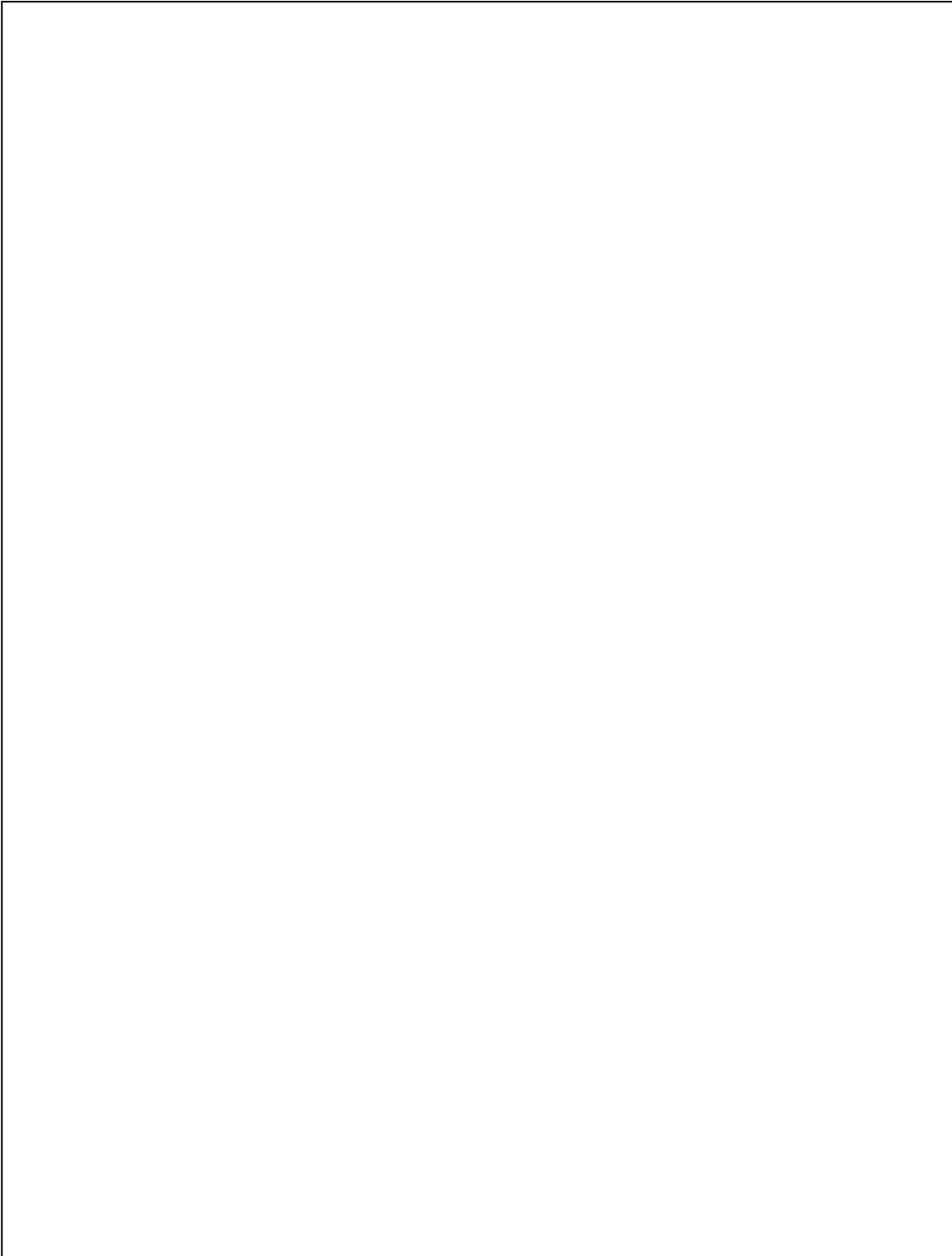
Yes  No

**Question 14.**

Have you got other needs that need addressing?

**Question 15.**

Are any of your needs not being addressed?

A large, empty rectangular box with a thin black border, intended for the user to provide a written answer to the question above.

**Question 16.**

How do you rate your experience of being at the AOT

☹️ \_\_\_\_\_ ☺️  
0 bad 10 good

Score 0 - 10

## **Appendix 2**

### **Case Story for xxxx**

**XXXXXXXXXXXXXXXXXX**

I started working with CJIT following my arrest in February. I was arrested for drunken, dangerous driving with a minor in the car, the minor being my Son.

From my initial interview with CJIT at the Bridewell, I was assigned to Ruth O'Love and Vanessa at CJIT.

I have suffered with addiction from an early age and spent time in the Priory 4 years ago, only to relapse earlier this year whilst going through a difficult divorce. When I went to court, my CJIT worker, Ruth O Love attended with me and due to the work that we had already done, services that I was accessing and the medical advice that I had taken, I was given an 8 month sentence suspended over 2 years, with a 6 month DRR and ATR.

My initial appointments at CJIT were really daunting as I had never been in this situation before. I found that the first 2 – 4 weeks were really chaotic which wasn't good for someone in my condition.

I had various meetings with different services, including CJIT, throughout the first few weeks which didn't all seem to go hand in hand. It was incredibly difficult to get me seen by the mental health team and this was something that I found very frustrating. The main issue with this was that I was arrested under the Nottingham City umbrella, however I then moved to my Mums house which was under the County jurisdiction. This created a lot of problems which took ages to sort out so it meant that I was being juggled between the two services. It was only due to the hard work of Vanessa and Ruth, who both petitioned for me to keep constant meetings with them, that I managed to get through at this stage.

It was during this time that I met my probation officer; again this person was then changed later down the line so there was no consistency from the beginning when it came to probation.

It felt to me as though all the different services were working individually rather than together at this time which I found difficult to deal with alongside my own personal issues.

The work that I did with Ruth and Vanessa was initially in accordance with my DRR and ATR 6 month orders. I was tested twice weekly at the initial stages and this was then reduced to once a week.

Ruth introduced me to the Women's Centre in Nottingham which she felt was a better place for me to attend than the Derby Road Probation office. I met my new probation officer, Lesley at the centre and also was put in contact with the Changes Programme as well. This provided me with various courses that I could attend to help increase my self confidence, money matters courses and various other things should I have wished to take part in them.

During my order, I found the probation experience really disjointed and totally unhelpful. There were several occasions whereby my appointments were changed or that my probation officer saw me for a maximum of 5 minutes. I wasn't really given any direction from probation or felt that I was of particular concern to them. One example during this time, which didn't help my anxiety or recovery, was when my probation officer failed to inform me of a court date and I was told I was due to attend Nottingham Crown court the following morning. I have a young child and was working hard at this time to regain my custody rights of him so to have to arrange childcare at the last minute was really stressful and the lack of information could have resulted in me being breached for not attending an appearance. This is something that I found really distressing and very unhelpful.

Throughout my order I have continued to work with CJIT and have made use of as many of the services that they offer as I can. I have been given holistic therapy session, when I could attend them, and also been introduced to the REACH project.

The REACH project invested in me to do an online drugs awareness course which I am due to finish early next year. I also had the chance to take part in the GOALS course, which I found extremely useful in boosting my self confidence and self awareness. It also gave me the courage to start looking for employment again.

I have now completed my order, moved back to my own house and started employment with Double Impact, another service provider. The whole ordeal has been incredibly hard and I am still working tirelessly to make sure that I stay in good recovery.

My experiences of probation during this time are not good and I think that the mental health system in Nottingham runs the risk of letting desperate and ill people down due to the length of time that it takes to get seen in Nottingham. CJIT on the other hand have been an immense support to me across the board and have helped me with my recovery wellbeing, my mental health, housing issues and personal issues.

Thankfully I am not someone who will reoffend and thanks to this order, I have finally got the tools that I need to make sure that I protect myself from a situation like this occurring again.

**Appendix 3 Service User Letter**

XXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXX

2<sup>nd</sup> November 2013

Dear Rebecca,

I have been attending CJIT for approximately 7 months and throughout this time I have been working closely with a member of your team Ruth O'Love.

I thought that it was appropriate to write to you with reference to Ruth because I shouldn't think that the job that she does always carries with it the "thanks" that it's due.

From day one of meeting Ruth, she has been incredible. Without her support throughout what's undoubtedly been one of the hardest years of my life, I don't think that I would be in the position that I am in now. Ruth has been a constant source of support, guidance and encouragement when I needed it the most; not just to me but also to my close family support network.

I have, thanks to her and Vanessa, finally received the correct mental health support that I was in desperate need for and since receiving a diagnosis and subsequent medication, been able to start rebuilding my life. Being in early recovery, both mentally and physically, is daunting to say the least but without Ruth's constant presence throughout, I truly don't think that I would have succeeded as quickly as I have done.

I would like to take this opportunity to let you know how grateful I am to her and other members of your team for all the help that they have and continue to give me.

Ruth is a credit to your organisation and to your team and without her, quite simply, I wouldn't have made it through and I think that she needs recognition for this.

Many thanks again to all of your team who have helped me to rebuild my life and special thanks to Ruth.

Kindest Regards

XXXXXXXXXXXXXXXXXX