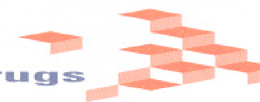
WAKEFIELD DRUG ACTION TEAM



NHS

Health v Criminal Justice

Plenary Session

Health and the Criminal Justice Agenda – A Delicate Balancing Act

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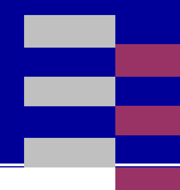


City of Wakefield Metropolitan District Council

NATIONAL PROBATION SERVICE
for England and Wales
West Yorkshire

Enforcement rehabilitation and public protection

Elements of the Debate

- Exploring the links between drugs and crime – ***Assumptions v facts***
- Political Drivers
- The Rise of the Community Model of Care
- Treatment providers working in partnership with criminal justice ***opportunities and threats***

Breakdown of drug misuse

1 million using class a drugs

4 million using illicit drugs

6 million have tried drugs

The Drug Crime Link – (updated drugs strategy)

79% of heroin and crack users claim they commit crime

75% of persistent offenders misuse drugs

Class A users commit 50% of acquisitive crime

99% of the 18 billion social and economic cost of drug misuse is generated by 250,00 drug users

The Drug-Crime link facts and assumptions

- "The links between drug users and crime have never been clearer"

Facts or Fiction

- Almost 2/3 of criminals test positive for one of more drugs (1999 HO commissioned research)
- (But….46% cannabis, 18% heroin 10% crack
- Heroin users have much greater drugs spends and crime incomes
- Shoplifting strongly associated with class A use
- 12,250 suspects arrested each week have taken crack or cocaine in previous two days
- NTORs – of 1,100 drug users 70,000 crimes had been committed in three months before entering treatment

The Drug-Crime link

- 100,000 persistent offenders are believed to commit about half of all the crime in this country
- Of those 2 out of 3 take “hard drugs”
- Half are unskilled
- More than a third are *looked after* children
- Nearly half have a history of school exclusion

Evidence from the US

- US Drug Courts (Dade County Miami 3,000 offenders, recidivism lower than non drug using offenders)
- Over 400 courts now in existence
- The quicker the treatment the better the retention rates
- The longer the treatment the better - < 3 months no better than detox
- $7 dollars saved for every $1 spent on treatment

Drugs as a public health issue

- Communities against Drugs strategy
- *Positive futures*
- Neighbourhood Renewal Fund - £900M to tackle deprivation in the poorest areas
- £450M for a Children's Fund
- *Connexions* - careers information, advice and guidance service for 13 – 19 year olds

Political Drivers

1. **Cost to the Taxpayer –** estimated 3.5 billion a year (80% on police, probation, prison courts and Benefits)
2. **Cost to Business** – shoplifting, credit card fraud, theft, accidents in the workplace, poor performance, sickness and absenteeism
3. **Cost to the NHS** – Drugs as a public health issue

Political Commitment

- Ten Year strategy (1998)
  - Halve the number of young people using the most dangerous drugs
  - Double the numbers of drug users in treatment
  - Halve the level of reoffending by drug misusing offenders
  - Halve the availability of drugs on the streets
- New resources - £712million over three years since 2000
  - More treatment – to tackle both health and crime consequences of drugs
  - Promote Integrated Approaches - Models of Care
  - Breaking down barriers between health and social care
  - Injecting cash into criminal justice initiatives

2000 spending review

(resources directly allocated to tackling drug misuse in millions linked to UK drugs strategy)

	00/01	01/02	02/03	03/04
Drug treatment	234	328	377	401
Protecting young people	63	90	97	120
Safeguarding communities	45	79	81	95
Reducing availability	353	373	376	380
TOTAL	695	870	931	996

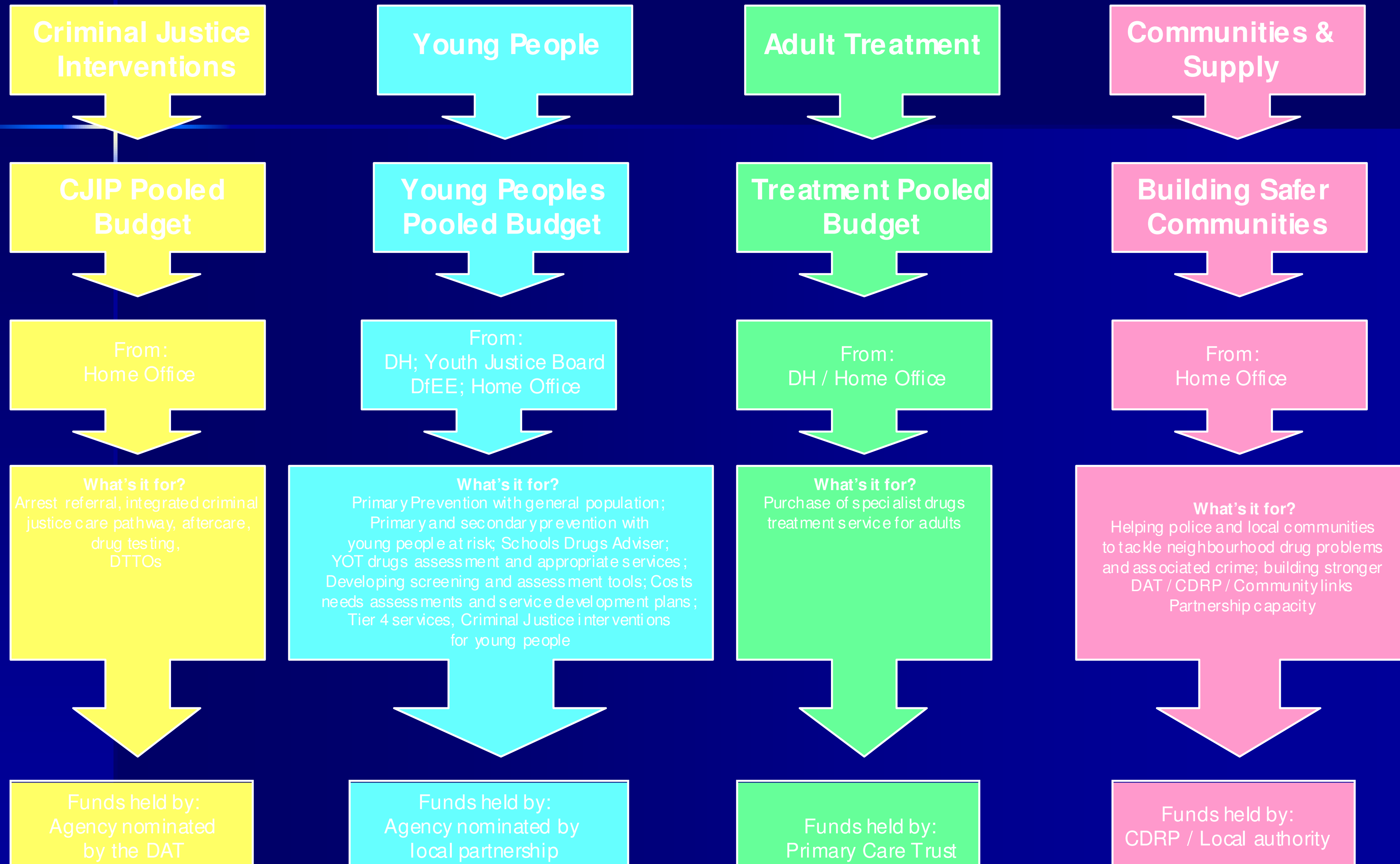
Cash for Communities and Criminals (2000 spending review)

	01/02	02/03	03/04
Criminal Justice System	1420	2290	2720
Neighbourhood Renewal Fund	200	300	400
Children's Fund	100	150	200
Connexions	77	177	tba

Cash for anti-drugs measures

	01/02	02/03	03/04
Strengthening communities	50	70	100
Extending drug testing in the CJS	0	20	30
Providing more help to find jobs	5	15	20
Strengthening DATs	5	5	5
Expanding positive futures	2	2	tba

Annex A (i)



“Cash for criminals”

- £2.7 billion since 1999 - a large proportion to the police
- £900 million through the neighbourhood renewal fund

Crime and Disorder Reduction Partnerships

- Statutory partnerships set up under the Crime and Disorder Act 1998
- 354 in number - Foundation stone of Governments crime reduction strategy
- Led by LA and police but include health, local stakeholders, community groups
- Responsible for conducting regular audits of crime and disorder issues locally and then developing a strategy to deal with the problems identified

CDRPs in action

- Street crime initiatives – visible police presence in high crime areas
- Mobile police units to make police more accessible to local communities
- Neighbourhood wardens
- ASBO's – action to tackle anti-social behaviour
- Environmental improvements including safety initiatives
- Extra housing managers
- Targeted police initiatives

CDRP/DAT merger

- To ensure DATs increase substantially their involvement in local communities
- ?More effective use of resources
- Improved mainstreaming and heightened profile of crime and drugs issues amongst stakeholders
- Reduced local beurocracy – reduced burden on agencies re representation
- More effective linkages with local partnerships – LSPs YOTs
- Strengthened engagement with the neighbourhood renewal strategy
- Streamlining of reporting and accountability arrangements

Merger – good or bad for health?

- Reducing costs and beurocracy
- Heightened profile of crime agenda

- Yes
- Good for acquisitive criminals but fears of inequitable services and reduced harm reduction initiatives

- More effective linkages at strategic level

- YES – but reduced health and clinical representation on CDRPs

The Community Model of Care

Medical Model

Social Model

Criminal Justice Model

Community Model

What do communities want?

1. To look after themselves and each other so that they are safe and healthy, having the skills and confidence to take more control over their lives
2. Environments that are attractive to live, learn, work and invest in
3. Where together with the younger people of the community the work done now will stand the test of time.

In real terms this means…………..

- “I want to drive the dealers out”
- “ I want my son helped to beat his addiction as soon as possible by qualified and committed staff”
- “I want my daughter to be able to reclaim her lost future through treatment training and employment”
- “I want to be able to measure and feel the difference where I live and work”

Key principles

- Empower communities to act
- Seek ownership of the Govt targets by communities
- Communities involved in designing strategies
- Communities monitoring progress and making us account for our actions
- User and carers involved in delivering care

Upstream activities

- Drugs education in schools
- Healthy Schools Partnerships
- Surestart
- Teenage pregnancy strategy – the success of peer educator schemes
- Getting kids interested in sports and the arts – e.g. positive futures
- Initiatives to reduce exclusion and truancy
- Connexions
- The Children's fund
- Business against drugs

Key public health issues What's at risk of getting lost? Here's just a few for starters…….

- Substance misuse - a chronic recurring illness implications of applying a chronic disease model of care –
- Drugs - responsible for the deaths of approx 3,000 people a year - 1 in 6 (approx 450) are under 25
- Hepatitis, HIV and the harm reduction agenda
- Managing the extent of the morbidity places huge burden on GP and community services, A and E, paramedics and mental health
- "Hidden Harm" – the effect of drug misusing parents on the health and welfare of children

Clinicians working with the criminal justice system

Health – Making a difference/measuring impact

- Drug Use
- Physical and Psychological Health
- Social Functioning and Life context

Improving Health – what works?

Harm reduction

Hierarchy of goals: -

1. reduce injecting
2. reduce use of street drugs
3. reduce use of prescribed drugs
4. increase abstinence

Strategies and Interventions

- Help stop, reduce or make safer injecting drug use
- Reduce amount and frequency of poly-substance use
- Improve physical and mental health
- Advise on safe drinking

- Treatment of drug dependence
- Needle exchange with safer injecting information and advice
- Health promotion and general health care
- Testing and immunisation programmes (e.g. hepatitis B)
- Social intervention and liasing with other agencies e.g. probation, employment schemes

Improving health – what works?

Methadone maintenance

NTORs after 5 years : -

- Treatment should be seen as a process NOT as an event
- Maintained clients show higher abstinence rates and reduced frequency of drug use
- ✓ Reduced crime
- ✓ Improvements in health
- Clients should be encouraged to stay in treatment for as long as possible

Improving Health – what works?

- Shared care
- Patient centred care
- Integrated working practices
- Hepatitis screening and vaccination programmes
- Reducing drug related deaths groups
- Access to training

NTA

- Equity of access and quality of treatment interventions nationally
- Promoting evidence based treatment including strong emphasis on harm reduction
- Protocols and guidelines
- Clinical governance
- Sharing best practice
- Encouraging joint working between heath and social care – complete packages of care
- Workforce and training

Drug treatment – but are we making ourselves clear?????

- Harm reduction
- Detox vs. maintenance
- New GP contract
- Prescribing heroin pilots
- *"Shipman"*
- High profile GMC cases
- Zero tolerance
- Declassification of cannabis
- User movement

Helping people out of drug related crime

- Arrest referral
- Drug Treatment and Testing Orders
- Prison CARAT Teams
- Enhanced arrest referral and targeted police initiatives
- DTTO "Light"
- CJIP

Arrest Referral

- Point of arrest seen as key opportunity to identify drug-crime link
- Drugs referral workers present in police custody suites assess and refer into treatment
- Initial pilots showed 81% reduction in drug spend and 61% stopped or reduced property theft

Collating the evidence

HO commissions three year research study to monitor and evaluate the arrest referral initiative

2 elements to the research: -

- National monitoring system – numbers, characteristics, referral outcomes,
- Area based research and evaluation studies looking at behavioural outcomes and best practice

Arrest referral – the findings

- Track record of reaching the target population (opiate a crack users, injectors and shoplifters)
- Average drugs spend £11,000
- Over half screened have never had a treatment episode
- Oct 00 – Sept 01- 48,810 screened, half referred for treatment but only a quarter of these made a demand for treatment
- Arrest referral clients were more likely to drop out of treatment when compared with self and GP referred users

The findings (continued)

- Repeat arrests reduced six months after contact with arrest referral worker
- Self reported drugs spend reduced in follow up interviews in all studies
- Self reported levels of injecting reduced
- Some studies validated self reporting with drug testing and were able to demonstrate concordance
- Improvements were noted in physical and psychological health indicators

Economics of arrest referral

- Preliminary findings suggest economic and social benefits of 4.4 billion over 8 years
- Economic and social cost benefit ration 7:1 increasing if treatment is sustained

Areas for improvement

- Delays between referral and treatment are demotivating
- Some clients particularly challenging to engage with: -
- BME
- Older clients (>31) with extensive prison record
- Young male crack using street robbers
- Female crack using sex workers

Enhancing arrest referral

- Consolidate and improve working relationships with police
- Develop local proactive approaches to contacting problem drug using offenders (e.g. cell sweep, cold contacting, assertive policing, taking the clinic to the client!)
- Develop local strategies to specifically target low engaging groups
- Develop brief interventions in alcohol as part of arrest referral remit
- Case work and facilitated placement
- Links to CJIP

DTTOs

- Created by UK Crime and Disorder Act 1998
- Community sentence aimed at high tariff criminals
- Defendant agrees to regular drug testing as part of comprehensive treatment programme with prescribed and monitored levels of engagement
- Court plays vital role in reviewing clients progress throughout the order

DTTOs remain key component in updated drugs strategy

- Number of DTTOs is set to double between 03 and 05
- West Yorkshire targets have risen by 50% in 2003/04 alone
- But evidence base only slowly emerging

Pilot sites (Turnbull et al 2000)

- Average drugs spend dropped from £400 to £25 after 6 weeks on the programme
- Offending dropped and all reported they were crime free by the end of pilot period
- Six month follow up showed change was sustained
- Serious teething problems experienced in terms of service delivery

Do DTTOs really work?

Recent HO study

Typical DTTO offender committing 4 offences a day and spending £400

Approx 6,140 orders were made in 02/03

-of those completing the order just over half were reconvicted within a year

-91% of those who failed to complete were reconvicted

-One third completed their order

-Overall reconviction rate 80%

Scottish Pilots

- Average cost of DTTO £7,293 compared with average prison sentence of £7,029 in 99/00
- Drugs spend reported down from £400 £57 after 6 months
- Drug testing and court review viewed positively by offenders as both "carrot and stick"
- Majority received methadone script (unclear if maintenance but treatment choice and access reported as patchy)

The West Yorkshire Evaluation

- 59 offenders - Jan 01 to July 02
- Completion of pre DTTO and six month questionnaire
- Questionnaire compiled from validated and non validated measures
    - Type and frequency of drug use
    - Average drug spend
    - LDQ and Maudsley Addiction profile
    - Drug related criminal activity
    - Financial accommodation and social situation issues

The West Yorkshire DTTO schemes six month outcomes

- Only third retained in treatment
- Statistically significant reductions in reported heroin use and drugs spend at six months
- Psychological dependency as measured by LDQ reduced by half
- Levels of self reported criminal activity reduced by 70%

(310 crimes prevented by operating 59 cases for an equivalent of six months)

West Yorkshire pilot sites

- General health problems reduced by 26%
- One quarter of offenders previously classed as unemployed reclassified as “economically active”
- Offenders reported improved financial situation with 10% reporting no problems
- Housing status of offenders much improved with no homeless and fewer reporting living with drug using co residents

"Softer" measures

- Positive changes made in how offenders view their relationships
- Regaining confidence and family ties biggest reason for why DTTO seen as important
- Managing withdrawal, maintaining motivation, learning new skills and changing the way you think and feel seen as most challenging aspects of the order
- High user satisfaction

DTTOs – National Standards

- Treatment provider to contact the offender within two working days of the order being made.
- Engagement - five days per week, twenty hours per week, for the first thirteen weeks of the order with discretion for this to be reduced to a minimum of three days per week and twelve hours thereafter
- Offenders must be tested at least twice per week for the first thirteen weeks of the order with discretion for this to be reduced to a minimum of once per week thereafter depending upon progress.

Best Practice in DTTOs – the emergence of what works

- Use accredited substance misuse programmes to address offending behaviour within DTTO context (e.g. ASRO)
- Deliver “wraparound” services (*employment, training and education (ETE), physical recreation and life skills*
- Foster good partnership working between CJS and health

Best Practice in DTTOs – the emergence of what works

- Dedicated and consistent clinical support
- Protocols and working practices that link in with the court and the probation team
- Confidentiality and information sharing policies agreed
- Deliver evidence based, shared care in accordance with the UK clinical guidelines
- Court team (including the doctor) working together to achieve a common goal
- Goal - to restore defendant as a productive ex addict and ex offending member of society
- Graduated sanctions imposed in response to non compliance with order

For Debate

- Currently no national evaluation of impact of DTTOs
- DTTO operates in relatively “open” policy environment concerning delivery
- There is a wide variation in choice, access, quality, range and emphasis of treatment
- Evidence that DTTO teams experience service problems to greater or lesser extents
- Unsure as yet what impact these have on offenders

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Health v criminal justice in DTTOs – enemies or allies

- Evidence suggestive of positive influence of harm reduction approach in terms of impact and outcomes
- Improved health and job prospects, stable accommodation and improvements in relationships can be taken as proxy indicators of reductions in drugs spend and offending

Assumptions, myths and must dos

- Strong partnership working is essential (community multi agency treatment model)
- Whole team must understand nature of addiction
- Successful DTTOs are intensive, individualised, highly structured programmes
- Successful DTTOs are not cheap
- Sanctions and rewards and "carrot and stick" approach are acceptable to clients
- Strong clinical leadership supports positive behaviour change and enhances the team

Questions

- Is there a need for firmer commissioning standards re content of DTTO packages of care
- Is there a place for a DTTO treatment team service specification
- What effect does coercion have on the Dr-Patient relationship?
- What are the ethics of sanctioning treatment to drug users on DTTO programmes

Recommendations

- Generate strategies to improve retention
- Promote harm reduction as preferred model for working with this client group
- Revisit policies and strategies relating to drug users still spending over £50 a week after 6 months
- Improve access to drug free housing options
- Formally and frequently review drug users social situation in terms of relationship building
- Explore current strategies/interventions that assist offenders to maintain motivation, learn new skills and change the way they think and feel
- Provide strong clinical leadership

DTTO Light

- More community sentences with a specific condition of treatment and testing
- “less intensive” treatment programmes in terms of hours of engagement
- Same testing regimens
- Offered access to same opportunities of “wraparound care”
- Enables greater numbers to access and benefit from treatment

Prison through care and aftercare

- CARATS teams
- More prison rehab schemes
- Introduction of maintenance prescribing
- Initiatives to tray and reduce drug related deaths – e.g. retoxification
- Initiatives to combat revolving door such as testing on licensing
- Combined and tougher community sentences such as DTTO + curfews

The "revolving door"

- Offenders will pass through many different teams: - the process lacks consistency, is inefficient, expensive and poorly coordinated
- Offenders are demotivated
- Recidivism rates are high
- Immediate relapse is common place
- Health risks – increased risk of DRD, Hepatitis and HIV

CJIP – Is this the "Holy Grail"?

- Aims to integrate drug treatment services for offenders in police stations in courts and in the community
- Designed to improve the aftercare of prisoners upon release from prison
- Three year £447M budget over three years

CJIPs - components

- CJIP plan
  - Membership and skill mix of integrated CJIP team
  - Care pathways from CJS back into community and beyond (custody suites – courts - single point of access to tiers 2/3 services – CJS
  - Prompt consistent process for dealing with prison releases
  - Caseload management system and case coordinator role
  - Dedicated prescribing
  - Structured care programmes
  - Estate that fosters good partnership working

CJIP - principles

- Mapping access points into treatment
- Reviewing existing criminal justice pathways
- Clients needs analysis
- Synergising with models of care
- Developing thoroughfare and aftercare strategies and action plans

CJS and health – Concerns vs Expectations

- Funding pressures leading to skewed services
- Criminal Justice model and community model sidelines health agenda
- "Winners and Losers"
- Resources stretched in meeting demands

(managerial and clinical)

Support services fail to keep up

Who is going to do all the training?

- Which prescribing model works best - specialists/generalists/shared care

CJS and health – ensuring the right balance

- Two BIG agendas –ONE health message
- Its NOT a competition
- We are ALL on the same side…….aren't we?
- Attempt to make a difference at a strategic level
- Clinicians MUST take a LEAD on ensuring the preservation of evidence based care and settle for nothing less