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Drug Treatment and Testing Orders: Final evaluation report

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Foreword

Drug Treatment and Testing Orders (DTTOs) were introduced as a new community sentence under the Crime and Disorder Act, 1998. The orders were established in response to growing evidence of the link between problem drug use and persistent acquisitive offending. Orders are targeted at serious drug misusing offenders aged 16 and over, with the dual aim of treating their drug use in order to reduce the amount of crime committed to fund a drug habit. The order requires the offenders to undergo regular urine tests and, unique to community sentences, court reviews to monitor progress.

This report presents findings from an 18-month evaluation conducted by South Bank University, on behalf of the Home Office, in three pilot areas - Gloucestershire, Liverpool and Croydon. Results include an evaluation of the type of offenders sentenced to a DTTO, how well they met the treatment, testing and review elements of the order, and how successful the pilot projects were in reducing their drug use and related offending.

The evaluation also makes recommendations about the most effective ways for multi-agency teams to deliver DTTOs.

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Summary

This report presents the findings of our evaluation of Drug Treatment and Testing Orders (DTTOs). We have examined the three pilot sites (in Croydon, Gloucestershire and Liverpool) as well as four additional projects which use Probation 1A(6)[1] orders in ways which closely resemble DTTOs. Our results cover the full period of the DTTO pilot projects, which ran from October 1998 to March 2000.

Throughputs

All three sites got off to a slow start, though the pace of referrals picked up half way into the pilot period. The comparison sites seemed to have experienced similar difficulties in getting their schemes up-and-running. In planning national roll-out a slow start should be expected. In total 210 offenders were given DTTOs. The pilots had differing referral and assessment strategies. Attrition rates between referral for assessment and acceptance for assessment were influenced by a number of factors such as an individual offender not consenting to an order, not accepting or attending an assessment interview, or being judged as unsuitable for an assessment by the DTTO team. Offenders must consent to a DTTO; these data therefore include some who decided to withdraw from the proposal and assessment process. The table below shows the number of drug-using offenders at each stage of the selection process.

The selection process

	Croydon		Liverpool		Gloucestershire		Total	
Referred for assessment	125	100%	172	100%	257	100%	554	100%
Accepted for assessment	118	94%	157	91%	239	93%	514	93%
Proposed to court for DTTO	57	46%	112	65%	119	46%	288	52%
DTTO made	42	34%	68	39%	100	39%	210	38%

1. A 1A(6) probation order, is an order with an additional requirement for treatment of drug or alcohol dependency. For more information see Criminal Justice Act, 1991.

Testing

We have records of 2,555 urine tests carried out by the end of March 2000 covering 173 offenders – an average of 14.7 each. Just over half (53%) were conducted at the Croydon site. As can be seen from the table below many tests were positive for opiates and cocaine. However as drug-using offenders continued on a DTTO, the rate of testing positive for opiates decreased. The impact on cocaine use was less clear.

Proportion of urine tests proving positive, by end of March 2000

Site	Opiates (excl. methadone)	Methadone[1]	Cocaine[2]	Amphet-amine	Benzo-diazepines
Croydon (1,364 tests)	34%	57%	53%	2%	13%
Gloucestershire (624 tests)	40%	53%	18%	5%	29%
Liverpool (567 tests)	63%	64%	39%	3%	15%
TOTAL (2,555 tests)	42%	58%	45%	2%	15%

1. Includes licit and illicit use.
2. Urine tests do not distinguish between crack cocaine and cocaine powder. Therefore, the term 'cocaine' is used in the report to cover both types of drug.

What the tests do not show, of course, is changes in level of drug use. Even though they were still using illicit drugs, most of those we interviewed reported steep reductions.

Enforcement

The three sites had widely differing approaches to warnings, breaches and revocations. In all three sites offenders quite often failed to meet the conditions of the order. The main form of non-compliance was failure to attend, but as noted above, many continued to use illicit drugs, especially near the start of their order. The table below summarises warnings, breaches and revocations for the three pilot sites up until March 2000. Further warning, breaches and revocations are likely to occur as offenders continue with their DTTOs.

Enforcement processes – figures until 31 March 2000

	Croydon	Liverpool	Gloucestershire
DTTO made	42	68	100
No. of offenders warned verbally	18	10	21
No. of offenders warned in writing	30	10	23
No. of offenders breached in	28	29	63
No. of revocations	17	19	60
% of orders revoked	40%	28%	60%

Reviews

We hold information on 413 separate review hearings for 154 offenders. Practice varied across the sites. There were practical problems in arranging reviews, mainly to do with case listing in two of the three sites. In Liverpool more than four out of five reviews were heard by the judge or magistrates who originally passed sentence; in Croydon the figure was a third, and in Gloucestershire a fifth. Especially for reviews which were heard by the original sentencer, the process seemed a useful one, welcomed by staff and offenders alike as making a positive contribution to the treatment process.

Impact on offenders

We carried out 132 interviews with offenders within six weeks of receiving the order; we re-interviewed 48 of these after they had been on their order for six months; and we carried out 50 'exit interviews' with those who had completed their DTTO successfully (or were within a few weeks of doing so) or had it revoked. Results from our self-report interviews on drug use are broadly consistent with the urine test results; the majority (75%) who tested positive admitted at interview that they had used the drug in question.

On the basis of self-report data, there were substantial reductions in drug use and offending at the start of the order. The average weekly spend on drugs fell from £400 in the four weeks before arrest to £25 in the first four to six weeks of the order (94% reduction in drug spend). Polydrug use had become much less common; typically people stopped using crack or amphetamine, but continued to use opiates, albeit at a much reduced level. There were commensurate reductions in acquisitive crime. The average number of acquisitive crimes committed by 119 offenders in the month before arrest was 137. The corresponding figure for 35 offenders during the month before first interview was thirty-four. As ever, one should be circumspect about self-report data, though the picture to emerge is consistent with the urine testing results and other surveys of this kind.

The six-month interviews showed that these reductions were largely sustained over time. This implies that if DTTOs succeed in retaining offenders within the programme, they seem likely to contain drug use and offending. We cannot say conclusively that this is the case, however, given the small number of offenders reaching this stage to date.

The exit interviews were completed on two groups – those who reached (or had nearly reached) the end of their order successfully, and those who had failed. The 31 successes said they were crime-free and 27 said they were drug-free – except for their use of cannabis. At present very few orders have matured to this stage. Therefore, all we can say is that an eighth of those on orders seem to have emerged drug-free. This proportion will obviously grow over time, but we cannot yet say by how much.

Even the failures had reduced their drug use, and some claimed to have benefited from their experience on the order. Although we cannot be certain, we strongly suspect that we managed to contact the "partial failures" and that there will be a disproportionate number of serious relapses amongst the remainder whom we were unable to contact.

Implications

Here we have tried to identify problems which are most likely to affect the national roll-out of DTTOs, and suggested possible solutions.

Inter-agency working

The lack of effective inter-agency working in every pilot site is perhaps the single most important factor to address. The pilot sites all encountered quite serious "teething problems"; and some of these remain unresolved. In order to aid a successful roll-out the Home Office and probation areas will have to invest heavily in the selection and training of staff, achieving clarity of roles, team building activities and planning better assessment procedures and treatment programmes.

Referral procedures

One reason why DTTOs got off to a slow start was that probation officers writing PSRs (Pre-Sentence Reports) and other agencies, such as the police, failed to refer appropriate candidates. It is important both to stimulate the flow of referrals and to minimise the proportion of inappropriate referrals. Probation areas need to put systems in place to ensure that PSR writers are aware of DTTOs and some broad criteria for acceptance on the programme.

Assessment

This is a two-stage process. First DTTO teams decide whether to accept a referral for assessment, and secondly they mount a formal assessment. There is scope for establishing tighter selection criteria and injecting more rigour into the initial screening process, as just over 40 per cent of those assessed were not put forward for a DTTO. It would be useful if teams drew up a clear set of criteria and filtered out inappropriate cases using published guidelines.

The assessment process needs to be more discriminating in winnowing out both those who are certain to fail and those who need very little help to address their drug problems. Given their cost, DTTOs obviously need to be targeted on those offenders on whom treatment programmes will have the greatest impact. There is certainly a need for a specific diagnostic tool.

Matching the individual to treatment

The pilots exemplify widely differing approaches in the intensity, nature and flexibility of the interventions delivered. It would be helpful to set some expectations nationally in terms of the level of restriction of liberty, the need for chaotic drug users to have a structured programme and the lessons of the Effectiveness Review which suggests that treatment needs to be matched to the individual (Department of Health, 1996).

Clarity of intervention objectives

Whilst there is a growing evidence base about the effectiveness of drug treatment, there is still much professional disagreement about the best approaches. Teams need to articulate their working philosophy, and to achieve a consensus within the team around this. It would be useful for DTTO teams to formalise in writing a clear plan of their proposed intervention. Given the level of breach and revocation soon after an order is made it is important that early interventions focus on engaging with drug-using offenders and retaining them in treatment.

'Expectations of drug use on DTTOs'

The pilot sites had widely differing expectations of offenders; the Gloucestershire pilot initially expected very rapid progress to drug-free status, the other two teams had the less demanding expectation that progress towards abstinence will be gradual and accompanied by relapses. Our reading of the research evidence is that it takes at least three months to engage successfully with this client group; and our own view is that requiring DTTO offenders to be completely drug-free in a matter of weeks is pushing them too far too fast.

'Consistency and effectiveness of urine testing'

The frequency of urine testing varies markedly between pilot areas. Very frequent testing may not be a good use of money, and can be counter-productive in those who are reducing the amount of drugs they use. We think that testing needs to be integrated fully with treatment programmes, with testing regimes tailored to the objectives set for individual offenders. However, we suggest the following minimum standard; twice per week for the first three months of the orders with discretion to reduce this to a minimum of once per week after that period.

Continuity of sentencers at court reviews

The review process seems to be of value. Offenders respond both to the praise and to the criticism of a sentencer who shows interest in their progress. Our sense is that the benefits are likely to be greatest when the same sentencer(s) is involved throughout the sentencing and review process. The difficulty is the practical one of getting this to happen. The Merseyside system of regular court sessions dedicated to the review of DTTO appears to be both effective and efficient.

Streamlining breach procedures

If there is to be greater consistency across areas, there is a need to produce clearer indications of guidelines for when breach is appropriate. We do not think that the revised (2000) National Standards for probation orders could be applied unamended to DTTOs. On the one hand the greater intensiveness of the DTTO means that the opportunities for failure are very much higher than for a conventional probation order. On the other, the nature of dependent drug use is such that relapses are very likely to occur even under the toughest regimes of control. Although an expectation of consistent reporting should be set, teams should be encouraged to concentrate mainly on the reduction and cessation of offending behaviour. Wherever the minimum acceptable attendance rate is set, it needs to be proportionate to the level of contact required by the programme. More work needs doing in clarifying the procedure for Crown Court breaches and improving the speed of the police response in executing warrants. It would make sense for probation areas to negotiate arrangements for executing warrants with their local police force, as was done in Croydon.

Monitoring

We think it important that, from the start, schemes should design monitoring arrangements into their programmes. Monitoring needs to cover the referral and assessment process, offenders' contact hours per week with the programme and the enforcement process. It is particularly important to monitor whether enforcement proceedings are removing offenders from the programme when they are still near the start of their order.

1: Introduction

This report presents the findings of our evaluation of Drug Treatment and Testing Orders (DTTOs), which were introduced under the Crime and Disorder Act of 1998. This introductory chapter falls into three parts. First it sets out the background to the development of DTTOs. It then considers previous experience, both in Britain and in America, of using the criminal law to coerce problem drug users into treatment. It ends with a section detailing the research methods used in evaluating DTTOs.

Drug Treatment and Testing Orders

DTTOs were introduced by the Criminal Justice Act 1998. They were designed as a response to the growing evidence of links between problem drug use and crime. For example, extrapolating from British Crime Survey figures and Home Office Addicts Index notifications, we have estimated that there are between 85,000 and 215,000 problem drug users who could benefit from treatment – or about three per cent of those who use drugs every year (Edmunds et al. 1998). It is increasingly clear that this relatively small group of problem users imposes heavy costs on both victims of crime and public services. Many are heavily involved in acquisitive crime, imposing losses on crime victims in excess of £1.5 billion, per year (Turnbull and Webster, 1998; Hough, 1996; Edmunds et al. 1999). There are additional costs associated with this group including those incurred by the criminal justice, social security and health systems.

As recognition of the links between drugs and crime has grown, so the probation service has been under increasing pressure to develop its work with criminally involved problem drug users. To date most work with this group has been undertaken in partnership with specialist drug services. Though several studies have shown the positive impact of existing arrangements for courts to impose treatment as a condition of a 1A(6) probation order[2], HM Inspectorate of Probation's thematic inspection of drugs found that relatively little use had been made of these arrangements (HMIP, 1997). The main reasons found for this were:

- little or no guidance from the Home Office and probation service to sentencers on the use of this disposal

2. Orders were usually under Section 1A(6) of the 1991 Criminal Justice Act, which is being superceded by the DTTO; though other powers, e.g. under Section 1A(2), with an additional probation order requirement to 'participate in activities' will remain in force.

- probation officers and treatment providers were reluctant to involve themselves in legally coerced treatment
- sentencers were unaware of the type and availability of treatment
- no arrangements were made to meet the cost of treatment.

DTTOs were intended to overcome these problems. The new order was designed to provide the courts with powers to make an order requiring the offender to undergo treatment as part of or in association with an existing community sentence. Two things distinguish it from previous probation orders carrying conditions of treatment:

- the requirement that courts regularly review offenders' progress
- the requirement that offenders must undergo regular drug testing.

DTTOs can be made for periods between six months and three years, on offenders aged 16 or over. Before it makes an order, the court must be satisfied that the offender "is dependent on or has a propensity to misuse drugs", and that the offender would benefit from treatment. The assessment of whether an offender is appropriate for a DTTO is presented in the form of a Pre-Sentence Report (PSR) to the court. The offender has to consent to a DTTO being proposed and made.

The Home Office has issued guidance on which drug-using offenders the order should target. The main selection criteria are dependence on drugs, seriousness of the offence, offenders' motivation to treatment and volume of offending. The guidance specifies that:

- the main aim of DTTOs is to reduce further offending
- those committing high levels of acquisitive crime to support their habit will form the core of the DTTO target group.

The Criminal Justice Act 1998 enabled DTTOs to be piloted. Three pilot sites were established in Croydon, Liverpool and Gloucestershire, with start dates planned for October 1998. The Criminal Policy Research Unit was contracted to carry out the evaluation of the pilot sites, the results of which would enable the Home Office to decide whether or not to extend the order across the country. As is discussed later in the report, the Home Secretary made a decision in favour of doing so in June 2000 on the basis of findings in our interim report (see Turnbull, 1999, for a summary).

The evaluation was designed not simply to support the decision whether or not to "roll-out" nationally, but to provide – in the event of a positive decision – research-based advice about the best way of doing so. Thus it seemed sensible to capture the experience not only of the pilot sites but also of some comparison schemes which were running similar schemes using 1A(6) probation orders. We collected information from four such schemes:

- the West Yorkshire drug court and STEP Programme
- the Plymouth Fast Track scheme
- the PASCO scheme in Cheshire
- Hastings Multi-agency Drug Treatment and Testing Programme.

Previous experience of coerced treatment

The DTTO has several innovative features, but is by no means a complete break with the past. As noted above, courts in England and Wales have had powers to order treatment as a condition of a probation order for several years, even if these powers were more limited than for DTTOs, and had been used sparingly. The United States has much more experience of trying to tackle drug-related crime through legally coerced treatment, and has a larger body of relevant evaluative research.

The experience in the United States

The US drug court movement has had a considerable impact on the development of approaches to court-based intervention with drug-using offenders in the UK. However, there are important differences in the types of intervention offered, the procedures and judicial systems.

The US drug court initiatives developed out of local courts' recognition that, on the one hand, problem drug use created significant criminal and social problems and that, on the other, increasingly tough and inflexible penal responses to drug dependency were failing to tackle the cause of these problems effectively. The drug court movement created local partnerships involving the judiciary, other criminal justice agencies and the drug treatment sector in order to achieve the goal of protecting the public by addressing problematic drug use among offenders. A striking feature of these partnerships is their almost evangelical enthusiasm and proselytising zeal. It is this commitment which leads people to talk of the drug court movement, as opposed to a drug court strategy or policy. Evaluations have identified the strength of these partnerships as key to the successful development and implementation of drug courts. There have been additional spin-offs, in that relationships forged within drug courts have led to increased co-operation between the court, other criminal justice agencies and the community; this has fostered a ‘problem solving’ approach to a wider range of criminal justice problems (see Belenko, 1999, for a review).

The “bottom-up” origins of drug courts have something in common with the comparison sites which we included in our evaluation, but contrast markedly with the “top-down” nature of the DTTO initiative. As we shall discuss below, this difference may go some way to explaining the difficulties which our pilot schemes encountered in establishing inter-agency working relations.

There are now over 300 drug court programmes in the US; many are still evolving, but most share some operational features. A survey of drug courts conducted in 1997 by the US General Accounting Office found that all had procedures to identify and recruit eligible offenders, placed offenders in a treatment programme, monitored treatment and had ongoing monitoring of treatment progress and judicial review. Most courts dealt only with offenders charged with drug possession; a minority (24%) dealt with property offences, and even fewer dealt with such offences as forgery (5%) and prostitution (4%). Only 26 per cent of those appearing before the courts had prior experiences of drug treatment, although most had previously been imprisoned (Belenko, 1999).

Those dealt with in drug courts are typically required to participate in treatment for a year or more, have at least three contacts per week with the treatment provider, and submit to one or more urine tests per week (at least in the early stages of treatment). Few courts agree to methadone maintenance as a treatment option. Treatment providers and case managers provide monitoring reports to the judge, who has a central role in overseeing treatment and sanctioning offenders who fail to comply. An important principle of drug courts is that non-compliance should only result in the suspension of the treatment programme as a last resort. The 1997 survey found types of sanctions used included imprisonment (used by 60% of courts, usually for very short periods, followed by the resumption of treatment), more frequent hearings (90%), more frequent drug testing (80%) and more intensive treatment (80%).

The drug court movement attaches as much value in rewarding success as in punishing non-compliance. Rewards are often symbolic – giving offenders a round of applause when they have made good progress, for example – but they can also be substantive. The successful completion of the treatment plan usually leads to the waiving of penalties that were conditionally imposed on the offender but suspended for the duration of the programme.

Both the targeting of treatment at offenders charged specifically with drug offences and the restrictions on the range of treatment options contrasts sharply with the approach taken with the DTTO pilots and with their predecessor, the 1A(6) probation orders. The involvement of sentencers in regularly reviewing progress is a feature common to drug courts and DTTOs, but one which is absent from 1A(6) probation orders (or any other British sentencing option). However, the role of US sentencers in drug courts approximates far more to that of "case manager". This, coupled with a sentencing ideology that emphasises reward as well as punishment, distinguishes drug courts from the DTTO pilot sites.

Evaluations of US drug courts

Many evaluations of drug courts have been undertaken in recent years. Most are based on relatively weak research design. Most have relied on urine-test data for the period covering the treatment programme; few have collected reliable outcome measures relating to re-offending. Even fewer have run for periods of time stretching beyond engagement with the programme, comparing treatment groups with comparison samples.

Nevertheless, the weight of evidence supports the crime prevention potential of drug courts. Belenko (1999) reviewed 30 evaluations of 24 drug courts. He concluded that drug courts have been more successful than other forms of community supervision in closely supervising drug-using offenders in the community, reducing drug use and recidivism while offenders are on the programme. He concluded more tentatively that drug courts can also achieve longer-term reductions in offending after offenders have left programmes.

One of the key predictors of positive treatment outcome are retention rates. Belenko found that retention rates for drug courts are greater than retention rates for criminal justice offenders and treatment clients in general. The 1997 survey of drug courts estimated a minimum, average, programme completion rate of 48 per cent for those who enter a drug court. Strategies therefore to improve the positive impact of drug courts should focus on increasing the length of time offenders participate in treatment.

Evidence of changes in drug use amongst drug court offenders is based on urine test results while in the treatment programme. Thirteen of the 24 drug courts covered by Belenko's review provided results of urinalysis tests; on average, 10 per cent of tests were positive. Few evaluations have examined post-programme drug use but these have found drug use is lower than for comparison groups.

Most evaluations show that criminal behaviour was substantially reduced during participation in drug court programmes. When comparison groups are utilised, again, criminal behaviour was shown to be much lower for clients while they participate in the programme. All evaluations that compare post-programme recidivism for drug court participants find lower rates of recidivism. However many of these evaluations only take into account those who have completed programmes and exclude programme drop-outs from the analysis.

Predictably, perhaps, many US evaluators conclude that there is a need for more robust evaluations of treatment-orientated courts. They argue that information is needed on the long-term impact on both drug use and re-offending; and that too little is known about the relative effectiveness of different elements – and styles – of treatment. Belenko also argues that better mechanisms for matching criminal justice clients to treatment need to be developed.

The UK experience

The UK experience of coercive approaches to treatment for drug using offenders has been much more limited to date. On the whole the criminal justice system has been used as a means of identifying those with treatment needs and encouraging drug-using offenders into treatment. Such approaches have had some success.

Most police forces now have arrest referral schemes which aim to identify problem drug users when they are arrested, provide an assessment and then refer them to treatment and helping agencies. Most schemes are not explicitly coercive: offenders do not have to decide between punishment and engaging in treatment. However it would be perverse to ignore the pressures on arrestees to demonstrate compliance and to show the intention of "turning over a new leaf" in advance of a court appearance.

The aim of schemes is to produce a reduction in drug use and therefore drug-related crime. Edmunds and colleagues showed that this type of intervention can have an impact on drug use and offending (Edmunds et al. 1999). They found steep reductions in drug use and acquisitive crime amongst those passing through the schemes; six to nine months after contact self-reported expenditure of drugs had reduced from £400 per week to £25. There were similar dramatic reductions in the amount of acquisitive crime also reported. Many (44%) reported that they had not committed any offences, and a further 17 per cent reported a reduced level of offending. Further interviews that were conducted with 50 arrestees 18 to 24 months after contact with the schemes showed that these changes had persisted. It should be noted that as with evaluations of US drug courts, this evaluation had a relatively weak research design; in particular it was not practical to assemble a comparison group.

Edmunds et al. also examined outcomes for a group of offenders in Derby given 1A(6) probation orders. The orders performed well in retaining people in treatment; of 35 probationers referred, 30 were still in or had completed their treatment six to nine months later. Those on the orders also made considerable changes in their drug-using and offending behaviour. Weekly spend on drugs fell from £300 before contact to £25 after contact.

A recently completed study of the work of the Inner London Probation Service considered the impact of probation supervision on drug use and crime six months into the probation order (Hearnden et al., 2000). Of 278 drug using offenders interviewed, most (85%) financed their drug use through crime before arrest, spending an average of £362 per week on drugs. Most (203) reported daily use of heroin. At least six months into a probation order the number reporting heroin use dropped to 138 and weekly spend on drugs fell to £40. Only a third now reported financing their drug use through crime. Excluding offences of drug possession, the median number of crimes committed dropped from 30 to five in the last month. Those subject to conditions of treatment (under 1A(6) orders) showed larger reductions in weekly spend (from £513 to £49) than offenders on orders without extra requirements (£297 to £36).

Our approach to evaluating DTTOs

The research presented here includes both an outcome and process evaluation. The outcome evaluation aims to give an indication of the success of the pilot projects in reducing offenders' drug use and related offending whilst on the order. The process evaluation provides "natural histories" of the pilot sites – how they were set up, how they functioned and how they evolved over time. The process evaluation also provides some pointers as to the sorts of organisational arrangements which work smoothly, and those which run into difficulty.

The overriding aim of the evaluation is to inform the national roll-out of DTTOs. This report attempts to throw light on a number of questions:

- What sort of structures for providing DTTOs are most likely to work?
- What use is best made of testing, enforcement procedures and court reviews?
- What implementation problems can be expected and how can these best be overcome?

We have assembled various datasets:

- a range of monitoring data produced by the pilot sites themselves on the offenders they come into contact with and the work they do with them
- individual interviews and focus groups with those involved in the delivery of DTTOs
- interviews with key professional groups

- interviews with offenders given a DTTO
- activity data from (for the first 12 months in most cases) focus group interviews with the four comparison sites.

These data enabled us to describe the pilot schemes' first 18 months in operation and the progress of offenders given DTTOs. We aimed to interview drug-using offenders on three occasions (4 weeks after the beginning of the order, six months later and on completion or revocation). At the time of writing many drug-using offenders were still on the order (some for less than six months (58)) and therefore had not yet had interim or exit interviews. Nearly half of the orders were revoked, many before interim interview (78). Some we were unable to interview at all because they failed to attend the schemes or stopped attending very early on in their order. The majority of outcome information we provide relates to the period of time when drug-using offenders were participating in DTTOs. We have not gathered information on offenders' progress after completion or revocation of their order. In the future we hope to do a reconviction study. Further details of data collection are at Appendix A.

The structure of this report

Chapter 2 provides a description of the three pilot sites and how they developed over the 18 months of the pilot period; we also offer shorter accounts of the four comparison schemes. Chapter 3 sets out details of the processes by which offenders were recruited to the three pilot schemes (including referral, assessment procedures and acceptance criteria). Chapter 4 describes the projects in operation, giving a fuller account of testing, court reviews and enforcement procedures. Chapter 5 considers the experience of the three pilots, and of the comparison site programmes, in establishing viable partnerships. In Chapters 6 and 7 we present results from our interviews with offenders. Chapter 6 considers their views and experiences of DTTOs and in Chapter 7 we describe changes in drug use and offending. At the end of Chapters 3, 4, 5 and 7 we have included "stock-taking" sections, in which we identify the key issues which need to be addressed for national roll-out, and offer our own views on the best ways of resolving them. The final chapter draws out our overall conclusions and offers learning points.

2: The Pilot and Comparison Schemes

In this chapter we provide descriptions of the pilot schemes and the comparison site programmes. Staffing, the main elements of the intervention and major changes throughout the pilot period are the three key issues covered. These descriptions are based on data from three main sources: material supplied by programme staff; information gathered at team focus groups; and information gathered from team leaders and other partners interviewed on an individual basis.

A large minority of drug-using offenders placed on DTTOs (74 out of 210) attended residential rehabilitation centres as part of their order. For these drug-using offenders, the work of the pilot teams focused primarily on preparing them for residential rehabilitation and organising funding. They had little further contact unless drug-using offenders were discharged early from the rehabilitation centres. Some of those who fared well relocated and had their supervision transferred to other probation services. Table 2.1 shows the main types of treatment received by offenders. The length of time over which individual offenders received these services varied.

Table 2.1: Types of treatment received by offenders

	Croydon	Gloucestershire	Liverpool	TOTAL
Residential rehab	5	49	20	74
Community detox	14	7	14	35
Reduction script	1	45	27	73
Maintenance script	28	0	14	42

The Croydon Pilot Programme

The DTTO team consists of a consultant psychiatrist (0.5 day per week), senior probation officer (1 day per week, increasing to 2.5), psychologist (1 day per week), two registered nurses (full-time), one probation officer (full-time), two probation officers (2.5 days per week) and a specialist group worker (full-time).

In contrast to Liverpool, but in common with Gloucestershire, the Croydon pilot was set up for DTTOs to be made alongside probation orders. The thinking here was to provide a legal basis for offering support over and above that which was narrowly defined as "drug treatment". The probation officers in the DTTO team hold both orders. It is a legal question whether a probation order has to be in place to allow DTTO teams to offer help on accommodation, for example, or employment. Our study cannot address this. However, there are implications about the enforcement of National Standards which are examined later in the report.

Main elements of the intervention

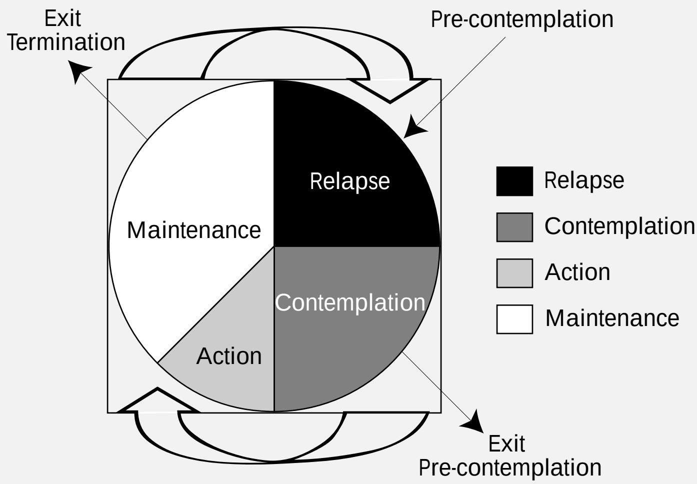
A team member attended court with the drug-using offender when a DTTO was proposed at the sentencing hearing and returned immediately with her/him to the office once an order was made. If time permitted, an initial one-to-one session was held and appointments were set up with the consultant (for prescribing if appropriate), with the psychologist for profiling (mainly as a baseline for evaluation), for urine testing and for further individual work.

Although the probation officer (PO) held both court orders (DTTO and probation), the team operated a system whereby each drug-using offender had a nominated key worker who could be a probation officer or nurse.

Initial one-to-one sessions were aimed at increasing offenders' motivation and resolving practical issues (such as accommodation and benefit problems). Some drug-using offenders on DTTOs went straight to a detoxification (n=14) or residential rehabilitation service (n=5). Detoxification could usually be organised very swiftly within a few days (the same day in some instances). Others had swift access to methadone or other prescription drugs. Many were seen under the supervision of the consultant psychiatrist who provides clinical input for the DTTO team.

Overall an individual package of care was negotiated with the offender. However the guiding philosophy of the programme was consistent with the Prochaska/DiClemente model of change (Prochaska and DiClemente, 1986). This identifies various stages of preparedness to engage in treatment, as outlined in Figure 2.1.

Figure 2.1: Preparedness to engage in treatment



Once the stabilisation took place, the programme remained intensive, with mandatory attendance at five half-day groupwork sessions plus one-to-one appointments and three-weekly urine tests (on a Monday, Wednesday and Friday). The groupwork programme, co-led by Community Drug Project (CDP) and a nurse or PO, included:

- relapse prevention (co-led by CDP + Nurse or PO)
- reasoning and rehabilitation (co-led by CDP + Nurse or PO)
- process support group (co-led by CDP + Nurse or PO).

This was a 12-week programme and all groups were run according to clearly agreed protocols.

Offenders who went to a detoxification service subsequently joined the groupwork programme. Offenders who went to residential rehabilitation were individually assessed as to whether they needed the programme on discharge into the community.

After the initial 12-week programme, offenders were required to attend a ‘Schema’[3] group which focuses on entitlement beliefs and impulse control. This addressed three key issues:

1. substance misuse
2. offending behaviour
3. maintaining attendance at/compliance with DTTO.

3. Schema Therapy is a psychotherapeutic model that integrates elements of cognitive and behaviour therapy, psychoanalysis and interpersonal therapy. It is designed to break lifelong psychological patterns and has been used extensively in the treatment of criminal offenders and relapse prevention for substance abuse.

The Schema group ran for one session per week for 12 weeks.

Following the groupwork programme, keyworkers sought to place offenders with education, training and employment (ETE) advice/placement services or constructive use of leisure organisations. However, the team felt a need to develop this area of work further since current options were limited.

The team identified the programme's main weakness as the lack of a "holding group" for new drug-using offenders. Their experience was that it was disruptive to run a rolling programme, which offenders joined and left as they progressed through their order. The team aimed to move to an arrangement where at any one time there was a core groupwork programme run for a closed group, with newcomers waiting in a holding group. This would enable some motivational enhancement and stabilisation to be done with new drug-using offenders, whilst avoiding constant disruption to the main group, by new members at different stages of motivation joining the programme. Resources did not allow the establishment of the holding group but this was a clear aim and at the time of writing additional resources were being sought for this. The components of a holding group would be:

- lifestyle modification
- managing emotions (including anger)
- offending behaviour work
- monitoring drug use.

These would be delivered in a series of stand-alone interventions which would mean that new drug-using offenders could attend immediately.

Major changes throughout the pilot period

There was relatively little change to the intervention at the Croydon pilot site over the course of the evaluation. The DTTO programme was designed specifically for work with drug-using offenders and the offending behaviour component of the intervention had been in-built from the start.

Towards the end of the pilot period, the team began to refer drug-using offenders on to other groupwork provision once they had completed the core programme. The intention was that this would include women's groups, domestic violence groups and the full range of probation groups available under the 'Pathfinder'[4] programmes.

4. Pathfinders are programmes, identified by previous research, often in other jurisdictions, which use techniques and/or approaches shown to have a strong possibility of reducing re-offending. They are being piloted in a number of probation areas with a view to spreading best practice throughout the Probation Service of England and Wales.

Links with ETE providers grew over the course of the evaluation and the team referred individuals at appropriate points in the order. There was an expectation that drug-using offenders would complete the core groupwork programme first. Arrangements are being made to contract with Prospects (an ETE provider) to provide groupwork sessions as part of the pathfinder programme, and then return offenders to individual action plans at times which match individual need.

The Gloucestershire Pilot Programme

The Gloucestershire DTTO team consisted of a senior probation officer (full-time), three probation officers (full-time), two drugs workers (full-time), two community psychiatric nurses (CPNs – 4 days per week although both these posts were vacant for a considerable amount of time), a GP (3 sessions per week) and an administrator (full-time).

In addition to the pilot DTTO, the team also operated the Drug Arrest Referral Scheme and provided clinical support to a probation and bail hostel. Additional funds were secured for this work.

Main elements of the intervention

This pilot site was beset with difficulties including severe staff shortages. At one stage referrals were suspended for a four week period due to these staff shortages. Here we have described the main elements of the intervention, as set out in the original programme. We have been unable to secure firm information from the team about the extent to which they were able to fulfil their original aims[5]. However it is clear both from our contact with the scheme and from interviews with drug-using offenders that implementation fell far short of plans.

The Gloucestershire team asked the court to make both a DTTO and a probation order. A probation officer in the team held both orders. Initially each case was given a key-worker who could be from any discipline and who was responsible for co-ordinating all aspects of work. Subsequently roles were amended to ensure probation officers were given the case management role for all DTTOs.

In describing the intervention it is important to remember that it was based on a pre-existing programme, the Drug Stabilisation Treatment Project. This programme was designed as a

5. For example, the team were unable to give us any clear idea of the amount of time per week that drug-using offenders had actually spent on the induction and core programmes.

drug-free programme. Positive drug tests were not tolerated after an initial period which was originally two weeks and was extended to between six to eight weeks by the end of the pilot period. A health and medical assessment took place in the first week following sentence and those requiring a prescription could normally receive one within a week to 10 days. Access to in-patient detoxification took a minimum of six weeks.

The intention was that individuals would be seen on a one-to-one basis for the first few weeks until they provided a clean urine sample. On average drug-using offenders were tested twice per week. Tests were done most days. Once drug-using offenders provided clean urine samples, they joined the induction group.

The induction group was to run for five mornings and one afternoon per week for 4 weeks. The group was designed as a rolling programme. There was no set programme but the work included motivational work, lifestyle modification and offending behaviour. In addition there were the following components:

- acupuncture (for first two weeks)
- employment, training and education advice
- sport or other constructive use of leisure time.

Offenders' progress on the induction group was assessed by four main criteria:

- attendance
- participation in group
- clean urine tests
- no disruptive behaviour.

The intention was that if offenders did well, they would move on to a 'core group'. If progress in the induction group was variable, they might redo all or part of the induction group or engage in work on a one-to-one basis. The core group was in the process of being developed by the team when it was halted for lack of staff time. Thus it was only offered to a small proportion of the drug-using offenders who were made subject to DTTOs during the pilot period. The group relied on using exercises and approaches from different sources. Although the exercises were drawn from reputable sources (eg Maguire and Priestly (1995), Ross and Fabiano (1985)), there was no clear protocol for how they were being assembled into 'modules'. The aim was to develop a number of modules which would form part of a rolling programme. Areas which workers envisaged including were:

- reasoning and rehabilitation
- relapse prevention
- assertiveness training
- problem solving
- offending-related work
- self-awareness.

Offenders were required to attend the core group three mornings a week; two sessions consisted of the work identified above, the other session alternated between ETE and sport/constructive use of leisure. Offenders were also required to attend two sessions of the induction group, one of which was sport/constructive use of leisure. This group was designed by probation officers and was therefore mainly run by them.

Major changes throughout the pilot period

As suggested above, major changes were forced upon the Gloucestershire team by staff shortages, particularly of nursing staff. This meant that the overall programme as originally envisaged was never fully implemented, assessed or developed.

However, some changes were made, particularly that of giving drug-using offenders a longer period to become drug-free. Whilst the time allowed for this was extended by four to six weeks, drug-using offenders were still expected to provide consistently clean urine tests much earlier by the end of the pilot than in the other two sites. Over the course of the pilot the team made increasing use of Subutex, Lofexidine and Naltrexone in supporting drug-using offenders to detoxify. The other two teams continued to use mainly methadone.

Drug-using offenders attending residential rehabilitation (49 out of 100) had very limited contact with the DTTO team. They did not participate in the programmes, and visited the project only for the preparation of review reports. DTTO staff monitored the progress of these drug-using offenders and sometimes visited them.

The Liverpool Pilot Programme

The Liverpool DTTO team consisted of five staff including a senior probation officer (2 days per week), two probation officers (full-time), two CPNs and a probation service officer (PSO) (full-time). The PSO post was created near the end of the pilot in October 1999. In addition, there were partnerships with a number of local drug and employment, training and education agencies with which drug-using offenders on DTTOs were placed.

Main elements of the intervention

The Merseyside team requested courts to make free-standing DTTOs, and attempted to have other pre-existing community sentences revoked. Unlike the other two pilot sites, the Merseyside programme was not centred on a groupwork programme, but tailored individual treatment programmes from a range of options, many of them offered by partner agencies.

Drug-using offenders were expected to report to a probation officer the day after sentence. They were also assessed by the CPN in the first week and by the PSO who assessed their suitability for a group and whether they needed to see partner organisations on what the team termed ‘lifestyle’ issues (for example employment, accommodation and benefits). They were also urine tested and could see the programme doctor.

It appeared that there were sometimes delays of over one to two weeks in seeing the doctor. However, some of those given a DTTO were already participating in a bail support scheme run by Mersey Drug Council in partnership with the probation service. For this group prescription of methadone could continue for up to four weeks after sentence, ensuring continuity of prescription.

The central feature of the Merseyside approach was the development of individual programmes for each drug-using offender. However, it proved difficult to get team members to describe who had responsibility for offence-based work or drug treatment work or even which partner organisation was used for what sort of drug-using offender at which part of their order or stage of treatment. There was also no clear expectation on frequency or intensity of contact, although the SPO stated that drug-using offenders were ‘expected to attend something most days’.

A weekly group was introduced at the end of the pilot period (see below) and in addition, a range of other interventions was offered on the basis of need including relapse prevention, acupuncture, reflexology, and other unspecified interventions provided by outside agencies.

Major changes throughout the pilot period

Towards the end of the pilot period, the team was moving towards a system where they concentrated on providing a direct in-house service in the first two months of the order to engage drug-using offenders in treatment and build motivation. This service was mainly provided by the additional PSO who ran a group for half a day once a week. There was no clear philosophy for this group, which offered a range of different interventions ‘according to what the clients are interested in’.

The comparison sites

At the time of the evaluation, a growing number of probation areas had anticipated the DTTO legislation (some by intention, others by convergence of thinking), and had developed programmes similar to the DTTO pilots. We examined four such sites.

PASCO – Cheshire

PASCO (Partnership Action on Substance Misuse and Crime and Offending) in Chester and Warrington had been running for a similar period of time as the pilot DTTO schemes although it had a longer time in development – 18 months. There were seven core members of staff employed across the two sites: two probation officers (funded part-time), two drugs workers (full-time) and additional input from a doctor, a senior probation officer and an assistant chief probation officer. Funding was provided from a number of sources including health, probation, the police and social services.

Drug-using offenders were given 1A(6) probation orders to attend PASCO. Once an order had been made offenders met with the PASCO team as soon as possible. This first session was used to highlight that participating in PASCO was part of a court order. First of all, drug-using offenders were stabilised (generally with methadone but other substitute drugs were also available). This was one of the key objectives in the initial phase. Drug-using offenders usually attended two or three times a week, but treatment was based on individual clinical need rather than a prescribed timetable. Case reviews were conducted weekly and once drug-using offenders were stable most were expected to attend a Day Programme managed by Arch Initiatives. In South Cheshire, where there is no day care provision, PASCO offenders were expected to attend local generic drug services.

The Arch Day Programme ran for 16 weeks. In the first eight weeks sessions involved individual counselling, groupwork, self-esteem workshops, help with accommodation, and ETE work. PASCO offenders were expected to attend 2.5 days per week. After this initial phase a further eight-week programme was provided for half a day a week, focusing on relapse prevention. If appropriate, drug-using offenders were then referred to ‘Next Steps’, an employment and training service. At this stage all PASCO offenders still had regular contact with a keyworker. A mentoring scheme was also offered to PASCO offenders by SOVA[6]. This extra support mechanism was seen as being particularly useful at crisis points.

6. SOVA is a national organisation that seeks to increase the involvement of local communities as volunteers working in crime reduction and offender rehabilitation.

The approach adopted by the scheme remained largely the same during the period of evaluation. The team felt that increasing the level of contact with offenders on the orders would bring benefits. A high level of contact with offenders, it was felt, would help reduce the number of positive urine tests, speed up progress and provide further discipline and structure to offenders' lives. In particular group-work and key-work sessions as well as ETE were seen as important elements of an increased level of service.

The Plymouth and Torbay Fast Track scheme

The Plymouth and Torbay Fast Track scheme had been running since September 1995. Once drug-using offenders had been given a 1A(6) probation order the aim was to stabilise them. Services were provided by Plymouth Community Services NHS Trust and Torbay Drug Services, both of which work to a definition of stabilisation which has been agreed by all partners. These criteria include key outcomes on offending and drug-using behaviour. Both services operated within a harm reduction model and Fast Track offenders were not expected to be drug-free. However, all were expected to make significant lifestyle changes within four months of the probation order being made. It was anticipated that by this point Fast Track offenders would be mostly abstaining from street drugs and not offending.

An individual care plan was drawn up tailored to the needs and circumstances of offenders. These plans were reviewed every three months. Most were prescribed methadone within a week of a 1A(6) order being made. Methadone was used as a vehicle for change – if offenders did not change methadone was discontinued. The average dose was between 60 to 80 mgs a day. The period of time, during which offenders received methadone was variable, depending on how well they were doing. No rapid detoxification was provided unless a drug-using offender had a short drug-using history.

Other interventions were provided to Fast Track offenders including counselling, health screening, Hepatitis B vaccination and psychotherapy. Offenders attended the drug service at least weekly for the first 12 weeks and had regular meetings with probation officers. The exact level of attendance was determined jointly by the courts, probation service and treatment providers. Typically drug-using offenders were expected to have had 18 to 20 contacts with the Fast Track team during the first three months.

Once stabilised drug-using offenders had access to existing probation programmes focusing on housing, employment, offending behaviour and education. During the evaluation period no major changes in the intervention delivered were reported.

The West Yorkshire drug court and STEP programme

Of the three comparison schemes, the West Yorkshire drug court and STEP programme was probably closest to a DTTO, and was designed to anticipate the new order. As with the two other schemes, offenders were required to participate in the programme as a condition of a 1A(6) probation order. In terms of the day-to-day delivery of the intervention, the STEP team consisted of a probation officer (full-time), two criminal justice workers (full-time) and a consultant GP (sessional). The management of the scheme was also multi-agency, being divided between a probation officer, a GP and a drug service manager. Orders were normally made for 12 months and the treatment programme initially comprised three main phases:

- detoxification (4 months)
- stabilisation (6 months)
- aftercare (3 months).

Offenders were expected to progress through these stages, but as the scheme developed it became apparent that a more flexible approach was appropriate allowing offenders to move between phases as and when their treatment required adjusting. During their time on the STEP programme offenders attended various sessions throughout the week including twice weekly urine testing, a clinic appointment, a key worker appointment and probation appointments. Detoxification was initially planned to take place over a 12-week period in which STEP offenders were prescribed drugs on a reduction basis. However, it became evident that there was a need to allow for a longer period for detoxification. Individual and cognitive-behavioural group work was undertaken at services throughout the Wakefield and Pontefract area, as was help with education and employment. These were seen as core components, though staff stressed that there were no 'typical' treatment pathways. A range of therapeutic approaches were incorporated in the treatment package. Failure to keep appointments, failing drug tests and offending whilst on the programme all resulted in offenders being sent back to the drugs court.

An unusual feature of the programme – and one which gives it a claim to be a drug court – was the use of a small group of specially trained magistrates to make the 1A(6) orders and to review cases when they are returned to court. Drug courts operated on specific days each week at both the Wakefield and Pontefract court. All other court personnel were also offered training.

The Hastings Multi-Agency Drug Treatment and Testing Programme

This programme was initiated in 1998 following a report by Sussex police highlighting that, within Sussex, Hastings had one of the highest levels of recorded crime, drug use, and specifically linked domestic burglary and problematic drug use. This scheme was initially set up to operate in both Worthing and Hastings. However by the time fieldwork was under way the Worthing branch no longer operated, having failed for a number of reasons, most notably a lack of referrals. A team of five comprising a probation officer, a criminal justice worker, a groupworker, a nurse and a consultant GP delivered the programme. All staff were funded on a part-time or sessional basis.

A six-month condition of treatment was imposed by the court as part of a probation order. The stated aim of the scheme was to stabilise drug misuse and its associated lifestyle and thereby reduce any drug-related offending behaviour.

Although treatment plans were designed to meet individuals' needs rather than adhere to any prescribed timetable, for most offenders on the order the initial aim was to stabilise their drug use with methadone. At this stage the team aimed to build a relationship with the drug-using offender, requiring a minimum attendance of two days per week for one-to-one sessions and other interventions such as acupuncture and massage. Drug workers then assessed offenders' suitability to join groupwork sessions which were part of the day care programme run by Addaction in Hastings. Groupwork focused on relapse prevention, offence-related behaviour and the promotion of self-awareness. drug-using offenders also had access to a limited range of training courses. Housing problems were particularly severe for drug-using offenders in Hastings, and thus support and assistance on housing was seen as an important part of the scheme's work.

Offenders given this order were required to submit to urine testing at least once a month; however because of limited resources testing was only conducted for the first six months of the scheme's operation. Financial restrictions have also led to the restriction of orders to six months' duration. However, by placing these limits on the length of orders it was felt that offenders were encouraged to make changes and progress more quickly.

Drug workers advised probation officers (who retained responsibility for enforcement) about kept or failed appointments. Three-way meetings between the client, the probation officer and the drugs worker took place on a regular basis throughout the order.

3: Choosing offenders for DTTOs

In this chapter we present information on the referral, assessment and selection processes for DTTOs. Figures cover the period from the start of the pilots until the end of March 2000.

The pool of potential candidates for DTTOs

Pre-Sentence Reports on drug-using offenders provide a useful source of information about the range of possible candidates for DTTOs. They can provide some background information on the types of drug-using offenders the services had contact with, the proposals for sentence offered to the court and the sentence actually passed by the court. We received PSR data from Croydon, Liverpool and Gloucestershire for 1997[7].

South East London

Details were provided on 163 offenders sentenced for whom offending was identified as related to drug use, or whose drug use needed to be addressed in a supervision plan. The majority were male (90%) with an average age of 29 (range from 14 to 59 years) and white (81%). Half of the offenders had no previous custodial experience and many (42%) were identified as having a high risk of re-offending.

For just over half (86), their drug use was identified as being both related to offending and needing to be addressed in a supervision plan. These drug-using offenders were described as ‘hard core’. This group was using a range of drugs but most usually heroin. The most common offences committed were theft and handling stolen goods (31%), drug offences (21%) and burglary (16%). Three-fifths of PSRs recommended either a straight probation order (47) or a probation order with additional requirements (5). A further 29 per cent of proposals made recommendations for either a community service order (8) or a combination order (17). The remaining PSRs proposed either a fine/discharge (2) or some ‘other’ form of disposal (7). The sentences passed by the courts for this ‘hard core’ group tended not to reflect those proposed by the probation service. The courts were more likely to sentence offenders to imprisonment and attach conditions to a probation order. The majority of sentences passed were community based, straight probation orders (23) or with additional requirements (12) and combination orders (12). A custodial sentence was

7. The data described here cover the wider probation areas of which the Croydon and Liverpool pilot sites are part (South East London and Merseyside) and differentiate between drug-using offenders per se and those whose drug use needs to be addressed as a priority.

imposed against one in four drug-using offenders (21). The remaining offenders were sentenced to either a community service order (5), a fine/discharge (3) or some ‘other’ form of disposal (10).

Merseyside

Many more offenders with drug problems were identified in the Merseyside probation area than in South East London – as might be expected in view of the size of the service. In total 656 PSRs identified offending as drug-related. This group of offenders had a mean age of 29 and the majority (94%) were white. While the majority were male (78%) this proportion was lower than in South East London. Most (59%) had previously been to prison. The most common current offence was theft and handling stolen goods (39% – including 114 shoplifting offences). Other common offences included drugs offences (24%) and burglary (10%).

Of the 656 offenders, 426 (65%) were assessed as their offence being drug-inspired or induced and a priority problem. Demographically the latter resembled the larger group of drug-using offenders although slightly more had previous experience of imprisonment (65%). For half (211) the current offence was theft or handling stolen goods, though shoplifting made up half of these (103). Other offences included burglary (14%) and robbery or violent offences (10%). Over half of the recommendations made by the probation service were for probation orders, either a straight probation order (25%) or with additional requirements (31%). Other proposals included community service orders (35), combination orders (45), a fine discharge (11) or some ‘other’ form of penalty (24). Custody was deemed likely for six offenders and in the remaining cases (66) no recommendations were made. Just under two-thirds were remanded on bail during this time, and 32 per cent were remanded in custody. When sentenced just under half (45%) received a custodial sentence, a fifth (21%) were given a probation order and 19 per cent were given a probation order with additional requirements. Of those given additional requirements, 60 were given 1A(2) orders (a requirement to participate in specified activities) and only seven were given 1A(6) orders (a requirement to receive drug or alcohol treatment).

These data show that there is potentially a large pool of offenders in Merseyside who may be susceptible to drug treatment. Many of these offenders were imprisoned. Very few received a probation order with a condition of treatment.

Gloucestershire

Gloucestershire assessed the offending behaviour of 189 offenders sentenced during 1997 as being either drug inspired, induced or defined. The vast majority were male (87%) and just under half (48%) were aged 25 or less. We have no data on the ethnic origin of these offenders. Shoplifting was the most common offence committed (23%), while other prominent offences included burglary (19%) and drugs offences (18%). Sentencing data exists for 146 of these offenders, 43 per cent of whom had received a custodial sentence following their most serious previous conviction.

From this group, the offending behaviour of 134 (71%) was also identified as being a priority problem. Again most of these ‘hard core’ offenders were male (87%), aged 25 or less (49%) and had committed shoplifting (29%), burglary (21%) or theft and handling offences (22%). Three-fifths (60%) of all PSR recommendations made by Gloucestershire probation service were for a straight probation order (11) or for an order with additional requirements attached (68). Data on 118 offenders reveals that upon sentencing half (51%) received a probation order either in isolation (37) or with additional requirements attached (23), while over a third (43) were given a custodial sentence. The courts in Gloucestershire were therefore more likely to sentence drug using offenders with imprisonment or straight probation orders and less likely to follow probation service recommendations for probation orders with additional requirements.

Referral, assessment and selection

Before a DTTO is made, offenders have to pass through a variety of selection processes:

- they have to be referred to the team for assessment
- the team must accept them as appropriate for assessment
- the offender must consent to the DTTO assessment and proposal
- the results of the assessment must indicate that the offender is a suitable candidate
- the court must accept the recommendation of the assessor.

Table 3.1 shows the number of offenders who had passed through the selection process by the end of March 2000. The nature of the process varied across the sites, and there were differences in how selective sites were. Nearly three-quarters of those proposed to the courts were given a DTTO (74% in Croydon, 61% in Liverpool, and 84% in Gloucestershire).

Table 3:1: The selection process [8]

	Croydon		Liverpool		Gloucestershire		Total	
Referred for assessment	125	100%	172	100%	257	100%	554	100%
Accepted for assessment	118	94%	157	91%	239	93%	514	93%
Proposed to court for DTTO	57	46%	112	65%	119	46%	288	52%
DTTO made	42	34%	68	39%	100	39%	210	38%

The length of time between an offender being referred for an assessment and actually being sentenced to, or receiving, a DTTO was broadly similar across the three pilot sites. In both Liverpool and Croydon more than half of the offenders given a DTTO were sentenced within three weeks of being referred for an assessment (with a mean of 4 weeks). In Gloucestershire this process took slightly longer (4 weeks) with a mean of six weeks.

Croydon

Croydon referrals were primarily male (84%). Their average age was 30, with a range of 18 to 51 years. Most (79%) described themselves as white; 12 per cent described themselves as black. Those referred had committed a total of 205 offences including theft (135), burglary (26), assault (6), breach (6), possession with intent to supply (5), handling stolen goods (4), theft from a motor vehicle (2), robbery (2), deception (1) and driving when disqualified (8). The majority of referrals were made by the courts (33), PSR authors (43) and senior probation officers allocating PSRs (48). Although the police passed information to the DTTO team concerning drug-using offenders they were targeting, this was of limited use since the DTTO team were not informed when such offenders were either arrested, charged or appearing before a court.

The Croydon team had the most intensive assessment process, where offenders were offered two assessment interviews. In approximately 60 per cent of cases, both interviews were jointly conducted by probation and nursing staff. The assessment took place within the normal remand period using a specifically designed diagnostic tool.

8. These figures include those offenders who chose not to proceed with a DTTO at various points between referral and sentence stages.

Of the three schemes, Croydon started with the strictest selection criteria, and as a consequence has had the lowest throughput. It originally targeted offenders whose cases were mainly heard at the Crown Court. As a result of this, the scheme struggled in its early days to locate a sufficient flow of candidates. There were insufficient numbers of drug-dependent offenders appearing at the Crown Court who were convicted of offences for which a community penalty was a realistic option; Crown Court cases relating to offences committed on or after 1 October 1998 took longer to work through the system; there was a shortage of offenders appearing at Croydon Crown Court who were resident in Croydon (and therefore eligible for a DTTO); furthermore, many offenders living in Croydon committed offences outside of the Crown Court's jurisdiction (again making them ineligible for a DTTO). A Crown Court focus may also explain why Croydon sentencers were less likely to accept proposals for DTTOs than the other two sites. Over 1999 the project broadened its selection criteria.

As will be discussed below, this low throughput should not necessarily be viewed as a weakness of the scheme, although it has undoubtedly contributed to a slow start. The Croydon team conducted two assessment interviews, undertaken jointly by a probation officer and a nurse. The growing workload occasionally made this difficult, but the team intended to try to continue with the approach.

Of 125 referrals 51 (or 41%) were assessed as unsuitable for a DTTO. The main reasons for not proposing a DTTO included: failing to fulfil primary criteria (either offence committed prior to 1 October, not a Croydon resident or were appearing in a court outside Croydon) (8); not attending for an assessment interview (18); a weak or unacknowledged drug/crime link (10); offences not serious enough (3); mental (5) or physical (1) health reason. Other reasons were mentioned for a further six offenders. Six offenders withheld their consent to undertake the order despite being assessed as suitable. Many of those referred and not proposed for a DTTO when sentenced received a probation order (17) or were imprisoned (15).

The courts rejected 15 of the proposed 57 orders. The majority of orders were made by magistrates (34) with a further eight being made in Crown Courts.

Liverpool

In Liverpool, probation officers preparing PSRs discussed the possibility of a DTTO with the offender and then made telephone contact with one of the probation officers in the DTTO team to discuss the case. If the DTTO probation officer agreed that the offender was a potential candidate, the PSR author requested a further adjournment for one week and the DTTO probation officer invited the offender in for assessment. The assessment interview was carried out by the probation officer alone and offenders were normally interviewed only once. A form which was a combination of an assessment and monitoring instrument was used.

More women were referred to the Liverpool site than elsewhere, making up a third of referrals (34%, n=59). Referrals' ages ranged from 18 to 52, with an average of 30 years. Only four referrals were from minority ethnic groups. The number of current offences committed ranged from one to eleven. The most frequently committed offence was theft (286 offences) followed by breach of a community order (45), burglary (32) and handling stolen goods (24). The majority of referrals (146) came through the PSR system although sentencers themselves sometimes asked for individual defendants to be considered (20 such cases were recorded). Only 15 of those referred did not turn up for an assessment. Nearly two-thirds (112) of those referred by PSR writers were proposed as potential DTTO candidates. A further 15 were assessed as unsuitable and offered an alternative programme or intervention. Eight offenders declined the opportunity of a DTTO. The courts rejected 44 of the 112 proposals for DTTOs. Of those rejected by the court most (36) were imprisoned. The majority of orders were made by magistrates (54), with 13 orders being made in Crown Courts.

Gloucestershire

In Gloucestershire the two main sources of referrals were PSR authors and sentencers requesting individual defendants be considered. However, it is estimated that between 15 and 20 per cent of referrals were triggered by the team through arrest referral work. Drug Arrest Referral Workers identified potential DTTO candidates and passed this information on to PSR authors. drug-using offenders were usually assessed at only one appointment owing to pressures of workload. Early in the pilot, assessments were undertaken by any of the DTTO team. Towards the end of the pilot, assessments were undertaken by a probation officer with the expectation of involvement from a health colleague and/or drug specialist.

Of the 257 referrals made to the Gloucestershire scheme the majority were male (83%) with an average age of 25 years (ranging from 16 to 48 years). Almost all of the referrals were white (93%) with only 4 per cent described as 'other'. Data were missing for the remaining 14 offenders. Collectively they were being prosecuted in relation to 672 offences. The main offence committed was theft (226 offences – 34%), followed by burglary (65 offences – 10%), drugs possession (69 offences – 10%) and breach of a probation order (66 offences – 10%). Just over 80 per cent of those referred were assessed; 30 offenders did not turn up for assessment. Under half (119) were proposed for a DTTO, of which the majority (100) had the order imposed.

Comparison sites

The majority of referrals to the Cheshire PASCO scheme were provided by the court and individual probation officers. The scheme initially expected force medical examiners (police surgeons) and police officers to be the main sources of referrals. However this proved to be a limited source for a number of reasons. In particular the low number of police referrals was attributed to the high turnover and rotation of custody sergeants and their perception that those offenders pleading 'not guilty' were unsuitable for the scheme.

Assessments were undertaken by a drugs worker, probation officer and doctor within four working days of the referral. Although this tripartite assessment procedure was resource-intensive it was seen as essential. Agreement from all assessors was necessary before a drug-using offender was offered by PASCO. There are no accurate data on the number of referrals made to the PASCO scheme (although for the period from January 1999 to March 2000 it was estimated to be about 60). Of those referred, 37 were accepted onto the PASCO programme. Most/all of those presented to the court as a possible recipient of PASCO received the order. The available data indicate that most orders were made by the magistrates' court.

Although initially referrals to and take-up of the scheme were slow, the team believed that as knowledge of PASCO grew so too did the number being referred and assessed. Streamlining and refining the referral and assessment process had also helped.

In Plymouth and Torbay Fast Track, the main route of referral was through the probation service. Early on in the scheme the police were able to flag up cases for probation to consider. However, changes in police personnel meant this route of referrals became less prominent. At the time of writing, it was anticipated that new arrest referral schemes would become a major source of referrals. The probation service carried out an initial assessment of whether the drug-using offender fitted the criteria for referral. These criteria aimed to identify whether drug use was the main causal factor in offending. A full assessment was then carried out within eight working days by a probation officer and a drugs worker. Assessments came to be limited to one a week. The team believed that they would find it easier to target those who would be successful on the scheme. All of those referred at the time of writing were found to be suitable for Fast Track at assessment. Over 100 assessments were carried out each year. In the first nine months of operation 143 drug-using offenders were assessed, 85 of whom were accepted on to the programme. However only 61 actually started the programme.

In the West Yorkshire drug court and STEP programme, potential drug-using offenders were initially identified at the arrest stage of the criminal justice process. Custody sergeants and arrest referral workers, using a screening checklist developed by STEP, ascertained whether a drugs/crime link existed. If so, the Custody Sergeant or arrest referral worker then made a referral to STEP. Visits to custody suites were also made by STEP project staff on a daily basis. The screening checklist was also used by magistrates and court clerks. This meant that the drugs/crime link was established prior to the PSR stage.

Initially the STEP team aimed to undertake assessment within 24 hours of receiving the referral. However, they changed this, aiming to achieve assessment within five working days. This process included an assessment of drug-using and offending behaviour, physical and mental health, personality and motivation. At this point information about the scheme, its requirements and demands were provided to drug-using offenders. Contact with the STEP programme was voluntary at this point and a one-day a week clinic was offered to potential clients. The process of assessment continued for a further four weeks. A three-tier assessment procedure operated involving the GP, STEP staff and probation officers. This period of time was used to judge motivation and levels of attendance. No prescribing of substitute drugs took place until an order had been made by the court. Offenders were expected to comply with drug testing during the assessment period.

The team believed they had a rigorous assessment process in place, having continually developed and refined it over the last two years. However the assessment relied heavily upon professional judgement rather than validated measures.

From June 1998 to May 1999 360 offenders were referred. The majority (278, 77%) came through the arrest referral scheme. In order to facilitate the identification of potential cases custody staff were provided with a screening checklist, which meant that most offenders with a drug/crime link were referred to STEP. A further screening exercise was undertaken by STEP staff before a full assessment was offered. Many of those referred via the arrest referral scheme were considered unsuitable to undertake a DTTO assessment and were referred to other treatment options. We currently do not have an overview of the numbers assessed. However, in the first 12 months 65 drug-using offenders were given a 1A(6) order to attend STEP. Most were referred via the police (47%), others accessed the programme via the drug court (28%) and the probation service (13%). (However since October 1999 the majority of referrals are made by the courts following the introduction of the Narey Fast Track Courts.) The majority were male (55) aged between 21 and 30 years old (46). All were white.

In Hastings most referrals made to the programme were by probation staff, although a number of referrals were made by the police, arrest referral workers, court staff and the prison service. The team also received criminal intelligence information from the police liaison officer to ‘flag up’ potential clients. As a result the team believed it had a good knowledge of who offenders were and who should be on the programme. Of the 57 referrals made during 1999, 58 per cent (33) were made by probation officers. Of those referred, 46 (81%) were assessed.

Initially a probation officer undertook a court assessment. This was then followed by an assessment by the drugs worker in order to gauge the drug-using offenders suitability for the programme. Finally a GP undertook a clinical assessment and carried out a urine test. Primarily the assessment process aimed to identify evidence of motivation to change. Substitute drugs were often available to offenders on the same day the clinical assessment was undertaken. The team aimed to stabilise drug-using offenders immediately and sometimes introduce them to the day programme prior to their court appearance. They believed that if progress had been made by drug-using offenders during this time courts would be more reluctant to undo the work already done.

Criteria for acceptance

Similar criteria for proposing offenders for DTTOs were presented by all three pilot sites. Across the three sites, 44 percent of those accepted for assessment were rejected as unsuitable for a DTTO. In Gloucestershire and Croydon the figure was just over a half, as opposed to around a third in Liverpool. Assessments were expensive, and those which ended up rejecting offenders were, in a sense, wasted; they may also have imposed (non-financial) costs on the offender. There may thus be scope in all three sites to screen out a larger proportion of inappropriate referrals in advance of assessment interviews.

Similarly there may be scope to reduce the rate at which courts reject proposals for DTTOs. A much greater proportion of those proposed by the Liverpool team were rejected by the courts (39%) than in Gloucestershire (16%) and Croydon (26%). We cannot say whether the Liverpool team was more inclusive than the other two in their proposals, or whether the Liverpool courts were more exclusive. But there are obvious advantages in minimising the courts’ rejection rates.

Criteria against which offenders were commonly assessed were:

- motivation (this was considered the most important criterion, but was seen as very difficult to assess)
- previous treatment history (acceptance of drug use as a problem was seen as a positive indicator)

- stability/home environment (stable accommodation was seen as an important issue by the pilot sites)
- tariff (seriousness and volume/pattern of offending)
- age (one pilot area had come to the conclusion that those aged over 25 seem to do best)
- levels of 'community support' available to the individual (i.e. housing, employment, family, friends and partners).

All three teams shared the view that on the whole they would be prepared to offer the DTTO programme to any offender who fitted the criteria and expressed motivation. Over the period of the pilot the Croydon site became less selective owing to the low number of referrals. The Gloucestershire team tightened their acceptance criteria to concentrate on more serious drug-using offenders with more established offending histories. This was achieved predominantly by targeting those appearing at Crown Court. The Merseyside team reported that they were able to be more discriminating owing to two main factors. Firstly the high level of referrals and secondly the Merseyside probation service continued to offer a probation order with a 1A(2) condition to attend treatment. The team continued to recommend this disposal for drug-using offenders who appeared to be less motivated or whom they assessed as likely to struggle to meet the commitments of the more intensive DTTO.

All the teams stated that assessing motivation was very difficult when drug-using offenders were facing a court appearance which could result in a custodial sentence. Both Croydon and Merseyside were developing forms of assessment for those remanded in custody.

Comparison sites

Acceptance criteria within comparison sites varied also. In Plymouth and Torbay those who committed domestic burglary were targeted (about 40 per cent of Fast Track offenders to date). Whether or not the offence was burglary, it had to be of sufficient seriousness for the offender to qualify for Fast Track. No assessment of offenders' motivation was undertaken.

A review of the West Yorkshire drug court and STEP programme made the point that de-selection criteria operate rather than selection so who exactly is targeted became less clear (Brown, 2000). In the absence of selection criteria, the reviewer argued there was a real risk that the STEP programme could become overloaded. With this in mind STEP now target those who commit serious and high volume offenders.

PASCO in Cheshire was aimed at opiate users who presented a high risk of re-offending. Volume of offending as well as seriousness of offence was also considered. Shoplifters were seen as an important group to reach because it was seen by offenders as being an easier, quicker and comparatively less risky method of raising resources than other forms of crime.

The Hastings Multi-agency Drug Treatment and Testing Programme reported that they had clear criteria for acceptance. They only accepted chaotic polydrug users with an average LSI–R score of 30[9]. Almost all would have failed previous treatment experiences.

Details of orders made

In Croydon most of those given DTTOs (37) also had a probation order which ran concurrently. Only five offenders had a probation order for a longer period of time than the DTTO. Five offenders were given a stand-alone DTTO. Orders were imposed for between six months and three years, but on average for 12 months. More specifically orders were made for six months (1), 12 months (21), 14 months (1), 18 months (15), 24 months (3) and 36 months (1). All were required to be tested three times per week and review hearings were either every four or six-weeks. Most (38) were expected to attend a two-stage treatment programme (described in Chapter 2).

In Liverpool the majority of orders were made for 12 months (60). Only two offenders were also given a concurrent probation order. Virtually all orders made specified treatment as directed by Liverpool Probation Service (74), a minimum of two tests per month and monthly review hearings.

In Gloucestershire, most orders specified community-based treatment at the in-house DTTO programme (43). Twenty-two orders specified residential treatment. Various testing requirements were made. Twice-weekly testing was proposed for most (39), once-weekly for 26 offenders and three times a week for nine offenders. Most orders were made for 12 months (94), and 95 had parallel probation orders.

Comparison sites

Of the 36 drug-using offenders on the Cheshire programme most (25) were given a 12-month probation order to attend PASCO. Sentences were also passed for six months (4), nine months (1), 18 months (4) and 24 months (4). No requirements were made for urine testing or reviews.

9. LSI-R is an assessment technique which assesses both risk of re-offending and “criminogenic need”. The score combines both elements (cf Andrews and Bonta, 1995). 30 is a relatively high score.

Currently we do not have full sentence information on all Fast Track offenders.

Those participating in the first year of the West Yorkshire initiative mostly received orders of 12 months' duration (75%). Seventeen per cent got two-year orders and eight per cent 18-month orders. All were required to comply with the STEP programme, urine testing with a minimum of twice a week and monthly court reviews.

All of those participating (between January 1999 and February 2000) in the Hastings programme (34) were given a probation order with a condition to attend the Multi-Agency Drug Testing and Treatment Programme. While the treatment aspect only lasted for six months most drug-using offenders received a 12-month probation order (15). Others received probation orders for six months (2), 18 months (6) and 24 months (8). Sentence data were missing for three offenders.

Profile of those given DTTOs

Of the 210 drug-using offenders given DTTOs, nearly three-quarters were male (74%; n=155). The majority, were white; only 14 orders were made on black offenders. They had a mean age of 28 years. In total they had been sentenced for 623 offences, an average of three offences each. The most common offence was theft (35% – 221 offences).

Stock-taking

In the early stages of the pilot all three sites struggled to produce candidates for DTTOs. Numbers picked up in the first quarter of 1999 in Liverpool and Gloucestershire, and in the second quarter of the year in Croydon. Similar slow starts occurred in the comparison sites. The main lesson for national roll-out is that things will get off to a slow start. Those projects which put most effort into pre-planning and programme development may indeed show slower progress than others, to start with. In the long term, investing heavily in preparation and partnership-building may prove an economy.

We are now quite optimistic that once firmly established, teams on the scale of the three pilot sites should be able to achieve a throughput of approaching 80 to 100 orders a year. If one team were established per probation area, this would imply an eventual throughput of over 5,000 cases a year. The figure would be higher if several teams were established in each of the larger metropolitan probation services. A proportion of these offenders would simply substitute for those previously given 1(A)6 and 1(A)2 probation orders, of which 2,277 were made in 1997.

Key decisions that probation areas will need to make in designing the selection process for DTTOs relate to how far they should cast their net in trawling for possible candidates, and how selective they should be in selecting candidates to propose to the courts from those who are netted by the referral process.

The purpose of the selection process is to ensure that available treatment resources are targeted on those who will show greatest reductions in drug use and therefore offending. Whilst the criteria applied by the sites in assessing candidates were geared to this, an important part of the process takes place earlier when, for example, PSR writers decide whether or not to refer, and when the team decides whether or not to accept the referral for assessment. It may be worth investing care and effort in ensuring that these parts of the process work as well as the formal assessment procedure. Given the pre-DTTO PSR data and the constraints placed on the pilot schemes it appears that there is a good level of awareness among PSR writers.

In two of the pilot sites (Croydon and Liverpool) to date there has been limited use of the police and arrest referral schemes as referral points. When utilised these referral points have led to better targeting of known drug-using offenders. There are obvious advantages to this, in ensuring that fewer people “slip through the net”. It may also have a spin-off benefit of improving the quality of police/probation partnerships. For this to occur it is important for DTTO teams to have close liaison with the police (divisional intelligence units in particular) and arrest referral schemes in order that information can be passed on when drug-using offenders are arrested.

DTTOs will obviously be closely monitored when rolled out nationally. This will impose some pressure on DTTO teams to ensure that they perform well. One possible perverse effect of this process may be that teams “cherry pick” only those people who are very likely to show good progress. Any team who wanted to ensure that they met performance targets would do well to ensure that they selected only those offenders who were:

- in their late 20s or older
- fed up with being drug-dependent
- highly motivated to change
- good community support (housing, partner, employment etc).

Whilst such offenders are likely to have good outcomes, it is possible that projects will achieve more in the long term by working with less tractable offenders. Put simply, helping one in three 20-year-old users to control their drug use is a more valuable achievement than helping two in three 30-year-olds do so; the latter are much nearer the natural end of their drug-using careers. The former are obviously a much more challenging group to work with than the latter, and expectations of success rates would need to be adjusted to take this into account.

Those who were referred, assessed and selected for a DTTO generally reflected the existing caseload of drug-using offenders in the pilot site areas. To date little attention has been paid to the potential needs of specific groups of offenders. In particular women, young and black offenders' needs will have to be considered more closely if DTTOs are to be offered as a realistic option to these groups.

The marked variation in the quality and intensity of assessments is cause for concern. It is perhaps surprising that the expertise of health and drug workers was not routinely enlisted in the assessment process in two of the pilot sites. The health and drug workers at both sites felt that the quality of assessment was adversely affected by being led by staff whose primary experience was in the offending rather than drug misuse sphere. Most of the non-pilot sites viewed joint assessment as helping to underpin their work with offenders and partnership between agencies. As we shall draw attention to later, the exclusion of health and drug workers at this initial point contributed to inter-agency difficulties in two of the pilot sites. We feel there should be an expectation that nursing/drug work staff are involved in the initial assessment process and consideration be given to the development of a national tool for assessing drug-using offenders for DTTOs.

4: Testing, Reviews and Enforcement

In this chapter we describe urine testing (regularity, results and action taken), court reviews (number, regularity, results and outcome) and breach proceedings. When reviewing these data it should be borne in mind that the three sites had very different expectations of drug-using offenders. For example in Croydon offenders are expected to attend the programme every weekday for the first 12 weeks whereas in the other two sites the intervention is much less intensive. Also only partial information has been provided by the Gloucestershire team.

Testing

As its name suggested a key feature of the DTTO was a drug testing requirement. The testing requirement was stated in each order, which specified for each month the minimum number of occasions on which tests were required; provided that this minimum was observed, the frequency and manner of testing was left up to the treatment provider. It also suggested that it would not be sensible to test offenders more than once every three days.

The legislation and the Home Office guidance made it clear that testing should be considered as an element of the treatment process, and that decisions about positive tests should be taken in the light of the offender's progress. While the Act required that the offender provide samples for testing, it did not specify any particular action to be taken if tests were positive. The guidance suggested that treatment should continue despite the occasional failed test. However, it also suggested that a second failed test for an index drug should always lead to a formal consideration of breach action by the treatment provider and supervising probation officer. If it was decided not to proceed with the breach action the decision had to be confirmed by a senior probation officer and the reason recorded. The same procedure was to be followed for any subsequent failed test.

If the guidance suggested a degree of flexibility about positive tests, it was very clear that refusal to provide a sample should always be interpreted as a wilful failure to comply with the conditions of the order. It advised that every effort should be made to persuade the offender that a failed test was likely to have less severe consequences than refusal to provide a sample; continued refusal would result in the immediate initiation of enforcement action.

Urine testing practices varied considerably between the pilot sites. In the early stage of the pilot the Gloucestershire team expected those on DTTOs both to be drug-free within the first two weeks of being placed on an order (using no drugs apart from prescribed methadone) and to maintain that status throughout the order. Testing clean was initially a condition of the groupwork programme. During the course of the pilot the team reviewed this requirement and by October 1999 offenders were expected to be drug-free in six weeks or demonstrating clear signs of moving towards abstinence. Although occasional lapses were expected by the team, drug-using offenders were expected to return to an abstinent lifestyle swiftly. By contrast the Croydon and Liverpool teams expected those on DTTOs to make progress towards being drug-free but did not expect them to be drug-free within a specific period of time.

The frequency with which urine tests were undertaken also varied between sites. Croydon administered tests three times a week, throughout the order. Whilst nursing staff took the vast majority of urine tests in Croydon, probation staff occasionally did so. Gloucestershire initially averaged two urine tests a week. However shortages of healthcare staff meant that this had to be reduced. As a short-term measure, pending the recruitment of nursing staff, the SPO was conducting most of the tests. The Liverpool team initially tested much less often, running at three or four tests in the first month and two or three a month thereafter. This was later increased to ‘about once per week’ with the CPNs doing all the tests.

Thus the majority view across the pilots was that, on the one hand, twice weekly testing for the first months of an order was an appropriate level but, on the other hand, more frequent testing than this was expensive and mainly redundant.

Before administering the test, DTTO staff asked drug-using offenders if they had used drugs. It was not uncommon for drug-using offenders to admit to drug use, in which case staff recorded a positive result without testing, in order to save money. Croydon was the only site where urine sample giving was observed routinely. Observation was frequently undertaken in Gloucestershire, although there was emphasis on an offender being observed if falsification of a sample was suspected. Of the comparison sites only the STEP programme routinely observed the provision of urine samples. The Hastings programme had no facilities for supervised testing; PASCO and Fast Track occasionally observed the provision of urine samples.

The main views amongst staff about the DTTO drug testing requirement were that:

- tests worked well in reinforcing good progress
- frequent testing was expensive and pointless for those who continued to use drugs
- tests were very destructive to the motivation of those who were reducing drug use considerably but were continuing to test positive (the tests did not show the amount of drugs used)
- tests were crude instruments, which did not reflect different patterns of use (e.g. daily opiate use versus binge crack use; type of cocaine used (crack versus powder); illicit methadone use).

Sentencers, both judges and magistrates, regarded urine testing as vital. They reported it gave them the confidence to make DTTOs on many defendants for whom they would normally have passed a custodial sentence. There was a wide range of views amongst sentencers about how quickly drug-using offenders should be producing clean urine tests. Whilst many stated that they expected drug-using offenders to be testing clean within the first month, others expected progress to be slow and to involve lapses. However, once drug-using offenders had completed between four to six months of the order, sentencers were often setting targets of clean urine tests for those who had not yet achieved this.

We have data on 2,555 tests which had been carried out by the end of March on 173 drug-using offenders. In Liverpool and Croydon, tests screened for all common illicit drugs, except cannabis, and for methadone. The Gloucestershire team was more selective. While nearly all samples were screened for opiates (93%), just under half (49%) were screened for cocaine, 64 per cent methadone, 43 per cent benzodiazepines and 39 per cent amphetamines.

The average number of tests per offender was 14.7, but there were large variations between sites. Just over half (53%) were conducted at the Croydon site, with the number of tests undertaken ranging from two to 139, an average of 34.9 tests per offender. In Liverpool the 58 DTTO offenders were tested between one and 26 times, averaging 9.8 tests each. In Gloucestershire 76 offenders were tested between one and 36 times, with an average of eight times each. Table 4.1 shows the results of urine tests by site. Obviously the test for methadone cannot differentiate between licit and illicit use.

Table 4.1: Proportion of urine tests proving positive, by end of March 2000

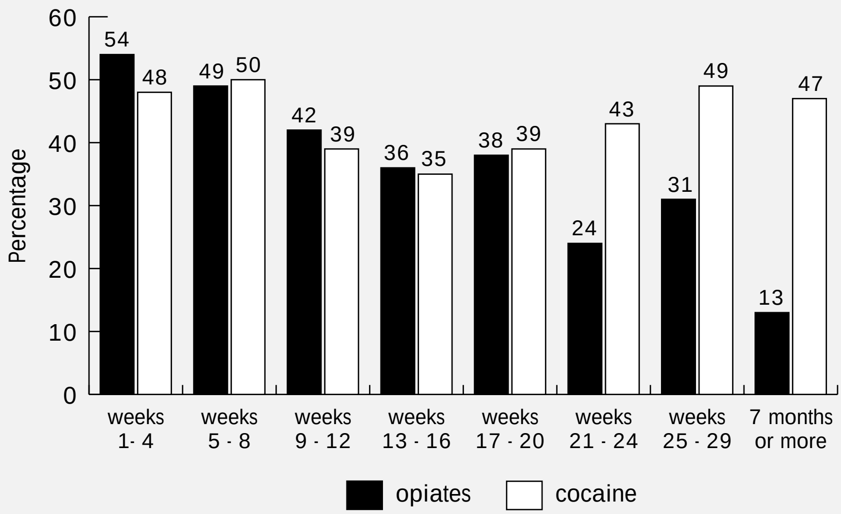
Site	Opiates (excl. methadone)	Methadone[1]	Cocaine[2]	Amphet-amine	Benzo-diazepines
Croydon (1,364 tests)	34%	57%	53%	2%	13%
Gloucestershire (624 tests)	40%	53%	18%	5%	29%
Liverpool (567 tests)	63%	64%	39%	3%	15%
TOTAL (2,555 tests)	42%	58%	45%	2%	15%

1 Includes licit and illicit use.
2. Urine tests do not distinguish between crack cocaine and cocaine powder. Therefore, the term 'cocaine' is used in the report to cover both types of drug.

Most drug-using offenders (59%) produced at least one test which was negative for opiates, cocaine and amphetamine. In Croydon 32 drug-using offenders had at least one negative test for drugs other than benzodiazepines and methadone. The total number of negative tests was 502, ranging from one to 76 negative tests per offender (mean of 15.7). In Gloucestershire 134 negative test results were recorded for 43 offenders, a mean of three, per drug using offender. In Liverpool 31 offenders gave at least one urine test that was free of drugs other than benzodiazepines and methadone during the pilot period. There were a total of 183 negative tests ranging from one to 20 per offender, with a mean of 5.9.

Figure 4.1 shows the percentage of urine tests which were positive for opiates or cocaine over time. Care should be taken when interpreting this figure since the number of test results and number of drug-using offenders tested changes considerably in each of the four-week periods reported. Further, the number of drug-using offenders with positive tests also changes throughout. A fuller description of these data (as well as a breakdown by pilot site) is provided in Appendix B. Given these caveats it is clear that as drug-using offenders continue on a DTTO the rate testing positive for opiates decreases. However the impact on cocaine use appears to be less clear.

Figure 4.1: Positive opiate and cocaine tests over time: all 3 pilot sites



Comparison sites

We have been able to gather some urine test information from three of the four comparison sites. Table 4.2 shows the test results; however the time period over which the tests were undertaken and the frequency of testing both vary considerably.

For clients of the PASCO programme urine testing was clinically determined. Frequency of testing therefore depended on offenders' stability and needs. Testing costs also prohibited more frequent testing. Some tests were observed. The team reported that testing generally took place on a monthly basis unless an offender admitted use. The results reported in the table relate to 30 of the 37 offenders given the order between January 1999 and March 2000 where testing data were available. Ninety-six tests were carried out with a mean of 3.2 (a range of 1 to 9 per offender).

Table 4.2: Proportion of urine tests proving positive at comparison sites

Site	Opiates (excl. methadone)	Methadone[1]	Cocaine[2]	Amphet-amine	Benzo-Diazepines
PASCO (96 tests)	39%	58%	19%	8%	32%
Hastings (97 tests)	88%	70%	25%	23%	70%
STEP (1,891 tests)	31%	53%	1%	3%	8%

1. Includes licit and illicit use.
2. Urine tests do not distinguish between crack cocaine and cocaine powder. Therefore, the term 'cocaine' in the report covers both types of drug.

Funding problems during 1999 meant that frequency of testing at the Hastings programme was reduced from once a week after six months to once a month. The scheme had no facilities for supervised urine testing. Testing was used for treatment purposes, being regarded as an important counselling and motivational tool. Offenders were expected to make changes in their 'lifestyle' and were allowed to continue to use drugs albeit at a reduced level. Twenty offenders were tested a total of 97 times.

The West Yorkshire STEP programme had the strictest testing regime of all of the schemes we looked at. Drug-using offenders were urine tested twice-weekly and at random intervals in between, and all test were observed. Those testing positive received a warning. Two consecutive positive tests led to a prescription being withdrawn, which was then reviewed within four weeks. In the period between June 1998 and May 1999, a total of 1,891 tests were conducted, with the highest number of recorded tests for an individual being 54. In terms of the volume of tests undertaken, the STEP programme and Croydon DTTO pilot were similar. These sites' test results show similar levels of being positive for opiates and methadone, but Croydon has a much higher rate of positive tests for cocaine.

The Plymouth and Torbay Fast Track programme carried out weekly tests in the initial weeks of an order. Following this, testing was then undertaken every three months in Plymouth and monthly in Torbay. Test results were not made available to either the probation service or the courts on a formal level. If an offender gave a positive urine sample then the frequency of testing was increased. Observed tests were not the norm but were undertaken following a suspicion that an offender may be falsifying a sample. Unfortunately, we do not have any test results for the scheme.

Enforcement

In all three sites offenders quite often failed to meet the conditions of the order. The main forms of non-compliance were failure to attend, and failed urine tests.[10] All three sites had procedures in place to respond to offenders' non-compliance. In general there was a graduated hierarchy of sanctions, from verbal warning to written warning to breach proceedings. Breach proceedings did not necessarily result in revocation of the order. These sanctions were combined with variations to the offender's treatment programme in different ways. In some situations, notably in Gloucestershire, failure of urine tests could result in suspension from the treatment programme until tests were clean. Sometimes, non-compliance could result in offenders re-taking earlier components of the programme.

Table 4.3 summarises warnings, breaches and revocations for the three pilot sites until March 2000. Also 30 breaches were pending at this point. Further warnings, breaches and revocations are likely to occur as offenders continue with their DTTO. In total 46 per cent of orders were revoked, but there were wide variations between the sites. Liverpool had the lowest rate, at around a quarter; Gloucestershire's rate was more than twice this, at 60 per cent.

Table 4.3: Enforcement processes – figures until 31 March 2000

	Croydon	Liverpool	Gloucestershire
DTTO made	42	68	100
No. of offenders warned verbally	18	10	21
No. of offenders warned in writing	30	10	23
No. of offenders breached	28	29	63
No. of revocations	17	19	60
% of orders revoked	40%	28%	60%

10. Strictly speaking it was not necessarily a breach of the order's conditions to fail the test – the requirement was to submit to testing with a view to the reduction or elimination of dependent drug use.

For drug-using offenders whose orders were revoked (96) the mean length of time on the order was four months (ranging from 0 to 11 months) (see Table 4.4 for further details). The majority (85%) of drug-using offenders whose orders were revoked within three months participated in the Gloucestershire pilot. In Gloucestershire the mean length of time on an order before revocation was 3.7 months, in Croydon five months and Liverpool six months. However given the problems with the speed of the revocation process, described in more detail below, most would have participated in the programme for much less than this. It is clear that the majority of revocations occurred soon after the order was made. This points to two areas that require further consideration by the pilot sites. Firstly further refinement of the assessment and selection process to enable a more accurate identification of those likely to continue with the order. Secondly specific strategies are needed to engage and retain drug-using offenders in the early stages of the order.

It is not possible to identify those factors (from a whole range which may have had an influence) which led to the higher revocation rate in Gloucestershire. However, an important influence is likely to have been the speed at which drug-using offenders were expected to be drug free. Although a positive test for drugs was not used in isolation as a reason for breach or revocation, non-participation in the programme was. The expectation to be drug-free within a short space of time is likely to have affected the ability and willingness of drug-using offenders to participate in the programme.

Table 4.4: Length of revoked orders

	Weeks 0 - 4	Weeks 5 - 8	Weeks 9 - 12	Weeks 13 -16	Weeks 17 - 20	Weeks 21 - 24	Weeks 25 - 29	Weeks 30 +	Total
Croydon	2		1	2	3	2	4	3	17
Gloucestershire	4	6	12	6	14	8	3	7	60
Liverpool			1	3	2	3	5	5	19
TOTAL	6	6	14	11	19	13	12	15	96

All three teams found it quite difficult to give precise definitions of breach criteria. They were conscious of balancing the needs of strict enforcement of a group of serious and prolific offenders with the knowledge that overcoming drug addiction is a difficult process which routinely involves relapse. Overall, however, offenders were generally breached for non-attendance or escalating drug use, as shown by tests or other evidence.

All the teams were happy with a strict enforcement policy and generally health and drug work staff were fully aware of the needs of the criminal justice system. This was reflected in interviews with sentencers who felt that although they did not always place offenders recommended for DTTOs on the order, once offenders were on the order, breach was recommended appropriately.

However, there were concerns amongst staff about National Standards and adopting an equitable enforcement procedure. In some of the pilots drug-using offenders were regularly expected to attend eight or more appointments per week. Teams felt that such requirements were much stricter than those usually contained in a probation order, and placed offenders at much greater risk of failure. They felt that it was unfair to breach a DTTO offender who had missed only two or three appointments out of 60 or more over a two-month period. Again, offenders sometimes made good progress, but then relapsed; they might miss all appointments for three days. Under such circumstances teams were more concerned to resolve the issues leading to the relapse and to build on previous progress than to breach the offender.

Despite these difficulties, teams discovered that initially difficult decisions about breaching often resolved themselves when it became clear that the offender in question was unable either to reduce their drug use or to cope with the intensity of the intervention. In such cases the number of failures to comply with requirements built up rapidly, and breach procedures were swiftly initiated. The high revocation rate is clear evidence of this.

For offenders who had significantly reduced their drug use and associated crime, the impetus was to continue to work with them but to set firm boundaries. Sanctions used included final warnings from probation staff and sentencers at court reviews. On occasions, teams would institute breach proceedings but, provided a drug-using offender responded well, would propose to the court that the DTTO be allowed to continue.

In Liverpool, the available data indicated that of the 68 offenders on a DTTO, two-thirds missed at least one appointment. Just over half (34) missed two or more appointments. However, only 37 per cent of all missed appointments were deemed unacceptable. Breach action was initiated against 29 drug-using offenders. For the majority (27) this was because they had not kept appointments. Probation officers recommended that most of these orders (15) should be revoked. Of the 19 orders revoked in Liverpool, 18 offenders were re-sentenced to imprisonment. One offender was fined and allowed to continue on the order.

In Gloucestershire the team mainly adhered to a 'three strikes and you're out' approach. The three failures could be made up of failures to attend, or dirty urine samples, or both. Unfortunately the records of warnings and absences were incomplete so the following figures must be treated with caution. However they suggest that there were 88 warnings issued to 32 drug-using offenders. Many were verbal warnings (41) but written (34) and final written warnings (13) were also issued. There were no overall data for missed appointments in Gloucestershire. Breach proceedings were initiated against 63 offenders. The most common reason given for instigating breach proceedings was failing to keep appointment. Other reasons included non-compliance, leaving residential rehabilitation prematurely, continued drug use and poor motivation. We have re-sentencing data on 39 of the 60 offenders whose orders were revoked. The majority were re-sentenced to imprisonment ranging from two to 55 months. Seven received community penalties (6 got probation orders, 2 with 1A(2) conditions attached, and 1 was sentenced to a community service order).

In Croydon 86 per cent of offenders (36) missed a total of 454 appointments (a mean of 12.6 each). This apparently high rate reflected the relatively high number of appointments which offenders were required to keep. Just under a quarter of all missed absences were acceptable. Thirty-four drug-using offenders received a formal warning. A total of 81 such warnings were issued, most were first or final written warnings (56). Most formal warnings were issued following missed appointments (66). Breach action was initiated against 28 drug-using offenders; in seven of these cases offenders were breached, permitted to continue on the order and then breached a second time. Most breaches resulted from poor attendance. Breach reports contained a variety of recommendations including revocation (9), re-assessment at the next review hearing (8), order to continue (3), custodial sentence (1), psychiatric assessment to be undertaken (1) and a fine to be imposed (1). Seventeen orders were revoked in Croydon, of which 12 were re-sentenced to imprisonment ranging from two to four months.

Sentencers at the Crown Court and magistrates' courts in all three pilot sites reported difficulties with the breach process and varying interpretations of the law. Different views included:

- Several judges in Merseyside shared the view that 'there is at the moment no sanction that the Crown Court has to direct attendance and/or to issue a warrant in the event of non-attendance'[11] at a review hearing. In the view of sentencers and the local DTTO team, this situation meant that many Crown Court judges were reluctant to make DTTOs. By contrast a judge in Croydon

11. Personal correspondence HH Judge Elizabeth Steel DL

stated that he had taken the view that he could remand a drug-using offender in custody if s/he was to be breached.

- Stipendiary magistrates in Merseyside stated that they did not have the power to revoke an order at a review hearing. They stated that they normally left breach matters up to the probation service, occasionally announcing in open court that they felt the probation service should breach a drug-using offender, but not then knowing if this was done.
- The same magistrates felt that the probation service were inefficient at prosecuting breaches and often brought inadequate paperwork to court.

The breach process, particularly for Crown Court orders, was seen by all the teams, but the Gloucestershire one in particular, to be cumbersome, time-consuming and bureaucratic. There was felt to be considerable duplication in producing the information, the Summons, the Statement of Facts and the Breach Report.

In all cases, judges' lack of powers in particular had a negative impact on the effectiveness of DTTOs – failure to comply was not being followed up swiftly owing, mainly, to the perception that the relevant legislation had been inadequately drafted.

The Gloucestershire and Merseyside teams had problems with the execution of warrants. By contrast, the Croydon team felt that warrants were executed promptly and efficiently. The Chief Inspector responsible had instituted a fast-tracking system. As soon as a warrant for breach proceedings had been issued, the DTTO manager informed the divisional intelligence unit and steps were taken to arrest them immediately. This was sometimes done via liaison with the local pharmacy where the drug-using offender picked up his/her prescription. The police considered drug-using offenders whose DTTOs were revoked to be a high target group because they knew that many drug-using offenders in this situation went on a spree of offending in the knowledge that they faced an almost certain custodial sentence when arrested. Therefore the swift execution of warrants met the objectives both of the police service and DTTO teams.

Comparison sites

In Cheshire breach proceedings were based on a combination of factors: positive urine tests, lack of motivation and failure to attend. However, revocation only followed non-compliance with the day-care programme or missed appointments with the Community Drug Team. An application for the order to be revoked was made after three missed appointments. The probation officer and drug treatment worker jointly decided on whether to initiate breach proceedings. Actually revoking an order appeared to have given the police more confidence in the enforcement element of the PASCO scheme. Between January 1999 and March 2000 there were a total of 850 probation appointments with drug-using offenders. Of these 687 were kept; of the 163 missed appointments, a quarter (40) were deemed unacceptable. Twenty-two first warning letters and 11 final warning letters were issued during this period. Breach proceedings were initiated on six separate occasions, and three orders were revoked.

Within the Fast Track programme breach proceedings could be initiated by either health or probation workers. If Fast Track offenders in Plymouth were not turning up at treatment services or appointments with the probation service (to National Standard level), or if they failed to provide a urine sample, they were breached. However, if offenders were maintaining contact with the treatment service and not probation, the latter might try to persuade the judge to let the drug-using offender continue with the order. This was not the case in Torbay, where if an offender failed to keep appointments with either probation or drug services, breach proceedings were undertaken. A register of clients had been introduced in order to monitor non-attendance more effectively. Very few Fast Track clients had been revoked. This was to some extent due to the reluctance of the Fast Track team to make such a recommendation if an offender was still engaging in treatment. If drug-using offenders were re-arrested for a further offence the probation order was revoked. Data on enforcement are currently only available for the Plymouth branch of the Fast Track programme and relate to the first two and a half years of operation. Of the 219 offenders, over 20 per cent (47) had either been breached or were in custody. Most breaches occurred within the first three months of being on the order.

In West Yorkshire, all contacts were recorded by STEP. Probation National Standards were applied and there was no flexibility. This stringent approach to attendance was advocated by all partner agencies. For the period June 1998 to May 1999 data are available on 52 drug-using offenders of which over half (28) were breached. Data from the WYPS ‘Form 20’ (a database focusing on the start and end of probation orders) indicate the failure (revocation) of 27 orders (42%). Most failed within six months of the orders being made.

We only have very limited information on enforcement practice at the Hastings programme. We have data on 19 drug-using offenders; who kept 93 per cent of 389 probation appointments. Seventeen of the 28 missed appointments were unacceptable. Two verbal warnings, five first written warnings and three final warnings were issued. Breach proceedings were initiated on six separate occasions and four of the 34 orders were revoked.

Court Reviews

The purpose of review hearings was to enable the judge or magistrate(s) who sentenced the offender to consider the offender's progress and to assess whether changes were needed in the requirements and provisions of the order. If treatment was going well it provided the judge or magistrate(s) with an opportunity to encourage and support further progress. If not, it allowed the sentencer to consider why this should be and what steps were desirable to bring it back on course. The Home Office guidance document suggests that the review process should take account of the views of all concerned (treatment providers, supervising probation officers and the offenders themselves). In general, the sentencer who imposed the sentence was expected to be responsible for holding the review hearings. The court could amend the requirements of the order with the agreement of the offender. The first review hearing was mandatory, subsequent reviews were specified by the court. Attendance of offenders was compulsory.

We have information on 413 separate review hearings for 154 offenders, an average of 2.6 hearings per offender. Unfortunately the Gloucestershire team were able to provide us with review information for only 60 of the 100 offenders, who collectively had 116 reviews. The Croydon and Liverpool pilots were able to provide review information on virtually all those given the order (Croydon provided information on 151 reviews with 40 offenders and Liverpool 146 reviews on 54 offenders).

Once again, there was a lack of consistency in practice. In Croydon and Liverpool reviews were held on a monthly basis. In Gloucestershire, the initial review was held after one month, and subsequent reviews were usually held at intervals recommended by the DTTO team member attending court. These intervals varied from between one and three months. The intervals increased as staffing shortages rose. In all areas, those drug-using offenders attending residential rehabilitation were expected to attend less frequently.

A third of reviews were heard in the Crown Court. The remainder were heard by magistrates, typically stipendiary magistrates in Liverpool and lay in the other two sites. The length of hearings ranged from one to 70 minutes, with an average of nine minutes. Almost all reviews were attended in person by both worker and offender, although in Gloucestershire occasionally written reports alone were submitted if the offender was attending residential rehabilitation, to ensure continuity of treatment. In Croydon either a nurse or probation officer attended; similarly in Gloucestershire health and/or probation staff attended. In Merseyside the task fell only to probation officers.

DTTO staff and sentencers held a strong belief that it was desirable for drug-using offenders to appear for review before the same sentencers who made the original order. This was thought to ensure consistency of approach, to personalise the nature of the contract between the court and the offender and thus to increase the pressure on the offender to meet expectations. (It will be remembered from Chapter 1 that US drug courts place value on the personal involvement of the drug court judge.) The original sentencers[12] were involved in 48 per cent of the 413 reviews on which we have data. In half of these cases the sentencers had also been involved in previous reviews of the same order.

Reviews in Liverpool were much more likely to be heard by the court that had originally sentenced them. Eighty-three per cent of reviews there were carried out by the original sentencer, and in almost two-thirds of these cases the sentencer had previously reviewed the order. The equivalent figures for Croydon and Gloucestershire were 34 per cent and 21 per cent. Thus in both Croydon and Gloucestershire the majority of reviews were carried out by sentencers with no previous involvement with the DTTO.

Continuity was achieved on the whole for those appearing at Crown Court, but only in Merseyside was it possible to achieve any continuity at all in magistrates' courts. The Merseyside team succeeded in negotiating with the court that there should be a fortnightly afternoon court session dedicated to the review of DTTOs. This process was much aided by the willingness of two stipendiary magistrates to take responsibility for the majority of these reviews. Both the team and the magistrates were very happy with this arrangement and stated that the clear oversight of an individual case and a growing relationship between drug-using offender and sentencers appeared to be effective both in reinforcing positive progress and in swiftly addressing problems. Nevertheless, team members reported that there were occasions where one of the two magistrates was more lenient than the other and that drug-using offenders who had mainly appeared before one magistrate were surprised by the actions of the other.

The stipendiaries also pointed out that with a large number of drug-using offenders, sometimes close to 20, appearing at any one review session, it could be hard to maintain the same high level of interest and attention to detail on the progress of those who appeared towards the end of the session.

On the whole, the system operating in Merseyside was both effective and efficient. Appearing at one court session per fortnight for all DTTO matters greatly reduced the burden on probation members of the DTTO team, releasing them for other duties, in particular the delivery of interventions.

12. In lay magistrates courts, we regarded consistency as achieved if at least one of the three magistrates had sat on the sentencing panel.

The position in Croydon and Gloucestershire could not be less satisfactory. To the disappointment of sentencers and DTTO team members it proved impossible to organise any significant continuity of sentencers between review hearings. In Croydon in particular, team members were still spending long periods of time at the end of the pilot period waiting for reviews to be heard, despite frequent negotiations with the listing office.

Lay magistrates in both areas were very disappointed in the failure to secure consistent magistrate involvement. The members of the benches we interviewed shared the following views:

- all magistrates should be able to make a DTTO where appropriate and sit on subsequent review hearings
- all offenders should be reviewed by a consistent bench
- it was the clerk's job to ensure that this happens
- it would be a bad idea to establish a central drug court
- it would be undesirable to place lead responsibility for DTTO reviews with a single stipendiary magistrate.

Although some magistrates accepted that it was not possible to ensure continuity of sentencer with such large numbers of magistrates (180 in Croydon), only a minority were prepared to contemplate possible solutions such as a specially trained panel of magistrates sitting on a set day.

Almost all workers agreed that the regular sentence reviews were positive. For those who were making progress, the recognition and praise of this by sentencers was seen as very valuable in reaffirming motivation and supporting positive progress. Staff felt that some offenders had responded to being criticised by sentencers and to being given a last chance to improve attendance and reduce drug use.

A number of people were involved in the review. Data on attendance were incomplete. However, the offender attended in 74 per cent of reviews (n=190). In most cases (80%) a probation officer was present. A drugs worker or a CPN attended in only 38 per cent of reviews (n=44); although this hardly occurred at all in Liverpool. Most offenders (78%, n=207) had no independent representation.

The workers felt that on the whole sentencers were prepared to listen to their views on an individual offender's progress and were likely to follow any application made for the order to be continued or revoked. Many workers thought that this positive attitude on the part of sentencers stemmed from their recognition that the team was prepared to initiate breach proceedings when appropriate. Available data indicates that the outcome of the majority of reviews was no change to the order (80%, n= 304). Only 37 hearings resulted in a revocation for breach.

Comparison sites

For those participating in the PASCO programme, orders were not reviewed by a court – except, of course, if breach proceedings were brought. While magistrates were generally keen to become involved in the review process, resistance had been met from court clerks, who were concerned about the capacity of their courts to undertake the work. Despite this some magistrates had contacted the team requesting information on the progress of offenders. However, most of those providing the programme acknowledged that reviews would be useful for enforcement purposes and might help change some of the negative and punitive perceptions and experiences that some offenders may have had of the criminal justice system.

In Plymouth and Torbay court reviews were rarely used. Several reasons were given for this. Firstly there was a belief that court reviews were not needed since sentencers trusted the decision of the probation and drug services. Secondly, staff felt reviews may give the courts too much control and lead to interference with the treatment process. Finally, courts were not keen because of the expense and likely amount of court time reviews would take.

Each offender participating in the STEP programme in West Yorkshire had a court-based review every month. The drug court ran weekly review hearings with a specifically trained panel of magistrates. Initially 60 magistrates operated on a four-weekly cycle, however to improve consistency this has been reduced to 24. The magistrates believed it important to spend time with STEP offenders in order to support them, although they raised a number of concerns including their limited powers of sanction and the call on the resources of the court. Problems arose with magistrates ‘interfering’ in issues relating to prescribed drugs. This was addressed by providing specific training sessions to magistrates.

Reviews were written by the key worker and attended by any member of the STEP team, though more often than not by a probation officer. Reviews were believed to have played a fundamental and crucial role in providing positive reinforcement for offenders. However offenders were concerned that if they received too much praise in the court when they were doing well, the ‘fall’ might be harder if they relapsed. No data are currently available on the number or outcome of review hearings.

In Hastings, due to the restrictions on court time available, reviews were not undertaken. However the liaison probation officer and drugs worker met weekly and discussed the progress of drug-using offenders on the programme. In addition the probation officer reviewed cases every three months with the offender. The team felt that court reviews would create a lot more work but accepted that in some instances they might prove useful. There was also concern expressed that reviews could create a lot of tension between courts and the programme.

Stock-taking

Decisions about testing and breach proceedings will be central to the success of national roll-out. The nub of the issue is the extent to which systems of control through the threat of sanction can be combined with a treatment regime. Quite clearly, many offenders in all three pilot sites (and in the comparison ones) were continuing to use illicit drugs. Would a tougher regime of testing and breaching have reduced the proportion?

We doubt this. Dependent drug use is a relapsing condition, and of all problem drug users those with extensive criminal involvement probably have fewest personal resources at their disposal to control their habit. We think it unrealistic to expect the majority of such cases to become drug-free in the course of a few weeks. It is more reasonable to demand progress towards this goal over a period of months, tolerating a degree of illicit drug use – provided that there is clear evidence that the offender is actually making progress, reducing frequency or level of use. We also think that the appropriate response to relapse is to provide more support, rather than less – which is, in effect what a punitive reaction to relapse involves. At the same time, however, a DTTO team has to establish rules, and by implication it has to police these rules.

Two of the three sites seemed to us to be striking the right balance between the need to respond positively to relapse, and the need to establish and maintain boundaries about acceptable behaviour. However, the balance they are striking sits unhappily with the spirit of the legislation and the related Home Office guidance. The tenor of the guidance is that test failure will be tolerated only exceptionally. What actually happens is that a majority of DTTO tests are positive.

We advocate an approach to testing whereby individualised targets for reducing drug use are agreed with offenders as part of their treatment programme and testing is used to assess success in meeting these targets. In other words, the testing regime is tailored to the individual and their individualised treatment programme. It might well be agreed, for example, that an offender should stop using crack immediately, and work towards being drug-free over a four-month period; in this case urine tests for cocaine should start immediately, but not those for heroin.

Using testing as a means to police abstinence seems to us a high-risk strategy which will make fewer gains at higher costs than a more pragmatic approach. In the middle term it may well involve large proportions of DTTO cases being revoked. In this event, DTTOs would serve simply as an expensive “waiting room” for further punishment.

The pilot schemes have operated at different levels of intensity and have different expectations of drug-using offenders. They have adapted enforcement practices to suit the needs of their programmes. As already pointed out it is a difficult balancing act between the need for strict enforcement and the need to manage a process that frequently involves relapse. If drug-using offenders on DTTOs were expected to comply with National Standards drafted in the same terms as those that were introduced in April 2000 for probation orders, the majority would fail, given the intensity of contact required by DTTOs. We feel drug-using offenders on DTTOs should be formally excluded from National Standards. Although an expectation of consistent and high attendance rates should be set, teams should be encouraged to concentrate mainly on reduction and cessation of offending behaviour. Wherever the minimum acceptable attendance rate is set, it needs to be proportionate to the level of contact required by the programme.

Court reviews seem to be a positive and productive innovation in those courts where sentencers are properly trained and where it is possible to provide for continuity of sentencers over the review process. Sadly this has been a rare occurrence in the pilot sites. All efforts should be made to have the same sentencer(s) presiding over court reviews with the same drug-using offender.

The integrity of the enforcement process would be greatly enhanced – as would partnerships between police and probation – if police services were set a target for executing DTTOs warrants, such as 90 per cent within seven days. Liaison between teams and divisional intelligence units should be encouraged.

5: Inter-agency working

All three teams struggled to develop an effective model of inter-agency work. Although inter-agency relationships improved at all three pilot sites, only the Croydon team resolved conflicts and disputes sufficiently thoroughly to be operating as an effective team whose whole was more than the sum of its parts.

Although there was training for team members at all the pilot sites, it did not appear that any of the teams had started with any formal or professionally assisted process of team-building. The teams had started from different standpoints.

In Liverpool, the probation service had strongly asserted the fact that the DTTO is an order of the court and was therefore the responsibility of the probation service alone. Merseyside Probation Service (MPS) had organised the service, contracting in CPNs to deliver a specific medical input. This approach led to considerable conflict within the team. Most of the health-care staff and several partner agencies were unhappy both with the quality of liaison work and the quality and effectiveness of service delivered to drug-using offenders. We would draw attention to the following issues relating to the Liverpool pilot:

- there are no formal or informal roles or responsibilities in terms of which members of staff deliver different components of the intervention to drug-using offenders. Although it is clear that probation officers are responsible for holding the DTTO and all associated legal procedures and that CPNs undertake an initial medical assessment and perform the urine tests, there appears to be no care planning procedures to prevent duplication of work and confusion of the offender
- there are no clear processes for reviewing supervision/treatment goals
- although there is an excellent range of possible interventions, the lack of a clear treatment/supervision philosophy means that drug-using offenders are often inappropriately referred – either to the wrong programme or at the wrong stage of treatment/supervision
- the medical expertise of the CPNs and consultant psychiatrist is under-used; they are not involved in the initial assessment, nor fully in the delivery of the overall programme
- CPNs feel downgraded, undervalued and sometimes feel their main role is simply to carry out urine tests.

Some of these issues were recognised during the course of the pilot and attempts have been made to resolve some problems. For example a team-based case review process has now been introduced. Over time the team have established a working relationship where cases can be openly discussed and tasks agreed.

In Gloucestershire, workers had been seconded to the multi-disciplinary team retaining the employment conditions of their host organisations. The intention was that staff from different disciplines would carry out similar key worker functions. The team believed in the multi-agency approach but all felt that it was difficult to organise in practice. Certainly the practice of assigning a key worker to each case has meant that there is more clarity around individual casework issues than occurs when casework is allocated according to skills. However the supervision of the DTTO remains – appropriately – with probation staff. Probation staff also tended to retain ‘ownership’ of the groupwork course. This was developed and mainly run by them, and therefore CPNs and drug workers had only a limited understanding of this key component of the intervention. Problems experienced over joint working revealed themselves in high staff turnover. At least five staff had left through a combination of personal reasons and an inability to adapt to inter-agency working to their satisfaction.

The staff we interviewed identified several obstacles to smooth joint working arrangements in Gloucestershire:

- different employers and lines of accountability
- different pay and conditions of service
- a lack of a sense of belonging to one team, and a degree of personal conflict
- different working cultures and expectations.

We encountered several examples of conflicting working cultures in Gloucestershire. For example, probation officers were prepared to work with high caseloads, whilst drug workers and CPNs expect to have firm limits on caseloads. From a probation point of view, they – but not their colleagues from other disciplines – were flexible and willing workers; from the other point of view probation officers sacrificed quality for quantity. Probation officers also tended to hold a more defined and demanding view of anti-discriminatory practice.

The Croydon team also found joint working difficult. They started from an approach where probation officers and nurses learnt each other’s work and where tasks were undertaken interchangeably. However, an increase in the workload meant that this duplication could not be supported and there were difficulties in defining roles and responsibilities. However, all the staff were of high calibre and mainly interacted in a professional manner. The quality of team management was high and once the time allocated to management had been increased, many issues were satisfactorily resolved. Managers from the lead agencies met regularly to resolve issues in a direct and professional manner. Managers from both health and drug agencies were prepared to devolve managerial responsibility for operational matters to the senior probation officer. A number of key issues were resolved in the course of the pilot:

- clarity of roles and responsibilities for probation officers and nurses
- nurses undertaking probation tasks for which they were not trained or qualified on appointment
- probation officers' concern that they would end up solely with the case manager role concentrating on assessment, reviews and breach and not be involved in the caseworker role
- nurses feeling that urine testing (most, but not all of which they undertook) was tedious and probation officers feeling the same about court work
- nurses feeling uncomfortable that their clinical independence was threatened
- it was easier for probation officers to learn about drug treatment (they have experience of working with drug-using offenders) than for nurses to learn about the Criminal Justice System (CJS)
- it was initially difficult for nurses to work with people whose motivation was solely provided by CJS
- there were different views about treatment and punishment with some probation officers valuing DTTOs as alternatives to custody while nurses were more concerned with treatability.

By the end of the pilot period, the attitudes, beliefs and working practices of all staff in Croydon had shifted to the point where all the workers were operating as a team with common beliefs in the objectives to which they were working. Nurses had come to accept the importance of protecting the public as a goal and probation officers had learnt considerable amounts about long term and intensive work with drug users.

Comparison sites

The comparison sites had generally established more robust partnership approaches than the pilot sites. This partly reflects the origins of the projects. They were established as local "bottom up" initiatives with the support of local "champions". The quality of staff enthusiasm for the work was palpable. They had also enjoyed longer developmental periods than the pilot sites. Although they had problems in working relationships along the way, this approach appeared to have enabled the resolution of many difficulties.

The strong commitment to the projects spurred partners to find ways of resolving problems. For example in Plymouth and Torbay initial problems in working relations revolved around the degree to which the probation service acted like commissioners and not a partner. This issue was only resolved when the drug service refused to deliver services to probationers. It is an issue which is now continually revisited in partnership meetings to ensure that any recurring problems are nipped in the bud. All levels of personnel involved see the projects as a partnership, with a sense of trust and respect for each professional discipline. On the strength of this has emerged a free and frank exchange of information.

Several points were made in focus group interviews at the comparison schemes about how to establish and maintain solid working relationships. These include:

- partnership and multi-disciplinary approach
- support at strategic level reinforced by frequent contact
- boundary and identity issues are very important. There is a need to keep professional identity
- partners need to take ownership of each others' outcomes
- written agreements spelling out what each partner will do
- demarcation of roles
- at least six months to one year set-up time
- flexibility needs to be built in and a constant review process undertaken.

Stocktaking

The pilot sites all encountered "teething problems"; and many of these remained unresolved by the end of the pilot. It would be wrong to discount the difficulties encountered by the schemes as a function of personality clashes or deficits in skills. They were a consequence of joint working on a difficult enterprise by organisations with big differences in working styles, traditions and values. We think they are likely to be widespread when DTTOs are rolled out nationally.

In getting teams to work effectively, several things need to be done. First it needs to be recognised that initiatives imposed by central government or senior probation management pass through the starting gate with a serious handicap, relative to those which are locally championed. Staff selection processes need to be sensitive to this. Where possible team managers and staff should have successful experience of joint working; they also need a commitment to the enterprise of work with problem drug users in a criminal justice setting.

We appreciate that these are predictable “health and sunshine” requirements which would be articulated in any recruitment process. But if probation areas pay only lip service to them, there will be a heavy casualty rate amongst DTTO projects when these are rolled out nationally.

Secondly, it must be recognised that it will take time for teams to develop into effective partnerships. They should be given time to pre-plan, and to develop coherent programmes before pressure is imposed on them to achieve high throughputs. These programmes will take time to work out. They need to be evidence-based, and to have realistic rather than politically-driven philosophies. Pushing problem drug users to travel too far too fast towards the goal of abstinence will end in failure.

Finally, guidance needs to be given about the best divisions of labour for multi-disciplinary teams. It is too early for us to reach any firm conclusions on this. The key thing is for each discipline to have some joint ownership of the outcomes sought by their colleagues. We are not at all sure that this is achieved by strategies requiring interchangeability of staff. Requiring criminal justice competence from CPNs and medical skills from probation officers is an inefficient use of the skills of both groups. There probably needs to be a clear and well-understood division of labour between staff from different disciplines. However, this needs to be achieved in a way which preserves the equality of the partnership. Clarity of function should not be achieved by demoting drug workers or CPNs to a mere supporting role.

6: The views of DTTO offenders

Within our interviews we asked drug-using offenders about their experience and views of being on DTTOs. In this chapter we first present offenders' views at the start of the order (132); then we consider reactions amongst those who were interviewed at the six month stage (48);[13] and finally we focus on the 50 drug-using offenders who had either completed or were within a few weeks of completing their orders (31) or who had their orders revoked (19).

Initial experience

Over two-thirds of the sample (89) were informed of the option of a DTTO by a probation officer. The remainder were told about the orders from a variety of sources including solicitors (11), magistrates/judges (6), drug workers (7), friends (2) and others (12). Almost all interviewees (120) said that the requirements of the order had been explained to them. When asked why they had agreed to the order, the vast majority of interviewees said they wanted to avoid imprisonment and to do something about their drug use.

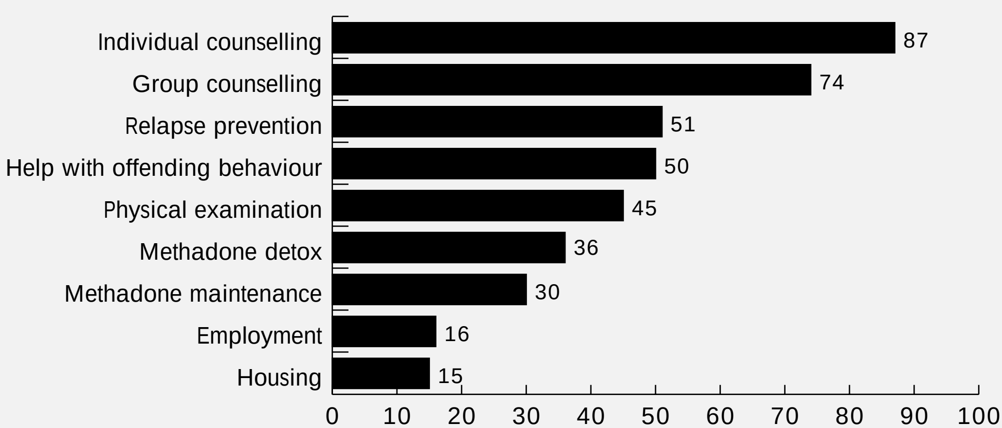
On average interviewees reported that they had to attend DTTO services for ten hours a week. Over two-thirds (92) of respondents thought that the frequency with which they had to attend was about right. This group stressed the importance of the supportive environment of the DTTO facilities and staff. Others described the need for establishing a routine and said that attendance on the programme reduced the chances of using and offending. As one interviewee commented '…the programme fills in time – it gives you something to do and stops me from using and re-offending'. Almost a fifth (24) thought they had to attend too frequently. The reasons given for this were difficulties adapting to structured activity and lack of flexibility preventing them attending other activities such as college courses and training programmes. Ten reported that they would like the frequency with which they have to attend DTTO activities to be increased because they wanted more structure to their day (especially at the beginning of the DTTO); they said they felt vulnerable to relapse, and did not want any free-time to be exposed to drug use. Others thought it important to build relationships with staff members to develop levels of trust.

13. The research was designed so that six month interviews were conducted only with offenders still on a DTTO. Offenders whose orders had been revoked before the six-month period were eligible only for an exit interview.

Some interviewees (especially in the Gloucester site) had to travel a considerable distance in order to attend the DTTO service (for example 40 miles or an hour and a half bus journey each way). For some this was particularly difficult because of childcare arrangements and reliance on family and friends.

Within the first six weeks of being on a DTTO offenders reported receiving, on average, six different treatment inputs. The most common intervention mentioned was advice and information (by 106). Over two-thirds (87) reported having individual counselling, just under three-fifths (74) group-counselling, two-fifths (50) help with offending behaviour, and a third (38) alternative therapies. Figure 6.1 shows the number of drug-using offenders who reported receiving different types of help or treatment.

Figure 6.1: Help and treatment received at first interview (n=132)



Views and experiences in the medium term

The 48 offenders whom we interviewed at the six-month stage had considerably more experience of the order, of course. Whilst over half (27) reported that their main motivation for agreeing to the order was to stay out of prison, a significant number (32) still referred to the desire to become drug free, and some (10) reported that access to treatment afforded by the order was also an important consideration when agreeing to a DTTO.

The intensity of the intervention received by this group also varied considerably. Fourteen were in residential rehabilitation centres when they were interviewed; the rest were attending community-based services. For those attending community-based services they were expected to attend between one and 20 hours per week, with a median of four hours.

Virtually all those that we interviewed six months into the order had received counselling in either individual (45) or group form (38). Other main types of help received included relapse prevention, physical examination, Hepatitis test or examination and help with offending behaviour. A range of other assistance was also reported. When asked to rate which intervention had been most helpful, drug-using offenders in the main identified one-to-one counselling (35) and group work (32) as being ‘very helpful’. Being referred to other services were also a highly rated form of intervention (17). They reported the least helpful interventions as alternative therapies (5) and methadone prescription (4). The majority (42) reported that they were getting the type of help or treatment they wanted, in particular they identified as important the structure and intensity of the programmes offered, the support received from DTTO staff and the assistance offered in accessing detoxification and residential rehabilitation services. Unmet needs reported at this time included help with education, training and employment, assistance with housing, ways in which to use time constructively and concern about help available when the DTTO is completed.

We asked whether being on a DTTO had an effect on drug use and offending behaviour and what factors helped or hindered drug-using offenders to make changes. As reported earlier most had stopped (30) or reduced (17) their use of illicit drugs. Twelve offenders however mentioned that some aspect of DTTOs had hindered or prevented changes in their drug use. These included withdrawal of substitute drugs (4), other drug-using offenders on DTTOs using (3), lack of structure (3) and inadequate support (2). Virtually all (47) reported that being on a DTTO had had an effect on their offending behaviour, most mentioned their reduced use of drugs as having the most impact. Factors identified (by six interviewees) as inhibiting further change in offending included waiting times for substitute prescribing, inadequate levels of prescribed drugs and drug dealing on DTTO premises.

When asked about testing, court involvement and court reviews, drug-using offenders were generally satisfied with the approach taken as part of DTTOs. In particular of the 39 offenders who participated in court reviews, 31 reported that they had been a positive experience, as the following quotes illustrate.

> “It was the first time I had gone to court and I heard something good said about me.”

> “It was good, it was the first time the judge had ever told me ‘well done’. I almost fell off my chair.”

However for those who were not doing so well reviews were seen as having negative consequences:

> "They [court reviews] were helpful when I was doing OK but I felt under a lot of strain when things weren't going well."

For some the whole process was seen as unhelpful:

> "They weren't really that helpful. Only negative stuff came out which was only part of the picture."

> "It's a waste of time. You're only there for a couple of minutes, they read a report out and tell you to come back in four weeks."

We asked offenders about weaknesses in DTTOs. They identified various problems, though there was little consensus about these. They included:

- having to remain in the same geographical area in which they had used drugs (7)
- limited access to prescribed drugs (5)
- coming into contact with other users (5)
- not enough activities to occupy their time (4).

A great variety of suggestions for improving DTTOs were offered by 40 drug-using offenders. These included:

- more counselling, groupwork and access to residential rehabilitation
- a greater focus on aftercare, housing and employment needs
- greater flexibility in assessing individuals' performance
- women-specific groups
- generally more structure and routine.

Views of offenders at completion or revocation of order

We interviewed ten offenders who had completed their orders, 21 drug-using offenders who are within six weeks of completion and 19 whose orders had been revoked (it should be noted that 18 of the 19 drug-using offenders whose orders had been revoked were from Gloucestershire).

Completers and those near to completion

Unsurprisingly, those who had completed or nearly completed their order were generally satisfied with DTTOs. The majority believed that it had helped them make significant changes in their drug use as well as offending behaviour. In fact the only offences of any sort reported to us by this group related to possession of cannabis. All reported that changes in their drug using behaviour enabled them to stop offending. Twenty-nine also reported that being on a DTTO had a positive effect on other aspects of their lives. The most commonly reported effect was an improvement in relationships with family members, partners and friends. Other positive outcomes included employment, access to education and training, gaining confidence and self-respect, and improved health.

A range of opinions were expressed by drug-using offenders as to which aspects of DTTOs had helped or hindered them to make changes. Positive features included access to residential care – which had generally been denied to them previously, group work and counselling. Nine offenders stressed these aspects of treatment as being particularly important. Only four of the 31 drug-using offenders mentioned the coercive or urine testing elements of the programme as being of value.

Factors inhibiting change included problems relating both to treatment interventions in general and to particular aspects of DTTOs. As with any community-based programme, some found it challenging to continue to have contact with drug users (some of whom were actually on the programme). It was particularly hard to stay drug-free when partners or friends were still using drugs. It was also difficult to live in areas where drugs were readily available.

Problems specific to the DTTO programmes included the lack of skills amongst DTTO workers and the lack of support once progress was being made. The orders were seen by some as being too strict and by others as too lenient. For one drug-using offender being constantly reminded by probation staff that the order was a punishment was unhelpful.

Revocations

We interviewed 19 offenders whose orders were revoked. All but one was from the Gloucestershire site. The reasons reported to us for revocation were continued drug use (9), non-attendance (6), re-offending (1), a combination of these three reasons (1), and other reasons (2). A range of reasons were given by those revoked as to why they could not keep to the conditions of the order. Four drug-using offenders simply found it difficult to stop using drugs. Others (6) maintained they were unable to meet the requirements of the order due to the type of treatment or the way care was provided. They cited inadequate levels of methadone prescription, poor levels of support, others using on the programme, and disagreements between staff. For several drug-using offenders in Gloucestershire, having to make a 40 mile round trip on a daily basis was a particular barrier to compliance. For some (7) their personal circumstances had an impact (such as being in a relationship with a drug user, problems with relationships and problems in looking after children).

We asked this group what might have helped them keep to the conditions of the order. Five mentioned increasing the level of prescribed drugs for a longer period of time. Being allowed more time to make changes was also seen as vital. For others the opportunity to move away from drug using partners, friends and acquaintances was seen as potentially useful.

We asked whether they would accept the offer of a further DTTO, if this were ever made. Surprisingly half (9) said that they would. Three felt that although they were not allowed to continue with the order they had benefited from it. Access to residential rehabilitation would be the prime motivation for others to agree to a DTTO. The reasons given by those who would refuse the chance of a DTTO were less clear. Most felt that on the basis of their experience either they were not suited to the programme or that it had nothing to offer them. Two out of the 19 reported that they would rather go to prison than be given the order again.

7: Changes in drug use and offending

In this section we provide information from interviews conducted with drug-using offenders given DTTOs. We provide a profile of those interviewed, drug use and offending history; then we examine changes in drug use and offending behaviour and treatment received whilst on the order. Information was collected from offenders at three distinct stages which allowed us to map changes in behaviour and circumstances covering the duration of the evaluation. In presenting the data we have focused on the three interview samples outlined below:

- 132 offenders were interviewed within six weeks of being given a DTTO (intake interviews)
- 48 offenders who had been on a DTTO for six months (interim interviews)
- 50 offenders who had either completed, were near completion of their DTTO or their order had been revoked (exit interviews).

We were also able to match self-report information on drug use for some of those interviewed with urine test results collected by the pilot sites.

At intake

Three-quarters (98) of all first interview respondents were male, with an average age of 28 years (ranging from 17 to 51). The vast majority (121) described themselves as white, nine as black and two as 'other'. Almost all (116) were receiving unemployment benefit, and most of the remainder were receiving sickness benefit. Three-quarters stated they had not worked at any time in the previous two years. Half (65) had children to care for. Just over half (70) of all interviewees described themselves as being single and not in a relationship. We asked those in relationships about their partners' drug use. Just under a half (29) said that their partners also had a problem with drugs and or alcohol. Over half (36) of those in relationships reported problems in their relationships with their partners in the past month. We also asked about their friends' drug use. The vast majority (116) said that most or all of their friends used drugs, and that most of these had problems with drugs or alcohol.

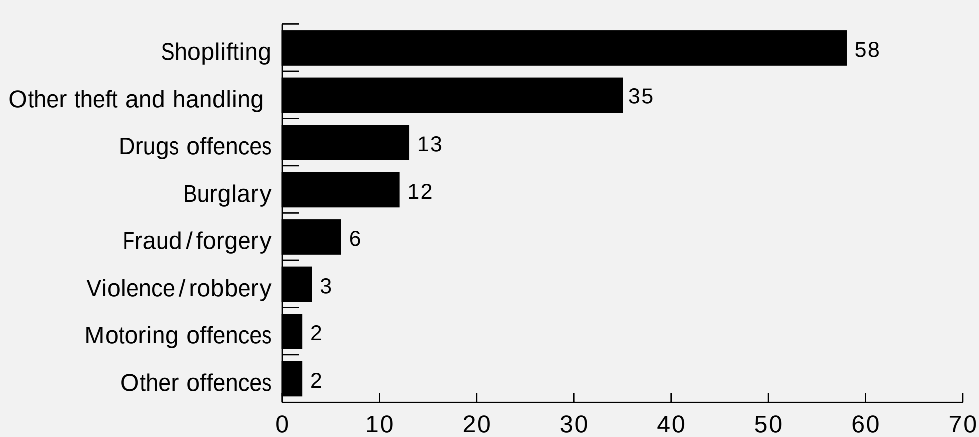
Most interviewees started using illicit drugs in their mid teens (average age 15, ranging from 7 to 34). Almost three-quarters (94) first used cannabis, and a tenth (13) reported using heroin. Just over three-quarters (101) had injected at some time, most commonly heroin; the average age for starting was 22. Seven interviewees reported overdoses in the month before arrest.

All drug-using offenders on DTTOs had numerous previous contacts with the CJS (an average of 31 convictions, ranging from 1 to 150). The average age of interviewees at first conviction was 16 years (ranging from 9 to 31 years). Four-fifths (105) of the interviewees reported having served a past prison sentence, with an average of five previous sentences (ranging from 1 to 50). Roughly the same proportion (109) had been remanded in custody with an average of six occasions (again ranging from 1 to 50).

Figure 7.1 shows the primary offence for which interviewees received their DTTO. Almost half (58) were sentenced for shoplifting. Over a quarter were convicted for other theft and handling offences (35), including theft from a property (20), other theft (5), and handling stolen goods (2). Just under a fifth were sentenced for burglary (12) or drugs offences (13). They received a combination of sentences usually consisting of concurrent probation order and DTTO. Almost three-fifths (79) received a 12-month DTTO, 25 received a sentence of 18 months, 21 received a sentence of 24 months and one 36 months.

Three-fifths had never previously received help or treatment for drug problems. For the two-fifths (53) who had, the average time lapse between their last treatment episode and current DTTO was 16 months. The average age of first contact with drug treatment services was 25 years (ranging from 15 to 38 years), the majority contacting specialist drug services (40). Only a tenth (14) had received treatment or help as part of a previous sentence. Fourteen interviewees had received help or treatment while serving a term of imprisonment.

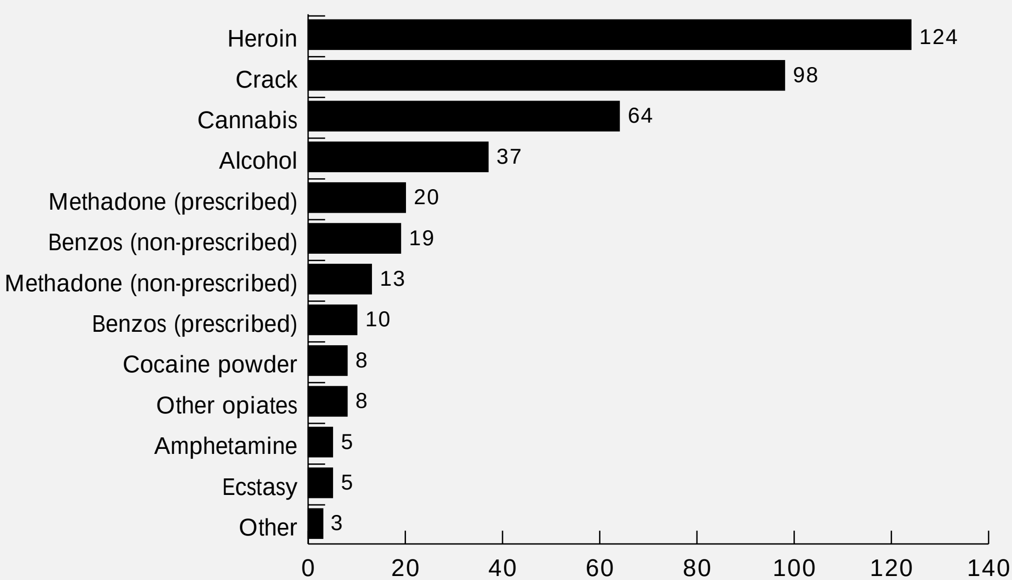
Figure 7.1: Main offence for which offenders reported receiving a DTTO (n=131)



Drug use and spend in the month prior to arrest

In the month before arrest the majority of drug-using offenders had used a combination of different drugs. Most reported having used heroin and crack at some time in the past (77%, n =102). However in the month prior to arrest most reported using heroin on a daily basis (91%, n = 120). Just over three-fifths (75) were injecting their drugs. Figure 7.2 shows the number of offenders using different drugs during the month before arrest. This group were using a considerable amount of drugs during this time at great expense. We asked them to estimate how much they were spending on drugs prior to arrest. The median drug expenditure for the interviewees was £400, which equates to about £21,000 per annum per drug-using offender, or almost £3 million per year for this sample of 132 drug-using offenders in aggregate.[14]

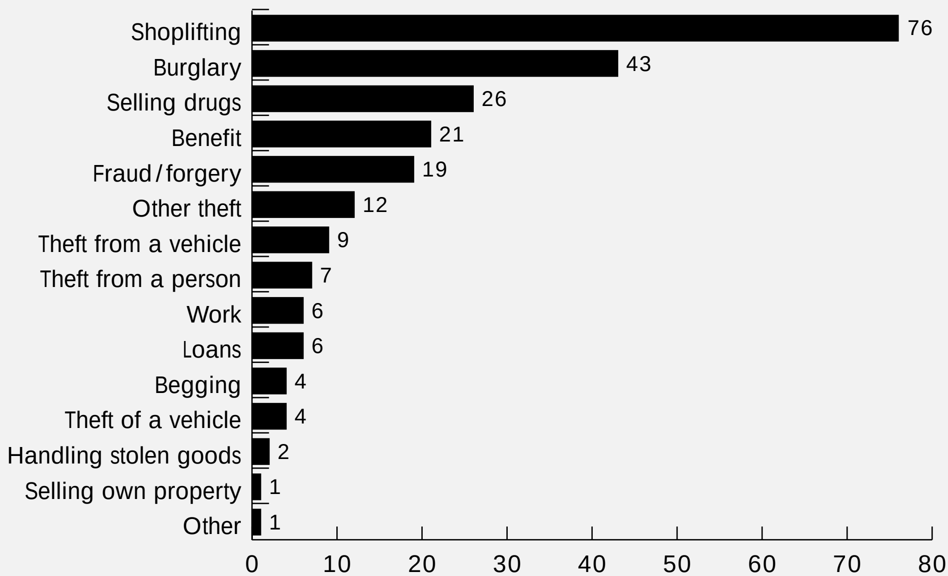
Figure 7.2: Drugs used by interviewees in the month prior to arrest (n=132)



As with previous studies of criminally involved problem users (eg Edmunds et al., 1999; Hearnden et al., 2000), the most common way of financing drug use was shoplifting (76). The next most common methods were burglary (43) and selling drugs (26). Figure 7.3 provides a breakdown.

14. This assumes, of course, that drug-using offenders had consumed drugs at a consistent rate throughout the year. It is equally possible that their use had 'peaked' in the months before arrest and that this increased the risk of arrest.

Figure 7.3: Most common methods of funding drug use (n=126)



Changes in drug use and drug spend

Here we compare drug use and spend in the month before arrest and the four weeks prior to first interview. Readers should remember that this period may include some time when drug-using offenders had not yet received any treatment. Most interviewees reported they had considerably reduced the quantity and range of drugs used in the first month of their DTTO (as can be seen from Figure 7.4). The most marked reductions were in crack use, which halved (53%). But there was also a considerable reduction in heroin use by a third (32%). As can be seen from Table 7.1 the most striking change is the shift from opiate and stimulant use in combination to opiate use only. This is not surprising for a number of reasons. Stimulants (and crack cocaine in particular) have a shorter withdrawal period with little physiological effect (although withdrawal is associated with longer-term psychological effects). The funds required to maintain regular crack use are considerable and participation in a DTTO will obviously have an effect on drug-using offenders' ability to participate in fund- raising activities.

Figure 7.4: Early reductions in drug use (n=132)

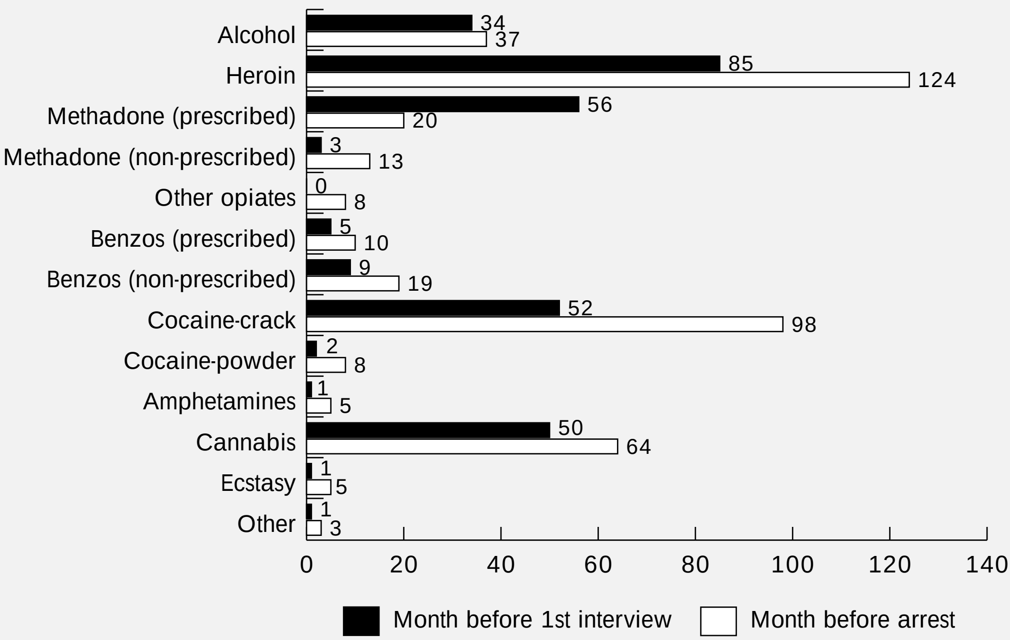


Table 7.1: Typology of drug use in the month before arrest and in the month prior to interview (n = 132)

	Month before arrest	Month prior to first interview
Opiates and not stimulants	31	48
Opiates and stimulants	96	48
Stimulants not opiates	5	5
Not stimulants nor opiates	0	11
Drug free	0	20
Totals	132	132

Of the 75 interviewees who reported injecting prior to their arrest almost two-thirds (47) continued in the first month of their DTTO. However, only five respondents reported sharing needles and syringes and 15 mentioning sharing other injecting paraphernalia.

The median weekly drug spend for all 132 interviewees was £25. Forty-seven of them said that they were now no longer buying illicit drugs. The median spend for the remaining 85 was £70. Just over half (48) reported financing this reduced level of use mainly from benefits. However, 40 were still offending, most notably shoplifting (25) and selling drugs (9).

We checked the self-report data on drugs used in the 30-day period before first interview with urine test data from the pilot sites. We were able to match 94 of our interviewees with test results for opiates and cocaine (about 70% those interviewed). For those tested for opiates we found:

- 54 reported opiate use and tested positive
- 17 reported no opiate use and tested positive
- 12 reported no opiate use and tested negative
- 11 reported opiate use and tested negative.

This means that for 70 per cent of those for whom we were able to link interview and urine test information on opiate use have matching data. The most likely explanation for the 11 individuals who reported use but did not test positive is that their use did not coincide with the windows of time covered by their tests. However 18 per cent (17) clearly provided self-report information which was unreliable.

The findings for cocaine are similar. Again we were able to link 94 cases of self-report and urine test data:

- 37 reported cocaine use and tested positive
- 14 reported no cocaine use and tested positive
- 37 reported no cocaine use and tested negative
- 6 reported cocaine use and tested negative.

For the majority (74 or 78%), self-report data and urine test results show a degree of concordance. Only 15 per cent (14) of cases did not match.

Reductions in offending behaviour

We asked respondents about the crimes they had committed in the 30 days prior to their arrest, and in the 30 days before interview. In the period before arrest, many were committing several types of crime on a daily basis. The majority reported that since starting their DTTO they had stopped committing acquisitive crime (84); a further 26 mentioning a reduction in the amount of acquisitive crime committed. The average number of acquisitive crimes committed by 119 offenders in the month before arrest was 137. The corresponding figure for 35 offenders during the month before first interview was 34.

When comparing the number of interviewees possessing illicit drugs in the thirty-day periods the figure fell from 122 to 87 individuals. The number of days on which interviewees were in possession of illicit drugs in the months halved from an average of 26 to 15 days. Additionally, those interviewees who reported selling drugs also fell by almost two-thirds from 29 to 11 in the two periods covered.

The reductions in both drug use and crime which occurred at the start of the order are marked. The study cannot provide any definitive answers about cause and effect, however. In thinking about the reasons for the falls, one should remember that offenders have been:

- arrested
- assessed by probation officers writing PSRs
- convicted by a court
- sentenced by the court
- assessed by the DTTO team.

At several of these points they will have been encouraged or pressurised to tackle their drug problems; and it will have been clear to most that they were at risk of a custodial sentence. It would be simplistic to argue that it was the treatment received as part of the DTTO which was responsible for the falls. The interesting question is not whether DTTOs can achieve short-term reductions in drug use and crime, but whether they can contain drug use and crime to these low levels.

Changes in the middle term

Our analysis of the 48 follow-up interviews which we did roughly six months into the DTTO can shed light on this. Here we provide information about drug use and offending for three time periods:

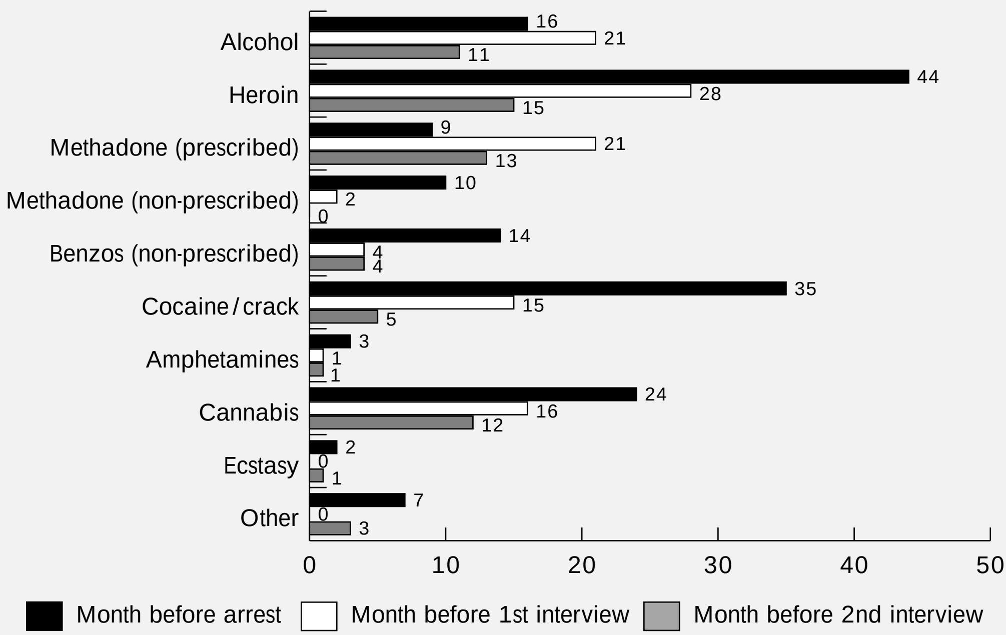
- the 30 days before arrest
- the 30 days before first interview
- the 30 days before second interview.

The sub-sample is substantially smaller than the original intake sample of 132, reflecting the fact that many drug-using offenders had been lost from the treatment programmes. However, it was very similar in demographic make-up, and in drug and crime careers.

Changes in drug use

Figure 7.5 shows interviewees' reduction in drug use over the three points measured. Illicit drug use in all categories was seen to decrease at each stage. Forty-four interviewees reported using heroin in the month before arrest and this fell by just over a third to 28 in the first six weeks of their DTTO.

Figure 7.5: Drug use in the months before arrest, first and second interviews (n=48)



Further changes were evident at the six-month stage, showing a further decrease to 15 reporting some use of heroin in the previous 30 days. Those who had used cocaine/crack prior to being on a DTTO reported the most dramatic falls from 35 using before arrest to five at second interview. The use of prescribed methadone increased from the month before arrest from nine to 21 in the first six week of their order, and fell to 13 interviewees at second interview. This pattern reflects the use of methadone detoxification by the programmes.

Table 7.2: Changes in typology of drug use by in the months before arrest, first and second interviews (n=48)

	Month before arrest	Month prior to first interview	Month prior to second interview
Opiates and not stimulants	13	20	17
Opiates and stimulants	33	14	4
Stimulants not opiates	2	1	1
Not stimulants nor opiates	0	3	7
Drug free	0	10	19

Examining drug use by substance types over the three periods also highlights some interesting changes in the nature of interviewees' use. Most markedly, there was a steady decline in the number of drug-using offenders interviewed using a combination of 'opiates and stimulants' (namely heroin and crack) from 33 respondents prior to arrest to just four at second interview. There appeared to be an overall scaling down of the range of drugs used to single use, which is shown with the increasing levels of opiates used. There was also an increase in the numbers of interviewees reporting being drug free.

Injecting and sharing

Health gains were also evident when considering changes in drug using practices. Before arrest almost two-thirds (30) of this group were injecting their drugs. Six weeks into treatment this had decreased to 20 and after six months of being on a DTTO just under a quarter (7) of injectors continued to inject. Similarly, the number of interviewees who reported sharing needles/syringes and other paraphernalia showed a marked decline. Over a third (11) of those injecting stated they had shared needles/syringes and three-fifths (18) other injecting paraphernalia. At the six week point the number sharing needles/syringes or injecting paraphernalia had dropped to two and six respondents respectively. At the six-month stage only one interviewee reported engaging in any form of sharing.

Changes in drug spend

Changes in drug expenditure for the sample corresponded with the reductions in drug use outlined above. Before arrest this group of 48 drug-using offenders had a median weekly drug spend of £400 (ranging from no weekly expenditure to £2,000). Six weeks into their DTTO they reported that this had fallen to £25. Eighteen respondents said they had stopped buying illicit drugs. The remaining 30 had a median weekly drug spend of £100 (ranging from £5 to £700). By the six-month stage, the number still buying illicit drugs had fallen to 19, with a median weekly spend of £50.

Very few of the 48 reported any offending beyond possession of drugs after they had been on their order for six months. The reductions in offending made within the first weeks of a DTTO were sustained and improved upon. The most frequently mentioned offence was possession of drugs (22). Three said they were selling drugs, one was involved in fraud and three said they were shoplifting.

In interpreting these results, we are fairly confident that the self-report data on drug use and crime have some basis in reality. We know that there was a fairly close correspondence between self-reported drug use and test data. This was also the second time that the offenders had been interviewed, in all cases by the same researcher who carried out the first; this should have allowed some trust to have developed. However we carried out six-month interviews only on those who had remained on their order. Those who had fallen by the wayside were eligible only for exit interviews, discussed below. In other words, the increasingly positive picture as time progresses is likely to reflect at least in part the drop-out rate. Those who were still using were being winnowed out of the programmes as a consequence of revocation and of reconviction for further offending.

In considering whether the programmes helped those who remained on them, we cannot prove any cause and effect, though the views of offenders presented in the previous chapter support this.

Exit interviews

We have conducted 50 exit interviews with drug-using offenders given a DTTO. Data are presented on two sub-samples:

- those who had completed or were nearing the completion of their orders[15]
- those who had their orders revoked.

Thirty-one interviewees had either completed or were nearing the end of their orders. Five of them had completed 12-month orders, the remainder had been on their orders for an average of 11 months. Those interviewees who were no longer on a DTTO (19) were interviewed an average of eight months after revocation of their order.

15. We decided to treat those near completion as if they had completed simply to increase the sample of exit interviewees.

Two-thirds (33) of the interviewees were male with an average age of 27 years. Only one interviewee was black. Of those who had completed or were near completion of their DTTOs, most (25) were male and slightly older with an average age of 28 years (ranging from 18 to 48 years). Eleven of the 19 interviewees revoked were female. Eighteen of those revoked were white. Four were interviewed while imprisoned.

Here we look at changes in drug use, drug spend and offending behaviour of these two groups.

Changes for those revoked

There were marked reductions in illicit drug use between the month before arrest and at the six-week research interview. Most notably there were falls in the use of crack (from 11 to 8 reporting use) and heroin (from 18 to 12). In the period between the six-week interview and exit interview, those revoked reported continued decreases in illicit use of crack (from 8 to 5) while heroin use remained stable with 12 offenders reporting use at both interviews. There was also a dramatic fall in the number using prescribed methadone with interviewees abandoning or losing their prescribed medication when breached.

Before arrest those revoked had an average median drug spend of £420. At first interview this had fallen to £40 (ranging from £0 to £850). However, at exit interview drug expenditure by this group of revoked drug-using offenders had risen to a median of £53 (ranging from £0 to £1,500).

In the month preceding arrest the 19 drug-using offenders reported a total of over 3,600 acquisitive crimes. The vast majority (84%) of which were for shoplifting, committed by two-thirds (13) of the group. At intake interview the overall levels of acquisitive offending had fallen to 743 (or 79% less). Again, shoplifting accounted for the vast majority of offences committed at this stage. At exit interview the sample reported an increase in the number of offences committed during the previous month – 912.

Changes for those completing or near completion

Reductions in drug use for those who completed DTTOs were sustained. In the period between the month before arrest and first research interview those who completed treatment orders stopped using amphetamines and non-prescribed methadone. There were also marked reductions in the use of benzodiazepines, cannabis and heroin. Crack use showed a sharp decrease, falling by almost half. The only drugs reported to have increased in this time were licit (alcohol and prescribed methadone). From the first six weeks of treatment to exit interview there were further reductions in drug use. The most dramatic falls were for heroin (from 21 to 2), crack (12 to 2) and prescribed methadone (16 to 5) which reflected the number of interviewees drug-free (27) at exit interview. There were also decreases in the use of alcohol and cannabis.

For those who completed treatment, there were large and sustained reductions in drug spend across the three measured periods. In the month before arrest this group had a median average weekly drug spend of £350 (ranging from £0 to £4,000). At the six-week follow-up interview this had dropped more than ten-fold to £25 per week (ranging from £0 to £300). Focusing on the 18 respondents who purchased drugs in the same period showed a median drug spend of £85 per week (ranging from £5 to £300). At exit interview 22 of the 31 were not buying any illicit drugs. The remainder had a weekly spend averaging £28 (ranging from £5 to £200).

In the month preceding arrest this group of drug-using offenders reported a total of over 3,000 acquisitive crimes. Of these, roughly half (49%) were for shoplifting, a fifth (21%) theft from property and a further fifth (20%) handling stolen goods. At intake interview, reported overall levels of acquisitive crime had fallen by 98 per cent to only 74 offences. At exit interview no interviewees in the sample reported any acquisitive offences.

Stock-taking

This chapter has presented information collected on the offenders serving DTTOs. It shows clearly that at the start of the order, the majority of offenders were still using illicit drugs and a large minority were still involved in acquisitive crime. On the other hand, both drug use and crime were on aggregate very substantially reduced.

By the six-month stage, those still on their orders showed further improvements. In part this reflects the process of attrition whereby offenders who were poor risks removed themselves from the programme by failing to meet conditions or by getting re-arrested.

Our exit interviews show a very positive picture for the small number of offenders who had successfully reached the end of their orders, or who were within a few weeks of doing so. This group of 31 said that they had stopped committing property crimes, and their drug use was largely restricted to cannabis. Those whose orders had been revoked were more heavily engaged in illicit drug use and reported some involvement in other offending – though they were still less involved in both drugs and crime than immediately before their arrest. We suspect that to date we have secured interviews with those amongst the revoked offenders who can be regarded as “partial failures”; those who were very hard to contact are probably faring much worse.

Whether this is a story of success or failure will emerge more clearly over time. It is too early to say at this stage what proportion of the 210 offenders will complete their orders. It is much too early to say whether the good progress shown on completion will continue into the long term. However, our results indicate that even if a minority of them successfully complete, the amount of crime prevented will remain substantial. We cannot compare these benefits against those derived from alternatives such as imprisonment, but it is worth bearing in mind that many of the sample had previously served several prison sentences, but that only a minority had had previous exposure to treatment services. Our results so far on the impact of DTTOs can be summarised as “promising but not yet proven”. This places the new order on a par with several other forms of sentencing option.

8: Summary and Implications

This report presents the findings of our evaluation of Drug Treatment and Testing Orders (DTTOs). We have examined the three pilot sites (in Croydon, Gloucestershire and Liverpool) as well as four additional projects which use probation 1A(6) orders in ways which closely resemble DTTOs. Our results cover the full period of the DTTO pilot projects, which ran from 1st October 1998 to 31st March 2000.

Throughputs

All three sites got off to a slow start. This was partly because of the way in which the legislation had been framed to require offenders to have committed offences on or after 1 October 1998.[16] But equally important, it took some time for the teams to get into their stride. Though progress was initially slow, the pace of referrals picked up half way into the pilot period (8 to 10 months). The comparison sites seemed to have experienced similar difficulties in getting their schemes up-and-running. In planning national roll-out a slow start should be expected, and this should be planned for.

In total 210 offenders were given DTTOs. Gloucestershire had the highest number (100) and Croydon the lowest (42); Liverpool had 68. The pilots had differing referral and assessment strategies. Liverpool winnowed out slightly more candidates when deciding whether or not to mount full assessments. In Liverpool the courts played a larger part in deciding who to accept and who to reject as suitable candidates for DTTOs.

Testing

We have records of 2,555 urine tests carried out by the end of March covering 173 offenders - an average of 15 each. Just over half (53%) were conducted at the Croydon site. In Liverpool and Croydon, the tests screened for all common illicit drugs except cannabis, and methadone. The Gloucestershire team was more selective. Across the three sites just over two-fifths of the tests (42%) were positive for opiates and 45 per cent were positive for cocaine.

16. This meant that even if teams had been fully prepared to accept them, very few offenders were eligible of having been convicted before Christmas 1998.

Results from our self-report interviews on drug use are broadly consistent with the urine test results. We have self-reported data on drug use covering thirty-day periods, at four to six weeks after the start of the order, after six months and – where applicable – on completion. Looking only at those for whom we have test data corresponding to these periods, the majority who tested positive admitted at interview that they had used the drug in question (72%). What the tests do not show, of course, is changes in level of drug use. Even though they were still using illicit drugs, most of those we interviewed reported steep reductions.

The main views from practitioners about urine testing were:

- tests work well in reinforcing good progress in stopping drug use
- frequent testing is expensive and pointless for those who continue to use drugs
- tests can be destructive to the motivation of those who are reducing their drug use but not managing to stop it completely.

Enforcement

The three sites had widely differing approaches to warnings, breaches and revocations. In all three sites offenders quite often failed to meet the conditions of the order. The main form of non-compliance was failure to attend, but as noted above, many continued to use illicit drugs, especially near the start of their order.

The three pilot teams had different expectations of drug-using offenders and varied in their readiness to warn or breach for non-compliance. The Gloucestershire team imposed the strictest requirements both about drug use and attendance. They had the highest revocation rate, at 60 per cent. Croydon's rate was lower, at 40 per cent, and Liverpool's much lower, at 28 per cent.

Reviews

We hold information on 413 separate review hearings for 154 offenders, an average of 2.6 hearings per offender. Practice varied across the sites. In Croydon and Liverpool reviews were held on a monthly basis. In Gloucestershire, the first review was held after a month, and subsequent reviews were usually held at intervals recommended by the DTTO team – usually between one and three months. Offenders attended in three-quarters of reviews.

There were practical problems in arranging reviews, mainly to do with case listing in two of the three sites. More than four out of five reviews in Liverpool were heard by the judge or magistrates who originally passed sentence; in Croydon the figure was a third, and in Gloucestershire a fifth. Especially for reviews which were heard by the original sentencer, the process seemed a useful one, welcomed by staff and offenders alike as making a positive contribution to the treatment process.

Impact on offenders

We carried out 132 interviews with offenders within six weeks of receiving the order; we re-interviewed 48 of these after they had been on their order for six months; and we carried out 50 'exit interviews' with those who had completed their DTTO successfully, nearly completed it or had it revoked.

On the basis of self-report data, there were substantial reductions in drug use and offending at the start of the order. The average weekly spend on drugs fell from £400 before arrest to around £25. Polydrug use had become much less common; typically people stopped using crack or amphetamine, but continued to use opiates, albeit at a reduced level. There were commensurate reductions in acquisitive crime. As ever, one should be circumspect about self-report data, though the picture to emerge is consistent with the urine testing results and other surveys of this kind.

The six-month interviews showed that these reductions were largely sustained over time. This implies that if DTTOs succeed in retaining offenders within the programme, they seem likely to contain drug use and offending. We cannot say conclusively that this is the case, however. To do this we would need some form of comparison group who had not been exposed to the programmes. However the qualitative (unstructured) data collected in the course of interviews supports the view that offenders who completed their order benefited from the programme.

The exit interviews were completed on two groups – those who reached (or had nearly reached) the end of their order successfully, and those who had failed. The 31 successes said they were crime-free and 27 said they were drug-free – except for their use of cannabis. At present very few orders have matured to this stage. All we can say at this stage is that an eighth of those on orders seem to have emerged drug-free. This proportion will obviously grow over time, but we cannot yet say by how much.

Even the failures had reduced their drug use, and some claimed to have benefited from their experience on the order. Although we cannot be certain, we strongly suspect that we managed to contact the "partial failures" and that there will be a disproportionate number of serious relapses amongst the remainder whom we were unable to interview.

Implications

In this section we have tried to identify factors which contribute to success or failure in setting up DTTO programmes, and have suggested possible solutions to problems encountered by the pilots. We have dealt with these under ten headings:

- inter-agency working
- referral procedures
- assessment
- matching the individual to treatment
- clarity of intervention objectives
- expectations of drug use when on DTTO
- consistency and effectiveness of urine testing
- consistency of sentencers at court reviews
- streamlining breach procedures
- monitoring and evaluation.

Inter-agency working

Achieving effective inter-agency working is perhaps the single most important factor to address in establishing programmes. All three pilot sites encountered quite serious "teething problems"; and many of these remained unresolved. By the end of the pilot only the Croydon team had addressed conflicts and disputes sufficiently thoroughly to be operating as an effective team whose whole was more than the sum of its parts.

It would be wrong to discount the difficulties encountered by the schemes as a function of personality clashes or deficits in skills. They are a consequence of work on a difficult joint enterprise involving organisations with big differences in working styles, traditions and values. We think they are likely to be widespread when DTTOs are rolled out nationally. To aid a successful roll-out, guidance should be issued that an inter-agency approach is expected and that probation services should be proactive in developing teams. Further the Home Office and probation areas will have to invest heavily in:

- selecting staff – especially at management level – with a track record in partnership work
- selecting staff with positive enthusiasm for work with problem drug users
- training staff both in working with problem drug users and in partnership working
- achieving clarity about roles and responsibilities
- designing and running team-building activities
- planning better assessment procedures and treatment programmes.

Teams have tried out different solutions to resolve division of labour issues between different disciplines. We are sceptical about aiming for inter-changeability of staff (where community psychiatric nurses, probation officers and drug workers all do largely the same work). There needs to be a clear division of labour which exploits the strengths of each discipline, but also allows for collaboration on key decision-making areas such as the assessment process and treatment plan. However this division of labour must not undermine the sense that the team is a partnership of equals. Obviously it is important to avoid an inflexible demarcation of labour.

One risk in setting up DTTO partnerships is that the agency with control of the purse-strings uses its financial and contractual power to diminish the professional autonomy of staff in partner agencies. It is a difficult balancing act for probation purchasers to get the service they need from other agencies without demoting them to “junior partners”. Staff from different agencies need to respect the competencies of their colleagues and to feel a degree of responsibility or ownership for the organisational aims and objectives of their colleagues' agencies. To date the pilots have a patchy – but improving – record in doing this.

Referral procedures

One reason why DTTOs got off to a slow start was that neither probation officers nor other agencies such as the police referred appropriate candidates. It is important both to stimulate the flow of referrals and to minimise the proportion of inappropriate referrals. Probation areas need to put systems in place to ensure that PSR writers are aware of DTTOs and the criteria for acceptance on the programme. The referral process can also be improved by the greater involvement of the police service (through divisional intelligence units and arrest referral schemes) in promoting DTTOs with arrestees and informing DTTO teams of potential candidates for orders.

Assessment

This is a two-stage process once offenders have given their consent. First DTTO teams decide whether to accept a referral for assessment, and secondly they mount a formal assessment. The latter are expensive and probation areas should aim to minimise the number of assessments which conclude that the candidate is unsuitable. Just over 40 per cent of those assessed were not put forward for a DTTO. This suggests to us that there is scope for streamlining the initial screening process. It would be useful if teams drew up a clear set of criteria and filtered out inappropriate cases using published guidelines. It is also important that areas should monitor the whole referral and assessment process closely; they need to ensure that referral guidelines are tight enough to avoid overload at the assessment stage – without discarding suitable candidates out of hand.

DTTO teams need to develop a specific diagnostic tool, a task which only the Croydon team appeared to have completed with a degree of success. The assessment process needs to be more discriminating in winnowing out both those who are certain to fail and those who need very little help to address their drug problems. Given their cost, DTTOs obviously need to be targeted at those offenders on whom treatment programmes will have the greatest impact. Teams are not yet clear whether a longer period of assessment (comparable to bail assessment at an approved probation hostel) would be helpful.

In two of the pilot sites the expertise of health and drug workers was not routinely enlisted in the assessment process. The quality of the assessment process is likely to have been adversely affected. The exclusion of health and drug workers at this initial point contributed to inter-agency difficulties in both teams. There should be an expectation that nursing/drug work staff are involved in the initial assessment process.

Matching the individual to treatment

The pilots exemplify widely differing approaches in the intensity, nature and flexibility of the interventions delivered. It would be helpful to set some expectations nationally in terms of the level of restriction of liberty, the need for chaotic drug users to have a structured programme and the lessons of the Effectiveness Review which suggest that treatment needs to be matched to the individual (Department of Health, 1996).

Clarity of intervention objectives

Whilst there is a growing evidence base about the effectiveness of drug treatment, there is still much professional disagreement about the best approaches. There remains a gulf between supporters of abstinence-based interventions and those who advocate a harm reduction approach. Whatever the case, teams need to articulate their working philosophy, and to achieve a consensus within the team around this. The Croydon team had probably made furthest progress down this route.

Given the level of breach and revocation soon after an order is made it is important that early interventions focus on engaging with drug-using offenders and retaining them in treatment.

The experience of the pilots suggests that it would be useful for DTTO teams to draw up a formal plan of their proposed programme including the following key points:

- named individual responsible for co-ordinating the order
- clear process for joint working, co-ordination of interventions, exchange of information and supervision planning
- roles and responsibilities of staff from different disciplines
- the objective for each intervention and how it will be delivered
- how the programme will meet the needs of poly/stimulant drug users
- how the programme will meet the needs of female drug-using offenders
- how the programme will meet the needs of younger drug-using offenders
- how the programme will meet the needs of ethnic minority drug-using offenders.

Expectations of drug use on DTTO

The Gloucestershire team initially expected very rapid progress to drug-free status. During the course of the pilot the team relaxed their expectations a little but retained the emphasis on abstinence. The other two teams had the less demanding expectation that progress towards abstinence would be gradual and accompanied by relapses. Our reading of the research evidence is that it takes at least three months to engage successfully with this client group; and our own view is that requiring DTTO offenders to be completely drug-free in a matter a weeks is pushing them too far too fast.

Consistency and effectiveness of urine testing

The frequency of urine testing varies markedly between pilot areas. Very frequent testing may not be a good use of money, and can be counter-productive in those who are reducing the amount of drugs they use. However testing does appear to be a powerful tool in reinforcing the motivation of those who are drug-free. Sentencers reported that urine testing gave them more confidence to make a DTTO on defendants for whom they would normally have passed a custodial sentence. We think that testing needs to be integrated fully with treatment programmes, with testing regimes tailored to the objectives set for individual offenders. However, we suggest the following minimum standard: twice per week for the first three months of the orders with discretion to reduce this to a minimum of once per week after that period.

Continuity of sentencers at court reviews

The review process seems to be of value. Offenders respond both to the praise and to the criticism of a sentencer who shows interest in their progress. Our sense is that the benefits are likely to be greatest when the same sentencers are involved throughout the sentencing and review process. The difficulty is the practical one of getting this to happen. The experience in Liverpool shows that it is possible to achieve this consistency with stipendiary magistrates. However the other two sites made little progress in ensuring that the same lay magistrates follow through individual cases. The Merseyside system of regular court sessions dedicated to the review of DTTOs appears to be both effective and efficient. The experience of the Wakefield drug court also shows that it is possible to put in place analogous arrangements for lay magistrates.

Streamlining breach procedures

If there is to be greater consistency across areas, there is a need to produce clearer indications of guidelines for when breach is appropriate. The thorniest issue will be in developing guidelines which are palatable to sentencers on the one hand, and on the other are pragmatic enough to recognise that reducing drug use can be a slow and fragile process. We do not think that the revised (2000) National Standards for probation orders could be applied un-amended to DTTOs. On the one hand the greater intensiveness of the DTTO means that the opportunities for failure are very much higher than for a conventional probation order. On the other, the nature of dependent drug use is such that relapses are very likely to occur even under the toughest regimes of control. Although an expectation of consistent attendance should be set, teams should be encouraged to concentrate mainly on the reduction and cessation of offending behaviour. Given the number of contacts with the programme which will be required of DTTO offenders, there is a persuasive case for setting the number of unacceptable failures which will trigger breach action at a higher level than for probation or community service orders.

More work needs doing in clarifying the procedure for Crown Court breaches and improving the speed of the police response in executing warrants. It would make sense for probation areas to negotiate arrangements for executing warrants with their local police force, as was done in Croydon.

Monitoring and evaluation

We think it important that from the start schemes should design monitoring arrangements into their programmes. We have already suggested that the referral and assessment process needs to be monitored, to ensure that resources are not being wasted on excessive numbers of assessments. Schemes should also be in a position to say how many contact hours per week offenders have with the programme. (It will be remembered that two out of the three pilots were unable to do this.)

Schemes need to keep a close watch on enforcement rates – the proportion of orders where warnings, breach proceedings and revocations occur. A high failure rate in the early stages of an order can mean several things:

- orders are being made for inappropriate offenders
- there are delays in getting offenders fully assessed and into treatment
- there are treatment queues or lack of appropriate treatment.

The evidence on treatment effectiveness suggests that at least three months is needed to effect any lasting change; thus retaining people in treatment for this period ought to be a priority for any DTTO programme.

Concluding thoughts

The decision to "roll-out" DTTOs nationally was taken – for understandable reasons – before the completion of this evaluation. We think that this was the right decision, though, for the range of reasons presented in this report, we could hardly portray the pilot programmes as unequivocally successful. Evaluations usually set out to test whether a particular approach is effective, and often end up concluding that the approach was put into practice so poorly that one cannot draw any conclusions at all about effectiveness. In this instance we think that there is sufficient evidence to say that the approach is viable, but at one stage it looked to us as if our main conclusion would be about implementation failure. At different stages in their life all three schemes struggled, and our judgement is that only one of the three ended up with a viable DTTO programme. However the experiences gained from all three pilots will prove invaluable.

The evidence from this evaluation and from previous research suggests that drug-dependent offenders can be successfully coerced into treatment as they pass through the criminal process. But it is equally clear that the best schemes rely for their effectiveness on local "champions" who are heavily committed to the enterprise. This is likely to be true of any enterprise that relies heavily on inter-agency partnerships. In rolling out DTTOs the challenge facing the Home Office and the probation service is how to engender for this "top down" initiative the same sort of enthusiasm and commitment which typify "bottom up" innovations.

Appendix A: Details of research methodology

This appendix summarises the various sources of data on which our conclusions are based, providing details about the number of cases in each dataset by March 2000.

Monitoring data

Pilot sites are required to collect a range of data including information on details of referrals received and assessments made; profiles of those who receive orders; the outcome of court reviews and urine testing data. These data are sent to the research team on a quarterly basis. While all sites collect the basic set of data to meet Home Office requirements some sites collect additional information.

Individual interviews and focus groups

In order to assess the development and delivery of DTTO interviews were undertaken with individuals from a range of stakeholder agencies and focus groups conducted with staff delivering DTTOs. The following table gives details of the people interviewed for the process evaluation. In addition to the individual interviews shown, two focus groups were conducted with each of the three operational teams. Additionally a focus group was conducted with a group of lay magistrates at both the Croydon and Gloucestershire sites. A further six focus groups were conducted with those involved in the development or delivery of the interventions in the comparison sites. Finally, two exit interviews were carried out with staff who left DTTO teams in the course of the pilot period. In total, 132 people were interviewed in an individual or group setting for this process evaluation.

Interview with offenders

We aimed to interview each offender who received a DTTO at three points, within a month of receiving an order, six months into the order and close to or immediately following the end of DTTO. Offenders were asked to give information about drug using and offending behaviour prior to and since being on the order, drug treatment/service use history, employment, accommodation, health and initial attitudes and experiences of DTTOs. This report contains information on 132 intake interviews, 48 interim interviews and 50 'exit' interviews. Of the 78 drug-using offenders given DTTOs not interviewed at intake many failed to participate in the scheme in the first four weeks of their order being made. They were therefore not available for interview. Sixty-three orders are on going and have not yet reached or are just about to reach the six months stage. A further 79 drug-using offenders orders were revoked before six months leaving 68 drug-using offenders who were eligible for an interim interview. One hundred and three drug-using offenders were eligible for 'exit' interviews. The table below shows the distribution of the interviews by pilot site.

Site	Total No. of orders made	1st interview	2nd interview	Exit interviews	Total No. of interviews
Gloucestershire	100	65	25	33	123
Liverpool	68	39	10	11	60
Croydon	42	28	13	6	47
Totals	210	132	48	50	230

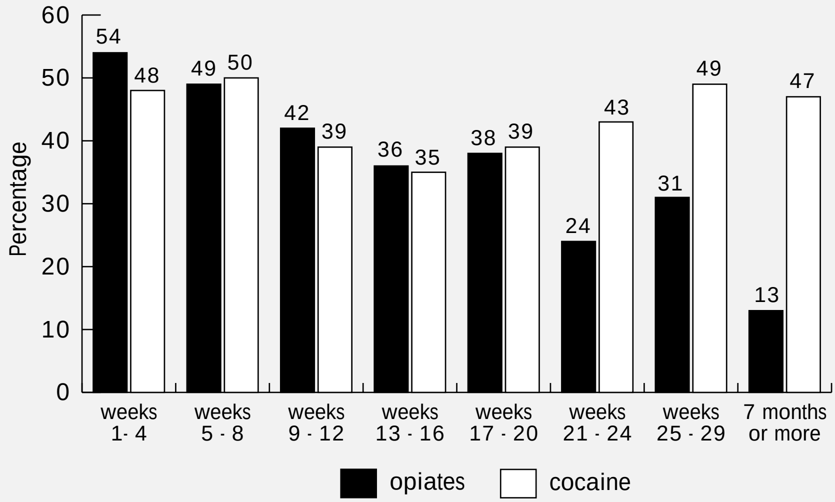
Activity data and focus group interviews with comparative non-pilot sites

The research team was asked to collect some comparative information from initiatives which have a similar approach as DTTOs to working with drug-using offenders. Activity data on the first 12 months of operation has been supplied by three schemes: the West Yorkshire drug court and STEP programme, the PASCO scheme in Cheshire and the Hastings Multi-agency Drug Treatment and Testing Programme. Fast Track in Plymouth and Torbay were able to provide us with data on the first nine months activity data. In order to gain an insight into the process of how these initiatives have evolved and tackled problems, focus-group interviews with those who developed, managed and delivered these schemes were undertaken. The West Yorkshire scheme was able to provide us with an unpublished process evaluation highlighting the main issues faced by them in the delivery of their scheme.

Appendix B: Details of urine test data

This appendix provides details on the urine test result collected by DTTO pilot sites by the end of March 2000.

Positive opiate and cocaine tests over time: all 3 pilot sites



Weeks 1 – 4[17 18]

Opiates: 157 offenders tested 750 times[19] (range 1 to 22, mean 5, median 4). 408 positive tests produced by 128 offenders (range 1 to 14, mean 3, median 2.5).

Cocaine: 157 offenders tested 626 times (range 1 to 22, mean 5, median 4). 301 positive tests produced by 92 offenders (range 1 to 13, mean 3, median 2).

Weeks 5 – 8

Opiates: 112 offenders tested 485 times (range 1 to 13, mean 4, median 3). 236 positive tests produced by 68 offenders (range 1 to 9, mean 4, median 3).

Cocaine: 112 offenders tested 424 times (range 1 to 13, mean 4, median 3). 212 positive tests produced by 53 offenders (range 1 to 11, mean 4, median 3).

17. Calculated using date of sentence and test date.
18. 69 tests appear to have been carried out on 29 offenders prior to them receiving a DTTO sentence. These tests have been categorised as taking place during the first month of the order.
19. Excluding missing cases.

Weeks 9 – 12

Opiates: 81 offenders tested 350 times (range 1 to 12, mean 4, median 3). 146 positive tests produced by 53 offenders (range 1 to 11, mean 3, median 2).

Cocaine: 81 offenders tested 325 times (range 1 to 12, mean 4, median 3). 127 positive tests produced by 37 offenders (range 1 to 11, mean 3, median 2).

Weeks 13 – 16

Opiates: 61 offenders tested 247 times (range 1 to 13, mean 4, median 3). 88 positive test results produced by 35 offenders (range 1 to 10, mean 3, median 2).

Cocaine: 61 offenders tested 226 times (range 1 to 13, mean 4, median 3). 78 positive tests produced by 27 offenders (range 1 to 11, mean 3, median 2).

Weeks 17 – 20

Opiates: 44 offenders tested 166 times (range 1 to 14, mean 4, median 2). 63 positive test results produced by 21 offenders (range 1 to 12, mean 3, median 1).

Cocaine: 44 offenders tested 153 times (range 1 to 14, mean 4, median 2). 59 positive test results produced by 15 offenders (range 1 to 10, mean 4, median 3).

Weeks 21 – 24

Opiates: 34 offenders tested 143 times (range 1 to 19, mean 4, median 2). 34 positive test results produced by 17 offenders (range 1 to 7, mean 2, median 1).

Cocaine: 34 offenders tested 132 times (range 1 to 19, mean 4, median 2). 57 positive test results produced by 13 offenders (range 1 to 11, mean 4, median 4).

Weeks 25 – 29

Opiates: 24 offenders tested 117 times (range 1 to 17, mean 5, median 3.5). 36 positive test results produced by 12 offenders (range 1 to 9, mean 3, median 3).

Cocaine: 24 offenders tested 112 times (range 1 to 17, mean 5, median 3.5). 55 positive test results produced by 7 offenders (range 2 to 17, mean 8, median 8).

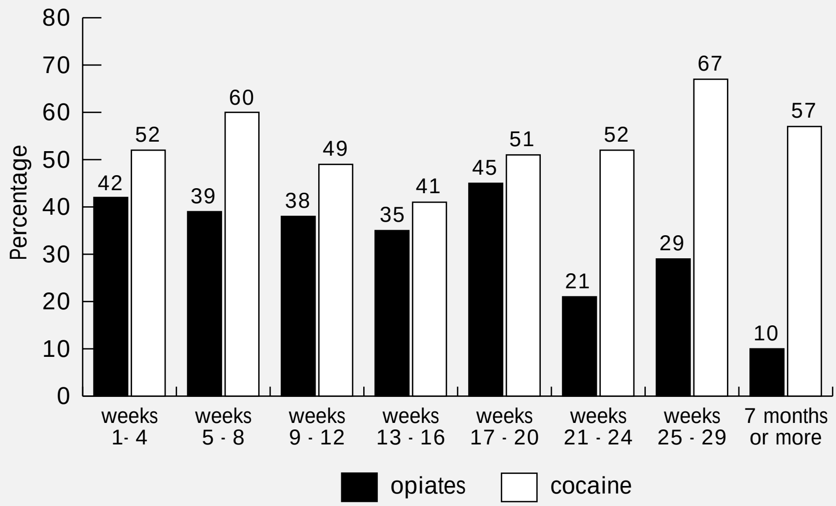
7 months or more

Opiates: 21 offenders tested 238 times (range 1 to 60, mean 11, median 6). 32 positive test results produced by 8 offenders (range 1 to 11, mean 4, median 3).

Cocaine: 21 offenders tested 236 times (range 1 to 60, mean 11, median 6). 110 positive tests produced by 8 offenders (range 1 to 36, mean 13.8, median 9.5).

Croydon data

Positive opiate and cocaine tests over time: Croydon



Weeks 1 – 4

Opiates: 36 offenders tested 330 times (range 2 to 22, mean 9, median 9.5). 137 positive tests produced by 23 offenders (range 1 to 14, mean 6, median 5).

Cocaine: 36 offenders tested 330 times (range 2 to 22, mean 9, median 9.5). 172 positive tests produced by 30 offenders (range 1 to 13, mean 6, median 5.5).

Weeks 5 – 8

Opiates: 29 offenders tested 240 times (range 1 to 13, mean 8, median 9). 94 positive tests produced by 17 offenders (range 1 to 9, mean 6, median 6).

Cocaine: 29 offenders tested 242 times (range 1 to 13, mean 8, median 9). 145 positive tests produced by 23 offenders (range 2 to 11, mean 6, median 6).

Weeks 9 – 12

Opiates: 25 offenders tested 200 times (range 2 to 12, mean 8, median 10). 75 positive tests produced by 17 offenders (range 1 to 11, mean 4, median 4).

Cocaine: 25 offenders tested 202 times (range 2 to 12, mean 8, median 10). 99 positive test results produced by 19 offenders (range 1 to 11, mean 5, median 5).

Weeks 13 – 16

Opiates: 20 offenders tested 139 times (range 1 to 13, mean 7, median 8.5). 49 positive tests produced by 12 offenders (range 1 to 10, mean 4, median 3).

Cocaine: 20 offenders tested 141 times (range 1 to 13, mean 7, median 8.5). 58 positive test results produced by 14 offenders (range 1 to 11, mean 4, median 2.5).

Weeks 17 – 20

Opiates: 14 offenders tested 98 times (range 1 to 14, mean 7, median 7.5). 44 positive tests produced by 10 offenders (range 1 to 12, mean 4, median 3.5).

Cocaine: 14 offenders tested 100 times (range 1 to 14, mean 7, median 7.5). 51 positive tests produced by 11 offenders (range 1 to 10, mean 5, median 3).

Weeks 21 – 24

Opiates: 12 offenders tested 95 times (range 1 to 19, mean 8, median 8). 20 positive tests produced by 7 offenders (range 1 to 7, mean 3, median 1).

Cocaine: 12 offenders tested 95 times (range 1 to 19, mean 8, median 8). 49 positive test results produced by 9 offenders (range 1 to 11, mean 5, median 6).

Weeks 25 – 29

Opiates: 9 offenders tested 72 times (range 1 to 17, mean 8, median 9). 21 positive tests produced by 6 offenders (range 1 to 9, mean 4, median 3).

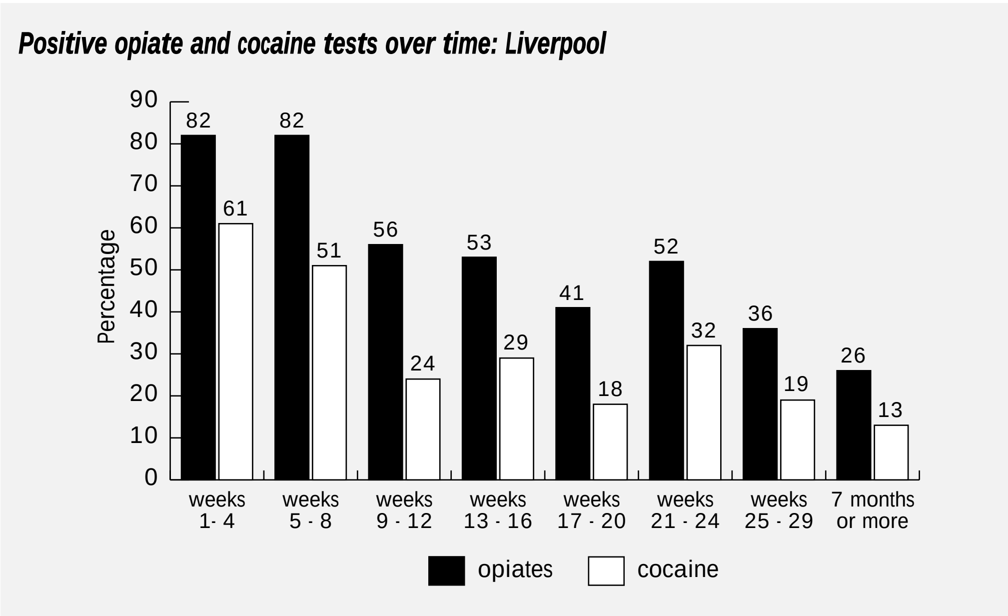
Cocaine: 9 offenders tested 73 times (range 1 to 17, mean 8, median 9). 49 positive tests produced by 5 offenders (range 3 to 7, mean 10, median 9).

7 months or more

Opiates: 6 offenders tested 179 times (range 10 to 60, mean 30, median 28.5). 18 positive test results produced by 3 offenders (range 2 to 11, mean 6, median 5).

Cocaine: 6 offenders tested 180 times (range 10 to 60, mean 30, median 28.5). 103 positive test results produced by 5 offenders (range 6 to 36, mean 21, median 18).

Liverpool data



Weeks 1 – 4

Opiates: 55 offenders tested 153 times (range 1 to 6, mean 3, median 2). 125 positive tests produced by 51 offenders (range 1 to 6, mean 3, median 2).

Cocaine: 55 offenders tested 153 times (range 1 to 6, mean 3, median 2). 93 positive tests produced by 42 offenders (range 1 to 6, mean 2, median 2).

Weeks 5 – 8

Opiates: 40 offenders tested 113 times (range 1 to 8, mean 3, median 2). 93 positive tests produced by 32 offenders (range 1 to 8, mean 3, median 3).

Cocaine: 40 offenders tested 113 times (range 1 to 8, mean 3, median 2). 58 positive tests produced by 24 offenders (range 1 to 6, mean 2, median 2).

Weeks 9 – 12

Opiates: 34 offenders tested 86 times (range 1 to 6, mean 3, median 3). 48 positive tests produced by 25 offenders (range 1 to 4, mean 2, median 2).

Cocaine: 34 offenders tested 86 times (range 1 to 6, mean 3, median 3). 21 positive test results produced by 12 offenders (range 1 to 4, mean 2, median 2).

Weeks 13 – 16

Opiates: 25 offenders tested 59 times (range 1 to 4, mean 2, median 2). 31 positive tests produced by 16 offenders (range 1 to 4, mean 2, median 2).

Cocaine: 25 offenders tested 59 times (range 1 to 4, mean 2, median 2). 17 positive tests produced by 10 offenders (range 1 to 3, mean 2, median 2).

Weeks 17 – 20

Opiates: 19 offenders tested 44 times (range 1 to 5, mean 2, median 2). 18 positive tests produced by 10 offenders (range 1 to 4, mean 2, median 1.5).

Cocaine: 19 offenders tested 44 times (range 1 to 5, mean 2, median 2). 8 positive tests produced by 4 offenders (range 1 to 3, mean 2, median 2).

Weeks 21 – 24

Opiates: 14 offenders tested 25 times (range 1 to 4, mean 2, median 1.5). 13 positive tests produced by 9 offenders (range 1 to 4, mean 1, median 1).

Cocaine: 14 offenders tested 25 times (range 1 to 4, mean 2, median 1.5). 8 positive tests produced by 4 offenders (range 1 to 4, mean 2, median 1.5).

Weeks 25 – 29

Opiates: 10 offenders tested 31 times (range 1 to 5, mean 3, median 3). 11 positive tests produced by 4 offenders (range 1 to 5, mean 3, median 2.5).

Cocaine: 10 offenders tested 31 times (range 1 to 5, mean 3, median 3). 6 positive tests produced by 2 offenders (range 2 to 4, mean 3).

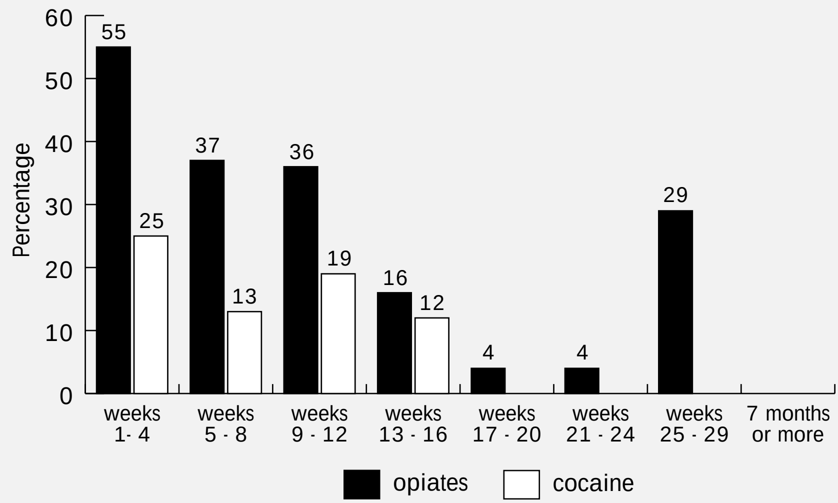
7 months or more

Opiates: 11 offenders tested 53 times (range 1 to 9, mean 5, median 5). 14 positive tests produced by 5 offenders (range 1 to 7, mean 3, median 3).

Cocaine: 11 offenders tested 53 times (range 1 to 9, mean 5, median 5). 7 positive tests produced by 3 offenders (range 1 to 5, mean 2, median 1).

Gloucestershire data

Positive opiate and cocaine tests over time: Gloucestershire



Weeks 1 – 4

Opiates: 66 offenders tested 267 times (range 1 to 12, mean 4, median 4). 146 positive tests produced by 54 offenders (range 1 to 9, mean 3, median 2.5).

Cocaine: 66 offenders tested 143 times (range 1 to 12, mean 4, median 4). 36 positive tests produced by 20 offenders (range 1 to 6, mean 2, median 1).

Weeks 5 – 8

Opiates: 43 offenders tested 132 times (range 1 to 11, mean 3, median 2). 49 positive tests produced by 19 offenders (range 1 to 8, mean 3, median 1).

Cocaine: 43 offenders tested 69 times (range 1 to 11, mean 3, median 2). 9 positive tests produced by 6 offenders (range 1 to 3, mean 2, median 1).

Weeks 9 – 12

Opiates: 22 offenders tested 64 times (range 1 to 8, mean 3, median 2.5). 23 positive tests produced by 11 offenders (range 1 to 5, mean 2, median 2).

Cocaine: 22 offenders tested 37 times (range 1 to 8, mean 3, median 2.5). 7 positive tests produced by 6 offenders (range 1 to 2, mean 1).

Weeks 13 – 16

Opiates: 16 offenders tested 49 times (range 1 to 9, mean 3, median 3). 8 positive tests produced by 7 offenders (range 1 to 2, mean 1).

Cocaine: 16 offenders tested 26 times (range 1 to 9, mean 3, median 3). 3 positive tests produced by 3 offenders.

Weeks 17 – 20

Opiates: 11 offenders tested 24 times (range 1 to 7, mean 2, median 1). One positive test produced.

Cocaine: 9 negative tests produced by 7 offenders.

Weeks 21 – 24

Opiates: 8 offenders tested 23 times (range 1 to 7, mean 3, median 2.5). One positive test produced.

Cocaine: 12 negative tests produced by 7 offenders.

Weeks 25 – 29

Opiates: 5 offenders tested 14 times (range 1 to 6, mean 3, median 2). 4 positive tests produced by 2 offenders (range 1 to 3, mean 2).

Cocaine: 8 negative tests produced by 4 offenders.

7 months or more

Opiates: 6 negative tests produced by 4 offenders.

Cocaine: 3 negative tests

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