Drugs, Criminal Justice and Treatment -

Working Together

Report of a conference held in June 2004

THAMES VALLEY PARTNERSHIP

WORKING FOR SAFER COMMUNITIES

Contents

1. Introduction and Aims of the Day

Sue Raikes, Chief Executive, Thames Valley Partnership
and ACC Mike Page, Thames Valley Police

This report brings together the notes of the presentations and workshops together with issues from the conference "Drugs, Criminal Justice and Treatment – Working Together" held at Unipart House, Cowley on Tuesday June 22nd 2004.

The Thames Valley Partnership "brings people and organisations together to work for safer communities". One of our roles is to act as honest broker between the range of organisations both statutory and voluntary, which contribute to community safety. In the last couple of years we have convened a series of meetings between the key strategic players involved in drugs and drug treatment at a Thames Valley level. This meeting brought together the Police, Probation Service and the Thames Valley Strategic Health Authority, together with representatives from DATs and drugs commissioning services. The aim of this group was to identify the issues that needed to be addressed at strategic level to support the work going on more locally through DATs, commissioning structures and within the criminal justice system.

During this period there has been an increased emphasis on joining together the drugs agenda with those of the Crime and Disorder Partnerships (CDRPs). There have also been a number of new initiatives in the criminal justice and treatment field including the recent introduction of the Criminal Justice Intervention Programme (CJIP).

In autumn 2003 the Thames Valley Partnership was approached by Thames Valley Police and Government Office for the South East (GOSE) with a proposal to jointly host a conference to bring together the various sectors involved in drugs, criminal justice and treatment, with a view to developing good practice, improving collaboration and identifying issues that needed to be addressed at a more strategic level.

The aim was to bring together people who are commissioning or providing services to offenders to tackle the drug problems which lead to crime and to: -

- Develop a wider understanding of policy and current changes in policy
- Share best practice on what is happening locally
- Identify problems and issues that emerge from working together

The event was designed to feed into the strategic discussions being held in other networks including the Local Criminal Justice Board, the Chief Constables meeting with Chief Executives of Local Authorities, the Thames Valley Strategic Health Authority and PCT strategy meeting, GOSE and other bodies.

The conference was supported by the Thames Valley Partnership, Government Office for the South East and Thames Valley Police.

It was aimed at senior practitioners and middle managers from Drug Action Teams, Community Safety, Local Authorities, Police, Probation, Prison, Primary Care Trusts, Magistrates and those working to support offenders with drug treatment, accommodation and other support services.

The event was designed and co-ordinated by a steering group with representatives from various sectors (see below) which met over several months and put together an interesting and challenging programme.

The final session of the day was a structured exercise designed to identify key messages and issues that needed to be taken back to the strategic bodies with responsibilities in this area of work including the Local Criminal Justice Board, Chief Executives of Local Authorities, the Thames Valley Strategic Health Authority and PCTs.

This report includes notes of the main plenary presentations and discussions, outline notes of the workshops and a report from the final session, which formed the basis for the report back to the key strategic authorities.

I would like to take this opportunity of thanking the members of the steering group for their unstinting support to this event and to thank Thames Valley Police and GOSE for their financial support to make it happen.

We hope that this report will be of assistance both to those who attended the event as a record of the day but also for those who were not able to be with us, but who are part of the complex jigsaw of improving our services, preventing drug misuse, and providing treatment.

Steering Group Members:

Sue Raikes, Thames Valley Partnership
Fiona Marshall, The National Treatment Agency for Substance Misuse
Janet Ashfield, West Berkshire Council
Liz Allen-Steer, Thames Valley Police
Liz Butcher, GOSE
Maxine Myatt, Thames Valley Probation Service
Pat Peters, Thames Valley Police
Paul Wolf, Home Office
Rachael Dalby, Wokingham District Council

Assistant Chief Constable Mike Page opened the conference stressing his own and Thames Valley Police's commitment to partnership working – but acknowledging the challenges in making partnership work effective.

"Partnerships need to establish trust in order to establish joint working possibly even a 'pre-nuptial' agreement before entering into partnership."

He recognised the huge progress which has already been achieved in this field between CDRPs, DATs and DAATs and expressed hope that today's event would be successful in sharing ideas as well as creating an agenda for change.

2. Key Messages for Strategic Bodies

One of the aims of the conference was to provide an opportunity for those working in the fields of drugs, criminal justice and treatment to consider problems and issues raised in current policy and practice and to consider messages that they would want taken back to the various strategic groups responsible for this complex field of work. The results have been taken back to the Thames Valley Criminal Justice Board, the Chief Executives of Local Authorities, the Thames Valley Strategic Health Authority and the Chief Executives of the Primary Care Trusts.

The following points were raised during the course of the plenary and discussion groups and collated through a structured feedback exercise at the end of the day. This account also includes some comments from the feedback events with the strategic bodies.

Issues of Importance for All Agencies

- The need for shared targets and key performance indicators that encourage partnership working rather than pull organisations in opposite directions
- Identify conflicting targets and prioritise those that work to shared objectives with other partners
- Devise joint funding systems and pooled budgets
- Improve information sharing and the quality of information that is both held and shared
- Improve leadership and strategic direction and give better support to practitioners and complex partnerships on the ground
- The need to include alcohol within the remit of drugs strategies and in the work of DATs/DAATs
- Greater attention to the views of service users and practitioners on the ground
- Better evaluation and a greater focus on evidence-based practice

In the initial feedback meetings it was suggested that agencies could develop Public Service Agreements to create shared targets. The Police pointed out that the Bichard Enquiry would be giving greater prominence to the need for information sharing and may clarify some of the data protection issues. The next section identifies issues of particular relevance to particular sectors and individual agencies

Local Authorities

- Stronger and more informed leadership including leadership of DAATs and DATs. A designated head of service responsible for drugs policy and practice
- More constructive engagement in the issue and with other partners
- More clarity on principles and procedures
- A more joined up approach within the local authority to include education, housing and benefits
- Closer links with crime and disorder and anti-social behaviour work

Housing

The issue of housing for drug users received a lot of attention during the day and is seen as crucial as to the successful resettlement of offenders and helping them to maintain a drug-free lifestyle. Specifically delegates called for: -

- Housing provision for independent units linked to treatment facilities
- Increased housing with support
- Drug users to be identified as a priority for housing provision
- A more positive approach to resettling those with rent arrears
- A recognition that housing cannot be achieved through the Supporting People initiative alone and needs a wider and mainstream response

Consultation and Local Responsiveness

Many groups identified a need for a more bottom-up approach which would be responsive to local needs. There was a call for better consultation and greater knowledge of the issues faced by service users and by practitioners on the ground. There was a general recognition that this could conflict with national performance indicators and targets but also a widespread sense that a purely top down strategy would not be effective.

Other Issues

- Inclusion of alcohol in all drug strategies and in the work of DAATs
- Recognition of the need for premises for voluntary organisations
- Better evaluation and more focus on 'what works'

Thames Valley Criminal Justice Board

Delegates felt that the Criminal Justice Board should be more visible and accessible to members of DATs and CDRPs. There is a need for better communication summed up in questions, including:

- What are you?
- What do you do?
- How can you help us?

Case Management for all agencies

- Improve information sharing throughout the criminal justice system and drug treatment systems in the broadest sense and with wider partners
- Good multi-agency assessment and care pathways should start on day one within the criminal justice system
- A national assessment tool
- Local case-working and multi-agency approaches should support the rehabilitation of individual
- Criminal justice interventions should be integrated more effectively with the NHS

Prison Service

- Keep Thames Valley people within the Thames Valley wherever possible
- Improve links between prisons and the local CJIPs – including prisons outside the Thames Valley
- Improve continuity of care for remand prisons
- Ensure sufficient resources to work with every substance-misusing prisoner to develop an effective plan prior to release

The Thames Valley Criminal Justice Board and the Local Authorities both suggest that these improvements are key to the new Prolific and Priority Offender Strategy which will be targeting interventions on identified offenders who are responsible for a large amount of crime. There is a significant overlap (between 70 and 90%) between these priority offenders and the drug using offenders who are the target group for CJIP.

(The Prison Service point out that not all Thames Valley prisons have drug treatment facilities).

Courts and Sentencers

- Need to access the views of sentencers and educate them about the current drugs agenda
- Ensure court and CPS involvement in drug strategy development across the Thames Valley including involvement in CDRPs and DATs
- Establish specialised drug courts and improve knowledge of available treatment

Police

- Develop a force wide approach and common attitudes towards the drugs issue
- Develop a crack strategy and protocols for Thames Valley Police and its partners
- Implement consistent standards for charging of drugs offenders
- Have consistent standards of data held at police headquarters available to BCUs

Thames Valley Strategic Health Authority and Primary Care Trusts

Much of the discussion about information sharing focused around the relationship between health and other agencies. Whilst health may, in principle, be signed up to local protocols there was a widespread concern that medical practitioners are holding on to information that should be shared. This was seen as an issue primarily about trust. It was felt that the Thames Valley Strategic Health Authority should be taking a stronger lead on information sharing. At local level the solution was to have an identified appropriate person attending partnership meetings and sharing the data. Public health was seen as a possible lead on data collection and analysis.

Engagement/Accountability

There was a strong sense that there needed generally to be more engagement in the drugs issue by the Thames Valley Strategic Health Authority, PCTs and GPs. Health need to engage and become active partners of CDRPs and DATs and the Strategic Health Authority should ensure that PCTs are accountable for the quality of drug treatment at local and strategic levels. The Strategic Health Authority needed a clear policy on drugs

and to delegate operational issues to PCT level. There was a sense that the structures were not right –and a call for PCT areas to be coterminous with local authorities and CDRPs. There was a need for greater clarity on who does what, including identifying financial contributions from PCTs. There is also a need for improved integration and involvement from mental health services and planning structures.

Shared Care

Shared care is working well in some areas but not in others. It is not universally in place and there is a widespread call to "make shared care happen". Drug users need better access to GPs and there should be greater involvement of GPs in local partnerships where appropriate.

Delegates identified a need for greater GP training and a better understanding of drug treatment and testing orders amongst GPs. There was a call for better information both **for** GPs and **about** GPs including local directories of GPs willing to work with substance misusers for prescribing etc.

One group called for a co-ordinated approach to tackling Hepatitis C epidemic in drug using community.

Over-viewing and Prescribing in Prison

There was a call for prescribing facilities to be available in prisons and for a co-ordination of substitute prescribing practice in prison and on release to ensure consistency.

The Government and GOSE

The issue of KPIs and targets was a common theme throughout the day. In particular there was a call for fewer Government targets linked to long-term outcomes. Agencies need greater freedom from top down performance management to allow for more bottom up responsive ways of working. The tension between national and local drivers came up frequently during the day and there was a call only to interfere when necessary i.e. when areas are under performing.

The data information sharing issue was again a frequent theme. In the final session there was a call for a stronger lead from GOSE and the resolution of these data protection issues at Government level between the Department of Health and the Home Office, summed up in one group's contribution that government needs to "Break the data paralysis".

Consistent Policy on Alcohol

The need to include alcohol as part of the wider drug strategy was highlighted throughout the day. It was felt that alcohol should have a much higher priority for all agencies and the Government should allocate resources and issue guidance. There was a sense of disappointment that the long awaited strategy has still not created a clear agenda for change.

There needed to be a more consistent message about alcohol and GOSE should take a stand about the conflict between the licensing legislation and the alcohol harm reduction strategy.

There needs to be new funding for alcohol treatment: - "Alcohol treatment should not be a poor cousin with no cash".

Funding

This topic inevitably also gained attention during the day. The main issues identified were: -

- Better communication and easier access to various funding streams at all levels/District/County/GOSE/Home Office
- The need for guidance and proper funding **before** projects are due and budgets set
- Funding should be at least for three years to enable proper planning and implementation
- Consistent and sustained funding for both drug and alcohol treatment is essential.
- Resources should match targets
- There should be more realistic expectation on return for the investment and in bids.
- PSA rewards should go into shared budgets

Treatment Strategy

The main issue here was the need to join up the key performance indicators, make them meaningful to all agencies and establish joint targets linked into a joint strategic framework. The Government is urged to resolve conflicting targets and develop outcome based KPIs related to real need – not just "vote winners".

The Government is urged to ease off on top down targets and priorities to enable long-term problem solving.

And a final plea - "How can we meet increased targets with decreased funding?"

Also identified was the need for: -

- Faster access to treatment
- Safe injecting areas
- Innovative solutions eg user rooms, vending machines for swab packs, ex-user mentoring etc
- Fast track access to benefits for substance misusers

Common Assessment

The potential for a common assessment tool was raised in both the plenary and in the final session with delegates calling for a national assessment tool – i.e. a single common assessment tool for all agencies which would follow the client (and reduce paperwork).

Resettlement

This was again an important theme throughout the conference with specific points emphasising: -

- More joined up support for drug related prisoners on leaving prison
- Resettlement should link with employment and training
- Better access to benefits and better plans prior to release
- The extension of the homelessness grant to those discharged from court

And Finally Some Messages for National Government

- "Publish the guidance before expecting action"
- "Better collaboration between Government departments – talk to each other when setting targets and funding decisions"
- "Think beyond the next election and easy gains to focus on long-term achievement"

3. Criminal Justice Intervention Programme

Ruth Pope, Legal Policy Team, Home Office

- CJIP Vision
- Priorities for 2004/05
- Long Term Future

CJIP takes a case management approach to support individual users
Key focus is to address very high drop out of treatment
Criminal Justice Integrated Team (CJIT) = a gateway for all services for drug users in the Criminal Justice System (CJS)
New trigger offences for intervention have been agreed by Ministers – likely to be in place in Aug 04
New restrictions on bail are being piloted for 18 months (no pilots in Thames Valley)

CJIP

- The criminal Justice Interventions Programme (CJIP) is a critical part of the Government's strategy for tackling drugs
- It is a 3-year programme to develop and integrate measures for directing drug-misusing offenders out of crime and into treatment
- CJIP – believed to be a world-first. Involves criminal justice and treatment agencies working together with other services to provide a tailored solution for individuals who commit crime to fund their use of Class A drugs
- It draws and builds on existing practice as well as introducing new and innovative elements

The aim of CJIP

- To reduce drug related crime by accessing problematic drug users, getting into treatment, retaining them in treatment and supporting them through and after treatment and sentences

- Or to put it more simply …
- Out of crime, into treatment
- Treatment is not a soft option and it works
- CJIP provides an opportunity for everyone to win
- Drug misusing offenders get help through treatment and support.
- Communities suffer less crime
- The taxpayer saves money as criminal justice costs are reduced
- Helps to restore public confidence in the CJ system

Question and Answer Session

Q. Has the Home Office considered the impact of the new charging scheme on drug testing? It is now CPS lawyers and not police who decide if an offender should be charged. And what about funding after 2005? Example given of prolific offender who would have been charged by police but under the new scheme ('473') CPS advised bailing for further 6 weeks thus offender was out committing further offences.

A. Previously the police determined whether an offender should be charged. From Oct 2004 it will be the CPS who will make this decision. Experience from the pilot scheme shows this is having a dramatic effect on the number of offenders charged because a higher standard of evidence is applied at charging stage. In the 2 months of the pilot being run in Slough out of 273 offenders who would have been charged by police, CPS advised only 9 should be charged and the remaining 264 should be bailed. Drug testing is currently done at the charge stage. Police are working with CPS to address this issue. The main problem is conflicting targets in different agencies e.g. CPS have a target to reduce non-effective prosecutions and therefore want higher standards of evidence before an offender is charged.

A. The Home Office is aware of current charging climate. Will take back examples of local issues. Prime Minister is considering bringing forward drug testing to the arrest stage. The funding after 2005 will depend on the results of the Spending Review.

Q. If drug testing is to be conducted at an earlier stage will offenders be able to refuse testing?

A. There will have to be primary legislation before the drug testing regime can be changed.

A. ACC Mike Page – will take this issue back to Local Criminal Justice Board (LCJB) to try and shift this problem in the short term.

Q. If CJIP is successful how can we be sure we have appropriate capacity within treatment provider services?

A. Central Government is working with the Department of Health and the National Treatment Agency (NTA). They have done mapping of capacity and needs and are committed to planning for sufficient services to be in place.

Q. Drug Action Teams (DATs) cannot be expected to do much more than they already are doing.

Q. Are we doing enough prevention and education? Parents are often aware their children are becoming involved in drug misuse. They are unaware of available support services to help them before the child become involved in crime.

A. CJIP focuses solely on the Criminal Justice System. Other strategies are in place to assist children/young people.

Q. It sounds as if everything is being dumped into treatment. Treatment achieves very few successes and all these issues cannot be dealt with by just improving access to treatment.

Q. Housing is an essential element. There are good bits of practice in the Supporting People programme. However, there will not be a huge amount of revenue in the next few years. There won't be much headway unless there is more funding.

Q. Different DATs and CJIPs operate very differently. The Thames Valley needs one system to negotiate care/treatment services. There are too many models of care in the Thames Valley.

A. National Treatment Agency –we do have Models of Care but the needs of areas are very different so they can't all use the same system.

A. ACC Mike Page – I lead on strategic partnerships, however, this is a political minefield and intervention can lead to accusations we are trying to take things over. The Thames Valley is an artificial boundary not recognised as a region by all agencies. We are trying to share good practice.

Q. Concern expressed over women and ethnic communities not being catered for in CJS.

A. We haven't focused enough on these groups and it is something we need to address.

4. Working with Offenders

Gerry Marshall, Chief Officer,
National Probation Service: Thames Valley

I would like to start with the same disclaimer as the previous speakers, as I too am not a drugs expert, but I do welcome this conference now: there is a real need to focus on working more collaboratively to: -

- Reduce the impact of drug misuse - on the public and users
- Get more people into treatment - of the right level
- To do so as speedily as possible
- Build upon improved identification of drug misusers through CARATs and ARREST REFERRAL and TESTING arrangements
- Maximise the potential of CJIP
- Maximise the focus on priority offenders through the Local Criminal Justice Board
- And to look beyond treatment to the issue of stabilisation and rehabilitation

Complexity

You do not need me to reiterate the complexity of the context in which we need to achieve these aims, especially Thames Valley, with so many DATs, with varying CJIP developments, BUT ALSO nationally with the various flows of funds and initiatives. We need to address: -

- Changes in sentencing through the arrival in April 2005 of the Single Generic Community Sentence
- And for Prisons and Probation the introduction of the National Offender Management Service - of which more later
- The balancing of national, regional and very local arrangements

But first a big "thank you" to all our partners and colleagues who have worked with us to ensure that we have managed to hit the national and local targets for DTTO commencements for both the last two years. Sharing and pulling together of our energies has really made a difference, and I know how hard this has been in the face of no growth in DAT budgets last year. An achievement to be proud of when we do work together.

Also it is to all of our credit, that our local figures for successful completions of DTTOs have been running several percentage points above the 28% reported by the National Audit Office. We believe the target of 35% is achievable in Thames Valley. With the arrival of DTTO lights, the increase in DTTO targets this year, and the single generic sentence, we need now to ensure that we spread the focus from the highest risk, and most complex DTTO cases, to all drug users sentenced by the courts. We need to have in place a wider range of interventions/levels of intervention, as at present courts, understandably, want to net widen the use of DTTOs - and want DTTOs/interventions as early as possible in people's offending careers.

Data and Information

I suspect in fact that some of our achievements have been made despite, rather than because of the information and data that we have.

Do we really have a handle on who drug users are, and, most importantly, what their collective - and individual - needs are?

We have again, really appreciated the support we have received to do the gap analysis work that is currently taking place, which should help to inform all of us involved in Crime and Disorder Reduction Partnerships.

EARLY INFORMATION: Of our non DTTO cases over 50% have identified drug problems. Over 27% have both drugs and alcohol identified. The figures are highest for short-term prisoners.

For our part, as Prisons and Probation, we are well on the way to having a single, shared, and thorough risk and needs assessment tool - "OASys". Soon every sentenced offender will have an OASys done, and updated, and we need to find the best way to share this detailed assessment with our partners.

OASys will give us individual assessments, but it will also, over time, give us aggregated information on the needs of offenders - not just in terms of treatment, but also in terms of reducing relapse by addressing offenders' wider needs.

We think it is important to bear in mind the fact that in the majority of cases offenders were offenders first (with the criminogenic needs in terms of housing, employment, family relations, basic skills, mental health) before they become problematic drug users; and many of those needs remain and persist once treatment has been started - or even completed.

We particularly need to know more about the needs of: -

- Women offenders
- Black and Asian offenders
- Younger offenders - 18 - 21/25

What we know from CARATS returns is that Prisons and Probation have contact with, and therefore can deliver access to, many of the most problematic drug users, who we know do not access mainstream services except through the criminal justice route.

We need to make it a reality that access to treatment is enhanced and accelerated through the criminal justice entry routes - at present that is only partially true. Especially as we know that these offenders have as high a clinical need as anyone who presents themselves for treatment.

It is in the area of resettlement from prison that the situation is probably most acute.

The change in the legislation which will mean that everyone leaving custody will have post-custody supervision by probation staff will not come in for a couple of years - in the case of adults sentenced to periods of imprisonment of less than 12 months, as we know

it is short term prisoners who are least likely to get treatment in prison and 62% of drug users in that group re-offend within two years.

We need to find ways of addressing the resettlement needs of short-term prisoners, and working with you and with CDRPs generally to do this - to address their criminogenic needs. So, coming back to OASys, we need to start establishing protocols for linking OASys into a common assessment tool - as a shared assessment tool will be critical.

NOMS

The National Offender Management Service will involve the bringing together of Prisons and Probation following the CARTER Report. The key aims of the new Service are: -

- Reduce re-offending by up to 10%
- End to end case management
- Resettling prisoners more effectively

I have always argued that Probation was in touch with more drug users than all drug agencies put together; the joining up with the Prison Service makes this indisputably the case. But the Carter Report is blatantly dependent upon changing sentencing practice - in order to achieve: -

- Less people going to prison
- More medium risk offenders supervised in the community
- Lower risk offenders being dealt with through mainstream services *without probation involvement*

The Rethinking Crime and Punishment Report emphasises the need for us all to convince sentencers of the validity and capacity of community sentences and mainstream services. A tall order at present.

NOMS involves the establishment of regional offender management structures; if we have found "Thames-Valley-Wide" complex, then the South East Region will be even more complicated.

There is the advantage potentially of close regional links with GOSE and the NTA and so with CDRPs, and there is the potential for regional joint commissioning and planning, but we also know that it is good local, and often very local links, that are needed to develop local effective arrangements to deal with individual offenders.

As yet we do not know how these local links will work, particularly as the NOMS model involves separating out the employing bodies of those who are "offender managers" and those who provide "intervention", with the "offender managers" becoming commissioners of interventions - whether from the public, private, voluntary or not for profit sectors. This is the principle of encouraging "contestability".

With the impending arrival of NOMS we have seen much greater cross departmental involvement already: -

- with the NTA
- with Housing (ODPM)

- with LSCs
- with Job Centre Plus

and this greater involvement brings with it great opportunities to work together, but even greater complexity.

But this is the recognition nationally that drug using offenders, like all offenders, need a more holistic approach.

CJIP too is a recognition of the need to have a wider focus on offending drug users than those in contact with prisons and probation. But there are complications here too, because we could easily find ourselves with two parallel "Case Management" systems (in CJITs and Offender Management). We could find ourselves debating `whose case is it anyway' rather than building on best/developing practice. This fits with one of the key concerns of the Local Criminal Justice Board in its first year, namely how do we have closer integration/co-operation between the criminal justice system on the one hand and CDRPs on the other.

The Chief Constable is having regular meetings with Chief Executives to improve these relationships, and is currently particularly focused on having a more collaborative approach to the current round of Crime Audits (and a plug here for the efforts made by Thames Valley Partnership to encourage this collaboration, particularly with the police and ourselves) - and by ourselves I mean Probation and Prisons.

Criminal Justice Act

I have mentioned the phased implementation of the Criminal Justice Act already, and the need to think wider than DTTOs now in terms of the needs of drug using offenders.

It is important not to widen the net of those on DTTOs - they are meant for the most problematic drug using offenders, and they make heavy demands that many offenders find hard to meet (as we know).

DTTO Lights are in part a recognition of this and partly a recognition of the resource constraints, and are not really an answer to the issue of how to meet the broader needs of the full range of drug misuse by offenders at all levels.

We need to establish access to treatment via the criminal justice system, and much has been achieved already.

Models of Care is clearly the basis and framework for this, and it is going to be important for us all to be able to explain the levels to sentencers. The new Act through the Single Generic Community Sentence creates the scope for new and wider requirements for drug treatment, and the nature of that treatment should reflect Models of Care. As Pre-Sentence Reports authors, the new Offender Managers will need to understand Models of Care and become confident about assessment, based on OASys, for access to treatment - of the half our caseload with drugs problems who are not on DTTOs. But these orders, like DTTOs, are not just about treatment. Treatment is a core element, but not the whole of the work of the order. As I said earlier, we need much more holistic approaches if resettlement and reintegration are going to happen effectively.

Our Service will also have to address the offending related attitudes of offenders, those attitudes which predated drug use, but also made it much more likely.

And Models of Care is, as you know, at different stages of implementation across Thames Valley, and the next 18 months may be difficult ones if the defined treatment needs cannot be met because the range of services are not sufficiently established, and access routes are not clear and agreed.

We need to work with DAT colleagues and treatment providers to agree what more is needed, and how we are to make it work in practice.

Beyond Treatment

So from our perspective treatment is only the start of reintegrating someone into a crime-free lifestyle.

Indeed, in some ways we could say that the arranging of treatment - script, detox, stabilisation - is the easy part. We have made major strides over these in the last couple of years, and DTTOs are fine as far as they go.

But drug use never happens in isolation: it happens in a wider context of domestic violence, of child protection, of rent arrears and housing problems, of employment and basic skills deficits, of family breakdown. Criminal justice and CDRPs need to work together on all of these fronts, especially housing, if we are not going to continue to see breakdown of treatment, relapse and further offending.

We need to develop a more varied set of responses to relapse - from my staff, from sentencers, from housing providers etc. We welcome the way the police have become increasingly interested in the wider aspects of offenders' lives, expanding their previous enforcement and conviction approach. But again we need to be careful not to tread on one another's toes, or do each other's core business. This requires real partnership, mutual trust and respect.

Relapse need not involve a return to crime and to custody if we can, together, work on the ways in which we can help drug users sustain stability, and especially with crack users, how we can help them restructure the whole of their lives without the previous levels of dependency.

Perhaps our Service is too keen to address relapse, particularly of licensees, by recall, rather than by renewed attempts to return people to treatment of some kind. It's almost as if the police have moved towards social support from enforcement, while probation has learned to respond with enforcement rather than enhanced support and intervention.

But to conclude, the scale of the challenge is best exemplified by the figures from the Prison Service which show that they do about 40,000 detoxs each year, but still only have 6,500 treatment places.

We are going to have to work on ways to provide longer-term case management of those who are stabilised or have successfully completed treatment. We are going to have to address both: -

- Why people offend, and
- Why people use drugs

And do this together.

And that is where I hope some of our discussions, today and beyond, can concentrate.

Complexity of the environment

- Thames Valley Structures
- Single generic community sentence
- Strategic vs local tensions:
  NOMS
  LCJB
  CJIP

  But:
  - DTTO targets met – and increased

1

Data and Information

- Gap analysis
- OASys and assessment tools
- Needs – not just treatment
- Women offenders
- Black and Asian offenders
- 18 to 21 year olds
- Prison/Probation (numbers hard to engage)
- Links to CDRPs

2

NOMS (Carter)

- Prison and Probation together
- Reduction in re-offending and resettlement
- Regional and local structures
- CJ route to treatment
- Joint Commissioning potential
- Links to: CDRPs – GOSE – NTA
- Cross government/departmental issues:
  Housing – LSCs – Job Centre Plus
- CJIP

3

Criminal Justice Act

- Wider focus than DTTOs
- Heavy/problematic offenders
- Models of core implementation
- New requirements for drug treatment
- Address treatment and attitudes

4

Beyond Treatment

- Wrap-around services
- Access to mainstream services
- Responses to relapse
- Sustaining stability
- Restructuring lives
- Case management longer term

5

Question and Answer Session

Q. We need a common assessment tool. All agencies should be looking at why people offend and we need to do this at an earlier stage. Police have no powers to ask people why they offend.

A. In operation "IRIS" (Oxford pilot) informal assessments are done. About 80% of offenders will have had an assessment done previously. There is a problem of ownership/sharing of data.

Q. There are too many offenders from the Thames Valley being placed in prisons outside the Thames Valley area.

A. About 70% of Thames Valley offenders are in prisons outside Thames Valley and similar proportion of offenders in Thames Valley prisons are from outside Thames Valley area. Is a problem with insufficient space in prison especially in prison for specific offenders. They can allocate prison spaces in Thames Valley area for some specified offenders and will aim to do so for Local Priority Offenders.

Q. Clients can be 'assessed to death'. There are too many different assessments being done on the same individual. How can we be more joined up?

A. It could be achieved by one assessment tool being imposed nationally on agencies. One tool that is 80% effective may be better than having a range of different tools.

A. The Bichard Enquiry may provide an answer.

Q. Remand prisoners can't access treatment. A lot of prisoners are on remand because they have no fixed address. If remand prisoners did have housing they are likely to lose it whilst on remand. How can we deal with this?

A. Criminal Justice policy is not currently addressing the needs of remand prisoners.

5. Models for Treatment

Paul Hayes, Chief Executive, National Treatment Agency

Making it Work

- Wanting it to work
- Getting the basics right
- Getting the Treatment right
- Consolidating and sustaining change
- Does it work?

1

Wanting it to Work

Shared Agenda
Treatment Delivers
Improvements in:

- Individual health and social functioning
- Public Health
- Community Safety

Barriers:

- Competing Priorities
- Dysfunctional Partnerships
- Ideology
- Poor management
- Lack of leadership

2

Getting the Basics Right

- Management
- Information
- Access:
  - Custody Suite
  - Court
  - Prison
- Attrition
- Deployment

3

Getting the Treatment Right

- Real or virtual CJITs
- Skills
- Care Planning
- Waiting Times
- Choice
- Relevance
- Evidence
- Integrated

4

Consolidating and Sustaining Change

- Offending behaviour
- Housing
- Employment
- Education
- Support
- Access

5

Does it Work?

More:
England 2,488
Reading 85

Quicker:

	Inpatient Detox	Specialist Prescribing	Day Care	GP Prescribing	Coun-selling	Resid Rehab
CJIP	1.9	2.5	1.0	1.4	1.1	2.4
England	2.9	3.9	1.5	1.9	2.5	3.7

6

Does it Work?

Better:
Care Planning
Care Management
Choice
Integration
Quality

Less Crime: ?

7

Treatment delivers health, social and community safety objectives every time. Doctors who are engaged with the criminal justice system gain access to 'hard to reach' group who are usually disengaged with medical services.

Competing priorities are an issue e.g. tackling serious crime or volume crime.

What does 'partnership' mean – not 'my ideas and your money'. Key to making partnership work is to ensure all partners get something out of it.

Need to address the damage done to communities and not just the damage done to the individual.

Poor management is an issue – often due to recruitment difficulties. Treatment services offer relatively low wages and working with an unattractive clientele.

Information is the key to knowing what you're doing and if it is working. Access to treatment needs to be available at all stages of the criminal justice system process. Need to improve the number of people remaining in treatment. Need to know optimum location to place staff to maximise effectiveness.

'Virtual' CJITs have not worked. Need to have identifiable staff preferably co-located. Staff skills are more important than qualifications.

Clients need to be able to choose most appropriate treatment for their needs. Drug treatment needs to be integrated into main social care systems.

Key issues to sustain change: -

- Give people a reason to stay off drugs
- Challenge offending behaviour and not just drug misuse
- Housing
- Employment
- Education
- Provision of support whilst client makes significant change

Questions and Answer Session

Q. Have we the capacity to meet the need?

A. Target is to double the number in treatment by 2008. These aren't new people entering treatment, they are already in the community. The aim is to channel resources more effectively.

Q. How can services be developed to reflect local need?

A. Need to integrate CJIT in to wider care provision. Need to gain access to knowledge of users and carers as they are the only sources of accurate information of needs. Then we will use that knowledge to plan the totality of services.

6. Workshops

6.1 Working Together - Collaborative Structures

Kurt Moxley, Oxfordshire DAAT and
Bill Oddy, Community Safety Manager for West Oxfordshire

Kurt and Bill divided the workshop into two groups and asked them to identify issues for CDRPs and DAATs in relation to: -

a) Policy
b) Problems/Issues
c) Best Practice.

The groups identified the following: -

a) Policy

- Crime and Disorder Act
- Antisocial Behaviour Act (enforcement)
- 'Building Safer Communities'
- Homelessness Act 2002 (Prevention)
- Licensing Act
- Financial Issues – Planning
  Joined up? Short/medium/long term
- Criminal Justice Act (Testing etc)
- Conflicting Targets and BVPLs
  Health/Police/Probation etc
- Information sharing protocols
- Harm reduction strategy
- Lack of understanding of limited capacity
- Need clarity in discussion re 'young people'

b) Problems/Issues

- Correct representation at meeting 'Doers and Influencers'
- Securing Health representation at DAT
- A real understanding of each others' roles ie, housing/employment etc
- Treatment budgets
- Do structures DATs/CDRPs deliver (accountability) more than feel good meetings
- Shared aims/goals – Trust!
- Information sharing protocols/IT etc barriers to...
- DAT under CDRP? Pros and cons
  Loss of treatment agenda
- Different boundaries
- Problems of engagement from all partners (resourcing issues) especially if working together, dependent on good will, problem when this wavers – also when turnover of representatives too great

c) Best Practice

- GOSE 'What's On' bulletin
- Resources/structures and framework built into any plan
- Single assessment process
- 'One-stop shop' approach to through and aftercare
- Political 'Buy-in' – engagement of those locally elected
- Service user involvement
- Solving different boundaries
- Leadership and commitment
- Local interpretation of national strategic aims by CDRPs
- Joint working CDRP and probation to consult with offenders re Motivations – crime reduction opportunities
- Personal contact between partners

6.2 Case Management Models

James Sainsbury, ACT - Buckinghamshire and Slough

The Workshop will cover the following areas

- The assessment system and allocation
- Integrated care pathways
- The needs of the clients
- Care co-ordination of clients

1

Assessment – Models of care recommends a three level system of assessment

Level 1 (screening):	Identification of substance misuse problem Immediate risks Urgency of referral
Level 2 (Triage):	Risk assessment Brief assessment of substance misuse Motivation to change Need for comprehensive assessment/care co-ordination
Level 3 (Comprehensive):	Risk assessment Motivation to change Substance misuse Psychological problems Physical problems Social problems Legal problems

2

Level two assessment (models of care)

- Level 2 assessment needs to be carried out in a standard way according to locally agreed criteria with a standard format across all SMS agencies in a given locality. Information obtained should be shared with all agencies to which the service user is referred.
- The assessor is accountable for the results of the assessment and treatment programme. Referrals are justified accordingly to locally agreed criteria. This will help to ensure that staff carrying out level 2 assessments are not tempted to keep hold of clients.
- It is a filtering process that aims to establish which intervention would best suit an individual substance misuser at the time of assessment. Triage assessment should take place when the substance misuser first contacts services. The substance misuser should be referred to the most appropriate agency.

3

Level Two/Triage/Brief Assessment

- Common assessment carried out by all Tier 2, 3, and 4a services.
- Assessment designed to ascertain enough information to signpost client to the most appropriate part of the combined service.
- Triage element to identify the need and speed of the intervention.
- Assessment to be designed for use by both statutory and non-statutory tier 2, 3, and 4 services.
- Common level 2 assessment to form the first part of the level 3 comprehensive assessment.

4

What is an integrated pathway A system of care which is dynamic and able to respond to changing needs and bring to bear at any given time a range of services and interventions that meet any individual needs in a comprehensive way. 5	**The development of ICP's in the substance misuse field is recommended for several reasons** • Substance misusers may have multiple problems which require effective co-ordination of treatment. • Specialist and generic service providers may be involved in the care of a substance misuser simultaneously or consecutively. • A substance misuser may have continuing and evolving care needs requiring referral to different tiers of service over time. • ICP's ensure a consistency and a parity of approach. • ICP's ensure that access to care is not based on individual clinical decisions or historical arrangements. 6
What are the care needs of a client presenting with a substance misuse problem? Discuss 7	**Care planning/care co-ordination** 'Good systems of care planning and care co-ordination will ensure that services are client centred and not determined by the modalities provided by a particular agency. Such systems are intended to facilitate access to a programme of integrated and co-ordinated social care and to maximise client retention….' 8
Standard Care Co-ordination • Systematic and ongoing assessment of the health and social care needs of those presenting to drug and alcohol services. • Care planning which identifies health and social care needs and responds to these. • Identification of a named care co-ordinator to organise care across health and social agencies and maintain contact with the drug and alcohol misuser. • Regular reviews of the care plan. 9	

ACT has been the main provider of therapeutic drug services in Bucks for the last 20 years working in partnership with statutory services – all services are now under one roof including arrest referral.

Recently there has been a proliferation of service providers in the Drugs field - how can you get them all to have a co-ordinated system of care? Non-statutory agencies competing against each other often gets in the way of joining up and communication.

There are 3 levels of assessment in the ACT case management model – for details see slides attached – Initial screening, triage and the comprehensive assessment

Level 2 Triage – assessing urgency/ need for further assessment – designed to be easily used and signpost the client to services

- Key to getting clients allocated to right/most appropriate service
- Defines where client goes in the system
- Roles in treatment blurred and ill defined – system ensures professionals are doing what they are best at

- Allocations meeting – multi-agency panel at end of triage process. Some clients are only getting repeat assessments and not moving on

Level 2 then forms part of Level 3 (comprehensive) assessment avoiding repetition/duplication and avoiding clients jumping unnecessary hurdles.

ICP - Integrated Care Pathway defined as a system of care with different treatment elements – not just one service provider – should be a comprehensive care package.

Care co-ordinator allocated at this meeting – continuity of care from initial worker also an important consideration.

Questions/Discussion

- **Should alcohol be included in this case management model?**
  CJIP – only concerned with drugs not alcohol aiming to break link between drug use and acquisitive crime

  Crazy not to include alcohol in this assessment framework but currently all funding coming through drugs remit

- **Can the triage assessment be accepted across areas?**
  Triage assessment varies between DAT areas so might need to do another assessment – but could accept it – should be accepting it from other areas

  Assessment should belong to the client – could this be incorporated into a smart card? Clients issues paramount

- **Who is the care co-ordinator? Who does care management and why?**
  Whoever has most contact with client takes on care co-ordinator – perhaps should be someone who hasn't got closest contact – more objective – has overview – but need knowledge of client to inform care plan

  Slough Model – in Slough care co-ordinator takes overview and co-ordinates all service interventions to ensure consistency

  2nd Model – enhanced care co-ordination through existing providers

  Can both models be incorporated at the same time? Some discussion around this issue – should we have care co-ordinators as separate new role or enhance existing workers? First model may build up bottle-neck.

- **What about information sharing?**
  Client agreement to care plan gives permission for all involved to share information.

- **What about care co-ordination for CJIP clients?**
  CJIP workers have an overview of client care plan so should CJIP worker to be care co-ordinator? All workers should be doing some care co-ordination – but for complex cases perhaps need enhanced care co-ordination – need named person responsible for co-ordinating the whole care package.

6.3 GP Engagement

Frances Davies GP and Oxfordshire DAAT

Reasons why people came to the workshop: -

- How to communicate with GP
- What are the barriers for GP in engaging with drug users
- How can GPs interface with criminal justice
- Representation from DATs where GP engagement is low

Frances' account of Oxfordshire experience – key parts

Legitimate for medical practice to treat a condition self imposed – not all GPs agree with this.

As problem has grown, GPs in some areas got involved.

Orange book established the principle that shared care is the way forward. Experience is now demonstrating that most drug users do not need Consultant psychiatrists – need medical practitioners with drug knowledge.

Oxfordshire forced to cut when specialist services went into crisis.

- Appointed specialist GP – level with CMP
- Get community pharmacists involved – lead with pharmacists
- Training programme – to address fears (violence/time/stereotypes), level of knowledge, prescribing regimes
- Support mechanism for GPs in dealing with Drug users
- Recognised need for peer group support

Shared Care model that identifies other needs

- Helps reduce anxiety about prescribing pressures
- Based in practices in some cases
- Pharmacists buy to this – supervised consumption vital
- Finance
- Identify work as priority need within wider PCT agendas
- Primary Care model fits chronic disease treatment
- Barriers for some users (especially prisoners)
- Not having a GP
- Pharmacists need support, training and funding as well – pharmacists highly trained and working to expand their role

Support Issues

- Resistance from other GPs in practice – need alternative peer support
- Need for stressing lead from PCT
- Royal College General Practitioner Certificate Course (five day programme) has established useful peer support
- PCTs need to sponsor training

- Some training for pharmacists/nurses/prison nurses and other with professional interest
- Shared Care Lunches – sponsored by DATs
- Access GP trainer
- Shared Care Clinics where there are gaps in GP engagement.
- GPs who have been trained run additional clinics for which they are paid separately.
- Specialist drugs workers attached to clinics – extra expertise – can stabilise more difficult patients. Should be seen as means of getting people into mainstream. Source of advice to GPs can also provide wider information to help meet wider needs.

The Oxfordshire Approach describes the protocol for GP who need to refer beyond Share Care Clinics.

Finance

GP Contract. Oxfordshire DAT had early model of payment.

Now compromise with National Enhanced Contract. Some GPs will drop out because new rates are not affordable for all. DATs have been negotiating with PCTs locally.

6.4 Meeting Needs/Commissioning

Claire Taplin, Oxfordshire DAAT and
Fiona Marshall, National Treatment Agency

Drug Misuse

Drug taking which causes harm to the individual, their significant others or the wider community.

- Intoxication
- Regular excess consumption
- Dependence
- Routes of administration

Drug problems

- Social
- Psychological
- Physical
- Legal

1

What is treatment?

'A range of interventions which are identified to remedy an identified drug-related problem or condition relating to a person's physical, psychological or social (including legal) well-being.'

2

Commissioning

Determination of priorities, purchasing appropriate services and their evaluation

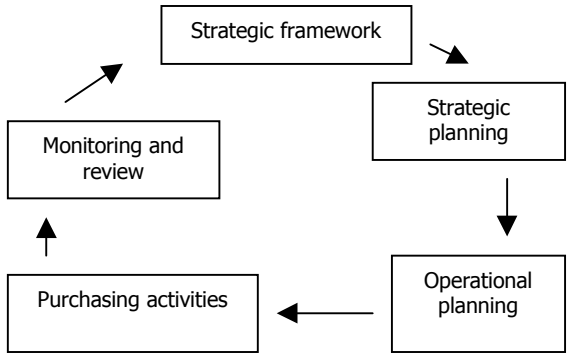
- Strategic activity involving developing a long term plan/vision
- National and local priorities
- Many different partners
- Needs assessment
- Consultation
- Developing evidence base
- Traditions

3

Needs Assessment

NOT a prevalence study
Different types of substance misusers
Different drugs and administration routes lead to different health impacts
Affected by the extent and nature of the problem in a given area – expected number of problem drug users/misusers
Look at service uptake
Calculate unmet need
Population segmentation/target groups
Map services and programmes offered
Treatment effectiveness

4



5

Models of Care

Tier 4	Residential Care	In Patient
Tier 3	Structured Treatment	Prescribing, day care etc
Tier 2	Open Assess	Needle exchange, advice, arrest referral
Tier 1	Generic Services	Primary care, housing, employment

6

Oxfordshire Profile – Commissioning in Practice • Predominantly rural • Dominated by city • 2 large growing towns • Number of small market towns • Population circa 606,000 • Prevalence – good question 7	**Oxfordshire Treatment Plan – Commissioning in Practice** • Joint Commissioning Group • Key Partners – Health and Criminal Justice • Strategic Priorities and Targets • Development of Treatment System • Outcomes • Models of Care • Monitoring and Reviewing existing services • Information – Research evidence and data system 8
Oxfordshire REACH Programme – Commissioning in Practice • System – Creating a better balance of Tier 3 and 4 services • Identified Need – DTTO and Offender Management • Problem – Cost pressure residential rehabilitation • Context – Review of existing services • Decision of Tender 9	**Oxfordshire REACH 2004/5 and CJIP** • Combined health and CJ approaches to treatment • Prescribing – Clinic in shared care scheme • Clear Care Pathways – Offender Management • Aftercare link with DISH including access to housing ISSUES • Pressure on Places – waiting times • Premises DEVELOPMENTS • Enhance treatment options with inpatient detoxification 10

Treatment

- Info and advice
- Open access – care working/harm reduction
- Structured – prescribing, DTTOs
- Detox, rehab, specialist
- Pills and/or talk
- Intervention
- Support through care/ aftercare
- Family/carers
- Links with other areas : mental health etc
- Service User Involvement

Medical

- Intervention – psychological
- Therapeutic intervention
- Varied levels of intensity/duration

Commissioning

- Purchasing (buying the service – clarity of need) – clarity of expectations of delivery (KPI's)
- Assessments
- Money
- Identification of needs
- Plan of services to meet needs of clients
- Creating infrastructure for above
- Funding issues/financial control
- Service user involvement
- Monitoring and evaluation outcomes
- National, plus local

6.5 Identifying Audits Need and Linking Strategies and Targets

Debbie Moon, GOSE and Paul Wolf, GOSE

Workshop aims and objectives

- To gain insight into how to tackle the audit and strategy process
- To share experiences to date
- To look at the guidance notes being developed for drugs audits

1

C&D Act 98, as amended by Police Reform Act 2002

Requires responsible authorities over a 3 year cycle to:

- Carry out a review of the level and patterns of C&D and drug misuse-
- Consultation-taking into account the views of the local community
- Formulate and implement a strategy for the reduction of C&D and for combating drug misuse
- Submit an annual report on implementation of their strategies

2

Single Tier Authorities

- DATS and CDRPs should operate on an aligned basis as a single partnership
- Partnerships decide whether to produce combined or separate Audits, Strategies and Reports
  If separate, the document will need to be cross referenced and complementary

3

Two-Tier Authorities

- DATs and CDRPs should, where practicable, work jointly to produce county-wide audits, strategies and reports
  - must have the agreement of all CDRPs, and comprehensive in coverage
  - each CDRP still required to consult locally on audit, and publish audit and strategy locally
  - free to choose combined A&S or separately for crime and drugs

4

Two-Tier Authorities

- Where a county-wide Audit and Strategy is not practicable:
  - each CDRP will be required to produce crime and disorder and drug audits, strategies and reports for their local area
  - CDRPs are expected to agree the drug element of these documents with the local DAT in order to ensure consistency with the county-wide audit, strategy and report

5

2-tier model 1

County Level Drug Audit and Strategy

County Level Crime and Disorder Audit and Strategy

6

2-tier model 2

County Level Drug Audit & Strategy

District C&D Audit & Strategy	District C&D Audit & Strategy	District C&D Audit & Strategy	District C&D Audit & Strategy	District C&D Audit & Strategy

7

2-tier model 3

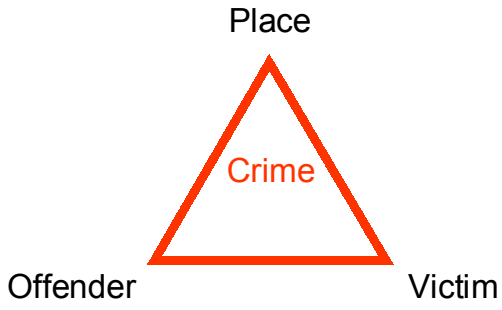
District D,C&D Audit & Strategy	District D,C&D Audit & Strategy	District D,C&D Audit & Strategy	District D,C&D Audit & Strategy	District D,C&D Audit & Strategy
District D,C&D Audit & Strategy	District D,C&D Audit & Strategy	District D,C&D Audit & Strategy	District D,C&D Audit & Strategy	District D,C&D Audit & Strategy

8

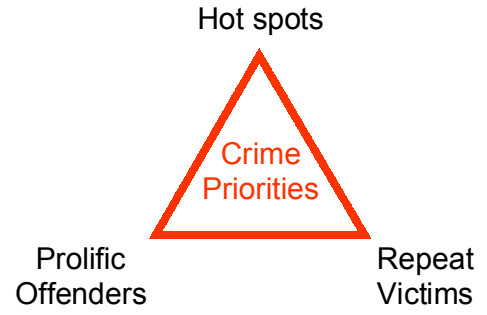
Key changes since the last audit

- Drugs, alcohol and ASB to be covered more comprehensively
- A lot more analysts - and their experience is growing
- The data is improving
- The analytical tools are much better, eg. Thames Valley performance management GIS system
- People are more open to the use of analytical products, eg. NIM
- Organisations are more outcome focused
- Three more years experience of 'what works'

9



10



11

Theme	Round 3 questions
Hot spots	What is driving crime in your hot spot areas?
	What has your CDRP been doing to tackle those crime drivers?
	What impact has been made?
	Can this impact be evidenced?

12

Theme	Round 3 questions
Prolific Offenders	What proportion of your crime is committed by prolific offenders?
	How many prolific offenders do you have in your area?
	How many are being targeted by your CDRP?
	What is driving their criminal activity?
	What has made an impact on their offending behaviour?
	What has made an impact on their recidivism post conviction?
	What has be done to divert the 'next generation' of prolific offenders? And has it worked?

13

Theme	Round 3 questions
Repeat Victims	What proportion of crime in your area is suffered by repeat victims?
	Who are the repeat victims?
	How has their victimisation been tackled?
	What has worked?
	What is it that is making people fearful? Signal crimes?

14

Lessons from last crime and disorder audit

- Progress from 1998 crime audits
- Wider range of data sources
- Additional crime and disorder issues
- Drugs, ASB, business crime, resettlement of offenders

15

Capacity

- Is there capacity in house?
- If contracting in services, allow plenty of time
- Think about co-opting partners onto an audit steering group

16

Audits and Strategies Toolkit

- End February/early March
- Available on www.drugs.gov and www. Crimereduction.gov
- Annex B (now end June)
  - Linked to new Performance Management Framework and National Drug Strategy
  - Covers potential data sources on misuse of drugs, availability of data and other drug specific information/links

17

Headlines of Annex B

- Builds on information already available to partnerships –YP needs assessments; research; local Homeless and Connexions strategies; progress against LPSA
- Use of existing personnel – police analysts – extend mapping to non offence related data; GIS hot spotting
- Data used for KPIs
- Treatment Demand Model-Annex F of PMFP
- Broken down to 4 sections of the strategy-treatment, Young People, Communities and Reducing Supply
- Suggests potential data-amount of class A seized; housing available; evictions
- Suggests potential sources-KPI info; SP; local authority/providers
- Suggests targets for strategy
- Gives useful links

18

What do you want the audit to do for your area?

- Present a clear picture of problems, and what is working; what has changed from last time?
- Establish baselines
- Analysis of data will support understanding of causes of problems and determine appropriate mechanisms for tackling them
- It will inform the strategy
- It will help target resources appropriately

19

Data Issues

- Produce a list of available data sources
  - Identify progress that has been made
  - Build on needs analysis work currently carried out by partners and any evaluation work
- Understand the data and its short comings
- Try to obtain data in the most disaggregated form possible
- Challenge inconsistencies
- Is area covered by data coterminous with partnership area
- What time period does it cover-most recent may be more valuable
- How will the data be collected
- How complete and accurate is the data

20

Suggested Data Sources

- Deprivation information
- Sex work and begging
- Police crime data
- DTTOs
- Homelessness information
- Arrest referral and CARATs data
- Supporting people data
- Arrest Referral data
- User networks
- KPIs data from centre
- Alcohol issues
- Demographic info – age, gender, diversity
- Police drug operations ..(contd)

21

Suggested Data Sources continued

- Local surveys/consultation
- Young people, Treatment, Reducing Supply, Communities
- Police incident data
- Drug Testing
- YOT data
- Drug referral data (NDTMS)
- Drug type (not just Class A)
- Treatment Demand Model
- Drug related deaths
- Hot spots
- Workforce levels: consultation
- Number of Crack houses
- A&E
- Evictions and ASBOs
- Drug litter

22

Analysis	**Consultation**
• Concentrate on analysis that shows the nature and extent of the problem • Think about how the analysis might be used for decision making • Ask why the problem looks like it does • Show both numbers and percentages • Include comparisons as often as possible 23	• If data is incomplete, consultation offers an opportunity to check out assumptions • Consultation is part of the community engagement process • Consultation is necessary to legitimise your strategy • Unless conducted using robust techniques it does not achieve the purposes • Timescales and budgets are tight and compromises may have to be made • Use existing fora for consultation – residents, BME, user and carer groups • Prepare a long term consultation strategy • Results may conflict with imposed targets 24
Strategy	
• Set out 4/5 key objectives – not too many targets • Cover all 4 strands of strategy and priorities • Address local priorities based on consultation process • Address national priorities 25	

- What gets measured gets done – we need joined up KPI's to get all partners involved – we need shared targets

- Everyone needs a reason to buy into work

    - group questioned accessibility of analysis, mapping etc
    - not accessible to everyone

- 'Data warehouses' have not happened

- There has been a lack of guidance on 3rd audits and drugs info.

    - audit will direct how money is spent
    - try to work smarter with consultation – however everyone is still doing this all over the place – need several different drivers – an overarching strategy

- Different things happening are pulling against us ie., Licensing Act – encouraging a 24hr drink economy – which will escalate ASB etc

- Six years down the line PCT etc are still not on board, sharing information etc.

    - Compare with child protection issues which have developed good information sharing
    - work can be developed on the personality of one person – which when they leave causes all this work to be lost
    - Oxfordshire has a list of health data available – was developed on a countrywide basis

- Health needs to be given reassurance about sharing health data (from Ministers)

- People need to know and understand what protocols are for, how to use them etc

- People need to be made aware of the issues associated with not sharing information

    - Burglary reduction
    - Academics have struggled to study this
    - Crime is now an enormous topic we need to look at "demand" not crime, or drugs etc.

- Concerns raised about drugs information given out – why are we being given guidance at such a late date?

- GOSE confirmed that the audit/strategy is not just drugs but substance misuse which also covers alcohol – although funding at present only covers drugs

6.6 Service User Perspectives in Oxfordshire

Rowan Williams and Glenda Daniels, Oxford User Team (OUT)

Rowan and Glenda set the scene by providing an overview of their experiences of drug use and the criminal justice system.

User involvement is encouraged in Oxfordshire at three distinct levels:

- **Individual care planning.** Educating users on their rights and responsibilities, the treatment evidence base, treatment goal setting, reviews, what to expect when entering treatment etc.
- **User involvement in service provision.** Providing feedback on good as well as bad experiences so that services can develop.
- **Strategic development.** Involvement in treatment planning. Input to service specifications, involvement in interviewing etc. Provision of user perspectives at DAT and NTA levels.

The Oxford User Team provides a variety of services including running workshops for drug users on harm minimisation, overdose prevention and management as well as Hepatitis C prevention. Over 250 people have been involved in these workshops. The running of such workshops allows for the education of drug users and for the OUT service to have contact with many drug users who are not in contact with treatment services. The OUT team can therefore seek drug users' views on issues in a rapid and informal manner.

Drug Testing in Custody

People who have been charged with certain trigger offences are drug tested. The OUT Team had sought the views from a group of chaotic drug users in Oxford City. The following points arose from this consultation: -

Some users reported negative results despite having used earlier that day. This then led to them not seeing the arrest referral worker as custody staff prioritised those whose tests were positive.

OUT did a Hepatitis C workshop in April 2004 and was told by six injecting drug users, not all tested at the same time, that their tests had been negative despite all reporting that they had used that day. Negative tests then often led to users not being seen by arrest referral or by medical staff and not receiving treatment information.

- "Drug testing is a good idea, it gives you the chance to link in with SMART and all the other places that can support me to get a better script to stop me using street drugs."
- If you don't go ahead with the test you seem to be treated as if you are guilty any way. I don't want everyone knowing the extent of my drug use."
- "I am quite able to tell the police, probation and anyone else about my drug use, I don't need to be tested. I think it's a human right that's been taken away from me, the right to have a private life that I do not have to tell anyone about. I have been arrested for things that have nothing to do with my drug use, but this has been brought up as something that has affected my bail."
- "It can go both ways. It can help you in Court to let them see you are in the grip of an addiction and offers an alternative to prison, but only if the alternative is not a

DTTO. But these tests aren't reliable anyway. I've had two that have said that I have not used when I know I have, that morning, so it was not helpful as I didn't get offered any help with my drug use."

- "I have had 3 tests that have come back negative, I was really shocked as I had used the night before. I was withdrawing at the time, but it's still supposed to stay in your system for 3-4 days, I could not understand it until others told me this happens a fair bit."

User's Views on DTTOs

The OUT team had quite a few anecdotal, but nevertheless valid views on DTTOs. Personal experience on such programmes has tended to be reported as being negative. The "one size fits all" approach leads to some levels of frustration. DTTOs can run for three years, there should be an individualised approach allowing for employment, childcare etc.

- "I think you should be able to give up to 6 dirty tests whilst on a DTTO because its hard to stay clean, its not as easy as every one thinks to stop using. I was refused a residential DTTO and I needed it, my family was very upset. This is not good enough for those of us who really want to go to rehab and change our lives."
- "I have been on a DTTO and think it's too hard, it is so demanding. They should give you more chances with the drug tests as its hard not to use when you are still living in the same place or made to live in places when everyone is using and you are expected not to use. It seems your only motivation not to use is to be taken ice skating on a Friday. You are asked to talk about drugs all day, then reprimanded when you use, I wish it was that easy to stop."
- "DTTOs are not realistic, we are not robots, stopping drugs does not happen overnight or by a set date. DTTO's don't always coincide with other treatment and appointments that are sometimes more helpful, but probation think the DTTO is the priority. I cannot just stop using because I have been told to. I need more time and my motivation needs to be right, recovery will not be successful if you are forced into all aspects of a programme that half of it is not relevant to you."
- "You can't force people into treatment. I would rather do a sentence than a DTTO."

Case Study

A case study made of a composite was then discussed. The themes that arose included the following points: -

- Structured day programmes are often aimed at a certain group of drug users with poor basic and life skills. There are a variety of drug users with widely differing needs.
- There needs to be some flexibility within the programmes; somebody with "A" level English shouldn't be expected to participate in a basic skills programme aimed at people with poor literacy skills.
- Groups tend to stick together after hours, people can be led into using when motivation is low.
- Housing such as bail hostels and supported housing tend to include people who are still using and can provide sources of temptation; people on DTTOs or who are trying to change should be able to live separately from active drug users.

- It would be useful to share care plans with the users and to encourage their input into the plans.
- The use of opportunities for personal development pertinent to the individual would be beneficial, eg people could be encouraged to develop personal interests away from a drug using lifestyle.
- Aftercare needs to be developed.
- Other courses and voluntary work can be very useful in people's development.
- The needs of the service/ staff need to be put aside so that the specific needs of the individual can be addressed; what do they believe they need, what do they think they will work for them?

6.7 Access to Services for Black and Asian People

Jeremy Beake, Community Development Manager, Wycombe District Council

Service Access

1. Chantler el al – report that 45% of 22 drug service managers they interviewed felt that the lack of provision of services to Black and minority ethnic groups was linked to a lack of information about their patterns of drug use and service needs. However, the authors argue that "This smacks of double standards" (p37) as it assumes that white communities need drug services, whereas others must prove the need.

   Chantler K, Aslam H, Bashir C, Darrell K, Patel K, Steele C (1998): An analysis of present drug service delivery to black communities in Greater Manchester. Project report, March 1998. Manchester: Greater Manchester Drug Action Partnership (SRB and Black Drug Workers Forum (BDWF) North West.

2. Fountain et al – comment on the issue of the lack of acknowledgement by drug service commissioners and providers of drug use amongst Black and minority ethnic communities as follows:

   "Reasons for this include a fear of accusations of racism by drawing attention to drug use in these communities, and a desire to avoid increasing stigmatisation of them. This stance is misguided. Ignoring or hiding a problem does not make it disappear: it must be confronted in order that appropriate responses can be developed. Many Black and minority ethnic groups are already stigmatised as drug users or dealers, yet refusing to accept that this behaviour may occur amongst them does nothing to decrease the stigmatisation, and obstructs consideration of their drug service needs by policy-makers and service planners and commissioners."

   Fountain J, Bashford J, Underwood S, Khurana J, Winters M, Patel K, Carpentier C (2002): Update and complete the analysis of drug use, consequences and correlates amongst minorities.

   Question: Is there a lack of acknowledgement by drug service commissioners and providers, of drug use amongst Black and minority ethnic communities?

Work Approaches

Question: Should we devise services that are Cultural specific?

1. Specialist or Generic Services –

   A report on research for the DPAS states: -
   "We highlight the importance of the difference between 'generic' services (those which are, in theory, open to users from all communities) and specialist or 'stand-alone' services, which target specific communities. Each has particular advantages and disadvantages.

   But most people we spoke to felt that, while specialist services could have an important role alongside other services, it was important, that mainstream providers developed appropriate ways of working with Black and minority ethnic communities. Some generic services showed many of the aspects of cultural competence and aimed to include the advantages of a specialist approach in a more general framework.

Wycombe Work Programme

	Area of Work	Targeted Outcome	Strategic Link	Main Actions	Groups Involved
1	Organisation	Develop partnership working between agencies, partners, users and local community members	Community Safety Strategy Priority Action Area 7	Networking and establishing partnership work and support	Thames Valley Partnership, WDC, Bucks CC, BCUC, Yea Warehouse and other Drugs Agencies * Projects
2	Agencies	More engaged local agencies able to work in partnership with the community as part of their model of care	Community Cohesion Route Map – Wycombe Partnership	*Encourage Agencies to meet with community groups *Use Health consultation process to establish *Champion the involvement of the community in models of care	Sefton House and other treatment agencies
3	Links to DAT Plans	Yearly Targets set by the Treatment, Young People, Training, Availability and Housing DRGs met	Bucks DAT Plans Corporate Priority – Housing	>Activity Reports >DRG Meetings > DAT consultation	DAT DRGs
4	Communication and Awareness	Raised public awareness of drugs action and the consequences of drug misuse	Community Safety Strategy – Priority Action 3	Projects that raise awareness	TVP , WDC, Bucks CC, BCUC, Yea Warehouse and other Drug Agencies and Projects
5	Community Development	An increase in the number of people in the community that participate in drugs education, awareness and support	Community Safety Strategy and Bucks DAT communities plan	Development of a group of people more actively involved in drugs awareness support	Individual and community orgs.
6	Capacity Building of Voluntary Agencies	A community against drugs	Community Safety Strategy – Priority Action 3	Sign up organisations to partnership aims Networking and establishing partnership work and support Networking with users	Churches, Vol groups, users and agencies as above
7	Community Events	The development of community events in the District	Bucks DAT communities Plan	Development of a roadshow to be used with community events	DAT DRGs and community events

Models of Care the Issues That Arise for People from BME Communities

The following is an extract from: -

Black and minority ethnic communities in England: a review of the literature on drug use and related service provision (National Treatment Agency for Substance Misuse and the Centre for Ethnicity and Health, London, April 2003)

6.6 Models of care

Models of care has been issued by the National Treatment Agency (2002) in order to provide a common framework for the commissioning and delivery of drug services "that is intended to achieve, equity, parity and consistency in the commissioning and provision of substance misuse treatment and care in the UK" (NTA, 2002:2). Models of care has similar status to a national service framework. The emphasis on equity, parity and consistency is particularly important for Black and ethnic minority communities and the specific issues they face are recognised throughout. For instance:

> *"Certain groups of substance misusers, such as stimulant users, rate information as being an important part of service provision… Other groups require information in an accessible format (eg culturally appropriate literature for those from minority ethnic populations)"(p8).*
>
> *"… black and minority ethnic stimulant drug users face barriers to accessing treatment and care services"(p112).*

'Black and South Asian' drug users are identified as needing to be prioritised for entry to structured day programmes, including targeted services (p70).

South Asian and Turkish drug users are highlighted for specific prevention initiatives with regard to injecting:

> "*There is now increasing interest in the development of interventions aimed at preventing and curtailing injecting and in 'route transition interventions' (RTIs) (Hunt et al, 1999 and 1998). It has been argued that policy must focus on encouraging people away from injecting in order to control HCV (hepatitis C virus) and overdose death. (Wodak, 1997: Strang et al 1997). The development of interventions that prevent transition to injecting are also particularly needed among Bangladeshi and other South Asian heroin users and other minority ethnic groups who exhibit much higher prevalence rates of smoking than injecting heroin." (p58).*

Models of care's specific section on Black and minority ethnic communities (pp. 130-138) draws on some of the evidence also presented in this literature review and identifies many of the same issues to be addressed. For example:

- It is specifically recommended in Models of care that commissioners of drug services should require, through the use of service specifications, that treatment agencies improve their collection of data (p.125). This reflects the findings reported in section 4.2 of this review.

- Models of care highlights that Black and minority ethnic women may miss out on harm minimisation interventions due to late entry to treatment (p.127).

- Chapter 4 of this review presents the literature that explains why Black and minority ethnic drug users generally, and Black and minority ethnic women in particular, are under-represented as drug service clients.

- In the context of care pathways, Models of care recognises that Black and minority ethnic communities especially require a multi-agency approach, and that this may need to include particular external agencies such as community organisations and those providing advocacy and interpreting services (p.130). This review discusses the literature dealing with these issues throughout chapters 5 and 6.

6.6.1 Needs assessments and commissioning practice

Models of care calls for research into Black and minority ethnic drug users' retention rates in treatment and the impact of retention on treatment outcome (p.131), and, in relation to the results of needs assessments stresses that (p.131):

> *"The particular service needs of minority ethnic problem alcohol and drug users are reflected in service agreements, service specification and broader purchasing agreements and monitoring requirements."*

The literature cited in chapters 4 and 6 of this review wholeheartedly supports this need, although the sheer wealth of data the review presents on the drug use and related service needs of some Black and minority ethnic communities – particularly South Asians – should not be ignored when allocating resources to future needs assessments.

6.6.4 Moving through the tiers

Models of care suggests that the Tier system will be experienced as 'seamless,' with service users being 'unaware' that they are moving within and across the Tiers (p.22). However, this literature review has shown that drug services that can appropriately meet the need of Black and minority ethnic drug users are so poorly developed that the Tier system will have a very real impact on the capacity of the individual Black and minority ethnic drug users to move within and across the Tiers. There is a risk that they will be identified in Tiers 1 and 2 but by unable to access Tiers 3 and 4. This discussion on barriers to drug service access identified by the literature in section 4.7 of this review particularly highlights this risk.

6.6.5 Needs-led drug services

Models of care states that commissioning should be needs led rather than based on historical precedent stressing that "it is the responsibility of DATs through their joint commissioners and joint commissioning groups (JCGs), to ensure that the diverse range of drug and alcohol misusers within their locality are catered for. Local variations in provision will include: demographic and socio-economic factors (eg population, age, ethnic diversity, levels of deprivation; substance misuse trends and patterns… and geography" (p 22). The risk here is that the result may be that needs

assessments are conducted only in areas with significant Black and minority ethnic communities (such as London) and/or those that have developed appropriate services and can demonstrate demand. As discussed earlier in this review (section 4.7) this may mean that commissioners in areas of relatively low numbers of Black and minority ethnic populations do not undertake needs assessments nor develop appropriate services.

Despite the reservations above, "Models of Care" provides a significant support to the evidence in this review and should result in more services and commissioners addressing the drug-related needs of Black and minority ethnic communities.

Question and Answer Session

Q. Is there a lack of acknowledgement?

A. Fear of getting it wrong
We ought to do something about it but nothing happens
Service design – may not link into community – evolve rather than imposed from above
Lack of knowledge

Q. Should we devise services that are cultural specific?

A. What works?
User involvement
Mainstream – incorporating cultural specific

Q. How could we approach working with the community?

A. Engagement – start with a focus
Opens up to other communities
Gatekeepers – more than a dialogue with these people – access others in the community particularly the young
Asylum seekers

Q. How do we build CAD (as above)
How do we build – needs led services

A. Dialogue leading to more engagement
Diversity of staff
Training/support networks
Self referrals
Monitoring of services – evaluation

Other comments

Danger of using term 'community'

6.8 Primary Care Trust and Health Involvement in DATs

Melissa Snaith, Reading Primary Care Trust

What are DAT's?

- Non-statutory partnership bodies
- Strategic implementation of national drugs strategy
- Sometimes merged with Crime and Disorder Reduction Partnership (CDRP's)
- Challenges for DAT's

1

Young People

- Aim 1 - "To help young people resist drug misuse in order to achieve their full potential in society".
- KPT – To reduce the proportion of people under 25 reporting use of illegal drugs in the last month and previous year substantially and to reduce the proportion of young people using the drugs which cause the greatest harm – heroin and cocaine – by 25% by 2002 and by 50% by 2008.

2

Communities

- Aim 2 – "To protect our communities from drug-related anti-social and criminal behaviour".
- KPT – To reduce levels of repeat offending amongst drug misusing offenders by 25% by 2005 and by 50% by 2008.

3

Treatment

- Aim 3 – "To enable people with drug problems to overcome them and live healthy and crime free lives".
- KPT – To increase participation of problem drugs misusers, including prisoners, in drug treatment programmes which have a positive impact on health and crime by 66% by 2005 and by 100% by 2008.

4

Availability

- Aim 4 – "To stifle the availability of illegal drugs on our streets"
- KPT – To reduce access to all drugs amongst young people (under 25) significantly, and to reduce access to the drugs, which cause the greatest harm, particularly heroin and cocaine, by 25% by 2005 and by 50% by 2008.

5

What is a Primary Care Trust (PCT)?

- Assesses the diverse health needs of their local population.
- Improves the health of the local community.
- Takes responsibility for securing the provision of a full range of services locally.
- Responsible for all family health service practitioners.
- Commissions tertiary services.
- Works with local authorities and the voluntary sector to maximise opportunities for patients and clients.

6

Health/DAT Interface

- How is it working?
- Public health
- In equalities in communities
- Substance misuse is a KPI for CHI
- Responsible partner
- Health/Crime agenda
- Prisons
- Money

7

The group looked at some of the complexities and issues in engaging PCT staff in drugs and the drug treatment agenda.

Issues included: -

- Conflicting targets and priorities
- Complex structures and non-coterminous boundaries
- A period of constant change in the organisation of the Health Service and mergers of PCTs
- The difficulty of knowing who to engage from health to reflect the various different aspects of the agenda
- Lack of knowledge and understanding of drugs issues amongst many PCT staff
- Problems of staff retention, high mobility and the loss of expertise
- Complex funding stream for drugs work which is different from other health funding
- The problems of small DATs and small PCTs
- Confidentiality and information sharing – health not signed up
- Little PCT involvement – CDRPs
- Capacity of service providers to attend meeting

Opportunities and Ways of Engaging

There is a shared agenda – but it is not recognised.

a) PCTs were set up to reflect the needs of local communities and were designed to be more accountable to local needs. Drug users are part of the community and their needs should therefore be reflected in local plans and priorities.

b) The introduction of star ratings for PCTs provide leverage. PCTs are now assessed on their performance to access to treatment and shared care.

c) Tackling drug use and offering treatment also contributes to other key health targets including: -
   - Reduction of inequalities
   - Reduction of accidents
   - Blood transmitted diseases including HIV
   - Engaging communities
   - Health promotion
   - Public health

d) PCTs are already carrying significant costs relating to drug abuse and drug users including the cost of prescribing (which is rarely counted as a contribution to this agenda). There are also significant hidden costs because of the demands made by drug users on normal health care. Also their new responsibilities for health in prisons in Oxfordshire.

e) Identifying a lead: -
PCTs have combined to create a lead for PCTs to link with DAT. This has the potential to provide a consistent link and also to bring other PCTs on board and keep them informed in a relevant way. In Oxfordshire the designation of a lead GP has been effective in providing a clear contact point and as a route for engaging and informing other GPs. PCTs identify a single person to be the link to CDRPs and DATs which has been successful in engaging across a wider agenda. These responsibilities need to be recognised in job description, appraisals etc.

f) DATs have become more powerful as they have been allocated more funding. There are several financial incentives for PCTs to get more actively engaged.

6.9 Housing for People with Drug Problems

Paul Williams, National Probation Service, Thames Valley

Introduction/context – There have been references to housing throughout the day when we know that many CJIP etc users are in very poor housing. Context of savings in supporting people - £400 million in 2005-06.

How do we address the housing issues for sub misuse offenders? 46% drop out from treatment.

Back to aims of conference – as day themes of this workshop.

Access

How do we access the housing that is there?
How do we prioritise?
What are the referral pathways?

Policy/Ideology

Messages – expectations for targeted individuals
Notices/Evictions – need constant messages
Activity – what kind of floating support is on offer and what other interventions?

Access Workshop

Prioritisation: -
- drivers for prioritisation
- who gets harmed/affected
- targets eg., antisocial behaviour, prison hpi, aftercare (DAT priority)
- people get missed
- pragmatism i.e. what's possible, eg., picking "easy to work with" groups
- complex needs

Provision: -
- supporting people – cuts and lengthy recommissioning process

Routes into Housing: -
- could use the tools – drugs assessment
- better links to prisons: community

Who leads on housing

- Local Authority }
- Social Services } housing - providers
- Supporting People
- Link to – CDRPs, DAT

Ideology Workshop

- Messages
- Notices/evictions
- Activity
- Robust policy (notices/evictions)
- Access to education local access finance
- Different levels of needs
- Support – prison
- Resources
- Levels of care

Ideology
- Wet or dry provisions?
- Prison – need support/housing interventions in prison
- Barriers – difficulty in making homelessness applications

Notices and Evictions
- Hostels need clear drug and alcohol policies
- Support plans focus on drug use

Activity
- As a means of preventing relapse
- Activity needs to be funded

"Easy to **mention** housing - not so easy to **provide** housing"

Housing got many mentions at the conference and this is a good thing. The housing workshop opened up the discussion around the issue of prioritising what housing is there for substance misusers although the discussions were more around problem identification than solution focus! – Although there were some discussions about operational issues that could have an impact on sustaining substance misusers in accommodation.

In housing terms – there is no rocket science to the strategic pressure points for new developments – there are: -

- Supporting people – the five year commissioning strategies are being written now – these must have excellent commitments in terms of the client groups offenders and substance misusers
- Homelessness Strategies – currently undergoing their first year review
- Regional Housing Boards – regional resettlement strategies have to be in place by April 2005 – so there's the chance

7. Speakers' Biographies

Sue Raikes, Thames Valley Partnership

Sue Raikes is Chief Executive of the Thames Valley Partnership, a charity which brings people and organisations together to work for safer communities. The Thames Valley Partnership works with statutory and voluntary organisations and the business sector across the three counties of Berkshire, Buckinghamshire and Oxfordshire – an area which includes 18 local authorities and 16 community safety strategic partnerships.

Sue has a background in social policy research and in the probation service. She joined the Thames Valley Partnership on secondment from Oxfordshire Probation Service in 1993 and two years later became its Chief Executive. Sue has contributed to the work of the Audit Commission, the Home Office, the LGA and the Youth Justice Board, bringing wide ranging experience of partnership work and of the interface between the criminal justice system, local government and the community and business sectors. Sue has particular expertise in domestic violence, early intervention and restorative justice and has published on community safety and community justice.

Ruth Pope, Home Office

Ruth Pope joined the Home Office in 2001 from the voluntary sector. Her policy work has centred around crime reduction, initially focussing on violent and sexual offences. She joined the Criminal Justice Interventions Programme in April 2003 as a member of the Legal Policy section, with responsibility for the development of future CJIP policy and relevant legislation**.**

Michael Page QPM, Ba(Hons), Thames Valley Police

Michael, aged 51, started his police career with the Thames Valley force in 1974, being promoted to Sergeant in 1978 and Inspector in 1979. In 1985 he was promoted to Chief Inspector. In 1988 he became a Superintendent and was promoted to Chief Superintendent in 1992.

Michael spent three years as sub divisional commander at Reading. From June 1998 to December 1999 he was Area Commander of Southern Oxfordshire; he then took up the position as Area Commander in Milton Keynes. Michael has also occupied the position of Head of Territorial Policing

He spent two years as Lead Staff Officer to HMI Colin Smith at the Bristol HMIC office. Michael has also spent time as Head of Personnel and has been an Associate Tutor at the Police Staff College, Bramshill.

His early career included work in the Research and Planning department, and experience as a Senior Investigating Officer. Michael has also undertaken a lecture tour of New South Wales and Victoria, Australia.

During his time on the Strategic Command Course at Bramshill he undertook a study of alternative approaches to community policing in the Netherlands jointly with Milton Keynes Council and presented a paper on 'Leadership in Community Safety Partnerships' to the National Community Safety Conference in Edinburgh.

He was appointed to the position of Assistant Chief Constable Community Services on 6 February 2003.

Michael has a BA(Hons) degree in History and the Diploma in Applied Criminology from Fitzwilliam College, Cambridge.

For the past 19 years Michael has been a governor of Kendrick Girls School in Reading.

He is married with five daughters. Michael's hobbies include history and photography.

In 2001 Michael was awarded the Queen's Police Medal 'For outstanding leadership and professionalism'.

Gerry Marshall, National Probation Service: Thames Valley

Gerry was appointed as a probation officer in 1978, spending 5½ years in Wallington and was a full-time group worker for two years. In 1985 Gerry was appointed as Senior Probation Officer in Lambeth in a generic field team which covered the central Brixton and Stockwell patches, but with lead roles on community involvement and victim support. Next Gerry took up post as Warden of St. Edmund's Voluntary Approved Probation and Bail Hostel.

Gerry's appointment at the start of 1993 as Assistant Chief Probation Officer for the London Borough of Tower Hamlets coincided with the election of a BNP councillor, and the violent assault on Quddas Ali. He spoke about the local context of race relations and racial incidents at the trial of the 'Mile End Six'. During his time as an Assistant Chief Gerry was lead officer for group work programmes across Inner London. He became lead officer for Race Relations in Inner London and was involved with John Grieve in developing the Association of Chief Police Officers' 'Hate Crime' Manual.

Gerry moved to Oxfordshire and Buckinghamshire Probation Service in May 1999, becoming Chief Officer of Thames Valley Probation Area in April 2001.

Paul Hayes, National Treatment Agency

Paul has been Chief Executive of the NTA since its creation in 2001. As Chief Executive Paul advises Ministers and senior officials in the Department of Health and Home Office about all issues to do with the provision of drug treatment in England. He is the lead advisor to the NTA Board which is responsible for shaping the NTA's strategic direction and leads the Senior Management Team in implementing the agency's work programme.

Prior to joining the NTA Paul worked for the Probation Service for over 20 years.

8. List of Attendees

John Adcock, Thames Valley Area Service Manager, Crime Reduction Initiatives
Sharafat Ali
Janet Ashfield, DAT Co-ordinator, West Berkshire Council
Jeremy Beake, Community Development Manager, Wycombe District Council
Chief Supt Adrian Becks, Thames Valley Police, Thames Forest Police Area
Amanda Brierley, Probation Officer, Thames Valley Probation Area
Nicky Brodie, Prison Area Housing, HMP Springhill
Sgt Kieron Brooks, Staff Officer to ACC, Thames Valley Police
Liz Butcher, Government Office For The South East
Chief Supt Simon Chesterman, Area Commander, Thames Valley Police, Chiltern Vale Police Area
Valerie Chesterton-Hunt, Specialist Care Manager, Drug and Alcohol Team, Social and Health Care
Hilary Clydesdale, Senior Probation Officer, Thames Valley Probation Area
Rachel Craggs, Community Safety Manager, West Berkshire Council
Glenda Daniels, Oxfordshire DAAT
Frances Davies, Oxfordshire DAAT
Chief Insp. Peter Davis, Thames Valley Police
Lorraine Donnachie, Quality and Performance Officer, Supporting People Team
Catherine Douglas, Alcohol and Drugs Team, Social Services Oxford
Supt Mick Doyle, Area Commander, Thames Valley Police, Aylesbury Police Area
Dennis Evernden, Crime and Operations, Thames Valley Police, Northern Oxfordshire Police Area
Tandra Forster, Reviewing and Monitoring Officer, Royal Borough of Windsor and Maidenhead
Mandy Goodliffe, Substance User's Tenancy Support Worker, Cranstoun Drug Services
Paul Goodman, Chief Executive, The Ley Community
Ann Gothard, Probation Officer, Thames Valley Probation Area
Supt. Duncan Graham, Area Commander, Thames Valley Police, Northern Oxfordshire Police Area
Ruth Hallett, CJIP Manager, R2H Consulting
Liz Hayden, Drugs and Alcohol Misuse Co-ordinator, Vale of White Horse CDRP
Paul Hayes, Chief Executive, The National Treatment Agency for Substance Abuse
Insp Keith Henderson, Acting Chief Inspector for Performance and Partnerships, Thames Valley Police, Southern Oxfordshire Police Area
Lee Hughes, Team Leader, Turning Point
Radlay Jugdoyal, Service Manager, Cascade
Linda King, Drugs Services Development Manager, Thames Valley Probation Area
Des Kirby, Hungerford Project
Chief Supt Brian Langston, Area Commander, Thames Valley Police, Slough Police Area
Chief Supt. John Liversidge, Area Commander, Thames Valley Police, Milton Keynes Police Area
Kayte Locke, Public Health Manager, South East and South West Oxfordshire NHS Primary Care Trusts
Toby Mallowan, Probation Services Officer, Thames Valley Probation Area
Gerry Marshall, Chief Officer, Thames Valley Probation Area
Fiona Marshall, SE Deputy Regional Manager, The National Treatment Agency for Substance Misuse
Olga McBarnett, Community Development Officer – Drugs Focus, Wycombe District Council
Chief Supt. David McWhirter, BCU Commander Designate, Thames Valley Police, Oxford Police Area
Debbie Moon, Government Office For The South East
Amy Moore, Buckinghamshire County Council
Shona Morrison, Force Drugs Co-ordinator, Thames Valley Police
Kurt Moxley, Director, Oxfordshire DAAT
Chief Supt. David Murray, Area Commander, Thames Valley Police, Reading Police Area
Maxine Myatt, Assistant Chief Officer, Thames Valley Probation Area
Viv Nicholas, Slough Policing Board
Supt. Brendan O'Dowda, Community Services, Thames Valley Police, Milton Keynes
Bill Oddy, Community Safety Officer, West Oxfordshire District Council
ACC Michael Page, Assistant Chief Constable, Thames Valley Police
Insp Chris Parker-Towle, Thames Valley Police, Oxford Police Area
Peter Penny, Cranston Drug Services
Pat Peters, Oxford City Drugs Co-ordinator, Thames Valley Police
Steve Pirrie, DAAT Data Manager , Oxfordshire DAAT
Ruth Pope, Legal Policy Team, Home Office
Acting Supt David Purnell, Thames Valley Police, Southern Oxfordshire Police Area
Acting Insp Ned Qureshi, Thames Valley Police, Southern Oxfordshire Police Area
Sue Raikes, Chief Executive, Thames Valley Partnership
Carly Readings, Drugs Intelligence Co-ordinator, Thames Valley Police

James Sainsbury, Addiction Counselling Trust
Samia Shibli, CDAT
Melissa Snaith, Joint Commissioner, Reading Primary Care Trust
Jeremy Spafford, Associate, Thames Valley Partnership
Gillian Stimpson, Community Safety Manager, Wycombe District Council
DCI Roy Summers, Thames Valley Police
Claire Taplin, Joint Commissioner, Oxfordshire DAAT
Carol Teifel, PA to ACC, Thames Valley Police
Elaine Tinn, Joint Commissioner, Buckinghamshire County Council
Patsy Townsend, Director of Youth Programmes, Thames Valley Partnership
Supt. Jim Trotman, Area Commander, Thames Valley Police, West Berkshire Police Area
Christine Vallence, DAT Co-ordinator, Milton Keynes Council
Inspector Shaun Virtue, Thames Valley Police, Thames Forest Police Area
Acting DI Geoff Webb, Thames Valley Police, Southern Oxfordshire Police Area
Narinder Whitfield, Drugs Adviser, GOSE
Tania Wickham, CRI Oxford REACH Programme Manager, Crime Reduction Initiatives
Rowan Williams, c/o Oxfordshire DAAT
Paul Williams, Housing Needs and Partnership Manager, Thames Valley Probation Area
Paul Wolf, GOSE, Home Office
Darren Worthington, Smart CJS
Di Wright, DAT Co-ordinator, Royal Borough of Windsor and Maidenhead
Supt. Melvyn Young, Thames Valley Police Headquarters