

# DRUG INTERVENTIONS RECORD

Background information for  
Criminal Justice Integrated Teams (CJITs)  
and Counselling, Assessment, Referral,  
Advice, and Throughcare Services  
(CARATs)

## A BRIEFING PAPER

Updated **16 March 2007** in preparation for the introduction of the new suite of DIR forms on 1 April 2007. This paper will be updated, as required, to complement related guidance, as and when published.

## What is the purpose of this briefing paper?

1. It is intended to be a reference document for criminal justice drugs workers in the community, and CARAT and Clinical workers in prisons who will be using the revised Drug Interventions Record (DIR 2007) and associated forms (Initial Contact form, Required Assessment form, Activity form) as:
  - the key tool for continuity of care and monitoring and research in relation to the Drug Interventions Programme (DIP) – CJITs and CARATs; and
  - the Substance Misuse Triage Assessment form – Prisons only.
2. It includes the background to the purpose of the forms, together with an overview of the changes that have been made since the original DIR was introduced in 2005. It should be read in conjunction with the revised field-by-field guidance, about completion of the various forms, which is available via <http://www.drugs.gov.uk/drug-interventions-programme/guidance/DIR> as well as other guidance referred to.
3. It describes how the DIR can be used to support effective sharing of information about clients:
  - the CJIT in the community, e.g. in custody suites or courts and
  - Prison Healthcare and CARATs teams and
  - Probation services / (Offender Managers (OMs)).
4. There are many things which this briefing paper does **not** try to do, including:
  - train workers on how to assess/refer clients
  - replace specific training tools
  - substitute for line management support and professional guidance
  - detract from workers' ability and duty to exercise their proper judgement and experience in deciding how to respond to a client's needs
  - provide detailed advice on how to establish effective teams and working practices
  - act as a risk management tool or a case management tool
  - replace the information sharing arrangements in place between DATs and local treatment providers.
5. This briefing paper complements existing information available to DATs and partnerships and recognises that in line with *Models of Care Update* (NTA 2006) there should already be information sharing arrangements as part of their referrals and care co-ordination with providers. It does not seek to duplicate existing guidance, for example on storage and safe-keeping of client-based information. It will also complement existing and impending NOMS guidance on the delivery of drug treatment and continuity of care in prisons.

## Who should use this briefing paper?

6. The DIR has been in use in all DAT areas in England and all prison establishments across England and Wales since 2005 and within the community in Wales since early 2006. This briefing paper is written primarily for those who will actually be completing the DIR because they work directly with clients in the community and /or in custody, i.e. mainly CJIT workers and members of CARAT and Clinical teams.
7. It should also be of use to other colleagues and stake-holders such as:
  - Other prison staff
  - DIP project managers
  - DAT Chairs, co-ordinators, commissioners and members
  - Government Office Drugs / Crime Reduction / Community Safety teams
  - Police – especially custody staff and DIP champions
  - Probation services/ Probation Offender Managers (OMs)
  - NTA Regional Teams
  - Regional Offender Managers (ROMS)
  - Prolific and Other Priority Offender schemes
  - Regional Management Boards and the National Assembly in Wales
8. For these and others, the briefing paper should provide useful information about the role of the DIR in contributing to the delivery of both the Drug Interventions Programme and the NOMS aim of reducing the demand for drugs amongst offenders through effective treatment interventions:
  - by assessing individuals' needs through the CARATs/Clinical intervention,
  - clinically managing their withdrawal from drug dependency and
  - providing rehabilitation, support and drug testing programmes to encourage them to remain drug-free.
9. The range of drug interventions available in prisons is at least comparable to those provided in the community – and address the needs of low, moderate and severe drug-misusing prisoners. Data gathered from the monitoring and research section of the DIR should inform the planning and commissioning of services, the management of contracts and the establishment of local performance management systems.
10. The briefing paper will also assist in describing the use of the DIR and the working relationships between CJITs, CARATs, Clinical and NOMS/ Probation/ Offender Managers in the management of drug misusing offenders.

## **Who has contributed to this briefing paper?**

11. This paper has been written jointly by the Drug Interventions Programme Unit (Home Office) and Drug Strategy Team (NOMS) in consultation with representatives from:

- National Probation Directorate / NOMS
- Government Offices
- National Treatment Agency
- Crime & Drugs Strategy Directorate, Home Office
- CJITs
- CARATs
- Police
- Prolific and Other Priority Offenders Programme, Home Office
- Legal Adviser's Branch, Home Office

## **What is the Drug Interventions Programme (DIP)?**

12. The Drug Interventions Programme (which was formerly known as CJIP or the Criminal Justice Interventions Programme), is a large-scale programme, established in April 2003 as a critical part of the Government's Updated Drug Strategy (2002). Its principal focus is to reduce drug related crime by engaging with problematic drug users and, using a case management approach, moving them into appropriate treatment, retaining them in treatment and supporting them through and after treatment, whether in a custodial or community setting.

13. It aims to break the cycle of drug misuse, offending behaviour and custody by intervening at every stage of the Criminal Justice System (CJS) to engage offenders in drug treatment and other support. In order to do so, it built on existing interventions, such as arrest referral, and introduced some new elements (drug testing in relation to selected acquisitive crime offences (originally on charge and from December 2005 and April 2006 at arrest), required assessments with a drug worker for those testing positive (since December 2005), follow-up assessments (from April 2007), Restriction on Bail, Conditional Cautioning etc). These individual interventions have been brought together to create an integrated approach which enables appropriate and continuing engagement with an individual at arrest, on charge, in court, during and on completion of community and custodial sentences or statutory supervision in the community and on leaving treatment.

14. DIP is designed to engage with a broad range of drug misusing offenders, who are at different stages in their drug misuse and offending careers. It aims to prevent crime through early interventions as well as reduce crime levels by engaging the most problematic and prolific offenders. DIP's main focus, however, given the need to target resources most effectively and given the evidence base around links between certain types of drug use

and offending behaviour, is on those who use Class A drugs, in particular, Heroin/Opiates, Cocaine and Crack Cocaine.

15. All areas are expected to deliver the Programme and to follow broadly the same approaches; the Home Office “expectations” of all areas (both intensive and non-intensive) in relation to the Programme is set out as part of the annual terms and conditions attached to the DIP Revised Main Grant. Although non-intensive areas may be at different stages of development, all areas are required to have in place Criminal Justice Integrated Teams (CJITs), and the DATs are ensuring delivery of key parts of the Programme and working towards the fully integrated approach.
16. DIP can only be delivered successfully through the effective provision of “throughcare and aftercare” because it is this which cements together the various elements of the Programme, and makes the step change from useful, but stand-alone, interventions to an integrated system.
17. In the context of DIP, *Throughcare* is the term used to describe arrangements for managing the continuity of care provided to a drug misuser. *Aftercare* is the package of holistic support that needs to be in place after a drug misuser leaves custody, completes a community sentence or leaves treatment. It involves access to additional support with issues, which may include housing, managing finance, re-building family relationships, learning new skills and employment.

### **Alignment of DIP with the Prolific and Other Priority Offender Programme**

18. There are close links between DIP and the Prolific and Other Priority Offender Programme. In some of the highest crime BCUs, indications are that up to 85% of the PPOs identified are problematic drug misusers, committing volume acquisitive crime to support a drug dependency. This is why the Home Office paper “Rebalancing the Criminal Justice System in favour of the law abiding majority” (published in July 2006) included a commitment to align the DIP and PPO programmes more closely, to improve the response to this group of offenders. In simple terms, closer alignment of DIP and PPO should mean that more problematic drug-misusing offenders are successfully targeted, and the combined impact of the two programmes on local crime rates increased. The closer alignment of DIP and PPO schemes should help to deliver an improved focus on the identification of offenders to be targeted, and reduce the risk of problematic offenders falling between the gap between the two programmes.
19. This will help to ensure that more problematic offenders are gripped by an improved interaction between DIP and PPO, together with a tighter grip of those offenders of most concern, and in particular the highest crime causing drug-misusers.

## Who delivers the Drug Interventions Programme?

20. **Criminal Justice Integrated Teams** (CJITs) are the key local delivery mechanism of the Drug Interventions Programme in the community. They are established by the DATs as co-located, multi-agency partnerships, comprising members from a range of disciplines with a range of competencies and skills. A typical team might include: drug workers based in police custody suites or courts (arrest referral workers), case managers, those with specialist knowledge of housing issues, mental health, education, training and employment, family support, outreach workers working in the community, dedicated PPO case managers etc.
21. CJITs provide interventions in line with the NTA Models of Care for Treatment of Adults Drug Misusers Update (2006), and deliver an enhanced Tier 2 service by offering the client ongoing support through case management arrangements in order to facilitate engagement in structured drug treatment. This includes:
- drug related advice, information and harm reduction interventions;
  - triage assessment (including where appropriate through the Required Assessment provisions of the Drugs Act 2005 following a positive drug test), and referral i.e. for comprehensive assessment and structured drug treatment where appropriate;
  - drawing up an initial care plan with the client following a triage assessment;
  - access to prescribing services;
  - provision of Tier 2 interventions (including brief psychosocial interventions e.g. motivational interventions) for those accessing or who have left treatment;
  - provision of a 24/7 phone line for clients particularly targeted at those leaving custodial establishments and/or treatment;
  - a single point of contact for referrals from professionals including criminal justice agencies, CARAT teams and treatment agencies;
  - a case management approach using key working and care planning to ensure continuity of care;
  - access to structured treatment through local care pathways commissioned by the local DAT partnership;
  - partnership work with Probation (Offender Managers) and Prison Healthcare teams / CARAT teams
  - partnership with other relevant service providers to broker access to wraparound services such as housing, employment, rebuilding family relationships, peer support, education, life skills (e.g. finance management) etc, to address the individual's broader range of needs on and after release from custody, at the end of a community sentence and following treatment.

## What are CARATs services?

22. **CARATs** (Counselling, Assessment, Referral, Advice and Throughcare Services) is a specialist support and advice service intervention that creates

a Care Plan based on the specific needs of an individual prisoner. If assessed as necessary, prisoners will be referred to more intensive treatment programmes. Available in all prisons holding adults 18+, in England and Wales, CARATs are the key workers/case managers for all drug treatment interventions in prisons and represent the key through-care link, linking with the community through CJITs. They provide interventions in line with the NTA Models of Care for Treatment of Adults Drug Misusers Update (2006).

23. The DIR processes will facilitate throughcare links supported by the fact that all CJITs now have in place a Single Point of Contact (SPOC) for referrals from professionals including criminal justice agencies, CARAT teams and treatment agencies; and all prisons also now have a SPOC for referrals from the CJIT using the DIR.
24. This briefing paper should be read in conjunction with the following guidance, which provides more detailed instructions on the joint working between CARAT Teams and CJITs: *Delivery of the Drug Interventions Programme in Prisons-Guidance for Prisons* (NOMS, 2006), *The First 28 Days: Psychosocial Support* (NOMS 2006) and the *Clinical management of drug dependence in the adult prison setting* (DH 2006).

### **What is the Integrated Drug Treatment System (IDTS)?**

25. The Integrated Drug Treatment System (IDTS) will provide for better quality clinical and psycho-social (CARAT) treatment for drug users, throughout their time in prison custody, but with a particular emphasis on their first 28-days in custody. IDTS will enable expansion and improvement of the provision of drug treatment within HM Prisons by: increasing the availability, consistency and quality of services; diversifying the range of treatment options available to those in prisons; integrating drug treatment provided by prison healthcare with those services provided by CARATs; and strengthening continuity of care for drug users entering, moving between and existing prisons.
26. The integrated drug treatment system will be implemented fully – Clinical and CARATs – in 17 prisons, and partially – Clinical only – in a further 32 prisons.
27. Within IDTS prisons clinical staff will open the DIR and complete up to the end of Section 6 before passing to CARAT teams to complete the assessment.

### **What is the Drug Interventions Record (DIR)?**

28. The DIR has three main roles. They are to:
  - facilitate and improve standards of continuity of care for drug users, and minimise duplication of assessments, especially when they are moving

- between custody and community but also when information is passed between case managers and /or treatment providers;
- support the monitoring and research functions around the Drug Interventions Programme, in line with the Programme's, and other related, Performance Management Frameworks;
  - be the Substance Misuse Triage Assessment form to be used for all CARAT (and clinical where IDTS is in operation) clients, whether or not they are likely to become clients of the CJIT in their home area of residence.

29. The DIR is part of a suite of forms which includes:

*Initial Contact Form:* The Initial Contact Form is to be completed when a non-caseload client has a meaningful contact with a CJIT worker, where a required assessment has not been imposed, or with CARATs/Clinical

*RA – Assessment Form:* This is a new form which has been introduced for monitoring and research purposes only and is only to be used by CJITs. The form captures information relating to a required assessment where this has been imposed by the police following a positive drug test for a specified Class A drug.

*Activity Form:* The Activity Form is for monitoring and research purposes only. The form collects information about clients who are on the caseload, or have been transferred between teams. There are separate activity forms for use by CJITs and CARATs.

*Continuity of Care Update Form:* This is a new form, the purpose of which is to update relevant personal client information to inform continuity of care if it has changed significantly from the information recorded on their DIR. Use of the form is not mandatory there is no obligation to adopt it. It replaces existing regional forms with a single standardised form. The form has no monitoring and research purposes and should not be sent to the Home Office.

## **Continuity of Care**

30. Successful implementation of effective throughcare and aftercare provision, particularly as clients move between community and prison, is dependent on the right people sharing the right information at the right time so that treatment and support can be targeted and delivered effectively. Continuity of care is vital to the treatment and support given to problematic drug using offenders as they move between different criminal justice and treatment agencies.
31. An analysis of barriers in 2004 to effective working and continuity of care highlighted the need for a national framework and system, which would enable and support the effective and efficient transfer of personal information between criminal justice agencies but particularly as people move from the community into custody (prison) and as they move from

custody to community. Drug treatment interventions delivered through CARATs or in the community, the continuity of care were not always co-ordinated when the client moved from one to another or ended an episode of treatment. For example, an individual who had made progress on a treatment programme in custody, released without any suitable arrangements for continued support in the community, would be at greater risk of relapse, re-offending and overdose. A person leaving treatment in the community without appropriate housing and related support might be equally vulnerable.

32. Improving continuity of care for the individual is reliant upon seamless case management through the effective provision and communication of the right information at the right time to the right people, throughout the journey of the drug misuser. Given the numbers of individual workers and different agencies involved in managing care in this context, the potential for confusion and inconsistency of service and response has been large. The DIR (2005) established a common tool for use by CJITs and CARATs containing a minimum set of data for monitoring on one side, whilst allowing additional free text space for extra continuity of care information on the other, to enable the worker to describe individual circumstances in more detail. Having a common form in use in all areas has enabled familiarity amongst practitioners through regular use, leading not only to easier ways of working but also to greater consistency and effectiveness.
33. The new DIR (2007) and associated forms (activity form, required assessment form etc) replaces, and builds on the lessons learned from, the DIR (2005), it includes more detailed information on drug and alcohol use as well as other aspects such as accommodation and employment status.

### **Monitoring and Research**

34. The Drug Interventions Programme and drug treatment in prisons have attracted significant public funding. It is essential that the Home Office can both monitor value for money and the progress of clients through the Programme and prisons.
35. This can only be done through measuring inputs, outputs and outcomes to monitor the effectiveness of the Programme. The results of monitoring will help to identify ways in which the Programme and drug treatment in prisons might be improved in the future to ensure that it continues to meet the needs of drug misusing offenders and continues to have a positive impact on crime reduction and on the communities affected by crime caused by drug misusing offenders.
36. Monitoring will also help to identify whether any specific aspects of the Programme are impacting disproportionately on certain groups (such as those from black and minority ethnic groups or women) to enable any necessary action to be taken to mitigate that disproportionality.

37. The DIR (2007) will substantially improve on the DIR (2005) in terms of collecting valuable information for Monitoring & Research, particularly in relation to the Drugs Act 2005 provisions (required assessment – initial and follow-up); and in relation to treatment in prisons and ‘activity’ between Prison and the Community.

### **Information sharing using the DIR**

38. CJIT and CARATs workers will collect personal and sensitive personal data through the DIR; the Data Protection Act 1998 (DPA) and Human Rights Act 1998 apply to the processing of this data. In processing this data it is essential to comply with the 8 principles set out in Schedule 1 to the DPA <http://www.opsi.gov.uk/acts/acts1998/80029--1.htm#sch1>. Principle 1 requires that the data be processed fairly and lawfully and requires at least one of the conditions in Schedule 2 to be met, where sensitive personal data is being processed. In addition, at least one of the conditions in Schedule 3 should be met.

### **Information sharing - Continuity of care**

39. In order to improve continuity of care and treatment, it is important to ensure consistency in terms of what, when and how information is shared. It is a sensitive issue and it is important that it is properly handled. Ensuring that a drug misusing offender is appropriately supported throughout his or her contact with the criminal justice system or treatment is therefore essential in maximising their chances of remaining engaged in treatment. It is likely that various individuals and agencies may be involved with the individual at different stages of their treatment and/or criminal justice process and therefore important for workers to clarify whether someone else is already involved in their care/case and whether (within the legal framework) they should be speaking to and exchanging information with that other individual or agency.

40. For continuity of care purposes, however, information may only be shared with informed consent. (NB exceptions apply in line with existing confidentiality arrangements e.g. where the client may be likely to harm themselves, or another person, and in relation to Required Assessment (RA) and Restriction on Bail RoB) where the CJIT is responsible for ensuring that RoB conditions are met.)

41. Therefore the client must not only be informed about and understand the uses to which the information will be put, but also the circumstances when confidentiality may be broken. They must agree to the information being shared for purposes as outlined. The worker and the individual must sign the consent form attached to the DIR to confirm that this has occurred.

42. Once consent has been given for such sharing in respect of those agencies, and not subsequently withdrawn by the client, workers can share information contained on the DIR between agencies. This means, for

example, that not only can a CJIT worker give information to a CARATS team, but that they may also receive relevant information in return without further consent being obtained. This is within the legal framework.

43. If the individual refuses consent in relation to continuity of care, appropriate referral should still be made but the client should be advised that treatment/support might be delayed as questions, assessments etc may need to be duplicated by each agency involved.
44. The consent form makes clear that individuals working as part of a CJIT or CARATS team will not normally disclose information on the DIR without consent to their parent organisation (or indeed anyone). However it is important to ensure that in line with local confidentiality arrangements, clients are aware of the circumstances in which information may be shared without their consent, and informed of this as early on in the assessment and subsequent contact. (See following paragraphs re sharing information for a different purpose from which consent has been given.)

### **Information sharing - for offender management purposes**

45. The following section outlines roles and responsibilities for CJITs and CARATS with respect to sharing information with consent from the DIR with Probation/Offender Managers to inform Pre-Sentence Reports and for the early identification of potential Drug Rehabilitation Requirement (DRR) cases. Further advice is being prepared by NOMS probation and partners on the arrangements and details relating to information sharing without consent for the administration of justice, such as management and enforcement of a community sentence:
  - with a DRR who may be subject to RoB,
  - without a specific DRR
  - with a licence condition to tackle their drug misuse
  - without a licence condition to tackle their drug misuse.
46. Where consent is required by the DPA, it must be “informed consent” i.e. the individual must understand when giving his/her consent what information is being shared with whom, and why. As highlighted previously, the consent form attached to the DIR relates to the sharing of information for continuity of care, it may also be used to inform:
  - a Pre Sentence Report
  - facilitate early identification of offenders who may be suitable for a community order with a DRR
  - inform sentence planning in custody and on release.
47. It is recognised that CJITs/CARAT workers play an important role in helping to identify potential DRR clients pre-sentence, as well as to help prepare/motivate clients if a DRR is to be proposed.
48. It must not be assumed that the same information may then be shared – even with those named on the consent form - for any other purpose, such as enforcement or PPO offender management. Currently where disclosure

from the DIR is for a purpose other than that for which consent was given, such as enforcement of a licence condition to tackle their drug misuse, it is recommended that the Probation/Offender Manager should seek to obtain specific consent from the offender when drawing up their 'plan' e.g. at pre-release stage.

49. The DPA exemption for sharing relevant and appropriate information without consent for the administration of justice must be applied on a case by case basis. Probation should have local protocols in place to facilitate effective communication between themselves, CJITs and local drug treatment agencies. Information sharing is agreed on a case by case basis, to monitor compliance with the Order/Licence for the purpose of the administration of justice. Information that may be requested includes whether the offender is on the caseload and whether they are keeping appointments in line with their agreed plan.
50. The CJIT /PPO guidance (<http://www.crimereduction.gov.uk/ppo/ppominisite10.htm>) also refers to the importance of information sharing protocols, which are the formalised statements agreed between relevant partners setting out the practical processes for the appropriate sharing of information. These do not replace the legal framework within which all of this must take place. Rather, they use the framework to help define the roles, responsibilities and actions required of all concerned if they are to operate within it. To put it simply, they set out – within the legal framework - who shares what information with whom, how, why, when, and in what format.
51. Such protocols will be particularly useful in the context of a case conference/Shared Priority Forum so that each person at the table is aware of what and how they should contribute.
52. Protocols should also include guidance for relevant workers about what to do when a situation arises which does not appear to fit with normal procedures. There should be nominated senior colleagues in each partner organisation who have the authority to deal with such instances.

### **Collecting information for monitoring and research**

53. As set out in paragraphs 34 - 37, the Home Office and NOMS is required to collect monitoring and research data, both to ensure it is delivering best value for the considerable amount of public money invested in DIP and drug treatment in prisons, and to observe the engagement/attrition rates of clients as they move through the Programme. This latter purpose will help to direct Programme development, allocation of resources and service delivery, by providing evidence about pressure points or issues arising for particular areas and particular groups of clients.
54. To achieve this, the Home Office needs to receive the personal and sensitive personal data contained in the DIR (orange sections) and activity/required assessment forms. This data is separated from the blue

(continuity of care) section of the DIR form in order to ensure that only non-identifiable data goes to the data managers/Home Office. The data will include attributors (initials, date of birth, gender, religion and partial postcode) so that it will be possible to track a data subject's progress through the Programme without being able to identify the individual.

55. The Data Protection Act requires that when processing personal data, at least one of the conditions within Schedule 2 is met, and in relation to sensitive personal data, that in addition at least one of the conditions in Schedule 3 is met.
56. The Home Office needs to receive the personal and personal sensitive data from the orange sections of the DIR in order to discharge its function of reducing drug-related crime and increasing the numbers of drug misusing offenders going into treatment. As part of that function, the Home Office needs effectively to monitor the progress of DIP clients through the Programme and to identify ways in which the Programme might be improved in the future. To do this effectively a complete data set is required. This would not be achievable if it were dependent on the data subject's consent. The monitoring data is being processed by the Home Office only for the purpose of monitoring and research and will not prejudice any particular data subject. Any further disclosure by the Home Office will be of de-personalised data (typically aggregated statistical data).
57. Paragraphs 5 and 6 of Schedule 2 and paragraph 7 of Schedule 3 to the DPA are satisfied, and consequently informed consent of the client is not required, for the personal and sensitive personal data contained in the orange sections of the form to be processed by the Home Office for monitoring and research purposes. (In practice, receipt of the data by the Home Office will depend on the provider being able to provide the data in question lawfully.) Good practice dictates that even if the informed consent of the client is not required, the individual should be told that information will be shared for this purpose and the consent form attached to the DIR gives a form of words for CJIT and CARATS/Clinical workers to use to ensure the client understands what information will be shared with the Home Office and the purposes for which it is being shared (monitoring and research only).

## **Further sources of information**

58. More about the DIR (including responses to frequently asked questions) can be found at <http://www.dip.my121.com> and <http://www.drugs.gov.uk/drug-interventions-programme/guidance/DIR>.
59. Guidance on the importance of fully integrated partnership working between CJITs and Prolific and Other Priority Offender (PPO) schemes is at <http://www.crimereduction.gov.uk/ppo/ppominisite10.htm>.
60. The Data Protection Act 1998 can be accessed via the following link: <http://www.opsi.gov.uk/acts/acts1998/19980029.htm>.

**Home Office  
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