Partnership Guidance

Aligning the Prolific and other Priority Offender (PPO) Programme and the Drug Interventions Programme (DIP)

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Home Office
BUILDING A SAFE, JUST AND TOLERANT SOCIETY

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Introduction

1. In July 2006, the Home Office published *Rebalancing the criminal justice system in favour of the law–abiding majority – Cutting crime, reducing re-offending and protecting the public*. This set out the results of the Government's review of the criminal justice system, with proposals for reform and areas for further consultation.

2. The paper recognised the success of the Prolific and other Priority Offender (PPO) programme in tackling the small hard core of offenders who commit disproportionate amounts of crime and cause most harm to their communities. It also recognised the success of the Drug Interventions Programme (DIP) in getting drug-misusing offenders into treatment. Recognising that many drug misusing offenders commit huge volumes of crime, the paper included a commitment to bring DIP and the PPO programme closer together to ensure that, between them, they identify and target the highest crime causing drug-misusers.

3. The Home Office has also now published a full evaluation of the PPO programme:

   - An impact assessment of the Prolific and other Priority Offender programme[1]; and

   - The National PPO evaluation – research to inform and guide practice[2].

4. These reports provide evidence of reduced offending amongst the first cohort of PPOs selected in September and October 2004. They also provide information about the characteristics of PPOs, indicate some of the success factors for local schemes and set out some recommendations for developing practice.

5. This guidance takes account of these reports, and in particular looks to use an improved alignment of DIP and PPO to build on exiting good practice. In so doing, it is important to bear in mind that not all PPOs are drug-misusing offenders and that not all offenders who test positive for Class A drugs will be PPOs. It is recognised, therefore, that the two programmes are, and should remain, distinct from each other. There

[1] Home Office Online report 08/07
[2] Home Office Online report 09/07

will, however, be some offenders who fall to be targeted by both programmes because of the nature of their offending and drug-misuse. The purpose of aligning DIP and PPO is to ensure that all offenders who fall in to this category – the DIP/PPO "cross-over group" (defined in more detail in paragraph 18) are identified and managed in the most effective way through closer working and an improved interaction between the schemes on the ground - including the provision of required drug treatment and other interventions to address the factors in their lives that increase the risk of re-offending.

6. 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.

7. This guidance is intended to assist local areas in aligning their DIP and PPO schemes. In many cases, alignment will have been achieved already, and in other areas good progress is being made. We hope that this guidance will assist the process, in particular by helping to define they key elements of alignment. While this will help to ensure some consistency in approach across areas, there inevitably remains scope for local flexibility to ensure that both DIP and PPO continue to respond to local needs.

8. This guidance builds on earlier guidance to support effective working partnerships between Criminal Justice Integrated Teams (CJITs), who are commissioned by DATs to deliver the Drug Interventions Programme locally, and PPO schemes. A copy of that guidance can be found on the crime reduction website[3], and this guidance should be read along side that earlier guidance, and other related guidance.

The aims of alignment

9. 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.

[3] www.crimereduction.gov.uk/ppo

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;
- there is stringent management for all PPOs under NPD supervision through DRR community orders and licences following release from custody.

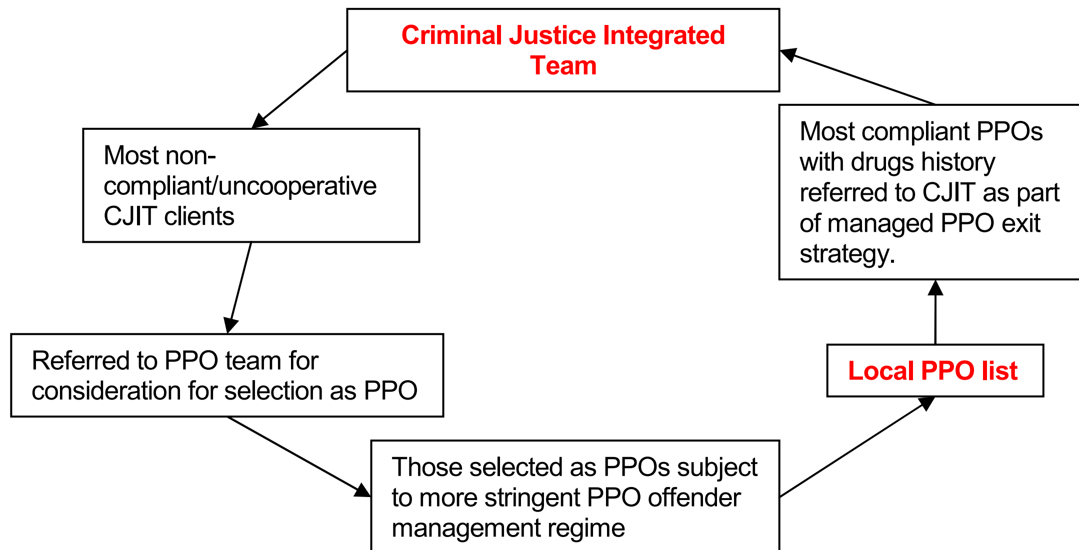
Improving the grip

10. Alignment should help to ensure that all offenders of most concern to the police and other agencies are targeted, including the highest crime causing drug-misusers. While many CJIT clients are primarily identified through drug testing on arrest or, in DIP non-intensive areas through drug workers in the custody suite, the selection of PPOs is more flexible and based on local priorities. This means that, where appropriate, drug misusing offenders who are not currently in the criminal justice system can be considered for selection as PPOs, such as those repeat offenders who are known to DIP but who have either not fully responded to previous offers of treatment or have consistently failed to co-operate or respond to the treatment provided.

11. The right interaction between DIP and PPO schemes also brings with it the opportunity to improve the case/offender management of targeted offenders. The management of offenders within the PPO programme is more intensive and coercive than under DIP. So drug misusing offenders who have a history of non-compliance or non-cooperation with DIP could be referred on to the local PPO selection panel for consideration as PPOs, to benefit from the more intensive PPO offender management regime, as a means of securing their engagement and reductions in offending and drug misuse.

12. Similarly, in the case of more compliant PPOs, who respond positively to the PPO offender management regime, but who have continuing drug misuse issues or who are in danger of relapse, consideration can be given to referral to the CJIT team to oversee their continuing case management for a further period, as part of a managed exit strategy from the PPO programme.

13. The approach, which envisages some two-way traffic between the schemes - is set out in the diagram below.



14. The clear overall objective is to achieve a greater reduction in drug misuse, crime and re-offending than would otherwise be achieved if the two programmes continued to operate in isolation from each other.

What we know about PPO/CJIT clients

15. Not all PPOs are drug-misusing offenders and not all offenders who test positive for Class A drugs are targeted as PPOs. The CJIT caseload will always be much larger than the number of offenders who can successfully be worked with by local PPO schemes. Nationally, PPO schemes work with around 10,000 – 11,000 offenders, while CJITs in both intensive and non-intensive areas work with over 40,000 drug users a year.

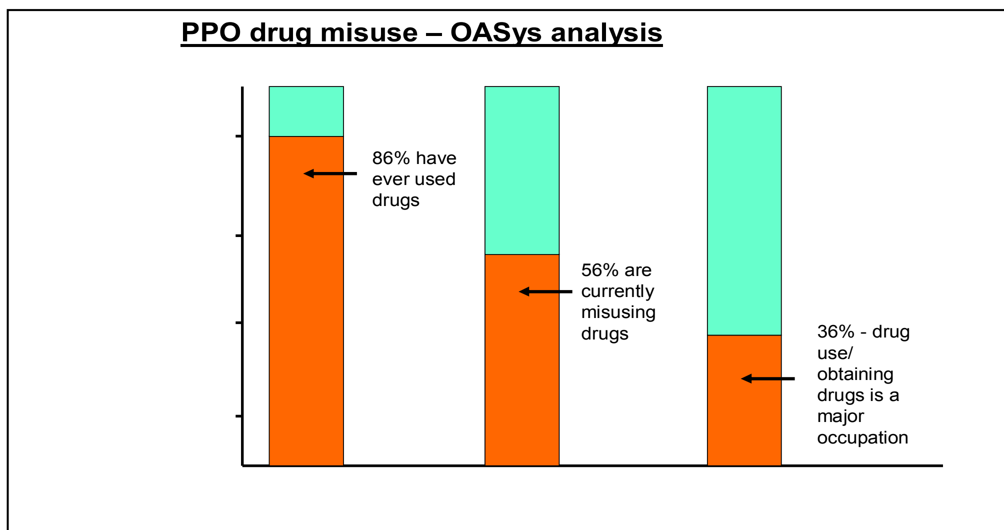
16. There will be some overlap of target group within these national statistics:

- within the 40,000 drug misusing offenders on the CJIT caseload, there will be a smaller number of more

active/persistent offenders, who are not complying with the care plan drawn up and agreed with the CJIT worker; and

- within the 10,000 – 11,000 offenders classified as PPOs, a smaller number will be high harm causing drug users whose prolific offending is driven by their drugs misuse.

17. There will inevitably be regional and local variations. A recent examination of OASys[4] data on adult PPOs found that, whereas slightly over half of all PPOs were currently misusing drugs, drug use and/or obtaining drugs was seen as the major occupation of just over one-third of all PPOs.



[4] OASys is a standardised process for the assessment of offenders developed jointly by the National Probation Service (NPS) and the Prison Service – now NOMS.

18. Similarly, a national comparison of the CJIT caseload and PPOs on JTrack[5] found that just under 3,000 offenders were being targeted by both programmes. This group of offenders were found to be:

    - more prolific, in terms of offending, when compared to both other PPOs and other offenders in the CJIT caseload; and

    - were both more serious offenders and more criminally versatile offenders (that is, offending covering a broader range of offence categories) when compared to other offenders on the CJIT caseload.

19. DIP/PPO alignment provides a real opportunity to ensure that the offenders who fall into the above categories – the "cross-over group" – are effectively targeted and managed to reduce both their drug misuse and related offending.

Guiding Principles

20. This section sets out some guiding principles for closer partnership working between CJITs and local PPO schemes which have been developed following consultation with practitioners. It does not set out precisely how fully aligned PPO schemes and CJITs should operate because there is a need to maintain local flexibility in delivering the two programmes. Rather, the guidance sets out the key features of alignment to assist local areas in bringing the programmes closer together at the local level.

21. The detail of alignment should be agreed locally, taking account of local considerations, such as the maturity of local programmes and the history of joint working; the availability and capacity of local drug treatment services; the involvement of wider agencies to meet the broader needs of the targeted offenders; and the profile of those offenders who are being targeted.

22. There may be some difficulties to work through in bringing the two programmes closer together, and these will need to be managed

[5] JTrack is a computer system that allows practitioners in police forces and Crown Prosecution Service areas in England and Wales to track PPOs, from arrest to finalisation, in a consistent way and measure their success in doing so.

through open and clear communication and the establishment of, and buy-in into, effective protocols for working together.

23. Where this is not already happening, a simple first step should be to consider representation from the PPO scheme on the local DIP Steering Group and, similarly, CJIT representation on the local PPO Steering Group. In some areas, these groups may sensibly be merged, whilst still retaining the necessary distinction between the two programmes.

24. All involved agencies should recognise that the aims and objectives of DIP and the PPO programme are complementary – the closer alignment of the two programmes will help to ensure a better grip of the more prolific/less compliant drug misusing offenders identified through DIP, and ensure that identified PPOs with drug misuse problems secure swift access to drug treatment, rehabilitative and other support services as appropriate. As suggested in paragraph 9 above, the most problematic drug misusing offenders should be jointly targeted to ensure the most effective case/offender management of the individual. Consequently, CJITs and PPO schemes should work closely together to:

    - achieve the greatest impact on offenders' drug use and related offending behaviour;
    - make the best use of local resources;
    - realise the most significant crime reduction outcomes possible; and
    - deliver the maximum positive impact for their local communities.

25. Closer working will depend on effective information sharing between CJITs and PPO teams, which will be facilitated by moving to a 'virtual joint team' approach where the day to day exchange of information about offenders on the CJIT and PPO lists becomes the norm – including, for example, information about drug misuse being included in the PPO selection matrix. This in turn will lead to a more effective management of key offenders between the two schemes, as described in more detail in the following section.

Key Features of alignment

26. In consultation, we have identified six key features of alignment which, when taken together, will help to bring local programmes together, to ensure more effective joint working. Together, these six features will deliver:

    - A more routine cross-referencing of the PPO list against the DIP caseload, to ensure that the highest priority offenders are being targeted and managed;
    - Offenders moved between the two schemes to reflect profile and compliance behaviour – generating "two way traffic" between local schemes;
    - Clearer expectations about "de-selection" – priority offenders (whether identified through DIP or PPO) should remain on the DIP/PPO list until they are no longer a threat;
    - A presumption that those offenders who test positive gain rapid access to appropriate treatment.

The six key elements of alignment

27. The following paragraphs outline the six key elements that should underpin effective alignment of local DIP and PPO schemes. The guidance which follows, includes some examples of good practice, and attempts to set out the spirit of closer working, recognising the need for local areas to adapt the guidance to meet their local conditions and priorities (rather than necessarily following the letter of the guidance in all instances). We do, however, recommend that working agreements are reached at a local level on each of the six key areas, to ensure that the spirit of alignment is fully embraced.

28. Annex C to this guidance includes a short alignment implementation checklist to (a) assist local areas in assessing their progress in bringing their DIP and PPO schemes closer together; and (b) to help with the process of alignment.

Element 1: Closer alignment of PPO teams and CJITs

29. This element is primarily about physical alignment to address the following questions:

    - Are the physical structures in place to enable the closer communication and working together between CJITs and PPO teams that is required by alignment?

    - What are the obstacles to this closer communication and working together, and have solutions to these problems been identified and/or implemented?

30. The essential requirement is the need to ensure that there are clear communication arrangements in place to enable close, day to day working across local PPO teams and CJITs. The ideal would be the physical co-location of PPO teams and CJITs, wherever possible, to enable the sort of day to day communication about individual offenders that is envisaged here. Experience of delivering the PPO programme has shown the benefits of co-location in improving communication and liaison between staff from different agencies and in improving information-sharing across agency boundaries[6].

31. **We do, however, recognise that physical co-location may not be possible immediately, or even in the longer term, in many cases.** This should not rule out the “virtual” team approach, which still allows for daily discussion between CJIT and PPO teams (and/or the key agencies represented on these teams), even where physically located in different places, in order to realise the sort of benefits described above.

32. Whatever physical arrangements, the emphasis should be on ensuring that clear communications arrangements are put in place. The key question to be answered is:

    - Are the arrangements in place for communicating across the teams sufficient to enable effective joint working, including multi-agency tasking and co-ordination arrangements where appropriate, allowing for the most cost-effective use of all partners’ time and resources?

[6] “The National PPO evaluation – research to inform and guide practice” Home Office online report 09/07

33. Whatever physical arrangements prove to be appropriate, they should allow for, and enable, (and not stand in the way of) the remaining key elements of alignment, including effective information sharing between teams and the involvement of CJITs in PPO selection, described in more detail below.

Case Study - Camden

Camden PPO team and CJIT are fully co-located, within the same voluntary sector agency. This means that the teams share the CJIT Single Point of Contact (SPOC), all police-based procedures, a common assessment tool and use of the CJIT database and drug users tracking procedures. They also share all referral procedures into prescribing, day programmes, and Probation, Housing and Rehabilitation Units.

The PPO team also spends part of their week co-located with the Probation Service, allowing them access to Probation systems and processes. This ensures that notification and breach proceedings are appropriate and completed to National Standards timescales. However, PPO workers have decided not to see PPOs in this context in order not to be seen as exclusively coercive.

Element 2: Effective information sharing

34. Effective working together will require information sharing about the offenders on the PPO/DIP lists between the CJIT and PPO teams. The report of the evaluation of the PPO programme[7] is clear about the value of information sharing between agencies: effective information sharing supports:

- enhanced partnership working;
- better communication between agencies;
- improved decision-making; and
- a more holistic view of the offender.

Any barriers to prevent sharing this information between the two teams should be addressed to allow for:

[7] "The National PPO evaluation – research to inform and guide practice" Home Office online report 09/07

- routine sharing of information about who is on the PPO list and the CJIT/CARATs caseload; and

- effective case management of individuals on either the PPO list or CJIT caseload, or both.

35. The CJIT should be prepared to inform the relevant PPO scheme about any PPO on the CJIT caseload. The objective is to ensure that both the CJIT and the PPO scheme are aware of any individuals who are on both lists – that is, fall into the “cross-over group” referred to in paragraph 18 above – as a key step in deciding the most effective management regime for that particular individual.

36. Similarly, one of the key benefits of alignment is to provide the potential for CJITs to refer the most non-compliant DIP clients on to the PPO scheme, for the scheme to consider their adoption as PPOs, in order to benefit from the more intensive offender management regime of the PPO programme. In this instance, it may be necessary to discuss details of the individual which goes beyond simply noting that they are on the CJIT/DIP caseload. The following guidance will apply to such instances, noting in particular the overarching principle set out in the paragraph below.

37. Where it seems desirable or necessary to share personal information about an individual between CJIT and PPO teams in order to provide enhanced case management, the individual’s consent to this should be sought and obtained, in accordance with current practice. It is likely that, in most cases, it will be possible to secure that consent by explaining the reasons and benefits of sharing information in this way. The central point is that information sharing will enable enhanced case management arrangements to be delivered with the clear objective of addressing the needs of the individual – both relating to drugs misuse and wider needs – in order to reduce the risk of re-offending. Referral on to the PPO caseload, where appropriate, will complement the support delivered by treatment and rehabilitation services. The incentive of avoiding intensive police monitoring, and an understanding of the potential ramifications of disengagement, can help to motivate the individual and facilitate a more positive response to the treatment and wrap-around services being provided. Sharing information can also monitor and manage offenders from receiving double prescribing that occurs on occasions.

38. In a minority of cases, individuals may refuse consent because they are disengaged from the CJIT or PPO scheme or both; and in a very small number of cases, an offender who is engaged with the programme may refuse to provide consent. The Home Office, Department of Health and National Treatment Agency have issued guidance on sharing information about Drug Misusing PPOs[8] in all of these circumstances. Refused consent is not an absolute barrier to the sharing of personal information between CJIT and PPO schemes, and cases where consent is withheld should be considered on their individual merits, in line with the Data Protection Act. This Act states that data should be shared where 'there is a substantial chance that not sharing the data would be likely to prejudice the prevention or detection of crime and/or the apprehension of offenders'.

39. The overarching premise is that information will be shared about individuals only to the degree that enables both the CJIT and PPO schemes to be sufficiently aligned to provide the most effective case management for the individuals concerned. The overarching principle of section 115 of the Crime and Disorder Act 1998 is to exchange information with relevant authorities where it is necessary for the purposes of crime reduction.

[8] Guidance to Support the Sharing of Information about Drug Misusing Prolific and other Priority Offenders. Home Office, Department of Health, National Treatment Agency April 2006.

Case Study - Ms E

The Offender Manager, Police Officer and CJIT caseworker were meeting to discuss some concerns on the progress of Ms E, who was under a parole licence with a requirement to address her drug problem and comply with a drug testing condition.

The CJIT Caseworker expressed concern that Ms E had been missing appointments for her script. The Offender Manager reported an increase in positive tests and the Police Officer stated that intelligence reports indicated she was seen on several occasions in the red light area late at night. A major concern was expressed about the welfare of her three children, in her and her partners care. This was immediately reported to social services team managing the children's welfare.

As a result of sharing this information she was confronted with this situation by all workers involved and the children were checked. She admitted a relapse and wanted help to restart her treatment. Within a few weeks intelligence reports fell, she attended her appointments and began giving negative drug tests. The Offender Manager gave her a formal written warning regarding her behaviour and she remained under close monitoring by all agencies over the following months.

Element 3: CJIT involvement in selecting PPOs

40. The relevant CJIT should be included in multi-agency arrangements for selecting PPOs for example, representation on the relevant PPO panel. This will help to ensure that drugs misuse is one of the factors to be considered, with others, in deciding the local PPO list. This will encourage CJIT staff to put forward appropriate referrals for consideration using the PPO coordinator to consider the appropriate panel forum.

41. The PPO evaluation report recommends multi-agency involvement in reviewing the procedures for the selection and de-selection of PPOs to ensure that the most problematic offenders are being targeted[9]. One of the key roles that the CJIT can bring to this is to help ensure that the most serious/problematic drug-misusing offenders, who are causing

[9] 'The National PPO evaluation – research to inform and guide practice' Home Office online report 09/07

the most damage to their local communities – the "cross-over" group (see paragraph 18 above) – are considered for inclusion on the PPO list. As discussed above, it is likely that these will be the most non-compliant offenders on the CJIT caseload; those who have repeatedly been arrested, tested and referred to treatment but who do not engage or stay in treatment, and who return swiftly to both offending and drugs misuse. Prolific drug misusing offenders who are included on the PPO list following referral from the CJIT should continue to receive a premium service in relation to treatment and wrap around services via the DIP care pathways, augmented by the PPO approach.

42. It is possible that CJIT clients who are not complying with their care plan do not appear on the PPO list or are not known to the PPO team. One of the advantages of including the CJIT in PPO selection is that they may be able to bring to attention offenders who may not otherwise be known to the PPO team. But the decision whether or not to include such offenders on the PPO list should remain the decision of the PPO scheme, based on their agreed selection criteria, which takes account of the needs and offending behaviour of other priority offenders in the local area, and the availability of local resources to respond to the needs of the targeted offenders

43. CJIT involvement in PPO selection should also provide the "two-way" traffic approach envisaged in paragraph 13 of this guidance, to enable more compliant PPOs (in appropriate cases) to be managed by the CJIT, as an alternative to de-selection as a PPO, as part of a managed exit strategy from the support provided by the PPO team. Where a PPOs drug fuelled crime rate has rapidly decreased and treatment is effective they will be eligible for consideration for de-selection from the PPO scheme, in accordance with existing guidance and practice.

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Selection of PPOs – Mr R

At the monthly review meeting there were several potential new PPOs who were being considered for registration with the scheme. An increase in drug misuse had been reported by the police and the CJIT. There had been more demand for treatment and users had reported that the price of Heroin had decreased over the last five months. Since the new DIP-PPO alignment, CJIT staff and their manager were now attending the monthly review meetings.

At the point of discussion when Mr R was being considered for inclusion in the scheme the CJIT worker was able to inform the group that he had attended two initial appointments for advice about treatment but had not attended the clinic for a script as prescribed. The police were able to report that he had been suspected of being an accomplice in the commission of several robberies with known offenders who were long term drug users (PPOs), and recently he had been arrested for two shoplifting offences where he was tested positive for opiates. His daily offending was on the rise. It was unanimously agreed to register him with the scheme. The Police and CJIT would work together and, hopefully with his agreement, encourage him into treatment as a first step to managing and reducing his offending.

Selection of PPOs – Mr L (a prolific shoplifter)

Mr L has been misusing drugs for several years, but has only been to prison twice. He is a long term Heroin user and has had periods where he has not used. He has not responded to treatment nor been registered as a PPO. He has in the past been discussed for inclusion as a PPO on the 'Catch and Convict' strand and his shoplifting has recently escalated with three court appearances in the last three months. Following police led intelligence he is now registered as a PPO and at the next arrest he will be managed using 'Restriction on Bail' interventions. He will also be encouraged to attend a CJIT assessment interview. The warning signs are there for PPO and DIP to work together to grip and challenge his behaviour. There are also concerns regarding his 14 year old son, who was recently subject to an ASBO.

Element 4: Effective offender and case management

44. For the purposes of this guidance, the following definitions are used:

- **case management**: the approach taken by the CJIT and delivered in line with Models of Care Update (2006) and reflects key elements of key working and care planning. Following assessment and being taken onto caseload, a key worker is allocated to draw up and agree a care plan and objectives with the client; co-ordinating further action and support as necessary. This is often referred to as 'case co-ordination' for treatment. They will ensure that the plan is regularly reviewed and updated;

- **offender management** : the overall responsibility of the PPO team to manage offenders through a combination of enforcement measures and incentives to change behaviour, using a multi-agency approach which brings together criminal justice agencies, local authorities and other social agencies, to give the PPOs the best chance of rehabilitation, or a swift return to the courts.

45. At a local level CJITs use a case management approach to offer access to treatment and support from the first point of contact with the criminal justice system through custody, court, sentence and/or when leaving treatment. Aftercare is the holistic support that needs to be in place as a drug misuser reaches the end of a prison-based treatment programme, completes a community sentence or leaves specialist treatment in the community. CJITs and PPO teams need to work together to ensure that case management is seamless and coordinated – for example, where an offender on the CJIT caseload is to be managed by the PPO team (involving a more intensive level of management) or where the offender is being de-selected as a PPO but will maintain engagement with CJIT because of continuing drug treatment needs.

46. In the past, engagement with DIP was on a voluntary basis on the part of the individual by encouraging drug-misusing offenders into treatment but without sanctions for non-engagement. However, to increase and encourage further engagement of individuals (often the most prolific, drug-misusing offenders), more coercive elements have been introduced in those areas which have the highest rates of drug related

crime; such as testing on arrest, required assessment and restriction on bail.

47. The chaotic lifestyles of many PPOs means that they are often the most difficult to move into and retain in treatment. The intelligence-led targeting approach of PPO schemes will add more of the "stick" of enforcement to the "carrot" of the treatment and support currently being offered by DIP for those CJIT clients who become PPOs. This approach would not be appropriate or affordable for all offenders on the CJIT caseload, which is why it is important that the broader PPO selection criteria continue to apply.

48. Where a PPO who is a problematic drug misuser is subject to a statutory order or licence, overall responsibility for his or her offender management will be with the National Offender Management Service; with CJITs providing or brokering the provision of services related to their drug misuse, where appropriate, for offenders subject to post custodial licence and community orders without a DRR. DRRs are separately funded and specific drug treatment is commissioned for those subject to DRRs. A named CJIT worker will provide case management on completion of the individual's statutory contact and for non-statutory cases where there is an ongoing drug related need that can be addressed through the CJIT. Detailed guidance has been issued about case management arrangements specifically for DRRs between CJITs and NOMS (CJITs and DRR clients: Case Management and Monitoring and Research Issues - July 2006), and those guidelines apply equally to PPOs who are subject to DRRs.

49. CJIT funding is generally allocated at a local level to provide services for drug misusing offenders. The CJIT funding excludes those offenders on DRRs as there are separate funding streams for DRRs. CJIT workers would not normally be involved in specific assessments for DRRs or any DRR treatment delivery unless specifically commissioned to do so. All other statutory probation cases (i.e. all those not subject to DRRs) can access CJIT and general drug treatment provision the same as voluntary clients. Regular liaison with CJIT , or CARAT workers (whilst in custody) will be important in working together to ensure PPOs access, receive and benefit from appropriate treatment through DIP case management.

50. Where there is effective co-ordination and information sharing the overall management of the offender's drug treatment and risk of re-

offending should, by applying a joined up approach, produce positive outcomes from effective alignment.

Case Study- Mr M (a young offender who is a PPO on a 3 month licence)

On the day of his release from custody Mr M was allocated, and seen by, a caseworker from CJIT. On the same day he received a prescription for Naltraxone (opiate blocker); although he remained adamant that he did not need this. However, within 3 weeks Mr M admitted that he had not taken his medication, as prescribed, and he acknowledged that during the period he had begun to again 'dabble' with illicit substances. Consequently, further appointments were arranged with both his CJIT key worker and the treatment provider (GP). Mr M was placed on a methadone programme of 80mls daily (supervised consumption).

Mr M has subsequently remained on his methadone programme until the end of his prison release licence supervision. The CJIT team report that since the end of his licence Mr M has asked the GP to begin to reduce the level of methadone he is prescribed. Mr M was urine tested twice a week during his supervision. After providing approx 5 positive tests in the initial stages of his licence he then went on to consistently produce tests negative for Class A substances for the remainder of his licence."

Element 5: Priority access to CJIT caseload

51. The Home Office evaluation of the PPO programme[10] suggests that, comparing PPOs to other offenders, PPOs are:

- more likely to misuse hard drugs;
- more likely to misuse a variety of drug types;
- more likely to be fully occupied by the pursuit and misuse of drugs;

[10] The National PPO evaluation – research to inform and guide practice" Home Office online report 09/07

- their offending is more likely to be judged as linked to their drug misuse.

52. Effective alignment should mean that all PPOs with drug misuse issues are, following an assessment, prioritised and gain swift access to treatment and support in the community, as appropriate, brokered through the CJIT. This will include where a PPO tests positive for Class A drugs use following arrest for a trigger offence[11] or under Inspector's authority. PPOs with drug misuse issues may also be identified following arrest for a non-trigger offence, or by the drugs worker in the custody suite in a non-intensive area. Where PPOs are identified pre-arrest as problematic drug misusers in order to support community sentences, those PPOs should be considered for a DRR assessment when appropriate, whilst preparing the Pre Sentence Report.

53. PPOs should also be prioritised for treatment, where appropriate, at other points in the criminal justice system. This can include:

    - PPOs entering custody gaining access to the CARATs[12] team;

    - PPOs prioritised for on-going treatment in the community, following release from custody;

    - PPOs released from custody on licence which includes a drug testing condition;

    - 'De-selected' PPOs with a stabilised drugs problem or in need of continuing support to be managed by the CJIT team until no longer assessed as being a risk by the CJIT and PPO team jointly. This will be a decision taken at a local level taking into account all relevant information on the PPO.

[11] Trigger offence: those offences proscribed in secondary legislation which are often committed by drug misusers to finance their drug habit
[12] CARATs: The non-clinical treatment needs of the majority of prisoners with substance misuse problems is met through CARATs: Counselling, Assessment, Referral, Advice and Throughcare Services

Priority access to CJIT caseload – Mr S

Mr S, a PPO, has been involved in prolific offending and has misused Heroin and Cocaine for several years, believing himself to be an addict. He was positively tested on arrest six months ago for opiates after committing a spate of domestic burglaries to feed his drug habit. Mr S appeared in court, where he received a six months custodial sentence based on the seriousness of his offending.

He showed positive motivation to tackle his drug dependency before and after his sentence. As a result he was seen by the CARATS team shortly after being admitted to prison, where a complete assessment was made of his treatment needs supported by the information contained in the Pre Sentence Report (PSR) written by the offender manager.

The CARATs team began processes to prioritise Mr S for appropriate treatment in Prison to ensure that an effective care plan was in place prior to release. On release Mr S entered treatment as a priority – the CARAT worker made contact with CJIT team in his locality within 24 hours in order to get a script and manage his drug treatment whilst he dealt with the difficulties of adjusting back to life in the community.

54. Where a PPO is transferred to the CJIT, as part of his or her exit strategy from the PPO programme, the CJIT should continue to provide a premium service in relation to treatment for any continuing drugs misuse issues in order to address the risk of relapse and further offending. The CJIT will remain responsible for the case management to address the broader needs of the offender (housing, education, training etc); informing the PPO scheme if there is any evidence of further offending.

Element 6: Performance Management

55. Aligned schemes should be able to bring together their current PPO and DIP performance management arrangements to enable them:

    - to keep track of the progress of individual offenders through JTrack and DIRWEB; and

- to monitor the effectiveness (and added value) of alignment, including crime reduction/reduced re-offending outcomes wherever possible.

56. A full outline of the PPO PMF, including data, can be found at www.crimereduction.gov.uk/ppo.

57. The need, at scheme level, will be to ensure that it is possible to keep track of the individual offender and to ensure that he or she is being subject to the appropriate interventions, whether managed for the moment by the CJIT or the PPO team. Where ever possible, local performance management arrangements should help to measure outputs and outcomes to show that the programmes – particularly when working more closely together – are meeting their objectives.

58. Closer alignment of performance management should allow for effective monitoring of PPOs entering and being retained in treatment as part of the PPO performance management arrangements. Similarly, the DIP performance monitoring framework should, over time, identify what forms of treatment are effective for PPOs

59. Nationally, we shall continue to monitor the numbers who fall within the "cross-over" group (see paragraph 18 above) by comparing the CJIT caseload and PPOs on JTrack. We are also exploring whether adjustments can be made to JTrack to indicate:

    - on selection, whether an offender has been placed on the PPO list following referral from the local CJIT; and

    - on de-selection, whether removal from the PPO list is on to CJIT case management as part of the PPO's exit strategy from the PPO programme.

Case Study – Ms N

Ms N has been on the PPO scheme for two and a half years, and during the last eighteen months she has received treatment to control her Heroin addiction.

During this time there is strong evidence that she has actively engaged in all parts of the programme; complying fully with her Community Sentence (DRR) and attending a series of treatments to reduce her Heroin dependency. She is now stable on a small maintenance script of methadone. Her personal circumstances have improved. She is reconciled with her partner and children and is living with them.

Throughout this period she aimed at becoming de-registered as a PPO. At the Performance Review meeting discussions were had by her Offender Manager and her key worker from the treatment provider. Probation records showed that she had complied with the DRR progress reports to the judge were excellent and his encouragement about her progress was very positive at the last court review. Police intelligence reports suggested a similar pattern. The treatment provider records provided a good picture of compliance with treatment and co-operation. Overall Performance was very positive. The Review team agreed to de-register her as a PPO and voluntary contact was to be maintained through the existing treatment provider and the 24 hour helpline offered under DIP.

As a result of the discussions the Review group agreed to undertake a small scale performance review on successful cases to try to identify what the key success factors may be. The performance review was to be a key feature of future meeting agendas.

THE PROLIFIC AND OTHER PRIORITY OFFENDER PROGRAMME

According to Home Office research[13], 100,000 offenders (10 per cent of all offenders on the offenders index) in England and Wales are responsible for over half of all crime, with their actions having enormous effect on fear of crime and feelings of community safety.

On 30 March 2004, the Prime Minister launched the Prolific and Other Priority Offenders (PPO) strategy as a cross-Government initiative to tackle this small number of hard-core offenders who commit disproportionate amounts of crime. The strategy is a single, coherent initiative in three complementary strands (prevent and deter, catch and convict, resettle and rehabilitate). It aims to reduce crime by targeting those who offend most or otherwise cause most harm to their communities. Across England and Wales, the programme is targeting over 10,000 PPOs, and a further 4,000 young offenders under Prevent and Deter.

Under the programme, each Crime and Disorder Reduction Partnership (CDRP) area has established a multi-agency led PPO scheme and using a range of local intelligence has identified a minimum of 15-20 offenders in their area for targeting and intensive management. This number includes offenders on custodial or community sentences and juveniles. Led by CDRPs, working closely with Local Criminal Justice Boards and Youth Offending Teams, the programme allows local partners to identify together the mix of individuals who are the most prolific offenders, the most persistently anti-social in their behaviour and those who pose the greatest threat to the safety and confidence of their local communities.

The 3 strands of the programme then aim to:

- **Catch and Convict** offenders who commit most crime in their locality, or whose offending causes most harm to their community;
- **Rehabilitate and Resettle** these identified PPOs, working with them to stop their offending by offering a range of supportive interventions addressing identified needs/risks of further offending. The opportunity

[13] 'Criminal Justice: the way forward' Cm 5074, published in 2001

to rehabilitate is backed by a swift return to court if offending continues; and

- **Prevent and Deter** young people engaging in crime with a specific focus on the most active young offenders to stop them becoming the next generation of PPOs.

These schemes have been operational since September 2004. The full evaluation of the programme shows a 62% reduction in convictions amongst the first offenders selected on to the programme in September and October 2004, over the following 17 months.

Local PPO Schemes

At a local level, PPO schemes are multi-agency partnerships, based on a very close working relationship between the Police and Probation services, to identify, monitor and intensively manage a key target group of offenders (PPOs) in a local area. PPO schemes could be real or virtual in form, depending on locally developed arrangements. The PPO programme has considerably improved inter-agency partnership and data sharing, particularly in schemes where the key partners are co located. It utilises a joined-up multi-agency offender management approach, bringing together all the criminal justice agencies, local authorities and other social agencies, who together give the PPOs the best chance of rehabilitation, or a swift return to the courts.

Once an individual is identified, schemes are expected to manage offenders through a combination of enforcement measures and incentives to change behaviour. Therefore the aims of the schemes are to:

- enhance arrest, investigation, detection, charging and prosecution of offenders, bringing to justice as much of the criminality committed by the targeted PPOs as possible;

- reduce re-offending of PPOs, and consequently reduce the number of victims of crime;

- develop a rapid and effective partnership intervention which enables effective supervision and monitoring of PPOs;

- address non-compliance/re-offending speedily and effectively.

Schemes are expected to provide incentives to change through providing the specific support and rehabilitation needs of the offender, drawing upon

relevant agencies and services to meet these. Case management of statutory offenders is undertaken by the probation service as part of the overall scheme.

Effective partnerships with local CJITs / DATs are vital to delivery.

THE DRUG INTERVENTIONS PROGRAMME

The Drug Interventions Programme is a critical part of the Government's strategy for tackling drugs. It began in 2003 as a three-year programme to develop and integrate measures for directing adult drug-misusing offenders out of crime and into treatment. It attracts significant public funding and is continuing beyond the original three-year period, with the aim of gradually ensuring that the constituent interventions and processes become the established way of working with drug misusing offenders across England and Wales.

The Programme, a world-first, involves criminal justice and treatment agencies working together with other services to provide a tailored solution for adults - particularly those who misuse Class A drugs - who commit crime to fund their drug misuse.

Delivery at a local level is through Drug Action Teams, using Criminal Justice Integrated teams (CJITs) who adopt a case management approach to provide, or broker access to, treatment and support which is appropriate to each individual client's needs. This begins at an individual's first point of contact with the criminal justice system through custody, court, sentence and beyond into resettlement.

Key partners to the Home Office are the criminal justice agencies such as the police, prisons, probation officers and the courts, along with the Department of Health, the National Treatment Agency and treatment service providers and those who provide linked services such as housing and job-seeker support.

Some elements of the Programme are in operation in all areas of England and Wales. Since its first year, 2003/4, the Programme has had a particular focus on and rolled out additional components only to certain Drug Action Team (DAT) areas in England and Community Safety Partnership areas in Wales. These are mainly areas with high levels of acquisitive crime, normally property crime such as burglary, shoplifting, robbery and so on. These areas, where the whole range of DIP elements are operating fully, are known as "intensive" areas and

comprise 68 DAT areas in England and 3 high crime areas in Wales (or 98 police BCUs in total).

The measures introduced under the Drugs Act 2005 to identify and assess the needs of more drug misusers in the early stages of the criminal justice system have now been introduced in these intensive areas. The measures are:

- **Testing on arrest** - a provision to move the point at which a drug test may be carried out to arrest rather than post charge. Testing on arrest will enable us to identify people misusing specified Class A drugs earlier in their contact with the criminal justice system, so that they may be steered into treatment and away from crime as soon as possible. It will also increase the volume so identified because it will ensure that those who misuse drugs - but are not charged with an offence - are nevertheless identified and helped to engage in treatment and other programmes of help.

- **Required assessment** - a new power for the police to require persons who have tested positive for a specified Class A drug when tested on arrest or charge, to attend an initial assessment of their drug use. Prior to this new power, such assessments were purely voluntary. Required assessment will increase the number of individuals taking this step towards addressing or re-addressing their drug use related needs and behaviour

In addition restriction on bail has been extended:

- **Restriction on bail** – for those who have tested positive on arrest or charge for specified Class A drugs and where the relevant conditions are met, the defendants will be asked to undergo an assessment of their drug use and agree to participate in any follow-up recommended by the assessor. If they agree, they will, in most cases, be released on conditional bail. If they refuse, the normal presumption for bail is reversed and the court will not grant bail unless it is certain that they will not offend whilst on bail

Three police force areas (GMP, South Yorkshire and Nottinghamshire) implemented the new measures in December 2005 and the remaining intensive areas followed on 31 March 2006. Restriction on bail is now available across the whole of England including non-intensive DIP areas.

From April 2004, the throughcare and aftercare parts of the Programme became nationwide elements, phased in across the whole of England and Wales. In England, therefore, all 82 Drug Action Team areas that are not "intensive" are nonetheless actively involved in delivering some of the most important features of the Programme. In Wales, there are three intensive sites – Cardiff, Newport and Swansea. The rest of the country, (which is divided into four regions and local Community Safety Partnerships) is operating the Programme non-intensively.

The key interventions points within DIP for adults are:

- testing on arrest or charge for certain trigger offences (or any offence where a police officer of Inspector or above believes that specified Class A drug misuse caused or contributed to the commission of the offence and authorises a test) [14];
- required assessment following a positive test – to be carried out by a CJIT drug worker, usually within the custody suite immediately after the test;
- voluntary assessment with a CJIT drug worker, in the absence of a positive test but where drug use is a factor in offending behaviour;
- conditional cautioning – an alternative to charge aimed at cases where the public interest would be met more effectively by the offender carrying out specific conditions (including a drug rehabilitative condition) rather than being prosecuted;
- restriction on bail – to move more drug using offenders into treatment;
- working with clients to prepare them for drug-related elements of community sentence such as the DTTO or DRR, and on completion of a DRR if there are ongoing drug treatment needs identified; and
- CARATs teams working with clients in prison

Following engagement with the programme, CJITs in the community and CARATs teams in prison then work with their clients and together to ensure continuity of care and retention in appropriate and effective treatment and support. They are supported in this by the Drug

[14] see Tough Choices Guidance (as above) Annex B for full list of trigger offences

Interventions Record (DIR). This is the key tool for continuity of care and monitoring and research in relation to the Drug Interventions Programme for CJITs and CARATs. It gathers information that CJIT workers will have received during contact and assessment(s). For CARATs teams in prisons, the DIR is also the Drug Misuse Triage Assessment Form, replacing the CARATs Initial Assessment Form. The DIR is transferred between the CJITs and the CARATs teams as the individual to whom it refers moves between the community and prison.

Since the Programme began in April 2003, over 69,000 drug misusing offenders have entered into treatment through DIP.

ALIGNMENT IMPLEMENTATION CHECKLIST

Aim	Action required by CDRP, PPO Team, CJIT and YOT at a local level	Person/organisation responsible for achieving the aim	Date completed
1. Closer alignment of PPO team and CJIT	Is it possible to co-locate the PPO team with the CJIT?		
	What barriers prevent co-location?		
	If co-location is not possible, have the teams established effective communication channels?		
	Are there secondment arrangements with staff?		
2. Effective information-sharing	Are there any barriers that prevent routine information sharing between the CJIT and PPO team?		
	Do the teams share information on who is on the PPO list and the CJIT/CARATs caseload?		
	Is there effective case management of individuals on either the PPO list or CJIT caseload?		
	Is there a common understanding of what is shared about offenders by whom, and at what key stages it is shared and how the information will be used to benefit PPOs and the community?		
3. CJIT Involvement in selecting PPOs	Are CJIT/PPO staff both involved in the initial identification and selection processes and procedures for placing and accepting offenders into schemes?		
	Has drug and/or alcohol misuse been added to the matrix selection assessment for PPOs?		
	Does the CJIT work with police to monitor multiple presenters/positive testers, bringing them forward for consideration as PPOs? If they are not selected as PPOs, does the CJIT then seek other means of engaging them in		

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	appropriate drugs interventions?		
4. Case Management and Offender Management	Have both the PPO team and CJIT been briefed about their respective case management and offenders management systems, processes and recording procedures?		
	Have the teams agreed the roles and responsibilities of the offender and case managers at each stage of the management process?		
	Does a member of the CJIT attend PPO operational meetings?		
	Does the PPO team use JTrack?		
	If a PPO is subject to statutory supervision, are all staff aware of the name and contact details of the Offender Manager?		
	Are PPOs prioritised for treatment services?		
	Do PPOs gain rapid access to treatment?		
	When entering custody, are PPOs gaining access to the CARATs team?		
	Are 'de-selected' PPOs with a continuing drugs problem or in need of continuing support automatically referred to the CJIT for support?		
5. Priority access to CJIT caseload	Are offenders on the CJIT caseload considered for inclusion on the PPO list; if they refuse to comply with the CJIT or their offending is escalating?		
	Do offenders know about the 24 hour help line?		
	Are management/ Team Leaders and Senior Managers of key agencies made aware of the content of the DIP and PPO Performance Management Frameworks and do they share regular reports and monitoring information?		
	What performance measures/data relating to the success of treatment are shared by the CJIT?		
6. PMF	Are management/unit team leaders and senior managers of key agencies made		

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	aware of the content of the DIP and PPO Performance Management Frameworks and do they share regular reports and monitoring information?		
	Is there a PPO/DIP alignment plan?		
	Does the PPO team use JTrack reports?		
	What performance measures or data relating to the success of treatment are shared by the CJIT?		
	Does the PPO steering group monitor PPO performance targets and KPIs?		

Annex D

BCU – Basic Command Unit

CARAT – Counselling Advice Referral, Assessment and Throughcare

CJIT – Criminal Justice Integrated Team

CJS – Criminal Justice System

DIP – Drug Interventions Programme

DIRWEB – Drug Intervention Record

DRR – Drug Rehabilitation Requirement

DTTO – Drug Treatment and Testing Order

ETE – Education, Training and Employment

GMP – Greater Manchester Police

GP – General Practitioner

HCCU – High Crime Causing Users

JTRACK – IT system: PPO CJS Tracking Database

NIM – National Intelligence Model

NOMS – National Offender Management Service

NPS – National Probation Service

NPD – National Probation Service (now part of NOMS)

OASys – Offender Assessment System

PMF – Performance Monitoring Framework

PPO – Prolific and other Priority Offender

SPOC – Single Point of Contact

YOT – Youth Offending Team