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# Drug Interventions Programme: clinical profile of service users *v.* attendees of standard services

**AIMS AND METHOD**

We conducted a retrospective survey of all cases referred to the Drug Interventions Programme in Hertfordshire for the first 9 months in order to compare them with those referred to one of the community drug and alcohol teams.

**RESULTS**

The Drugs Interventions Programme had significantly more White British clients and clients who had dropped out from previous treatment. Compared with community team clients, the Programme had a higher percentage of clients with an opioid problem (92%), of whom a high percentage also misused other substances (78%) and injected drugs (30%, half of whom shared needles).

**CLINICAL IMPLICATIONS**

More chaotic clients who had failed previous treatment have entered treatment with the Drug Interventions Programme.

The long and enduring relationship between crime and illegal drug use has been well documented over time (Hall *et al*, 1993). The results of follow-up studies indicate that drug treatment does facilitate the reduction of acquisitive crime in offenders addicted to illicit drugs (Gossop *et al*, 2000). At the moment in the UK there are two main treatment models addressing the treatment needs of drug users involved with crime, namely the Drug Rehabilitation Requirement and the Drug Interventions Programme (DIP). The Drug Rehabilitation Requirement (DRR) is a multi-agency initiative that involves courts, probation services and treatment providers. The concept of enforced treatment is designed to facilitate treatment access for individuals trapped in the vicious circle of crime to fund drug use (Kouimtsidis *et al*, 2007). Drug Interventions Programme services were implemented in 2005. They are multi-agency initiatives that involve police, probations and treatment services. In contrast to DRR, this is not enforced treatment. The aims are:

(a) to offer a treatment alternative to people involved in substance misuse and crime before their involvement with the law
(b) to provide assertive treatment to prolific offenders not responding to less intensive interventions
(c) to offer immediate access to treatment to those released from prison facilities in order to reduce the well-documented risk of overdose (Singleton *et al*, 2003).

Assertive community treatment is a well-established treatment model in mental health. There is good evidence from the USA to support its effectiveness (Stein & Test 1980; UK700 Group, 1999), whereas the evidence from the UK is somehow controversial. The selection of patients appropriate for this therapy is based on severity of clinical presentation and social complexity. Drug Intervention Programme services share some of the characteristics of assertive community treatment, but there is a fundamental difference in the criteria for client selection. The selection of DIP clients is based mostly on their involvement with crime; severity of addiction, overall clinical presentation and social situation are secondary criteria, and are presumed to be correlated with the severity of offending behaviour.

The DIP services in Hertfordshire were established in 2005. Treatment services include:

- the clinical team, consisting of two psychiatric nurses, one staff-grade psychiatrist and one part-time consultant psychiatrist
- a team of keyworkers
- an arrest referral team
- one probation services worker
- eleven police officers, two police sergeants and one detective inspector.

The aim of the project reported here was to assess the demographic and clinical characteristics of people entering treatment with the clinical team during the first 9 months of DIP services and compare them with the characteristics of people entering treatment at one site of one of the five community drug and alcohol teams in the county.

## Method

A retrospective cross-sectional study was conducted of all new referrals to either the DIP clinical team or the

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Hemel Hempstead site of the North-West Hertfordshire community drug and alcohol team (CDAT). The latter site was selected because it was meeting National Treatment Agency key performance indicators for ease of access and retention in treatment. The study took place during April–December 2005. Data were collected from clients' clinical notes using a specifically developed form. The information used was collected as part of the routine assessment procedure. No name was recorded on the data forms.

Data were analysed using SPSS version 15 for Windows. Descriptive statistics were used. For differences between groups, *t*-tests for parametric and chi-squared tests for non- parametric categorical data were used.

## Results

There were 96 new referrals to the DIP and 66 new referrals to the CDAT during the study period. There was no major difference between the trimesters. The male to female ratio for DIP was 8:2, whereas for CDAT it was 7:3. The mean ages of the two groups were similar: 30 years (range 19–52) for DIP clients and 33 years (range 22–55) for CDAT clients. There was significant difference between DIP and CDAT clients as far as ethnicity was concerned: 92 (96%) DIP clients were White British compared with 55 (83%) CDAT clients ($\chi^2$=7.30, $P$=0.09).

### Clinical profile

#### *Previous treatment*

Data were collected with respect to the clients' last treatment episode, defined as the most recent treatment episode prior to the current treatment episode with DIP or CDAT. Clients leaving and re-entering treatment during the same trimester were only included once and the treatment episode was considered as one. There was a significant difference between the two groups as far as last treatment episode was concerned ($\chi^2$=21.99, $P<0.001$). Among DIP clients, for almost 30% ($n$=30) their last treatment episode was with their local CDAT, for 15% ($n$=14) it was with the DIP (in the previous trimester), for 12.5% ($n$=12) it was with the DRR and only 17% ($n$=16) had no previous treatment experience. Only 9 out of the total 96 clients had their most recent treatment in prison. Forty-four per cent of CDAT clients had no previous treatment experience; for another 44% of CDAT clients the last treatment episode was with their local CDAT, suggesting that the team was re-recruiting people who had previously left this service (Table 1).

There was a significant difference between the two groups regarding completion rates of the last treatment episode for those who had previous treatment experience ($\chi^2$=6.12, $P$=0.01). Completion of treatment for DIP was defined as clinical stability that could justify transfer to a less intensive service, i.e. the local CDAT. Completion of treatment for CDAT was defined as either clinical stability that could justify transfer to shared care or successful completion of detoxification. Twenty-three (30%) DIP clients had completed their last treatment episode, whereas 54 clients (70%) had either dropped out (44) or their treatment was interrupted. Ninety per cent of CDAT clients had dropped out from their last treatment episode; the majority of these had been treated by the same CDAT.

#### *Substances used*

Data were available for 89 DIP clients and 50 CDAT clients. Eighty-two (92%) DIP clients had an opioid use problem. Of these opioid users, 61 (74%) were also using cocaine or crack cocaine. Only 2 clients were using benzodiazepines in addition to heroin and 4 (5%) had used all three substances. Five clients were abstinent at the time of referral (4 had undergone detoxification in prison) and requesting prescription of naltrexone (Table 2). The profile of CDAT clients was different. Forty-three (86%) clients had an opioid use problem; of these, 21 (49%) had additional crack problem, and 7 (14%) used all three substances. Only 25 (26%) DIP clients and 3 (20%) CDAT clients self-reported harmful use of alcohol.

#### *Injecting and sharing practices*

One-third of DIP clients were injecting drugs at the time of entering treatment and half of those doing so were sharing needles or works. The picture changed over time. In the third trimester a smaller percentage of clients were injecting and sharing (26% and 44% respectively), suggesting a harm minimisation and health promotion effect of treatment (in the third trimester most clients re-entered treatment following previous drop-out from the DIP) (Table 3). There was a smaller percentage of people who were currently injecting within CDAT (13 clients, 20%) and none reported sharing needles or works.

**Table 1. Type of last treatment episode**

| | Last treatment episode, *n* | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Service | None | CDAT | Non-stat | GP/SC | DIP | DRR | Prison | Total |
| DIP | 16 | 30 | 6 | 7 | 14 | 12 | 9 | 94 |
| CDAT | 29 | 29 | 2 | 0 | 0 | 4 | 2 | 66 |
| Total | 45 | 59 | 8 | 7 | 14 | 16 | 11 | 162 |

CDAT, community drug and alcohol team; DIP, Drug Interventions Programme; DRR, Drug Rehabilitation Requirement; GP, general practitioner; Non-stat, non-statutory; SC, shared care.



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**Table 2. Substances misuse profile**

| Service | No use, *n* | Heroin, *n* | Heroin + crack, *n* | Heroin + crack + BZD, *n* | Heroin + BZD, *n* | Crack, *n* | BZD, *n* | Total, *n* |
|---|---|---|---|---|---|---|---|---|
| DIP | 5 | 15 | 61 | 4 | 2 | 1 | 1 | 89 |
| CDAT | 0 | 11 | 21 | 7 | 4 | 6 | 1 | 50 |
| Total | 5 | 26 | 82 | 11 | 6 | 7 | 2 | 139[1] |

BZD, benzodiazepine; CDAT, community drug and alcohol team; DIP, Drug Interventions Programme.

1. Missing cases are not included.

## Discussion

The study reported here has several limitations that might affect the generalisability of the results beyond the Hertfordshire population. This was a retrospective study and data were collected from the clinical notes, therefore the quality of data depended on the quality of information recorded. Results reported here suggest that clients in both types of services are similar in terms of gender ratio and age but different as far as ethnicity is concerned, with far more White British clients entering DIP. This difference might be explained by either a higher involvement of this ethnic group in offending or better accessibility of CDAT services from British Black and minority ethnic groups. Results also suggest that CDAT services attract mostly treatment-naïve individuals and those who have dropped out previously from CDAT treatment. In contrast, it seems that more than a third of the DIP clientele were previously involved with services provided by the criminal justice system. It is important to notice that less than 10% of DIP clients had their previous treatment in prison. Although information regarding the interval between release from prison and DIP treatment and the total number of released opioid-dependent prisoners during the same period (the high-risk group for accidental overdose) is not available, it can be argued that this percentage, although higher than that of the CDAT, is low for an assertive type of service that focuses on this vulnerable population.

The substance misuse profiles of clients were different between the two groups. Although opioids were the main drug of misuse for clients of both services, the percentage of users was higher among the DIP group. For both groups the prevalence of additional crack cocaine use is very high, making this group (heroin and crack users) the most prevalent group. There was a higher percentage of people who injected, and of 'chaotic injectors' (those sharing equipment) in particular, entering DIP treatment. In conclusion, we might argue that although the main client selection criterion for DIP services is criminal behaviour, it seems that in Hertfordshire the people who entered treatment during the first 9 months of the programme had failed previous treatment, were chaotic injectors and were involved with treatment services provided by the criminal justice system. They therefore have an appropriate clinical profile for involvement with assertive services.

**Table 3. Injecting and sharing profile of clients of the Drug Interventions Programme**

| | Injecting, *n* | | Sharing, *n* | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| First trimester (*n*=24) | 8 | 16 | 5 | 19 |
| Second trimester (*n*=36) | 14 | 22 | 8 | 28 |
| Third trimester (*n*=34) | 9 | 25 | 4 | 30 |
| Total[1] (*n*=94) | 31 | 63 | 17 | 77 |

1. Missing cases are not included.

## Declaration of interest

None.

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