social research

Scottish Government
Riaghaltas na h-Alba

Research Findings

CRIME AND JUSTICE

No. 75/2023

Review of community sentencing options for people with substance use problems: A summary of key findings

Justice Analytical Services

Background

This short paper summarises the key findings from Justice Analytical Services' review of Drug Treatment and Testing Orders (DTTOs) and Community Payback Orders (CPOs) with drug treatment requirements. The evidence review underpinning the findings related to good practice in respect of court mandated treatment is attached at Annex 1, and the full report containing all analysis of the current approach in Scotland is attached at Annex 2.

This review takes place in the context of an urgent public health crisis for Scotland - one in which 1,051 people died drug related deaths last year, the highest drug-death rate in Europe, while thousands more suffered the health and social harms associated with both drug use and its criminalisation.

In response to this ongoing crisis in 2021 the Scottish Government announced a National Mission on Drugs, which has involved significant work and funding to extend a public health approach to drug use. The Mission is premised, in part, on the wealth of evidence showing that treatment is a protective factor against drug-related harms including death.

In addition, the National Strategy for Community Justice (published in 2022) reflects the Scottish Government's longstanding aim to encourage a shift towards community justice interventions and away from using custody as a response to people who commit crimes. It recognises that while public protection is paramount, there is clear evidence that community-based interventions and

sentences can be more effective in reducing reoffending and assisting with rehabilitation than custody.

Currently in Scotland, courts have a range of sentencing options they can impose for offending behaviour, including a prison sentence at the most restrictive end, and a spectrum of community orders with various degrees of restriction or requirement on the person's movements or behaviour.

The two main community orders specifically aimed at people with substance use problems are a Drug Treatment and Testing Order (DTTO) or a Community Payback Order (CPO) with a drug treatment requirement. For both orders, the person must confirm that they are willing to comply with the relevant requirements before the order is made – although it is important to note that a prison sentence is a possible alternative, so the voluntaryness of such consent may be contested.

The two orders have slightly different legal definitions – a CPO *is a sentence* of the court, while a DTTO is an *order instead of a sentence*. This creates a technical distinction in the person's status, with CPO recipients being convicted and sentenced, while DTTO recipients are convicted with no sentence passed. However, the orders function in broadly the same way. For both orders if the person fails to comply the court may vary or revoke the order, or impose any sentence competent for the original offence, but should take account of the time spent on the previous order. Both orders are also listed in Section 5D, subsection (2) of the Rehabilitation of Offenders Act 1974, and consequently have the same disclosure periods in respect of the person's criminal record.

DTTOs are widely, but not universally, available across Scotland. CPOs are available in all areas across Scotland, and delivering them is one of the major functions of all justice social work departments.

Aims

The need for this review was identified by the Drug Deaths Taskforce, who recommended that "The Scottish Government should review drug treatment and testing orders, Community Payback Orders and other community sentencing options to assess how they have been used, their outcomes and whether they are the most effective mechanism to support an individual's recovery and reduce recidivism rates." This recommendation proceeded from:

- evidence that professionals involved in delivering DTTOs felt parts of their structure are inconsistent with what is known about the recovery process, and
- an interest in improving community based alternatives to custody, to improve our options for protecting people from the multiple risk factors for drug death that are prevalent in prisons and/or caused by spending time in custody.

More broadly, there has also been a lack of focussed evaluative work to date on either DTTOs, or people who use drugs as a specific sub-group of CPO

recipients. This review aims to go some way towards filling in this gap in the evidence base.

The review focused on four aims:

- Identify what “good practice” in relation to court-mandated substance use treatment looks like
- Gather all available evidence on people with substance use problems serving community sentences in Scotland
- Collate the most comprehensive picture possible of the processes, services and interventions involved in delivering treatment-based orders across Scotland
- Assess the extent to which the current approaches being delivered across Scotland appear consistent or inconsistent with the evidence on good practice, and identify areas that may warrant further consideration by policy makers or exploration with stakeholders, including people with lived experience of drug use and the justice system.

This research findings document summarises the main findings.

Methods

This review has sought to conduct a thorough and rigorous analysis of the relevant issues and available data, while balancing this against the need for rapid insights to support swift progress.

The time available, and very large literature on both recovery from substance use and desistance from crime, did not permit a strictly systematic literature review. However the authors have sought to build the most rigorous and relevant picture possible with the time and resources available by attempting to prioritise:

- More recent research
- Systematic reviews and meta-analyses, and/or studies with high quality designs, larger sample sizes and longer follow up periods
- Research that draws on people’s lived experience of substance use, treatment and/or the justice system
- Research that provides clear policy implications
- Research from Scotland and the UK or from jurisdictions with comparable social / legal contexts

Literature was identified for triage in the Google Scholar and Idox databases, using various combinations of search terms related to ‘drugs’, ‘treatment’, and ‘court supervision’.

The outcome is a literature review where the majority of works cited are academic journal articles, with some books or book chapters, government reports and relevant unpublished grey literature also included.

The current position in Scotland draws primarily on administrative datasets and published reports from Scottish Government and Public Health Scotland sources. Where time and data access has permitted, the review has created new breakdowns of these data, not previously published, to provide more detailed insights than are available in periodic statistics publications.

Additionally, this review conducted novel analyses of previously unpublished data from the Level of Service / Case Management Inventory (LS/CMI) database. LS/CMI contains data captured in cases where the court requests a social work report prior to sentencing, and also when a person receives a sentence that will involve supervision or custody. The analysis is based on a snapshot of the data taken in July 2023, where cases were completed and closed between 2017 to 2021.

The more detailed analysis that underpins the conclusions regarding the current position in Scotland and the relevant population will be published in a shortly forthcoming publication.

Main results

What does “good practice” in relation to court-mandated substance use treatment look like?

At the very highest level, the evidence seems to suggest that overall and on average, **court ordered treatment is less effective than voluntary treatment, but still likely to produce more positive outcomes for people than custody**. Beyond that, the evidence on how best to maximise the potential benefits, and minimise the potential harms, of court ordered drug treatment in response to offending behaviour is growing but remains uncertain.

The evidence suggests that the most evidence-based community sentencing option for people with substance use problems would be one that:

1. Does not widen the reach or deepen the intensity of punishment.

2. Prioritises keeping people out of custody, in recognition of the harms prison causes, particularly by elevating their risk of drug related death due to multiple risk factors that are prevalent in, or directly caused by, prisons.

3. Recognises that substance dependency is a health condition and should be treated that way.

4. Recognises that while traditional models of voluntary treatment begin at the “action” phase, people who are mandated to treatment have several preparatory steps to move through first. Therefore, sentences need to support the person to make an agentic choice to change.

5. Recognises that a strong therapeutic alliance and support system forms the basis of almost all effective drug treatment, and prioritises a strong therapeutic alliance.

6. Recognises that no single response is appropriate to everyone, and effective responses are based on thorough individualised assessment and targeting.

7. Recognises the role of social exclusion and economic distress in substance use and offending, and provides an integrated and comprehensive care package addressing multiple needs.

8. Provides a range of different types and modes of drug treatment for different needs.

9. Recognises the significant resources needed to provide a consistent, thorough and high quality service at appropriate dosage.

The following findings are summarised from the evidence review, which is annexed in full (including all references) on page 25.

Understanding drug use, recovery and desistance

Substance use disorder and offending behaviour are both extremely complex phenomena. Like all complex and contested concepts, there are many different definitions of problematic or disordered substance/drug use, and every person affected will have a unique experience. Its symptoms manifest in a variety of ways: *cognitive* (affecting the person's thoughts and the way they think), *behavioural* (affecting the actions the person takes) and *physiological* (affecting processes and chemistry in the person's body, especially their brain, the organ that coordinates their thoughts and actions).

This experience is overall characterised by a lack of control over ones own thoughts or actions - the person can perceive the potential or real harm to themselves and their loved ones, yet experiences an inability to turn these thoughts into a different behaviour, and possibly suffers acutely when they try. This must be borne in mind when thinking about how our services, and their policy environment, can best support people recovering from problematic drug use.

Recovery, desistance and agentic change – what can we expect from "treatment" for this group?

There are a number of theoretical models of how recovery from problematic substance use and desistance from crime each work. Ultimately all models rely on some degree of intrinsic individual motivation to change, and all models to date have failed to identify consistent types of external events that can make someone change. Rather, the most consistently reported experiences of change are not linked to an external "cause" but instead depend on the person's self-motivated decision to use their own agency to change their behaviour.

Extensive evidence has been found for a congruous account of recovery and desistance along the following lines:

1. The person must experience a genuine "**crystallization of discontent**" – meaning that they must come to truly believe that the behaviour (whether that is offending or substance use) is causing other problems or failures in their life, and that the benefits and rewards no longer outweigh the risks and consequences.
2. The person must experience a genuine "**vision of the feared self**" – meaning that they must come to see themselves as being on a trajectory that will lead them to become a person they do not want to be.
3. The person makes an "**agentic decision**" to change – meaning that, as a result of the experiences above, their personal agency guides them logically to the decision to change their behaviour, because it has become what they themselves want (regardless of motivations linked to external forces like what their family members or employers want).
4. The person then embodies and takes action on that decision, through "**changing preferences and supports**" – meaning that, once a person makes a genuinely agentic decision to change, their preferences will naturally begin to align with a more "pro-social" lifestyle and identity, and they can then safeguard those changes by putting supports such as treatment services and lifestyle changes in place.

Notably, while this process is similar for both desistance and recovery, the ability for these two processes to influence one another does not appear to be symmetrical in the studies reviewed. In general, when a person first made an agentic decision to stop using drugs, this most often led to them also ceasing offending behaviour. However, when a person first made an agentic decision to stop committing crimes, ending substance use did not always follow.

Recognising that this process of agentic choice must be at the core of anyone's recovery or desistance if it is to last, highlights the importance of considering very carefully what "success" or "progress" might look like for the population of people receiving court sentences. There is some evidence that mandated treatment can be as effective as voluntary treatment (eg NIDA, 2014), and other evidence contesting this claim (eg Van Wormer and Davis, 2016). What is clear is that mandated treatment cannot be effective if it does not first address the person's motivation and readiness to change. This is supported by findings from LS/CMI data from assessments of people on community sentences in Scotland, which show that those with drug related problems are significantly more likely than those without drug related problems to be recorded as having "motivation as a barrier".

There are two groups of clients who may enter mandated treatment:

- those who have already made a genuine agentic decision to change, and for whom drug treatment will be helpful in enacting that decision and maintaining consequent lifestyle changes.

- those who have not yet made a genuine agentic decision to change, and for whom treatment may be useful to either help them reach that point, or provide knowledge they can utilise in the future when they reach that point themselves.

Mandated intervention can be effective, if the goals and modes of delivery are set appropriately, with cognisance of the need to foster the person's agentic change rather than putting them through a general "treatment" they are not yet ready for. Additionally, those populations with lower treatment efficacy may still be efficient investments, considering that the costs and harms of their chronic condition and frequent contact with the justice system are likely also higher.

Role and aims of treatment for this population

The evidence demonstrates that mandated treatment for the population of people who have substance related problems and also criminal charges must be cognisant of this population's different starting point in the stages of change, compared to people voluntarily entering treatment. In order to foster lasting change in people's lives and behaviour, treatment must focus on fostering a genuine agentic change in the person's worldview. Therefore, there is a larger role for interventions aimed at developing the person's readiness to change, than there might be for other populations, and those involved in treating and supervising them must recognise that their progress may appear slower and face more setbacks.

Court process and judicial supervision have the potential to either support or disrupt the development of this agentic change. Since a necessary step is for the person to develop a genuinely held belief in the connection between their drug taking behaviour and other problems in their life, clear communication and timely processing can help the person to draw this connection, while decisions that seem arbitrary or so slow as to become disconnected from the precipitating behaviour may sever this connection in the person's mind.

Features of evidence based mandated treatment

As with all complex interventions in complex systems, there is a wide range of ideas about what outcomes should be sought, how to measure those outcomes and also how to prioritise them when they may be in tension. Moreover, the body of literature that assesses interventions for this population may be significantly biased in favour of interventions and outcomes that lend themselves to rigorous study designs and measurement, rather than those that make the most difference to people in actuality.[1]

This means that, overall, while there is extensive literature on drug treatment and on recidivism from crime, there is a lack of high quality, comparable evidence to draw on in relation to people at the intersection of both issues. To help overcome this limitation, Wallace argues that policy makers and practitioners should expand their ideas of evidence for "effectiveness" for this group.

[1] Substantial practical, legal and ethical challenges make it very rare for studies in this space to utilise the most rigorous methodologies like randomised controlled trials (RCTs) or robust quasi-experimental or matching approaches, meaning that researchers seldom have access to a meaningful comparator group that would allow them to confidently attribute impact.

This section summarises the current available knowledge on effective interventions for this group.[2]

The leading work on effective mandated drug treatment (Wallace, 2019) proposes that the ideal approach to delivering treatment to mandated patients is the "Matrix Model". This involves medically supervised detoxification if required, then the person being enrolled in a day-treatment / outpatient model that is:

1. Intensive (4-5 days per week),
2. Extensive (minimum 18 months including continuing care), and
3. Comprehensive (incorporating multiple approaches including a therapeutic alliance, various forms of individual and group counselling / therapy, drug testing, education and family / peer involvement, and addressing multiple needs).

In essence, this model makes many of the features laid out below available, and matches people to those best suited to their needs at any given time.

Specific features of evidence based mandated treatment **are:**

- **Thorough individualised assessment and targeting:** Assessment and targeting are crucial to ensuring people receive the right interventions for their circumstances and needs. This should begin with thorough assessment at intake, and continue throughout treatment.

- **Strong therapeutic alliance:** There is extensive evidence that the relationship between a person and their practitioner(s), (often referred to as a strong Therapeutic Alliance / Support System (TASS)), is a key factor in both treatment retention and success.

- **Integration and recognition of early stages of change:** there is a need to lengthen expectations regarding how long a person may take before being ready to make a change, and also to refocus treatment on fostering the conditions for the person to make an agentic choice to change and develop an internal motivation to maintain recovery.

- **Effective interventions:** the following types of interventions are generally considered to be either effective or state-of-the-art (although only partially validated):

  - Cognitive Behavioural Therapy/Relapse Prevention/Social Skills Training

  - Twelve step facilitation / guidance using AA/NA/CA/CMA[3] etc

  - Individual Drug Counselling and/or Supportive-Expressive Psychotherapy

[2] It is organised based on Wallace's (2019) "Recommended Menu of Evidence Based Addiction Treatment" from the leading textbook on mandated drug dependency treatment, supplemented with evidence from the wider literature on addressing people's complex needs in this setting.

[3] These acronyms refer, respectively, to Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous and Crystal Meth Anonymous

- Community Reinforcement Approach/ Contingency Management
- Integration of harm reduction and moderation approaches / abstinence by gradualism
- Affective, Behavioural and Coping skills
- Medication Assisted Treatment (MAT)

- **Respond to multi-problem clients with an integrated and comprehensive care package:** there is a longstanding and well-corroborated evidence base showing a complicated but strong correlation between people who experience trauma and/or mental ill-health, people who experience severe multiple disadvantage, and people who use substances, both generally and problematically. The most effective treatment approaches help to target all of the areas in which the person is struggling or requires support. The data presented below on the needs of people on community sentences in Scotland shows that, in general, those with drug-related problems are assessed as having poorer mental health, higher rates of trauma, and higher rates of homelessness or housing insecurity, than those without drug related problems.

The role of judicial supervision in community drug treatment

The idea of judicially supervising a person's journey through substance use treatment raises many complex issues that are impacted substantially by consideration of what the alternative path for that person might be. There are a number of theoretical mechanisms that may be relevant to considering effectiveness, and can be summarized as:

- In favour of judicial supervision:
  - Formal accountability and fear of negative consequences may be effective for a small proportion of people, who otherwise struggle to commit to recovery.
  - If processed in a timely way, the experience of judicial supervision may help the person to connect their problems with their substance use, contributing to developing their agentic decision to change.
  - The ability to supervise someone's treatment closely may be the factor that causes a court to give the person a chance in the community instead of sending them to custody.
- Against judicial supervision:
  - Increased time spent in court and around justice professionals may contribute to strengthening the person's identity as an offender, which is a known criminogenic risk.
  - A number of features of judicial supervision may be harmful to the therapeutic alliance.

- Judicial supervision (in particular, negative reaction to lapses or mixed messages between court and treatment providers) may trigger resistance or reactance from the person.
- A number of features of judicial supervision may provoke fear, stress and anxiety, potentially to an existentially threatening level, for the person – which can be a trigger for relapse, recidivism and/or disengagement from the process.
- The more frequently a person comes before a court, the more opportunities the court has to send them to custody, with the associated disruptions to treatment and elevated risk of death due to multiple risk factors that are prevalent in, or directly caused by, prison.

The core of recovery (agentic change), and the core of treatment (the therapeutic alliance), are both in tension with the criminal justice system's focus on compliance and enforcement. While court mandated treatment may recognise the need for support and treatment in order to change behaviour, requiring someone comply with the treatment and support package or face punishment can in fact rupture both the agency and the alliance. This may weaken the potential benefits and reduce the impact of treatment.

However, this argument only suggests that mandated treatment will be less effective than voluntary treatment. If the alternative to mandated treatment is even more focussed on compliance and control, such as a prison sentence or an order with multiple onerous requirements, then mandated community-based treatment may still be less harmful.

What do we know about people with substance use problems serving community-based sentences in Scotland?

There are significant limitations in the data available on people in the justice system who use drugs. In particular, around two thirds of people convicted are sentenced without a social work report, so no information is available about them.

For those who do receive an assessment and report before sentencing, data on drug use specifically are not recorded. The best proxy measures available are a variable called "drug or alcohol problem: work/school", and the presence of drug offences in the person's history. By this measure, between 2017-2021 around 1,433 people assessed per year are potentially likely to have drug related problems.

More detailed data is available only for people who receive a supervision-based community order, or some custodial sentences. Amongst this group, consistent with other research in this field, the data shows that multiple disadvantages tend to cluster together with higher prevalence amongst those with drug related problems. For example, between 2017-2021, people with drug related problems were more likely than those without drug related problems to:

- face homelessness or housing insecurity

- show indications of poor mental health, depression, anxiety and distress

- have experienced trauma and victimization

Variables from the LS/CMI database held by the Risk Management Authority on all of those receiving initial assessments are presented here. However, quantitative data relating specifically to drug use at this assessment stage is very limited and this analysis is therefore based on proxy measures for identifying people with drug dependency. These proxy measures are not ideal for a number of reasons, and may under or over estimate "true" rates. However, currently these are the best measures available and are presented here to give some idea of the order of magnitude of people who may have a drug problem identified at this stage.

- Around one third of people convicted have typically received a social work report before sentencing (between 2016/17 and 2019/20).
- Of those receiving a social work report before sentencing, there are an estimated 1,433 people who may potentially have drug related problems per year over the last 5 years (average, with a total of 7,163 people in this group between 2017 and 2021).
- 65% of those who may potentially have drug related problems (4,660) did not go on to receive a more detailed social work assessment.
- On average for this period, 68% in the group who potentially have drug related problems received a CPO, 13% received a custodial sentence and 8% received a DTTO, however there has been a shift away from CPOs in favour of custody for this group in the most recent year for which data is available.

Compared to the remainder of the population receiving initial assessments, people potentially likely to have drug related problems are:

- Significantly more likely to be identified as requiring supervision or intervention (83%, compared to 67% for those with no indication of a drug problem), but only slightly less likely to be identified as feasible for community disposal (94%, compared to 96% of those with no indication of a drug problem)
- Slightly more likely to be identified as being on a trajectory of worsening offending (47%, compared to 43% for those with no indication of a drug problem)
- Somewhat more likely to be identified as meriting fuller assessment (7%, compared to 5% for those with no indication of a drug problem)
- Slightly less likely to receive the disposal that social work recommend to the court (47%, compared to 50% for those with no indication of a drug problem). It is also notable that the disposals recommended by social work, and those imposed by the courts, appear to have diverged over time.

More detailed data are available for people who do receive an order that includes supervision. For the purposes of this analysis, people scoring 0 or 1 (on a scale from 0-3) on the LSCMI variable "current drug problem", meaning those with

more than minor drug related problems, have been compared to the remainder of the population receiving the same assessments. For ease, these groups will be referred to as “people with drug-related problems” and “people without drug related problems” in this section of the analysis.

- People with drug related problems in this group are more likely than those without drug related problems to face housing issues (23% recorded homeless or transient and 42% recorded as having accommodation problems, compared to 10% and 21% respectively).
- People with drug related problems show indications of significantly poorer mental health than those without drug related problems (for example: higher prevalence of attempted or threatened suicide (28% cf. 20%), self harm/mutilation (22% cf. 13%), as well as multiple indicators of depression, anxiety and distress).
- People with drug related problems also appear to have experienced significantly more trauma than those without drug related problems (for example higher prevalence of victimisation in; family violence (39% cf. 27%), physical assault (43% cf. 27%), sexual assault (12% cf. 8%), as well as higher rates of exclusion from school and indications of “severe problems of adjustment in childhood”).
- People with drug related problems are more than twice as likely to be assessed as having motivation as a barrier than those without (48% cf. 23%).

What do we know about the processes, services and interventions involved in delivering treatment-based orders across Scotland, and to what extent do the current approaches being delivered across Scotland appear consistent or inconsistent with the evidence on good practice?

The broad outline of the Scottish approach broadly aims to achieve most of the features of good practice identified in the review – the legislation, guidance and policy aim to concentrate both resources and intervention on those with the greatest needs and the most likelihood of benefiting, while moving towards a public health oriented approach to people who both use drugs and commit crimes. However, whether the scale and relevant thresholds are ideally calibrated is not clear, as is the merit of substantial regional variability. Moreover, the necessity of offering both DTTOs and CPOs with a treatment requirement remains unclear, as the conditions of a DTTO can be almost exactly replicated within the CPO framework.

The picture of service delivery and outcomes for people subject to mandated drug treatment in Scotland is unclear. What is clear is that services vary widely in their structures and approaches across the country.

Eligibility, targeting and assessment

CPOs and DTTOs are available for similar populations. Both are for people whose offending is sufficiently severe that they have not been diverted from the justice system earlier, are imposed in situations where the person might

otherwise receive a prison sentence, and can provide (and require compliance with), drug treatment for people who use substances problematically. However, a CPO is potentially both available and suitable to a wider range of people, as it is a more flexible and general-purpose order.

The specific procedures and assessments used will vary depending on local court practice, local authority social work arrangements and local health board and Alcohol and Drug Partnership (ADP) arrangements.

The process established by the legislation and practice Guidance is complex, containing multiple pathways and many key decision or transition points – each of which reflects a potential opportunity for someone with substance related problems who needs treatment to "fall off" of the pathways to a treatment-based community order.

Assessment of practice against the evidence base: eligibility, targeting and assessment

Eligibility and targeting

The evidence suggests an apparently high number of people in prison who have substance use problems, and a relatively low number of people who receive DTTOs or CPOs with a treatment requirement. The data demonstrates a mismatch between the proportion of people recommended for community based sentences by justice social work, but receiving a custodial sentence instead.

There are some potential tensions in the practice guidance for the orders. For DTTOs, social workers are advised to prioritise those with high-risk use patterns. However, they are also advised that CPOs may be more suitable for people if complex social circumstances might impede their focus on treatment, there are additional issues related to the offending that would not be addressed, or the person requires medium to long term residential treatment. One possible reason for the low rates of DTTO usage, is that it is unlikely that there will be many, if any, people whose substance use is sufficiently problematic to make them eligible for a DTTO, who don't also have the kind of co-occurring problems that then exclude them.

Assessment

The community sentencing process in Scotland is largely based on individualised assessment, uses a well-validated tool (the LSIR or LS/CMI) to assess Risk, Need and Responsivity (RNR), and aims to tailor the sentence and interventions a person receives based on RNR principles – all of which are generally supported by the evidence.

The treatment offered in a DTTO or CPO drug treatment requirement is also based on the individual's assessed needs, but the fidelity between needs and treatment received may be higher in CPOs with treatment requirements than DTTOs, because the treatment details are not specified by the court.

However, while this general approach is consistent with the evidence, there remain questions about whether this approach is implemented in optimal ways, specifically around:

- Timing and coverage of assessment
- Criteria for orders
- Assessment tools
- Resources and time required

The complex geographic arrangements in the court, community justice, and health systems may mean that in cases where a person is tried for offending in an area other than where they live, the court may have less information about, understanding of, experience with, or trust in, the community services they can receive. While the sentencer can still request a report from the justice social work department in the person's local area, this reduced familiarity may have an impact on the decision to request an assessment, and about what sentence is believed will best serve the intended purpose.

Service Delivery

Overall, both treatment based orders provide a similar framework, based on accessing treatment relevant to the person's assessed substance-related needs, while keeping them in the community.

However, DTTOs can be seen as offering less flexibility in how they are delivered. On the other hand, a CPO with a drug treatment requirement offers less scrutiny of the person's progress in drug treatment (because tests are not reported to the court, and court reviews are less common), but also involves both more support *and* more scrutiny of their progress in other domains of life. Depending on the person and their circumstances, and the court's and social worker's expectations, this could either be an enabling factor or a barrier to successful completion of the order.

While DTTOs may offer less flexibility in the delivery and management of individual cases, Justice Social Work departments and Alcohol and Drug Partnerships have a wide degree of flexibility in terms of how they structure and deliver services for their local area.

Assessment of practice against the evidence base: service delivery

The evidence reviewed shows a complex system and a high degree of local variability. While limitations in the data make it difficult to draw a complete picture, in general the evidence suggests that justice social work services tend to provide quality assessment and support, while drug treatment services can be more variable, but are working through a period of implementing change and are aware of key challenges the sector faces.

DTTO Guidance

The DTTO practice guidance is now significantly out of date: having been published in 2011, it pre-dates the current Community Justice structures that have been in place since 2017, as well as the current crisis of drug deaths. It also refers to a number of outdated features in the justice system, including Probation Orders (replaced by Community Payback Orders) and Social Enquiry Reports (replaced by Justice Social Work Reports). Other elements of the

guidance appear to be inconsistent with current day practice or service structures, and the advice it contains on both mental health and homelessness are ambiguous. To make the practice guidance fit for purpose in the current context, consideration of review and update in line with current evidence and best practice is warranted.

The balance between support and enforcement

DTTOs and CPOs vary in the extent to which they might be considered to take a realistic approach to recovery that recognises goals other than abstinence and accommodates the need to build the person's motivation and readiness to change. CPOs with a treatment requirement generally provide more flexibility for these factors, as the order only requires the person engage with treatment. This leaves more room for the person and their treatment provider to develop goals and tasks together, potentially incorporating harm reduction as appropriate, or changing approach as the person's needs change. However, DTTOs include the specific treatment activities and testing frequency that must be adhered to. This means a gradualist approach is harder to take; the goal of treatment is often set (or at least strongly implied) by the court's expectations about testing results, and treatment is less flexible in terms of providing harm reduction alongside other treatments, or adapting to the person's changing needs. This is understandable if one takes the perspective that the increased monitoring is necessary in order for the court to be comfortable keeping people with higher reoffending risk levels in the community instead of custody. However, it is less aligned with the perspective that people with the highest risks and needs are also those who may be slowest to make progress, and require the most flexibility and accommodation in order to remain engaged in treatment. The way both orders and expectations are calibrated for different target groups may therefore also warrant further exploration with stakeholders.

The dynamic between the offer of support, and the enforcement of engagement with that support, is a nuanced one. This is particularly true in the context of the present legislative limitations on supervision in DTTOs. The evidence review found that one feature of effective mandated community drug treatment is responding to multi-problem clients with an integrated and comprehensive care package. Compared to a DTTO, a CPO with a drug treatment requirement offers less scrutiny of the person's progress in drug treatment (because tests are not reported to the court, and court reviews are less common), but also involves both more support *and* more scrutiny of their progress in other domains of life. Depending on the person and their circumstances, and the court's and social worker's expectations, this could either be an enabling factor or a barrier to successful completion of the order. Such scrutiny and enforcement may have the unintended consequence of de facto criminalising need, but on the other hand it may also be a necessary level of control to hand the courts in order for them to be willing to keep the person out of custody. This dynamic, and the legislative limitation on social work's role in supporting people on DTTOs, may therefore warrant further exploration.

Some areas have developed models where additional, voluntary support is offered to people on Level 1 CPOs (who are not required to engage with supervision). This may be one model worth considering within the bounds of the

current legislation for providing additional support to people on DTTOs as well, and indeed this Review was made aware that some areas may already be doing this. Considering the generally positive findings regarding the quality of community justice social work services, there is reason to believe they may be a valuable asset to many people on DTTOs.

Therapeutic alliance and harmonising expectations

The crux of designing effective approaches to mandated treatment is balancing the justice system's need for accountability and enforcement with effective treatment's reliance on a compassionate and patient therapeutic alliance. Whether this balance is appropriately struck by current approaches is worthy of deeper consideration, particularly from the perspective of people with lived experience of court mandated treatment.

Service structures and funding

This review has found a high degree of variation in service structures and funding, the appropriateness of which may warrant consideration. The delegation of community justice and health care is intended to provide flexibility to local needs, and it is a natural consequence of this model that community sentences and drug treatment will vary in different areas. However, the high variation in arrangements presently observed, coupled with the grave seriousness of both the public health emergency and the prospect of using the state's coercive power to mandate drug treatment, raises questions about what consistency might reasonably be expected, and in turn about equality before the law. It may be appropriate to consider whether more should be done to standardise provision, or to facilitate systematic learning between services so that over time we might expect to see more convergence on models that are most effective.

Services available

Generally, more work is needed to better understand the range of treatment types available in each area, and whether they reflect a model that is sufficient as per the recommended Matrix Model. The literature reviewed suggests that, in particular, there may be gaps in terms of integrated mental health support, treatments for people who use stimulants or have complex poly-drug use patterns, availability of residential rehabilitation, and intensive structured day programmes. Consideration may be warranted in relation to whether the interventions offered are sufficiently ambitious in terms of engaging people early in the process of considering change, and whether current standards of motivation and readiness for change being applied in assessments are appropriate.

Opportunities for, and following, revocation and reconviction

A key difference between DTTOs and CPOs are the opportunities they present for revocation. While this consideration should not be overstated, due to the similar completion rates for DTTOs and CPOs with a treatment requirement, the CPO model is arguably closer to that which the evidence canvassed in this review supports. Consequently, it is worth exploring the role that each opportunity for revocation plays in an order over all. In particular, how important do sentencers consider the monthly DTTO review to be in their decision about

whether they are comfortable keeping someone in the community? A more tailored, and evidence-based, approach may be achieved through the CPO model, where reviews are scheduled only if the court feels they are necessary. Similarly, how important do sentencers consider the monthly testing results to be in their decision to maintain or revoke an order? A more evidence-based approach recognising that people can engage well with treatment but still test positive for drugs, may be for justice social workers (collaborating with health and social care professionals) to interpret the meaning of testing results within the context of the person's broader engagement – and raise the results with the court if they consider them a cause for concern.

Relatedly, it may be valuable to explore the factors that affect decision-making when a person either has a treatment-based order revoked, or is reconvicted after serving one. Current legislation does not prevent multiple treatment-based orders from being made, so the low levels of DTTOs (or other community based disposals) for reconvictions following a DTTO should be explored with stakeholders to better understand the reasons for current patterns and whether they are considered to reflect good practice.

Finally, the gap in the quality of care between community and custody settings, and disruption to treatment in transitioning settings, is concerning, particularly for the significant number of people receiving a custodial sentence following revocation or reoffending. While not a primary focus of this report, these findings form an important part of the context in which sentencing decisions are made, and custody is the most likely counter-factual for many, if not most, people on mandatory treatment orders.

What areas may warrant further consideration by policy makers or exploration with stakeholders, including people with lived experience of drug use and the justice system?

This evidence review identifies five key areas for further consideration by policy makers, which are:

1. The experiences of people with lived experience of substance use, mandated treatment, and the justice system are integral to improving our understanding and delivery of community justice and treatment services. There is a need for people with lived experience to be engaged with, alongside health and justice professionals, to explore the issues identified in this report and contribute to any future work on potential improvements to the sentencing and service delivery landscape.

2. The current practice guidance on DTTOs is significantly out of date and does not reflect the current legal landscape, Scottish drug context, or current practice. To make the guidance fit for purpose in the current context, consideration of review and update in line with current evidence and best practice is warranted.

3. Scotland's experiences with drug court, alcohol court, and problem-solving courts present an opportunity to capture learning, and consider whether these

models warrant specific funding, legislation or policy development work in support of national implementation.

4. It may be beneficial for there to be dialogue between the judiciary, justice social work and health and social care partners, to explore the differences in their expectations of people in treatment, and potentially work towards developing a more mutually congruent understanding of recovery with more harmonised expectations for people on treatment based orders.

5. In light of findings indicating significant porosity between the community-sentenced and prison populations, particularly amongst people who use drugs, consideration should be given to any opportunities to prioritise and accellerate the implementation of the MAT standards in prisons, to reduce harms of custody to people who either cannot be safely managed on a community order, or who have their community order revoked.

It also identifies a number of areas for further exploration with stakeholders, and suggests further work is necessary to deepen our understanding in relation to three key questions:

1. Are we identifying the right people for treatment orders, and optimising opportunities for referral or assertive outreach for those for whom a treatment order is either not appropriate or not imposed?

2. Are we delivering the right supervision and services to the people who receive treatment orders?

3. Are our legislative and policy environments fit for purpose?

The findings of this review indicate five key areas for policy makers to consider (listed above), but the majority of work to improve this area must be underpinned by more detailed consideration in partnership with stakeholders and people with lived experience of drug use and the justice system. Consequently, the following three priority areas for further exploration have been identified:

Areas for further exploration with stakeholders, including people with lived experience of drug use and the justice system

1. **Are we identifying the right people for treatment orders, and optimising opportunities for referral or assertive outreach?** In particular:

a. In the current system, **some people who are appearing in court and who would benefit from receiving an initial assessment, or a specific assessment for treatment, may not be assessed or offered treatment**. This may happen for a number of reasons, including the court not requesting an initial assessment (meaning their needs are never identified at all), the social worker not pursuing an assessment for a treatment based order, or the court not agreeing to defer sentencing for assessment of drug-related needs. Whether there may be opportunities for earlier assessment or triaging of cases, or assertive outreach separate from court ordered treatment, is a question worthy of

exploration with stakeholders.

b. It is important that the **best decisions possible are made at each transition point**, to engage and retain those who would benefit in treatment, while chanelling those who would not to other pathways without up-tariffing them. It may be worthwhile for future work to consider whether each decision rests with the right professionals, whether they have access to adequate information at each stage, and whether current practice leads to the best outcome for the circumstances in each case.

c. The pre-sentence **assessment and planning process** for DTTOs is longer and more involved than that for a CPO treatment requirement, because it requires a full multidisciplinary assessment rather than just a statement from a health specialist, and must specify the full details of treatment for the court to include in the order. This may have strengths in terms of detail considered and support offered, but also limitations in terms of the number that can be conducted and (potentially) the length of time added to the sentencing process in order to convene all the relevant professionals. How these factors are balanced against one another, and against the value courts place on detailed information, warrants further exploration with stakeholders.

d. While **LSIR and LS/CMI are well-validated tools for understanding offending risk and management, they are not specialised for exploring substance use**. It may be worth considering whether they facilitate a sufficiently structured and consistent approach across areas. Beyond the quality of information informing recommendations and provided to the court, it would also be beneficial if consideration were given to whether more specific variables on drug use could be recorded in the data at earlier stages, to assist future monitoring and allow us to understand more about this population in future research.

e. There is a notable **gap between the number of people recommended for community based treatment** orders by social workers (based on their risks and needs), **and the number who receive such a sentence,** and evidence that this gap is growing. The reasons for this gap and its trajectory may warrant further exploration.

f. Consideration may be warranted in relation to **whether the interventions offered are sufficiently ambitious in terms of engaging people early in the process of considering change**, and additionally, whether current standards of motivation and readiness for change being applied in assessments are appropriate.

2. **Are we delivering the right supervision and services to the people who receive treatment orders?** In particular:

a. As DTTOs include the specific treatment activities and testing frequency that must be adhered to, **a gradualist and flexible approach is harder to take**. It may be that the increased monitoring is necessary in order for the court to be comfortable keeping people with higher reoffending risk levels in the community instead of custody. However, this should be considered alongside the perspective that people with the highest risks and needs are also those who may be slowest to make progress, and require the most flexibility and accommodation

in order to remain engaged in treatment.

b. Compared to a DTTO, a CPO with a drug treatment requirement offers less scrutiny of the person's progress in drug treatment (because tests are not reported to the court, and court reviews are less common), but also involves both more support and more scrutiny of their progress in other domains of life. This dynamic, **the legislative limitation on social work's role in supporting people on DTTOs, and the range of current practice within this legislative limit, may therefore warrant further exploration.**

c. The delegation of community justice and health care to local areas is intended to provide flexibility to local needs, and it is a natural consequence of this model that community sentences and drug treatment will vary in different areas. However, the **high variation in arrangements** observed, coupled with the grave seriousness of both the public health emergency and the prospect of using the state's coercive power to mandate drug treatment, raises questions about what consistency might reasonably be expected, and in turn about equality before the law. It may be appropriate to consider **whether more should be done to standardise provision, or to facilitate systematic learning between services** so that over time we might expect to see more convergence on models that are most effective.

d. A key difference between DTTOs and CPOs are the **opportunities they present for revocation**, with the CPO model arguably closer to that which the evidence canvassed in this review supports. Consequently, it is worth exploring the role that each opportunity for revocation plays in an order overall. A more tailored and evidence-based approach may be achieved through the CPO model, where reviews are scheduled only if the court feels they are necessary, and to transfer interpretation of testing results to justice social workers who, (collaborating with health and social care professionals), can interpret the meaning of testing results within the context of the person's broader engagement and raise the results with the court if they consider them a cause for concern.

e. The crux of designing effective approaches to mandated treatment is **balancing the justice system's need for accountability and enforcement with effective treatment's reliance on a compassionate and patient therapeutic alliance**. Whether this balance is appropriately struck by current approaches is worthy of deeper consideration, particularly from the perspective of people with lived experience of court mandated treatment.

f. Consideration should be given to the specific **resource and logistical challenges** highlighted by services and experienced in key parts of the social work and health sector work forces. The evidence suggests that adequate specialist staff, co-location of justice and treatment staff, pre-review meetings, dedicated coordination roles, and joint training and awareness raising are all features likely to improve service quality.

g. Ensuring that sentencers **accurately understand the support and treatment available** - both in each area and on each order - is also essential. Ways of improving access to timely, accurate information on this sometimes shifting landscape should be considered.

h. It may be valuable to explore the factors that affect decision-making when a person either has a treatment-based order revoked, or is reconvicted after undertaking one. Current legislation does not prevent multiple treatment-based orders from being made, so the **low levels of DTTOs (or other community based disposals) for reconvictions following a DTTO** should be explored with stakeholders to better understand the reasons for current patterns and whether they are considered to reflect good practice.

i. The **gap in the quality of care between community and custody settings, and disruption to treatment in transitioning settings,** is concerning, particularly for the significant number of people receiving a custodial sentence following revocation or reoffending. While not a primary focus of this report, these findings form an important part of the context in which sentencing decisions are made, and custody is the most likely counter-factual for many, if not most, people on mandatory treatment orders.

3. **Are our legislative and policy environments fit for purpose?** In particular:

a. There are some **potential tensions within the guidance**. For DTTOs, social workers are advised to prioritise those with high-risk use patterns, such as poly drug use (especially in “chaotic circumstances”), injecting, high frequency, worsening chronic long term use, and the most harmful substances such as opioids, benzodiazepines, cocaine and crack (DTTO Guidance for Schemes, 2011). However, they are also advised that CPOs may be more suitable for people if: complex social circumstances might impede their focus on treatment; there are additional issues related to the offending that would not be addressed; or the person requires medium to long term residential treatment. The guidance is also somewhat ambiguous regarding people with co-occurring mental health problems and/or homelessness. Considering what we know about the issues that form the common causes of both substance use and offending, it is highly unlikely that there will be many, if any, people whose substance use is sufficiently problematic to make them eligible for a DTTO, who don’t also have the kind of co-occurring problems that then exclude them.

b. The complex geographic arrangements in the court, community justice, and health systems may mean that in cases where a person is tried for offending in an area other than where they live, the court may have less information about, understanding of, experience with, or trust in, the community services they can receive. It may be worthwhile to explore **whether professionals in the sector feel knowledge and information sharing across areas is adequate**, and where court ordered treatment may fall in relation to the future National Care

Service.

c. While international guidelines on **human rights** and drugs policy do not have official standing in Scottish law or policy, they are relevant, reputable and reflect international consensus on good practice. Two are particularly relevant when considering community based treatment orders made by a court, and Scotland's current arrangements may arguably be inconsistent with them. These are:

i. If treatment is court mandated, no penalties should attach to failure to complete the treatment.

ii. Treatment as an alternative to custody must only be offered with informed consent, where medically appropriate and must not be ordered for longer than the applicable custodial sentence.

While these rights are not Scottish policy or law, and may be contestable in the Scottish context, they were developed by international experts working with leading bodies including the World Health Organisation and reflect international consensus on public-health based best practice. As Scotland aspires towards a human rights respecting, public health based approach to drug use, they therefore warrant consideration in consultation with people with lived experience of drug use and the justice system.

How to access background or source data

The data collected for this social research publication:

☐ are available in more detail through Scottish Neighbourhood Statistics

☐ are available via an alternative route <specify or delete this text>

☐ may be made available on request, subject to consideration of legal and ethical factors. Please contact <email address> for further information.

☒ cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.

Annex 1: Evidence review of good practice in court mandated treatment

The evidence base related to court supervised, community based treatment for people with both substance use problems and criminal charges is complex and mixed. A 2020 systematic review of substance use and community supervision found that “internationally, there is a high prevalence and complexity of substance uses amongst people under community supervision. Despite clear benefits to individuals and the wider society through improved health, and reduced reoffending, it is still difficult to identify the most effective ways of improving health outcomes for this group in relation to substance use from the literature” (Sirdifield et al). The authors recommend a detailed, and up-to-date profile of this population’s needs is essential to designing and planning interventions – notably something Scotland does not currently have.

Drug treatment itself is generally associated with reduced offending. For example, one study (Bukten et al, 2011) estimated that crime rates halved in a three year follow up, for people using opiates who entered treatment. There is also evidence that diverting people away from prosecution can help address their needs better than criminal prosecution can. A systematic review and meta-analysis looking at diversion from prosecution for people who use class A drugs, found that although class A drug users were less likely to complete treatment than users of other drug classes, there was still evidence of reduction in drug use and a limited impact on offending behaviour for those diverted to drug treatment.

However, not all people can or should be diverted away from prosecution and if a person’s alleged offending behaviour reaches a threshold of seriousness or repetition, in line with the COPFS prosecutorial guidelines, prosecutors may bring that person before court, and the court must respond to them in the way they deem most appropriate in line with Scotland’s sentencing laws. This Annex reports on the evidence base for developing effective court ordered, non-custodial treatment based court responses that can support people in the justice system.

1. Understanding drug use, recovery and desistance

1.1 Substance use and its relationship to offending

Substance use disorder and offending behaviour are both extremely complex phenomena. They both have a wide array of causes, many of which overlap or are correlated with one another.

It is beyond the scope of this report to attempt to disentangle the fundamental causes and effects involved in the development of either substance use disorder, a pattern of offending behaviour, or both. However, to understand how our policies and criminal sentences can best respond to people in this position, it is important to first define problematic substance use, and then understand how the experience of substance use, offending, recovery and desistance happens.

Like all complex and contested concepts, there are many different definitions of problematic or disordered substance/ drug use, and every person affected will have a unique experience. Its symptoms manifest in a variety of ways: *cognitive* (affecting the person's thoughts and the way they think), *behavioural* (affecting the actions the person takes) and *physiological* (affecting processes and chemistry in the person's body, especially their brain, the organ that coordinates their thoughts and actions).

The medical description of this experience is well summarised by the Diagnostic and Statistical Manual of Mental Disorders (5th ed), which lists, as diagnostic criteria, the types of things people experience:

- **Impaired self-control** – such as consuming larger amounts, over longer periods than initially intended. This is the experience of deciding (cognitively, in your brain) that you want to reduce or cease usage, but finding yourself using drugs again anyway, often because of strong cravings (which are intense physical feelings experienced in your body, and thoughts about obtaining and using the substance, experienced in your brain).
- **Social impairment** – such as failing to meet obligations at work, school or home, or giving up valued relationships or activities. This is the experience of valuing a person or part of your life, but finding yourself doing the behaviour of using drugs instead of behaviours that maintain that relationship or part of your life, even though you know that this may harm that person or your relationship with them.
- **Risky use** – such as injecting, sharing equipment, using large doses, or obtaining drugs through means that may risk violence, sexual

victimisation or criminalisation. This is the experience of being aware of a potential risk to your safety, wellbeing or health, but doing the behaviour of continuing to obtain and use drugs instead of the behaviour of seeking to avoid this risk.

- **Tolerance and withdrawal** – which may be seen in requiring larger quantities to achieve the same high, or experiencing negative physical symptoms when they stop taking the substance. This experience varies greatly between different substances, but often includes a range of general somatic symptoms associated with many illnesses, such as nausea, headache, diarrhoea, sweating, shaking, aches and cramps.

  This experience is overall characterised by a lack of control over one's own thoughts or actions - the person can perceive the potential or real harm to themselves and their loved ones,yet experience an inability to turn these thoughts into a different behaviour, and possibly suffers acutely when they try. This must be borne in mind when thinking about how our services, and their policy environment, can best support people recovering from problematic substance use. In particular, it is worth highlighting that the process of recovery and desistance described in the next section, is made up entirely of mental and behavioural steps that the person misusing substances can only take using their own brain. While these steps may appear straightforward to people who have not experienced dependency before, it must be borne in mind that those who actually need to take them are operating in the circumstances described above.

  Researchers have suggested a number of different pathways that might explain the relationship between this experience of substance use, and its well documented correlation with offending behaviour. These include: criminal behaviour conducted to support a substance dependency (eg acquisitive crime or drug dealing), lowering of inhibitions secondary to substance use (ie, offences committed as a consequence of impaired judgment due to intoxication), and/or exposure to anti-social or pro-criminal peers and environments. Such exposure may be due to multiple factors including the fact that drugs can only be sold illegally, are typically distributed via serious organised crime groups, and can cause isolation from more pro-social relationships (White and Gorman, 2000).

  If we ask what it is that causes some people to both develop substance problems and commit offences, there are many answers depending on how the question is approached. The person's

thoughts and behaviours are produced by their brain, so that is perhaps the first place to look. The brain's main function is to manage the flow of different signals and chemicals, in order to keep a person's body alive and functioning. A crucial one is dopamine, a "reward" chemical that has evolved as a tool our brains use to signal that we are doing something that is good for our survival – it feels positive and thus rewards our brain for producing that behaviour. However, drugs can also produce large, artificial spikes in dopamine, despite not reflecting a behaviour that aids survival.

If the person experiences these large artificial spikes in dopamine repeatedly over time, their brain will start to normalise this and apply the excess dopamine not just to the substance itself, but to behaviours, environments or other cues that are merely associated with the substance for that person. Volkow et al (2011) suggest that over time, the person's brain chemistry shifts in such a way that the excess dopamine becomes associated with increasing engagement in behaviours that are associated with obtaining and using drugs. Depending on the person's circumstances and legal context, this might often involve behaviours like lying, stealing, following impulsive or compulsive urges, spending time with drug dealers and their networks, or spending time in places where drugs are used. The authors summarise thus: "their behaviours are now governed by the uncontrollable overvaluing of the drug and by growing insensitivity to the deterrent value of potential punishments".

It is important to note that this neurological model of drug use only partially answers the question of why some people experience substance use problems and offend. It is well documented that a host of familial, social and economic circumstances contribute to both criminogenic risks, and the risk that someone will start to use drugs, or that their drug use will escalate. Fully explicating the complex relationship between substance use and offending behaviour is beyond the scope of this review (and indeed, of current human knowledge), but the two share many other frequent correlates such as adverse childhood experiences, trauma, victimisation, bereavement, learning difficulties and neurodivergences, economic and social exclusion, and mental health difficulties.

1.2 Recovery, desistance and agentic change – what can we expect from "treatment" for this group?

There are a number of theoretical models of how recovery from problematic substance use and desistance from crime each work. They generally show many similar considerations as well as some key differences. However, theories that focus on one or other problem are not necessarily apt to apply to the population of people at the intersection of both categories.

The idea that perhaps most consistently appears in relation to both, though, is the person's identity and their degree of (bounded) agency in determining their own behaviour. This idea is key to many leading models in the present literature[4]. There are some models such as the Life Course Theory of Desistance (e.g. Laub and Sampson, 2003; Hser et al, 2007), or the Cognitive Theory of Transformation (e.g. Giordano et al, 2002; Coleman and Vander, 2012) that seek to identify external or causative factors that can support desistance and recovery. But, ultimately all models rely on some degree of intrinsic individual motivation to change, and all models to date have failed to identify consistent types of external events that can make someone change. Rather, the most consistently reported experiences of change are not linked to an external "cause" but instead depend on the person's self-motivated decision to use their own agency to change their behaviour.

Recent work by Streisel (2021) provides the most detailed accounts of this process, and is supported by an unusually long follow up period – whereas most studies on recovery or reoffending report outcomes over 6 months–2 years, Streisel explores participant's justice and treatment related experiences and outcomes over a 20 year period. Although the study draws on a relatively small sample, the length and breadth of experience the participants bring, and detailed qualitative analysis conducted, make it a useful source. Drawing on Identity Theory of Desistance, Streisel finds extensive evidence for a congruous account of recovery and desistance along the following lines:

1. The person must experience a genuine "**crystallization of discontent**" – meaning that they must come to truly believe that the behaviour (whether that is offending or substance use) is causing other problems or failures in their life, and that the benefits and

[4] See, for example, the Identity Theory of Desistance (ITD) (Patenoster and Bushway, 2009), the Social Identity Model of Cessation Maintenance (SIMCM), the Social Identity Model of Recovery (SIMOR), and Social Identity Model of Transition (SIMT)(Frings and Albery, 2015; Best et al, 2016; Kay and Monaghan, 2018).

rewards no longer outweigh the risks and consequences. In Streisel's sample:

a. For desistance from crime, this typically revolved around feeling out of control or unable to have a normal life, and the impact on loved ones.
b. For recovery from substance use, this typically revolved around the physical and mental effects of drug use, and the drugs becoming less effective at their original purpose in the person's life (eg self-medication or escape from reality).
c. "Failure" in treatment was often linked to the person not experiencing crystalised discontent because, for example, they were heavily involved with or reliant on peers who used, they used substances in order to manage chronic stress or past trauma, or they did not understand their substance use as a problem (perhaps in the context of other, perceived bigger problems or because they were still finding pleasure in their substance use).

2. The person must experience a genuine "**vision of the feared self**" – meaning that they must come to see themselves as being on a trajectory that will lead them to become a person they do not want to be. In Streisel's sample:

a. This was the primary motivation for most of those who had desisted from both drug use and offending.
b. The person often reached this point through both personal experience and by witnessing peers.

3. The person makes an "**agentic decision**" to change – meaning that, as a result of the experiences above, their personal agency guides them logically to the decision to change their behaviour, because it has become what they themselves want (regardless of motivations linked to what external forces like what their family members or employers want). In Streisel's sample:

a. For both desistance and recovery, commitments to change and engagement in treatment were typically only successful when the person had undergone this agentic change.
b. When the person's commitment to change was done for the sake of others, such as to appease family or employers, change was either impossible, or did not last.

4. The person then embodies and takes action on that decision, through "**changing preferences and supports**" – meaning that, once a person makes a genuinely agentic decision to change, their preferences will naturally begin to align with a more "pro-social" lifestyle and identity, and they can then safeguard those changes by putting supports such as treatment services and lifestyle changes in place. In Streisel's sample:

a. People desisting from crime made changes to their daily routines and the people they spent time with, and some found connecting with organised religion helped them find alternative ways to deal with hardship.
b. People recovering from substance use made similar changes, and also engaged with treatment and support groups, and sought to learn more about managing stressors and resolving past traumas.

Notably, while this process was similar for both desistance and recovery, the ability for these two processes to influence one another does not appear to be symmetrical. In general, when a person first made an agentic decision to stop using drugs, this most often led to them also ceasing offending behaviour. However, when a person first made an agentic decision to stop committing crimes, ending substance use did not always follow.

Recognising that this process of agentic choice must be at the core of anyone's recovery or desistance if it is to last, highlights the importance of considering very carefully what "success" or "progress" might look like for the population of people receiving court sentences. There is some evidence that mandated treatment can be as effective as voluntary treatment (eg NIDA, 2014), and other evidence contesting this claim (eg Van Wormer and Davis, 2016). What is clear is that mandated treatment cannot be effective if it does not first address the person's motivation and readiness to change.

There is evidence to support the suggestion that practitioner interactions and interventions can serve to enhance a person's intrinsic motivation (summarised well in Wallace, 2019). People mandated to treatment are responding primarily to external pressure (ie, an order from the courts), which is unlikely to be adequate to sustain long term change. However, if their practitioner can help the person to identify and reflect on their own concerns or problems, this can create an opportunity for the person to, (in Streisel's language) reach a stage where their discontent with their drug use becomes more "crystalised", and they are able to contemplate possible futures if they remain on the same trajectory.

Wallace notes that early on (what might be considered before the agentic decision to change), people will generally have a range of internal and external concerns related to their drug use, but may also suffer from ambivalence, a lack of confidence or self-efficacy in making change, or from insufficient coping skills to manage any other

way than the one they already know. These are all barriers that interventions such as motivational interviewing or relapse prevention with specific skills training components can help to reduce, so that the person's concerns may be amplified into an intrinsic motivation to change over time (Patterson, 2018). To put it most simply: there are two groups of clients who may enter mandated treatment:

- those who have already made a genuine agentic decision to change, and for whom drug treatment will be helpful in enacting that decision and maintaining consequent lifestyle changes.
- those who have not yet made a genuine agentic decision to change, and for whom treatment may be useful to either help them reach that point, or provide knowledge they can utilise in the future when they reach that point themselves.

It is fair, therefore, to share Hunt and Stevens (2004) concern that substantial investment in coerced or mandated treatment may waste scarce resources on more uncertain, coercive interventions than those delivered to entirely voluntary clients, and divert staff from treatment modalities with better-known efficacy. However, this analysis misses two important points: first, this type of intervention can in fact be effective, if the goals and modes of delivery are set appropriately, with cognisance of the need to foster the person's agentic change rather than putting them through a general "treatment" they are not yet ready for; and second, that those populations with lower treatment efficacy may still be efficient investments, considering that the costs and harms of their chronic condition and frequent contact with the justice system are likely also higher.

1.3 Role and aims of treatment for this population

With the above in mind, what role can treatment play in improving the health, circumstances and offending behaviour of people who have both substance use problems and criminal charges?

It has long been recognised that recovery from substance use (and other addictive behaviours) is a process that takes time and has a number of phases. The most common model based on the person's experience is the Stages of Change, as described by Prochaska and DiClemente (1983), while many others relate these experiences to the treatment process (for example Wallace's Phases of Treatment and Recovery (1996), and similar constructions (Mercer and Woody, 1999, Daley and Mercer, 2002, McLellan, 2003)). The Stages of Change, as typically understood, are:

- **Precontemplation:** before the change process begins, the person is living with the thoughts and behaviours of problematic substance use and is not even thinking about changing
- **Contemplation:** the person begins to think about ideas related to change, such as imagining what it would be like to change and wondering whether they should change their behaviour
- **Preparation:** the person has made a decision that they want to change and are preparing to do so, but have not yet taken tangible actions
- **Action:** the person begins to take actions and change their behaviour
- **Maintenance:** the person has made the key changes they wish to, and now works to maintain and strengthen their new identity and lifestyle to prevent relapse.

In reality, of course, these steps are not so discretely defined, and the process is not linear, meaning people regularly relapse from one stage to the previous one as they work on their recovery.

As typically presented, the traditional phases of the drug treatment process can be very broadly characterised as follows:

- **Withdrawal** phase (also called detoxification or stabilisation of care, lasting several days)
- **Prolonging abstinence** (also called intermediate stage of care, lasting several weeks to months)
- **Pursuing lifetime recovery** (also called continuing care, lasting one or more years)

However, this model of care, beginning with the “Action” step of withdrawal, leaves an expectation the person will contemplate and prepare for change, and indeed take the first action by reaching out for treatment, before they start to receive specialised support. This makes sense for a tradition rooted in voluntary treatment that works primarily with people who have made an agentic choice to change. But for people who are attending treatment due to a court order, many will not have been through these internal steps, making it inappropriate to begin immediately with such action steps.

In light of this, as well as the extremely diverse needs of people mandated to treatment, Wallace proposes practitioners use a broader, and more flexible approach. She recommends thinking of this process as simply:

- Approximately 6 months “Early Phase”, which may include moving the client from pre-contemplation through contemplation and preparation, and into withdrawal, or possibly even prolonging abstinence.
- Thereafter, a “Mid-to-late Phase”, which may include action in order to prolong abstinence and/or maintain recovery.

This has important implications for both what we expect is a realistic amount of progress for someone mandated to treatment to make in a set period of time, and also for the types of interventions and services we provide. Wallace highlights that since mandated treatment must meet the person exactly where they are, there is a significant role for:

- Integrating the earlier stages of change (contemplation, preparation) into the treatment process, rather than commencing with withdrawal. This means a greater emphasis on education and consciousness raising and interpersonal techniques like motivational interviewing (described in more detail in the next section).
- Using a “gradualist” approach that integrates Harm Reduction and Moderation Approaches, potentially but not necessarily in the pursuit of abstinence

Additionally, Wallace (2019) also notes that it may not be possible to identify the extent of problems such as depression, anxiety, PTSD, paranoia or hallucinations until the person has been abstinent for at least four weeks. This highlights the importance of frequent reassessment of the person’s symptoms and needs, and treatment plans and pathways that are flexible and able to incorporate contemporaneous mental health treatment if the need emerges.

There is certainly a role for drug treatment for the population of people who have substance related problems and also criminal charges. However, the evidence above demonstrates that such treatment must be cognisant of this population's different starting point in the stages of change, compared to people voluntarily entering treatment. In order to foster lasting change in people's lives and behaviour, treatment must focus on fostering a genuine agentic change in the person's worldview.

It is also worth noting that the court process and judicial supervision have the potential to either support or disrupt the development of this agentic change. Since a necessary step is for the person to develop a genuinely held belief in the connection between their drug taking behaviour and other problems in their life, clear communication and timely processing can help the person to draw this connection, while decisions that seem arbitrary or so slow as to become disconnected from the precipitating behaviour may sever this connection in the person's mind.

2. Features of evidence based mandated treatment

If we accept, then, that there can be a useful role for treatment for at least some people mandated through the justice system, the next question is what we might hope that treatment looks like. There is a large body of research, and many different sets of principles or frameworks for what constitutes effective or evidence-based interventions for this population. A relatively comprehensive example is the US National Institute on Drug Abuse's 13 principles of effective treatment, which are:

- Drug dependency is a complex but treatable disease that affects brain function and behaviour. Changes in brain structure and function persist long after cessation of drug use, resulting in a risk of relapse even after long periods of abstinence.
- No single treatment is appropriate for everyone.
- Treatment needs to be readily available.
- Effective treatment attends to multiple needs of the individual, not just his or her drug use.
- Remaining in treatment for an adequate period of time is critical.
- Behavioural therapies including individual, family or group counselling, are the most commonly used forms of drug abuse treatment.

- Medications are an important element of treatment for many patients, especially when combined with counselling and other behavioural therapies.
- An individual's treatment and services plan must be assessed continually and modified as necessary to meet all the person's changing needs
- Many people with substance use problems also have other mental disorders or illnesses
- Medically assisted detoxification is only the first stage of treatment, and by itself does little to change long term drug abuse
- Treatment does not need to be voluntary to be effective (if it can foster a person's readiness to make an agentic choice to change, or if it gives them skills and knowledge to minimise harm or help themselves change when they are ready)
- Drug use during treatment should be monitored, as lapses occur and should be addressed honestly in treatment
- Treatment programmes should also offer testing for blood borne viruses and infections that are known to be associated with some drug use practices.

These principles vary significantly in their specificity, and in how directive of practice they are. On the other hand, Wallace's (2019) guidelines for deploying a unified theory and model for mandated drug treatment can be abbreviated into the following process:

1. Understand client's context and past experiences
2. Perform thorough individualised assessments
3. Deliver evidence-based interventions, tailored and individualised to the person's needs, preferences and culture as required
4. Respond to multi-problem clients with an integrated and comprehensive care package
5. Engage in continuing reassessment and ongoing observation to adapt to the client's changing needs and progress.

These are important practices that require a well-trained workforce and an enabling policy context. But this outline only gets us a limited distance – it is a model for deploying good practice, but does not in itself tell policy makers what they should be prioritising. What are the "evidence based" interventions that should be delivered, and how are they best implemented? Before answering that question, we must consider what "effectiveness" and "evidence based" mean in this space.

As with all complex interventions in complex systems, there is a wide range of ideas about what outcomes should be sought, how to measure those outcomes and also how to prioritise them when they may be in tension. Substantial practical, legal and ethical challenges make it very rare for studies in this space to utilise the most rigorous methodologies like randomised controlled trials (RCTs) or robust quasi-experimental or matching approaches, meaning that researchers seldom have access to a meaningful comparator group that would allow them to confidently attribute impact. Prochaska (2008) points out that thorough evaluations of effectiveness can generally only take place where a single intervention targets a single behaviour or problem – which is of limited utility when in actuality the people accessing these services typically have multiple problems and health disparities, with myriad roots, necessitating multiple interventions, and most psychological interventions treat more than one symptom or behaviour.

One consequence of this is that the body of literature that assesses interventions for this population may be significantly biased in favour of interventions and outcomes that lend themselves to rigorous study designs and measurement, rather than those that make the most difference to people in actuality. For example, Wallace points out that field effectiveness studies using longitudinal designs are not considered a highly rigorous methodology by traditional empirical research standards “yet have provided the most extensive empirical knowledge of the effectiveness of the three main publicly funded treatment modalities [in the US]: methadone maintenance, drug free outpatient, as well as residential therapeutic communities”.

This means that, overall, while there is extensive literature on drug treatment and on recidivism from crime, there is a lack of high quality, comparable evidence to draw on in relation to people at the intersection of both issues. To help overcome this limitation, Wallace argues that policy makers and practitioners should expand their ideas of evidence for “effectiveness” for this group. In particular, since we do know that people in this population are to some extent, (In Wallace’s language) “inherently multi-problem”, it is essential to deploy multiple interventions that impact on multiple behaviours. She points out that interventions delivered from a multi-behaviour paradigm cannot be classed as “evidence-based” in the strictest, traditional sense because they have not been extensively evaluated and validated in RCTs or similar studies. However, these approaches can instead be considered “state of the art”, as they are “in use,

promising, valued" and based on evidentially supported components, despite the overarching approach not being empirically validated.

Additionally, Streisel's (2021) study exploring people's 20 year outcomes and experiences found that treatment may still be helpful to those for whom it "fails". Her participants had found treatment helpful in two ways:

- **While in treatment** the support system, sense of security, and daily structure were all reported to be helpful in maintaining sobriety for a period.
- **After treatment** participants reported that knowledge gained in treatment, about drug dependency as a chronic disease, how to cope with stress or trauma, and what practical steps they can take to avoid triggering cravings, was helpful. This was both for maintaining sobriety, but also even if the person relapsed – they reported drawing on this information to help them reduce harm while using, and to re-engage with treatment later once they had experienced an internal agentic change.

This highlights the importance of broadening ideas about what we regard as "effectiveness" when thinking about this population. This delayed effect is another example, alongside harm reduction practices and the short-term protectiveness of treatment engagement, that may not be captured by simple "recovery success" metrics.

Moreover, Streisel further complicates the idea of identifying "what works", by highlighting that many things that are helpful in treatment for some people, are viewed as unhelpful or even harmful by others. For example, group work that facilitated learning from other's experiences was highly engaging and effective for some participants, but others found some group work to be overly backward-looking and some even reported feeling it triggered them to use drugs again because of the cravings these conversations provoked

With these complexities stipulated, this section summarises the current available knowledge on effective interventions for this group. It is organised based on Wallace's (2019) "Recommended Menu of Evidence Based Addiction Treatment" from the leading textbook on mandated drug dependency treatment, supplemented with evidence from the wider literature on addressing people's complex needs in this setting.

2.1 Gold Standard: The Matrix Model

Combining many of the considerations in this section, Wallace (2019) proposes that the ideal approach to delivering effective mandated treatment is the “Matrix Model”. This involves medically supervised detoxification if required, then the person being enrolled in a day-treatment / outpatient model that is:

1. Intensive (4-5 days per week),
2. Extensive (minimum 18 months including continuing care), and
3. Comprehensive (incorporating multiple approaches including a therapeutic alliance, various forms of individual and group counselling / therapy, drug testing, education and family / peer involvement). In essence, this model makes many of the features laid out below available, and matches people to those best suited to their needs at any given time.

2.2 Feature: Thorough Individualised Assessment and Targeting

Assessment and targeting are crucial to ensuring people receive the right interventions for their circumstances and needs. This should begin with thorough assessment at intake, and continue throughout treatment.

From a treatment perspective, Wallace (2019) summarises the best practice: “adherence to one theoretical model or a particular method of treatment is not required and not recommended” but rather “it is essential for practitioners to exercise both some degree of fidelity to evidence based treatment interventions as well as flexibility in responding to individual client needs via individually tailored treatment”.

This then enables practitioners to adapt interventions in response to each person’s:

1. degree of dependence on substances, and related problems.
2. stage of developing their readiness to change, as covered in previous sections.
3. learning or communication needs, which are relevant to both how interventions are delivered, and also understanding their wider support needs. This may also reveal the need to refer to specialist assessment for previously unidentified neurodivergences that would warrant support and/or treatment, such as Autism Spectrum Disorder (ASD), Attention Deficit/ Hyperactivity Disorder (ADHD), or Dyslexia.
4. wider needs including shelter, housing security, safety, food, income, meaningful use of time, and social bonds. This informs both what

should be prioritised in holistically supporting the person, and what can realistically be accomplished in terms of substance use reduction.

5. each person's unique background. This might include incorporating aspects of their cultural background, religion, sexual orientation, gender identity, or family context where these are helpful to strengths-based identity formation, or being sensitive to the diverse and potentially negative experiences some people may attach to these identities.

In the literature on offending, there is a similarly longstanding and well-validated principle relating individual assessment and careful targeting to improved outcomes. This comes from Andrews and Bonta's (1990) framework referred to as "Risk, Need, Responsivity" or RNR. The RNR model for all offending behaviour can be broadly summarised as follows:

- **Risk:** Different people have *different levels of risk* for offending. These risks can often be identified or measured by looking at 8 "major risk factors" which are:
  - A personality pattern that is anti-social, impulsive and/or "restlessly aggressive"
  - Attitudes that are pro-criminal or negative towards the law
  - Having friends and family members with the above attitudes, especially in the absence of friends and family members with more pro-social attitudes
  - Substance use
  - Poor family or marital relationships
  - Poor performance, disengagement from, or low satisfaction with school or work
  - Lack of involvement in pro-social recreational activities or positive uses of time
- **Need**: When people offend, it is usually to meet some *underlying need* that they have. In order to desist from offending, people must find alternative ways to meet these needs. For example:
  - attitudes and peer groups are likely to have been shaped by economic circumstances and past experiences that impact how and when the person feels safe
  - pro-criminal, or otherwise dysfunctional relationships with friends or family may persist because they represent the only meaningful relationships and sources of support and human connection that the person has

- Substance use and disengagement from activities, learning and formal employment likely reflect struggling to cope with particular situations, and/or mental health difficulties or unresolved trauma.
- **Responsivity**: Different people respond differently to interventions. Interventions should provide cognitive behavioural treatment along with other support to reduce the person's risk by addressing their needs, in ways that are *tailored based on factors that affect their responsiveness*, such as the person's:
- learning style
- source and degree of motivation
- abilities and strengths
- personal circumstances, economic and social context

Adherence to the core RNR principles has been found to be associated with reductions in reoffending – adherence to all three principles has been found to result in a 17 per cent positive difference in average recidivism between treated and non-treated offenders for interventions in custodial settings, and a 35 per cent difference in community settings. In contrast, recidivism increases when there is a failure to adhere to any of the RNR principles (HM Inspectorate of Probation, 2020).

Marlowe summarises the most reliable predictors of risk amongst people who use drugs and commit crimes as being: younger age, male gender, early onset of substance use, prior convictions, previously unsuccessful treatment attempts, anti-social personality disorder, and a preponderance of antisocial peers (Marlowe, Patapis and DeMatteo, 2003).

Adaptive interventions adjust the dosage and type of services in response to participants clinical presentation or performance in treatment. For example, some US studies have suggested that high-risk participants were more likely to graduate from drug court programmes, provide more negative drug tests, and report less drug and alcohol use, when required to attend fortnightly court hearings rather than court hearings only as necessary. Marlowe et al (2006) found "evidence for the utility of prospectively matching drug offenders to different dosages of judicial supervision based upon an assessment of their risk status and clinical needs (Marlowe at al 2006). These findings are supported by subsequent meta-analytic evidence that specialised courts that adhere to the "risk and need" principle are related to greater reductions in offending compared to

treatment as usual (Guttierrez et al, 2016; Gutierrez and Bourgon, 2012).

Apart from the cost implications, some have argued that the intrusion of the judge into the treatment process could be disruptive or harmful to the therapeutic alliance (eg Schottenfeld 1989). Moreover, being "treated like a criminal" by being brought into court regularly might produce counterproductive feelings like resistance or reactance, and may in fact strengthen the person's identity as a criminal or their tendency to identify with other criminal peers. The authors state it is therefore important to determine which offenders require intensive monitoring by a judge and which can be adequately supervised by clinicians or case managers.

Kearley and Gottfredson (2020) note that across the US, drug court eligibility criteria tend to be highly restrictive, often only serving low risk, non-violent offenders (Franco, 2010), despite evidence that suggests higher risk offenders do equally well or better (Marlowe et al, 2003; Marlowe et al, 2007; Rossman and Zweig, 2012). Lowenkamp's 2005 meta-analysis found the effect size for drug court participation was twice as large for high risk participants as low risk. In fact, placing low risk offenders into residential or group-based treatment can even have an iatrogenic effect – that is: it may in fact cause worse outcomes than if they had been left in a mainstream court process (Lovins et al, 2007; Lowenkamp and Latessa, 2005).

2.3 Feature: Strong therapeutic alliance

There is extensive evidence that the relationship between a person and their practitioner(s), (often referred to as a strong Therapeutic Alliance / Support System (TASS)), is a key factor in both treatment retention and success. There are multiple mechanisms through which this effect may accrue:

1. The practitioner demonstrating openness and social support creates the conditions for the person to feel comfortable sharing about themselves and their actions and experiences, an essential pre-condition for thorough and accurate assessment.
2. A positive experience and meaningful relationship developing at treatment appointments helps to engage the person and keep them returning so that interventions can be delivered.
3. Building trust between the person and the practitioner allows the person to feel comfortable confiding when they struggle or relapse.

This enables the practitioner to support the person through the setback, rather than the person disengaging.

4. Over time, this relationship allows the practitioner to naturalistically observe the person, learn their patterns of cognition and behaviour, and their triggers for lapse and relapse, so interventions can be adapted flexibly to their needs.
5. By replicating the positive regard and care of a functional personal relationship, the practitioner can help the person to:

- develop their self-esteem and healthy ideas of how they can relate to others
- safely experience and express their emotions in a way that develops their skills for managing interpersonal relationships and related feelings in their wider lives.

The counsellor-client working alliance has proven to be a better predictor of positive treatment outcomes than any other variation of treatment models or theoretical orientation (Hauser and hays, 2010; Wampold et al, 1997). Because of this, Wallace (2019) states that strong therapeutic alliance from the very beginning of treatment, and throughout service delivery, is the foundation for almost all effective interventions. This is supported by Lebow et al's (2002) review of literature on relational factors in drug dependency treatment. They developed a set of principles for producing positive treatment outcomes, which are summarised below:

- When a stronger helping relationship is established at initial intake, the client is more likely to enter treatment.
- When a stronger alliance is established during treatment, the client is:
  - More likely to remain in treatment longer and complete treatment
  - Less likely to experience distress, and more likely to experience a pleasant mood during treatment
  - More likely to abstain from alcohol and drugs while in treatment
  - More likely to experience positive outcomes from treatment
- When the therapist is more confrontational, the client is more likely to show negative in-treatment behaviour.
- A strong treatment alliance may be especially beneficial for specific subgroups, including those with anti-social personality disorder or high levels of anger.
- Better outcomes are achieved for people who receive general social support as well as substance-related support during treatment, and for people who are part of non-substance-abusing-networks.

- Spouse, family or peer involvement in treatment may help engage clients in treatment and produce better outcomes, but the impact of family involvement may be complex and highly variable depending on the client, family and therapeutic circumstances.

  Relatedly, meta-analytic studies have shown that practitioners who are “rigid, aloof, tense, uncertain, self-focussed and critical” tended to have poorer working alliances with clients, while those who demonstrated “dependability, benevolence, responsiveness and experiences” tended to foster most positive working alliances (Ackerman and Hilsenroth, 2001; 2003). This is consistent with qualitative drug court research that found participants who perceived treatment as being offered through a “punitive and judgmental” lens felt this hindered their engagement and ability to complete the programme (Gallagher et al, 2017), and also with Wallace’s observation that “experiences of empathy and equality may be vital ingredients in those treatments tailored to meet the needs of those who have been marginalised”.

  Mechanistically, in this field of research the working alliance is generally conceived as developing through three main steps:

1. the creation of shared goals between the practitioner and client
2. the collaborative identification and allocation of tasks between the practitioner and client, in pursuit of the person’s goals
3. the development of an interpersonal bond between the practitioner and client, begun during this process and growing as the practitioner and client work together on the tasks in pursuit of the shared goal.

  An important question then, is how the therapeutic alliance is impacted when treatment is mandated in a criminal justice context. In the only significant study on this question to date, Zongrone (2022) studied therapeutic alliance formation in participants of a US drug court. She notes that mandated treatment does not align well with clinical practice because the goals and tasks are often pre-determined by the court. This poses a number of problems:

1. the goals and tasks may not align with the person’s own goals or preferences.
2. by short-cutting the goal-setting process and the discussion and negotiation involved, the person is denied the opportunity to develop a goal for themselves that could ultimately help to crystalise their agentic choice and intrinsic motivation to change.
3. by short-cutting both goal-setting and task allocation, the person misses out on the *process and experience* of collaboratively working

through these with their practitioner. This means that the initial alliance formation is truncated, leaving the person and practitioner in significantly worse conditions for bond development.

4. By reducing collaboration in the early stages, the relational dynamic between the client and expert may become less trusting, more power imbalanced, and more characterised by the practitioner being seen as a “consultant or expert” instead of the person’s partner in a therapeutic alliance.

Additionally, qualitative findings from US drug courts indicate that “since treatment providers become an extension of the participant’s probation officer – as they are required to report updates on progress as well as any lapses in their treatment – the participants were less likely to wholly trust their provider” and consequently “began to refrain from reporting lapses or struggles in their substance abuse counselling service for fear that it would be reported back to the court” (Gallagher et al, 2015).

Wider research from mandated mental health treatment supports this proposition. For example: Sheehan and Burns (2011) found that amongst mental health clients, a higher perception of coercion when entering treatment negatively impacted their therapeutic relationship with their assigned practitioner; Manchak et al (2016) found that mandated treatment relationships “involve substantially more therapist control and client submission” compared to voluntary participant research findings.

2.4 Feature: Integration and recognition of early stages of change

As noted earlier, mandated patients typically enter treatment at an earlier stage in contemplating or preparing for change, than the voluntary patients that most drug dependency treatment models are based on. Consequently there is a need to lengthen expectations regarding how long a person may take before being ready to make a change, and also to refocus treatment on fostering the conditions for the person to make an agentic choice to change and develop an internal motivation to maintain recovery.

A key tool for this is **Motivational Interviewing / Motivational Enhancement Therapy**, including incorporating identity development theory for clients with a minority identity. These approaches involve regularly meeting with a client in order to have collaborative, guiding but informal conversations aimed at helping the person to identify

and strengthen their own internal motivation to change by positively reinforcing their goals and change talk, and compassionately exploring their misgivings or difficulties. This approach is rooted in over 30 years of empirical study (Naar-King and Safren, 2017), and supported by meta-analysis suggesting that MI is “associated with small to medium effect sizes across a variety of behavioural outcomes, with the strongest body of evidence being on addictive behaviour.”

Millar and Arkowitz (2015) also note that this can be a circular and recursive process, further underscoring the time needed for this to take place before expecting a person to make significant behavioural changes.

2.5 Feature: Effective interventions

As noted earlier, defining and measuring “effective” interventions for this population is a fraught exercise. However, the following types of interventions are generally considered to be either effective or state-of-the-art (although only partially validated). They may form part of an evidence-based package of support for people with multiple complex needs including substance and justice related problems

1. **Cognitive Behavioural Therapy/Relapse Prevention/Social Skills Training**
   These are forms of intervention that focus on helping the person understand their behaviour and develop the skills to behave differently in the future. These approaches typically involve compassionate, therapeutically oriented conversations between the client and practitioner, that explore the factors that are fostering the person’s substance use or may be a relapse risk, and actions the person can take to manage those situations or risks. This may involve delivering psycho-education to the person about their brain as an organ, their substances of choice as chemicals, and the complex relationship between their past experiences including trauma, their brain, the drug and the behaviour that their brain produces. It may also involve developing alternative ways of coping with stress, traumatic memories, or interpersonal difficulties.
   These approaches have a strong evidence base, but Wallace (2019) notes that they are most recommended for use alongside other interventions addressing the person’s wider needs as well.

These interventions are also generally supported by the research on offending: Marlowe et al (2011) found that effective counselling interventions are highly structured, specified in a treatment manual, and behavioural or cognitive behavioural in orientation.

2. **Twelve step facilitation / guidance using AA/NA/CA/CMA[5] etc** Twelve step programmes have a longstanding tradition in recovery work, and a large body of evidence shows that in general these programmes can be effective in supporting people to maintain recovery and develop their self-efficacy and non-substance-using support network. Wendt et al (2017) found that this efficacy is enhanced when combined with other treatment, and when attendance is frequent and consistent.

   Twelve Step Facilitation is a manualised approach practitioners can use to support and encourage people to participate in 12 step programmes. Treatment programmes can also support through formal referral, introducing people to potential sponsors in the programme, and addressing barriers to attendance such as childcare or transportation.

3. **Individual Drug Counselling and/or Supportive-Expressive Psychotherapy** These are therapeutic approaches to supporting the person, based on person centred, psychodynamic therapeutic practice, and potentially integrating psychoanalytic therapeutic approaches as well, but distinct in their focus on shorter term or more behavioural goals, and priority placed on substance related issues. A common model of delivery may involve thirty six sessions over six months, with booster sessions afterwards. Both IDC and SEP have demonstrated effectiveness with both opioid and stimulant type drugs (Wallace, 2019), and have been shown to increase the effectiveness of other treatments when used in combination, including methadone assisted treatment and group drug counselling.

4. **Community Reinforcement Approach/ Contingency Management** Contingency Management is an example of a behavioural intervention that can produce substantial benefits for people charged with drug offences (Marlowe and Wong, 2008). This is the practice of escalating rewards for attending and engaging in treatment. However, despite its effectiveness, CM is rarely used in correctional

[5] These acronyms refer, respectively, to Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous and Crystal Meth Anonymous

settings, typically because it does not sit well with many professionals to reward people for doing what they are legally required to do.

The inverse is a graduated sanction (such as a fine or a quick (eg one night) stay in custody), which are common in US drug courts, and available but rarely used in Scottish drug courts. There is some evidence from quality drug court studies that graduated sanctions can be helpful (Harrell and Roman, 2001; Marlowe and Kirby, 1999; Roman et al, 2011). However these findings were not replicated in Trood's rigorous and more recent meta-analysis of problem solving courts (2021), and it is unclear whether this is because of their ineffectiveness in general, or the other non-drug specialty courts included in the study.

Importantly, the authors also note that some practitioners have argued that sanctions, graduated or not, are inappropriate to mental health court clients (King, 2009; Trawver and Rhoades, 2012). Considering the high co-morbidity of drug problems and mental health problems, and the need for treatment to address both, this point is arguably equally applicable. The authors conclude that more research is needed on the most effective ways to deliver judicial supervision, including how and when to reprimand participants.

Collins (2019) also notes that the system of sanction and reward "essential to the US drug court model and its underlying philosophy of drug dependency, requires the imposition of a novel idea for the British courts system: the use of 'multiple sanctions', something without clear precedent (Bean, 2002)." This raises the important philosophical question of when a sanction becomes a "double punishment" for the original offence, and also a practical one, about the acceptability of this practice to Scottish jurists.

Considering the contested effectiveness of graduated sanctions, the Scottish judiciary's relatively low use of them, and the difficulty they may pose to the therapeutic alliance, they should be treated cautiously. On the other hand, any opportunity to retain someone in community based treatment and avoid revocation and custody should be considered. This is an area that warrants greater exploration with stakeholders and the judiciary in Scotland.

5. Integration of harm reduction and moderation approaches / abstinence by gradualism

Practitioners must meet people where they are in the stages of change. For many people entering mandated treatment, this will be a relatively early point in their recovery journey. Consequently, many people in this population may benefit more from a harm reduction or moderation approach than abstinence, especially in the early phases of engagement. There is plenty of literature contesting the relative merits of harm reduction approaches as compared to abstinence – but Tatarsky (2002) rightly points out that in many cases the best approach is both. Integrating harm reduction and moderation approaches may look like:

- Making referrals to needle exchange programmes, safe consumption facilities, methadone maintenance programmes etc
- Delivering education about how to minimise risk when consuming drugs, for example education on safe injecting practices and blood borne viruses
- Providing equipment that makes people safer when using drugs

Miller (2001) notes that some people fear or resist entering treatment because they do not think they will cope with being required to immediately become sober. A gradualist or moderation approach can help to retain these people in treatment as they move through the early stages of developing their readiness to change. McLellan (2003) summarises this approach: “Gradualism seeks to create a continuum in which people who are using alcohol or substances in a dangerous or destructive manner are gradually led through a channel that first seeks to reduce the destructiveness of their use, and then seeks to help them attain a life free of addictive behaviour. The continuum also acts as a safety net in the case of relapse”

Wallace (2019) points out that in order to successfully integrate these approaches, practitioners require a supportive policy and legal context – these approaches need to be understood, accepted and enabled amongst probation or parole officers, judges, social workers, and government agencies.

6. Affective, Behavioural and Coping skills

The integration of psychoanalytic theories and cognitive behavioural therapy in drug treatment has developed into a practice with a very practical emphasis on helping people to acquire emotional, behavioural and cognitive coping skills (Wallace, 1996). Because relapse frequently happens when a person encounters a triggering situation or is challenged by coping with negative emotions or painful affective states (Marlatt and Gordon, 1985), learning new coping

skills is essential for this population. However, people in this group also often suffer from an inability to recognise, label or process their feelings, and difficulty regulating their emotional state (Derby, 1992; Rothschild, 1992; Yalisove, 1992;1997). The causative mechanisms of this association are complex and likely to be multi-directional. For example, a person's emotional skills may be limited by past trauma, but limited emotional skills may also make traumatic experiences more likely (due to the social, relational and behavioural impact they have), and may also cause people to experience common setbacks as more traumatic than the general population.

This process can take time, as it requires the person (with the help of their practitioner) to identify the need and trigger, learn new coping responses, practice these in their everyday life, generalise the skills to a variety of situations, and learn to discern when it is best to use different coping strategies. Often, this process may need to be repeated in multiple steps as the person learns first to avoid the most destructive outcomes – for example: a person may respond to certain triggers with aggressive or violent behaviour. Initially, the most adaptive coping mechanism they can manage may be to walk away and sit in silence until they are calm. However, walking away in silence is an avoidant response that is not healthy if it remains the person's only response to common every day frustrations. Over time, once the person has developed confidence in their ability to avoid violent outbursts, the practitioner can then take the person through this process again to help the person acquire a more active coping skill, such as being able to deliver a positive, assertive verbal response (Wallace, 2005).

7. Medication Assisted Treatment (MAT)

MAT involves the use of medications, along with counselling and behavioural therapies, to provide a whole-patient approach to treatment (Abuse, 2013). As reflected in Scotland's recently developed MAT Standards, there is a compelling body of evidence for using opioid-agonist medications to reduce opioid use and retain people in treatment.

Opioid dependence causes the greatest disease burden of all extra-medical drug use (Degenhardt et al, 2019). Access to and retention on Opioid Antagonist Treatment substantially reduces premature mortality. The medical evidence base is well rehearsed elsewhere, and beyond the scope of this report, but the following points warrant

noting in relation to optimising effectiveness in the community justice population:

- There can be a number of common barriers to MAT engagement, including attitudes, convenience of daily pharmacy prescribing, and stigma perpetuated by attitudes that see drug dependency as a choice rather than a disease justifying medical treatment.
- MAT's impact both supports, and is supported by, being delivered in conjunction with other interventions, such as the various psycho-social options listed above.
- Heroin assisted treatment can play a valuable role in reducing deaths and crime (Strang et al, 2015), and despite its higher initial costs it has been shown to be cost-effective overall (Byford et al, 2013).
- MAT is only an option for certain types of illegal or criminogenic drugs (mainly opioids, but also benzodiazepines and alcohol). There are no medications known to effectively assist with other drugs of abuse such as stimulants like cocaine, crack cocaine or amphetamines (Degenhardt et al, 2019).

2.6 Feature: Respond to multi-problem clients with an integrated and comprehensive care package

As summarised by Wallace (2019): "Not only are practitioners faced with problems of addiction, but also the following: incarceration; ongoing criminal justice system supervision; performance of risky behaviours; loss of child custody; histories of trauma across the lifespan; engagement in violence; psychiatric co-morbidity; and, a risk of recidivism and relapse to more than one problem behaviour." This reflects a longstanding and well-corroborated evidence base showing a complicated but strong correlation between people who experience mental ill-health and people who use substances, both generally and problematically. For example, studies have found:

- Offenders with substance problems were more likely than others to have increased mental health problems and risk factors for suicide or aggression. (Ruiz et al 2011)
- There is a high incidence of co-occuring substance use and history of trauma and trauma related symptoms (Blanco et al, 2013; Ehlers et al, 2013; Reynolds et al, 2005). Moreover, a person is more likely to escalate to injecting drugs if they have experienced violence or trauma in the past (Fuller et al, 2002; Ompad et al, 2005; Lake et al, 2015). A survey of mental health needs amongst over 250 clients at one Scottish Justice Social Work service found that over 70% had some kind of mental health issues, and that "there is little point in

asking solely about mental health without asking about drug/alcohol use and prescribed medication" (Community Justice Scotland, 2021).

- Opioid users typically experience elevated mental health symptoms compared to the general population, including depression, anxiety, and post-traumatic stress (Becker et al, 2008; Fink et al, 2015; Kerridge et al, 2015). Moreover, people with opioid dependence who experienced multiple childhood traumas and/or mental disorders, were less likely to engage in treatment and more likely to have contact with the justice system (Santo et al)

This pattern is borne out in Scotland . Research with community-sentenced people who use drugs is now somewhat out of date, but this population is significantly more similar to the prison population than those who are not involved in the criminal justice system, so the Scottish Government's recent Health Needs Assessment (2022) for the prison population is informative. It reported that: "various respondents noted that mental health needs were common amongst individuals living in prison who experience problems with substances... We heard reports that some individuals are inappropriately remanded to prison if there are no secure hospital beds available or that some people were being placed in prison as a result of a lack of appropriate community and/or psychiatric provision. This is considered as leading to significant levels of vulnerability for these individuals. Respondents were clear in their view that prisons should not be a place someone is sent for their own protection and that Sheriffs are sometimes considered as believing this to be appropriate." The report recommended that there should be "a fully functional and integrated approach to address the consistent overlap between substance use and mental health".

The evidence for integrated mental health and drug treatment is promising to strong:

- A 2019 systematic review of interventions for people who both use drugs and commit offences, with co-occurring mental health problems showed that, in general, the evidence base on these types of interventions is relatively scarce - only 13 studies met the quality standards for inclusion. This may reflect a limited number of programmes in existence with this dual focus for this specific population, but may also be because the complexity of the problems, systems, interventions and ethical considerations involved makes it extremely challenging to conduct randomised controlled trials – the standard for inclusion in the review. Notwithstanding this challenge, from the 13 studies included, the authors found that therapeutic

communities and specialised mental health courts may help people reduce substance use and criminal activity.

- Outside of the literature on people involved in the justice system, multiple systematic reviews have found that treatments designed to treat PTSD and Substance Use Disorder at the same time hold promise for reducing symptoms of both (Van Dam et al, 2021; Torchalla et al, 2012; Simpson et al, 2017; Bailey et al, 2019).
- Similarly, Roberts et al (2016) conducted a systematic review and meta-analysis looking at both individual and group psychosocial therapies, which also concluded that trauma-focussed interventions could be delivered effectively alongside substance use treatments. This body of evidence was more fully extended to criminal justice populations in a 2020 systematic review of group interventions for trauma and substance use for women in the justice system, which found that while this is a relatively under-studied area, the literature shows promising results including reductions in substance use and PTSD symptoms over time.
- A systematic narrative review focussed specifically on amphetamine type stimulant users concluded that this group is a highly diverse population, with drug use trajectories shaped by a complex dynamic of individual, social and environmental factors. Tailored, joined up interventions are needed to address overlapping economic, health and social care needs in order to support long term abstinence" (O'Donnell et al, 2018).

It is also important to note Baughman et al's finding regarding the prominence of violence or trauma exposure and co-occurring mental and substance disorders: as decreasing use of mood-altering substances can increase the person's experience of violence- or trauma-related memories. If unaddressed, the associated negative feelings can put the person's programme participation, and continued sobriety, at risk. Overall, the authors' data suggest the need for services that can address these issues as part of the treatment continuum. They argue that mental health providers need to be integrated into the court team and participate in team meetings and court hearings.

Beyond mental health support, people in this population also often have a number of wider social needs. A recent piece published in the Lancet regarding how to minimise drug harms in the UK argued that "interventions need to address drug use more holistically, and recognise the contribution of economic distress and social factors to drug use and harms." Work by Public Health Scotland found that

people in the most deprived areas were 18 times as likely to have a drug-related death as those in the least deprived areas, and 8 times more likely to have an alcohol related death or hospital stay (2020). In Community Justice Scotland's annual report on Outcome Activity Across Scotland (2022), "partners reported that service users were presenting with needs linked to alcohol and substance use, physical and mental health, wellbeing, employability, housing and more. Many individuals were experiencing more than one issue concurrently."

The Robertson Trust's report Hard Edges Scotland (2020) highlighted severe and multiple disadvantage in Scotland, with 191,000 people having experience across substance dependency, offending or homelessness in a typical year. The report emphasises the significance and long-lasting impact of childhood harms, such as poverty, mental illness, and homelessness, leading to problems in adulthood. Similarly, the Independent Care Review's series, The Promise Scotland (2020), included an economic model on human costs that showed care experienced adults are one and a half times more likely to experience severe multiple disadvantage, including substance use, homelessness, mental health issues and offending. The Scottish Drugs Forum (SDF) also identifies poverty in Scotland as the root cause of the drug deaths crisis, which has not been seen in other comparable European countries.

The prison needs assessment, mentioned earlier, also found that: "the biggest and most consistent need we heard expressed was housing upon liberation. The importance and benefits of having secure non-hostel/homeless residential status upon release was consistently emphasised, whether maintained or a new tenancy, through family, or via residential rehab… Greatest concern was expressed over those individuals who are released onto the streets, into a hostel, or into a House in Multiple Occupancy [HMO], where they are faced with the prospect of going straight back into a substance using community… A further unmet need that respondents talked about was a desire to feel human, loved, valued, connected, and to have a sense of hope."

2.7 Human Rights Considerations

International guidelines on human rights and drug policy have been developed by experts working with the World Health Organisation, United Nations Development Programme and UNAIDS. These guidelines do not have official standing in Scottish law or policy, but

are relevant, reputable and reflect international consensus on good practice. While many of these guidelines are pertinent to the treatment and care of people with substance related problems in the justice system, two are particularly relevant when considering community based treatment orders made by a court. These are:

- If treatment is court mandated, no penalties should attach to failure to complete the treatment.
- Treatment as an alternative to custody must only be offered with informed consent, where medically appropriate and must not be ordered for longer than the applicable custodial sentence.

3. The role of judicial supervision in community drug treatment

The idea of judicially supervising a person's journey through substance use treatment raises many complex issues that are impacted substantially by consideration of what the alternative path for that person might be. There are a number of theoretical mechanisms that may be relevant to considering effectiveness. The literature on these is explored in more detail below, but briefly:

- In favour of judicial supervision:
  - Formal accountability and fear of negative consequences may be effective for a small proportion of people, who otherwise struggle to commit to recovery
  - If processed in a timely way, the experience of judicial supervision may help the person to connect their problems with their substance use, contributing to developing their agentic decision to change.
  - The ability to supervise someone's treatment closely may be the factor that causes a judge to give the person a chance in the community instead of sending them to custody.
- Against judicial supervision:
  - Increased time spent in court and around justice professionals may contribute to strengthening the person's identity as an offender, which is a known criminogenic risk.
  - A number of features of judicial supervision may be harmful to the therapeutic alliance.
  - Judicial supervision (in particular, negative reaction to lapses or mixed messages between court and treatment providers) may trigger resistance or reactance from the person.
  - A number of features of judicial supervision may provoke fear, stress and anxiety, potentially to an existentially threatening level, for the person – which can be a trigger for relapse, recidivism and/or disengagement from the process.

- The more frequently a person comes before a judge, the more opportunities the court has to send them to custody.

  Kearley and Gottfredson (2020) further highlight the tensions that can exist between the aims of justice intervention and those of a public health approach to substance use: “on the one hand, drug use is treated as a crime that must be punished; on the other hand, it is treated as a chronic relapsing disease or behavioural condition that requires ongoing treatment and support. Some scholars view these two approaches as wholly contradictory, others point to research that suggests these distinct mechanisms (sanctions and treatment) may actually complement one another… [in this] perspective, legal actors may put pressure on drug users to seek and remain in treatment, and drug treatment providers may help legal actors by delivering a more effective response to persistent drug use than prison. Of great importance, then, is some clarity regarding the extent to which coerced treatment strategies provide substantial benefits over alternatives, without widening the reach or deepening the intensity of punishment”.

  Moreover, clear communication between the court and the person being sentenced or supervised is essential if they are to draw a strong causal relationship between their actions and the consequences they face in court. This is a key part of the theory that judicial supervision deters criminal behaviour, as well as potentially contributing to the person connecting their substance use to their problems, and thus moving further in the direction of crystallizing their desire and readiness to change. Festinger et al (2018) note that there can be challenges with communication in the court room. This arises from a number of factors, including that people with substance related problems and offending behaviour may, on average, have had less access to formal education, have a higher prevalence of (potentially undiagnosed) neurodivergences, and have a more chaotic lifestyle than the general population, or even the general population passing through the courts. These factors, and the fact that the person may also be either intoxicated, or withdrawing from the substances they usually depend on, may also mean they experience higher levels of situational stress when appearing in court. All of these issues may make communication, comprehension and memory more challenging. In addition to these general challenges, the person may use drugs on multiple occasions, which may or may not coincide with dates of testing, and there may be delays before results are received, again before discussion with their

case worker, and again before their court date. The combination of this disrupted timeline, and the general issues that may impact communication, can make it difficult for the person to develop an understanding of their longitudinal drug use pattern and this pattern's relationship to the consequences they experience in court. This can contribute to the person struggling to understand what is expected of them, or viewing the court's actions as arbitrary, mean-spirited or prejudicial.

Most research on judicial supervision of drug treatment comes from the US, and is almost exclusively rooted in the idea of a drug court, or sometimes more widely a 'problem solving court', which takes a similar approach but a wider remit in terms of the issues that may be addressed. A drug court is not usually a purpose-built physical facility, but rather a specially focussed court session that forms part of the general programme of hearings and sessions that comprise the business before a local court. In "Defining Drug Courts: The Key Components," the typical key components include: the integration of services, reliance on a non-adversarial approach, early entry into treatment, provision of a continuum of services, frequent monitoring, continued judicial involvement, and interdisciplinary coordination (Drug Courts Program Office 1997). However, the ways in which drug courts are implemented, and the populations at whom they are aimed, vary widely.

Before getting into this literature, it is important to remember Nolan's (2009) observation: "embedded within problem-solving courts are cultural assumptions that…when transplanted may significantly challenge or alter the legal cultures of importing countries… Without a deeper understanding of the ongoing dialectic between law and culture, then, importers can underestimate the degree to which these programs carry with them features of a foreign cultural context". Collins argues further that this "produces an assumption of belief in their efficacy based on how they "could" or "should" work if functioning correctly, based on a set of abstract international principles, and results in an assumption that if models do not thoroughly replicate the US model, they are inevitably pre-destined for failure." Collins argues that a country importing court models from others runs the risk of, metaphorically, importing trains that run on the wrong kind of tracks – ultimately they will not connect with and run on the national infrastructure.

This important point notwithstanding, drug courts are now a longstanding intervention with a large, if not entirely consistent, body of research around them, and are the main source of data on how people can be supervised judicially while engaging in drug treatment, and what that experience is like for people.

One way US drug courts can be classified is by the point at which the person receives intervention: pre-adjudication models offer intervention at the pre-charge stage, with charges dismissed on successful graduation, whereas post-adjudication models offer intervention as an alternative to a custodial sentence. Scotland's DTTOs are a post-adjudication model, but it is worth noting that the Problem Solving Approach adopted at Aberdeen Sheriff Court for people with several convictions and multiple complex needs sits somewhere between these two models. It used structured deferred sentences to support people to engage with services to address their needs (typically including substance use), and upon successful completion many participants would be admonished, rather than receiving a community or custodial sentence.

Overall, drug courts show extremely variable results, for example, graduation rates range from 11% (Brewster, 2001) to at least 72% (Mackin et al, 2008) in different individual programmes. Several systematic reviews and meta-analyses have sought to address high level questions about whether drug courts' "work" overall or on average (although the warnings about the concept of "effectiveness", expressed earlier in this report, should also be borne in mind). Work by Lowenkamp suggests that studies generally find effective treatment and interventions coupled with "appropriately balanced surveillance and monitoring" produces the best outcomes (eg, Lowenkamp et al, 2006A; Lowenkamp 2006B; Lowenkamp et al, 2010, Paparozzi and Gendreau, 2005). Trood et al (2021 report that most studies on drug courts report follow ups of 6 months to three years, so it is notable that an unusually long study of Baltimor City Drug Treatment Court resulted in significantly fewer arrests, charges and convictions across a 15 year follow up. The authors suggest this indicates drug courts have the potential to lead to sustained, long term effects on offending even for those with significant criminal records and chronic substance use histories (Kearley and Gottfredson (2020))

However, in perhaps the most comprehensive review and meta-analysis to date, Trood et al (2021) looked at the role of judicial

supervision in problem-solving courts, in relation to both recidivism and individual wellbeing outcomes. They found that problem-solving approaches, compared to treatment as usual, demonstrated a significant average reduction in offending, but that the unusually high variation in outcomes across studies meant they "cannot conclude with reasonable certainty that the true effects of problem-solving courts favour treatment, or that analogous results will be found among future studies". They also found that mental health courts were associated with a larger decrease in offending, compared to both drug courts and specialised driving while intoxicated courts.

The authors also report that prior meta-analyses showing meaningful reductions in offending compared to conventional approaches appear to be driven primarily by lower quality studies, and that results are weaker or even non-existent when only the highest quality studies are included (Gutierrez and Bourgon, 2012; Mitchell et al, 2012). Overall, they found that although problem solving court participants appeared to recidivate less when compared to groups who received only a standard court process, this pattern did not hold when compared to groups receiving a standard court process plus treatment. This finding may indicate that the majority of the benefit of specialty courts comes from the treatment itself, and not from the judicial supervision or other court processes.

This raises the important question of what the intervention is being compared to, and what is likely to happen to the person if they do not go through the drug court or mandated treatment process. While the studies above demonstrate mixed results for people in the justice system when compared to the alternative justice response they might face, it is not clear whether that alternative is very similar in these mostly US jurisdictions to what it might be here in Scotland.

The evidence when mandated treatment is compared to voluntary treatment depends significantly on which markers of "success" are used, and the time period in which they are measured. There is evidence that, especially when delivering person-centred support alongside motivational interviewing, mandated treatment can help move people through the phases of change and concurrently reduce harms (Wallace, 2019). However, the causative relationship with any long term benefits is less certain – Streisel's study on the drivers of recovery and desistance over people's 20 year journeys with substances and criminal justice found that for "those who were sentenced to treatment or mandated to attend treatment as part of a

criminal justice aspect…even when there were direct legal consequences to not completing treatment, respondents who were not attending treatment programmes out of their own volition did not attain the change that the criminal justice system wanted to see." They often found it easy to remain abstinent during treatment because they "didn't want to go back to jail", but this motivation ended when the order did, and they did not sustain change after discharge.

This finding also raises another point that relates to the purposes of sentencing discussed in the prior section. If a sentence keeps someone abstinent only for the length of the order, is this valuable? On one hand, this will at least be protective of overdose death for the person during this time, but on the other hand, this period of abstinence may also reduce their tolerance and put them at greater risk of overdose death if/when they do lapse. Additionally, there is some evidence that even short-lived periods of abstinence can serve as a useful reference point to help people connect their drug use to their problems and develop an agentic choice to change, but on the other hand, negative experiences with treatment can deter people from seeking help in the future when they are more ready and the treatment may be more likely to be successful (Streisel, 2021).

With high variability and evident potential tensions in the drug court model, can the research help to identify the features that make some approaches more successful than others?

Much of the research is focussed on the importance of frequent contact between judicial officers and court participants, but there is relatively little research on other mechanisms used by judges and problem solving courts, such as pre-court review meetings or specific training for the judicial officer, which may also be equally important to impact (McIvor, 2009; Winick, 2003). However, Trood et al (2021) included the moderators that were available in the literature included in their meta analysis, and found that amongst those studies:

- Programmes with individualised treatment had stronger treatment effects than those with standardised treatment.
- Programmes that included specialised training for court staff were more effective than those that did not
- Courts that required weekly attendance once per week in the initial stages were associated with a stronger reduction in offending behaviour than those with fortnightly hearings in the initial stages. This is consistent with earlier meta-analyses (Mitchell et al, 2012,

Sevigny et al, 2013) that found more frequent hearings, especially in the initial stages, is conducive to both drug treatment and reducing recidivism. However, further research is needed to harmonise this with other strong evidence for individualising treatment and dosage of interventions.

The US National Institute of Drug Abuse, drawing on their own extensive research, concluded that the most effective models integrate justice and treatment services, and are characterised by collaboration between the personnel employed in the justice system, and those employed in the health and social support system throughout the screening, planning, treatment and testing, and monitoring processes (NIDA, 2018).

The United Kingdom has had a tiny number of drug courts over recent decades, compared to the estimated 3-4000 in the US (US Department of Justice, 2020), and consequently the evidence from UK studies is sparse.

DTTOs, when first brought in, essentially sought to replicate a drug court intervention, via a national sentencing approach rather than through local court-centred initiatives. Two studies on DTTOs in England and Wales (Eley et al 2002; McSweeney et al, 2007) suggested improvements in participants' drug use and offending. However, it should be noted that the only study to control for other factors affecting retention in treatment (McSweeney et al, 2007), found that people ordered into treatment with a DTTO did not have better retention in treatment than those attending voluntarily.

Research on DTTOs in England and Wales (Powell et al, 2009) found that people had quite different outcomes, depending on whether they were sentenced in Magistrates or Crown Court, and whether they commenced treatment in custody or the community. In the original pilot, revocation rates varied greatly between sites – from 30% to 60% of orders (Turnbull, 2000).

The research on DTTOs in England and Wales also identified key challenges around inter-agency working and availability of treatment (Eley et al, 2002, McSweeney et al, 2007, Turnbull and Webster, 2007). This body of research points to the following as necessary for effective delivery:

- Clear communication between agencies and courts regarding who is suitable for an order

- Clear national standards regarding what is a realistic and acceptable level of drug use whilst on a DTTO, how quickly participants can become drug free, the likelihood of relapse, and how the results of drug screenings should be used
- Reducing delays in court reports, assessments, and processing breach proceedings.

Collins (2019) characterises the implementation approach as challenging: “Dedicated Drug Courts in England and Wales were expected to simultaneously react to and reflect local needs, while implementing a centrally determined, national social service and court programme,” and argues that this paradoxical expectation made their eventual removal inevitable: “no level of local enthusiasm for, or belief in, the ideas of therapeutic justice can bridge the fundamental need to secure central government funds and coalesce highly centralised service provision around a new policy innovation”

Similar implementation challenges appear to have been encountered in the small number of English and Welsh dedicated drug courts that have been piloted. A process evaluation of the dedicated drug courts pilot in England and Wales from 2005-2011, implementing the Drug Rehabilitation Requirement community order (which replaced DTTOs in England and Wales), noted the importance of clear national guidance on how the model should be both theoretically and practically implemented, and the fact that success was contingent on central government funding for dedicated roles, which was not generally permanent (Kerr et al, 2011).

While this evaluation did not assess outcomes or impact, it is noteworthy that respondents had conflicting views on whether the dedicated drug court was “more lenient” in terms of either non-custodial sentencing, or interim sanctions for infringement.

The practical resource challenges identified included:

- The dedicated drug courts were supposed to be cost neutral after initial set-up, but some courts found the dedicated drug court encroached on the space and time of other courts. Others “languished with a lack of case work”.
- To be effective, all wraparound services would require more resources and support to engage with the dedicated drug court. The pilot evaluation reported that if numbers continued to rise at their present (in 2011) rate, it would be necessary to provide: “more court space and time, a larger pool of magistrates, potential staffing

increases at treatment agencies and probation to cope with increased offender caseloads and extra time spent preparing reports and attending court (Kerr et al, 2011).

This literature sits alongside a report published in 2009, reviewing the pilot Glasgow and Fife drug courts, which opened in 2001 and 2002 respectively (Nolan, 2009). This review identified relatively strong support for the drug courts amongst stakeholders, and that sheriffs had found their own specific practices that they felt were helpful, although these could not be assessed for their specific impact – these were practices like beginning each sitting with a "particularly successful individual", so that other participants could see that it was possible to change for the better for others on the same order. Pre-review meetings between the professionals and sheriff were also viewed as facilitating better information sharing and more collaborative decision-making, and were seen as a key distinction between the drug court and a standard DTTO. Relatedly, the dedicated drug court model also meant it was possible to roll all of someone's charges together so the court could respond holistically to the person's full legal situation, and also make it more likely someone would consistently see the same sheriff, compared to a DTTO process in a mainstream court.

Nolan's 2009 evaluation of drug courts found that sheriffs are reluctant to impose interim sanctions, and explicitly maintained court formalities, in contrast to the traditional American approach. Learning from the experience of Irish colleagues, the Scottish drug courts allow the sheriff to attend the pre-court meeting (Collins 2019).

Most funding for the pilots was used to resource the dedicated treatment and testing team for each court. Stakeholders reported that this allowed more contact time with people, including increased home visits and group work – although the extent or impact of this could not be assessed. Some concern was also expressed that if treatment and support available through criminal justice is significantly better than that available through mainstream services and the NHS, this may create an incentive for people to escalate their offending in order to access adequate drug treatment. This appeared to be a greater concern in Fife (where mainstream treatment was less well resourced), than Glasgow (where most people entering drug court were already known to local treatment services). While this specific observation is now substantially out of date, it highlights the

importance of local context in terms of population needs and existing infrastructure.

4. Conclusions from the evidence review: fundamental paradoxes of treatment and desistance

As this review has shown, substance use, treatment and recovery, and offending, sentencing and desistance, are all complex phenomena that interact with one another and with many social and economic factors in people's lives. Coupled with legal, political and cultural considerations (such as the stigma many people who use drugs experience, or the arbitrary illegality of some drugs of abuse but not others[6]), we find a large literature, but few simple answers or consistently effective models for responding to the population of people affected by all these issues at once.

At the very highest level, the evidence seems to suggest that overall and on average, court ordered treatment is less effective than voluntary treatment, but still better for people than custody. Beyond that, the evidence on how best to maximise the potential benefits, and minimise the potential harms, of court ordered drug treatment in response to offending behaviour is growing but remains uncertain.

As Streisel (2021) put it: "the reasons that treatment "worked" for some people were the same reasons that they "didn't work" for others. Even more confounding, the same reasons it "worked" and "didn't work" could occur within the narrative of one respondent… some respondents noted treatment episodes where they disliked a particular modality, but later noted a different episode where this modality worked". Human agency emerges as the distinguishing factor – whether the person had made an agentic choice to change before engaging in the treatment. This finding presents an opportunity for two possible interpretations: optimistically, it might suggest that interventions refocussed on fostering the conditions for agentic change (rather than merely fostering abstinence itself) may hold promise for helping people; pessimistically, removing people's agency by mandating them into support, no matter what it aims to

[6] See, for example, the literature canvassed in International Approaches to Drug Law Reform (Scottish Government, 2021): International approaches to drug law reform: research - gov.scot (www.gov.scot)

foster, may inherently reduce their opportunity to make a truly agentic choice, which is necessary for lasting recovery.

Moreover, the core of recovery (agentic change), and the core of treatment (the therapeutic alliance), are both in tension with the criminal justice system's focus on compliance and enforcement. While court mandated treatment may recognise the need for support and treatment in order to change behaviour, requiring someone comply with the treatment and support package or face punishment can in fact rupture both the agency and the alliance. This may weaken the potential benefits and reduce the impact of treatment. However, this argument only suggests that mandated treatment will be less effective than voluntary treatment. If the alternative to mandated treatment is even more focussed on compliance and control, such as a prison sentence or an order with multiple onerous requirements, then mandated community-based treatment may still be less harmful.

Finally, compatible policy goals can come into tension when the resources required to deliver them are scarce. For example, the current aims of preventing deaths, getting more people into treatment and reducing waiting time for treatment may all compound one another in terms of resource requirements. This is obviously not to argue against any of these as worthy aims – only to underscore the importance of adequately funding and resourcing services to meet the needs in this space – which the evidence consistently highlights is essential to success.

With all these tensions stipulated, the evidence canvassed in this review suggests that a rough sketch of the most evidence-based community sentencing option for people with substance use problems would be one that:

1. **Does not widen the reach or deepen the intensity of punishment.**

2. Recognises the harms of prison and the risk of death for people with substance use problems who are sent there, and **prioritises keeping people out of prison**. This requires that the judiciary:

- are aware of the services offered locally, and adequately informed on them. This is supported by:
  - awareness raising from local providers
  - collaborative working between court staff and practitioners

- detailed information to accompany recommendations in social work reports
- a well-resourced and regularly maintained database of information on local services

- trust that these sentences are effective at achieving their purposes. This is supported by:

- training on substance use and treatment
- well-resourced services with adequate staff and minimal delay commencing treatment

- accept that abstinence may not be the goal of treatment, and testing results may not reflect a person's level of engagement in treatment or progress through the phases of change
- accept the additional time and work required in the court process to conduct the necessary assessments and planning

3. **Recognises that substance dependency is a health condition and should be treated that way. It** impairs the control a person has over their thoughts and actions, and recognises the profound difficulty of enduring cravings or withdrawal in order to make progress.

4. Recognises that while traditional models of voluntary treatment begin at the "action" phase, people who are mandated to treatment have several preparatory steps to move through first. Therefore, sentences need to **support the person to make an agentic choice to change**. Some things that contribute to this are:

- being as consensual as possible while recognising that the alternative criminal justice sanction the person will face makes truly free consent impossible to obtain.
- fostering the conditions necessary for the person to connect their drug use with the problems in their life, and to see their current path as one leading to their "feared self", and alternative paths as leading to a more preferred future self by:

- ensuring the person sees their treatment as fair and not arbitrary
- processing through court quickly enough to help the person connect their behaviour with its consequences
- Communicating clearly to help the person draw a clear connection between behaviour and consequences, and using aids adapted to their needs
- Motivational interviewing and relapse prevention skills training
- Accepting that it takes time to safely explore the person's thoughts and feelings to resolve ambivalence and build their confidence and coping skills so they feel able to take on the actions of change

- using a gradualist approach including harm minimisation and moderation to retain the person in treatment as they move through the phases of change at their own pace.

5. Recognises that a **strong therapeutic alliance and support system** forms the basis of almost all effective drug treatment, and prioritises a strong therapeutic alliance by:
- maximising the person's trust in their practitioner. Something that can help with this is giving them discretion in what they report to the court.
- minimising the intrusion of the court into the therapeutic alliance by:
  - minimising review frequency
  - allowing the person and practitioners to develop their own goals and tasks, rather than these being dictated by the court
  - applying the principles of therapeutic alliance to the court's relationship with the person by:
- ensuring the person sees the same judge each time they appear in court
- providing judges with specialist training on substance use, sub-conscious stigma and the skills of therapeutic alliance building
- integrating drug, mental health and social workers into the court process, for example through pre-review meetings with the judge
- training judges and court staff to:
  - take a compassionate and non-stigmatising approach in the court room and with their remarks,
  - have regard for the very high probability of trauma in the backgrounds of the people in this population, avoiding being "rigid, aloof, tense, uncertain, self-focussed or critical", and instead showing more "dependability, benevolence and responsiveness"
  - have collaborative conversations with the person before them about their progress and goals
  - give positive reinforcement for the person's efforts even when the outcomes being achieved fall short of expectation.

6. Recognises that no single response is appropriate to everyone, and effective responses are based on **thorough individualised assessment** and targeting, and consequently:
- assesses every person who may warrant it
- uses an assessment that covers:
  - health and substance related issues
  - stage of developing motivation to change
  - learning or communication needs, including screening for previously unidentified neurodivergences that would warrant support and/or

treatment, such as Autism Spectrum Disorder (ASD), Attention Deficit/ Hyperactivity Disorder (ADHD), or Dyslexia.

- Criminogenic risk factors and underlying needs, including wider needs such as shelter, housing security, safety, food, income, employment, meaningful use of time, and social bonds.
- each person's unique background, and social and economic context. This might lead to incorporating aspects of their cultural background, religion, sexual orientation, gender identity, or family context where these are helpful to strengths-based identity formation, or being sensitive to the diverse and potentially negative experiences some people may attach to these identities.
- Assessment should take place in the community if at all possible.
- Both treatment and level of court supervision should be adapted to the person's risk and need, including:
- Recommended weekly or fortnightly reviews in the first month, then adjusted based on need and minimised to the extent possible
- Providing adaptive, but adequate dosages of intervention, specifically:
- Support for a minimum of 18 months
- At the higher ends of community based treatment, ideally 4-5 days per week
- Recognising that mental illnesses like depression, anxiety, PTSD, paranoia, or hallucinations may not be apparent until the person has been abstinent for at least 4 weeks, by:
- allowing flexibility for responding to emerging issues or diagnoses.
- accepting that this may be a challenging time for compliance as the person copes with these symptoms without substances.
- integrating mental health assessment, treatment and support.
- Using structured deferred sentences to assess people's needs within the community as they begin to engage with support, so that judicial expectations and the person's treatment and support plan can be flexibly adapted.

7. Recognises the role of social exclusion and economic distress in substance use and offending, and provides an **integrated and comprehensive care package addressing multiple needs**, including:

- Drug treatment and integrated testing
- Mental health and wellbeing
- Self-care and self-efficacy
- Addressing trauma
- Physical health, including blood borne virus clinics

- Housing
- Safety and violence
- Income and employment
- Social bonds and family
- Meaningful use of time
- Education

8. Provides a **range of different types and modes of drug treatment** for different needs, including:
- Education
- Cognitive Behavioural Therapy, Relapse Prevention, Social Skills Training,
- Individual drug counselling and/or supportive-expressive psychotherapy
- Community Reinforcement Approach / Contingency Management
- Affective, Behavioural and Coping Skills
- Medication assisted treatment, including agonist, antagonist, heroine assisted, and benzodiazepine prescribing
- Twelve step facilitation
- Gradualist approach accepting “experimental” brief commitments to specific periods of sobriety before expecting a longer term commitment to abstinence
- Harm reduction and moderation education
- Referral to available needle exchanges, safe consumption facilities etc
- Providing safe equipment
- Both individual and group modes of delivery

9. Recognises the **significant resources** needed to provide a consistent, thorough and high quality service at appropriate dosage, and:
- resources all justice, health and social services adequately
- provides clear national standards and sentencing guidance for what is expected
- fosters collaboration between practitioners and the court through steps like:
  - co-location
  - shared pre-review meetings
  - dedicated coordination roles
  - collaborative screening and assessment
  - joint training and awareness raising

- provides specialised training for court staff and judiciary on the implementation model, its intended benefits, and each person's role in making it successful.

Annex 2: Applying the evidence to current practice in Scotland

Annex 2 reports findings from the review of data on Scottish practice and assesses the extent to which current approaches reflect or foster the elements of good practice identified in Annex 1.

It addresses:

- The role and aims of sentencing, and the place of DTTOs and CPOs within it
- Eligibility, targeting and assessment of people for treatment-based orders, and the extent to which this appears to reflect good practice, and whether further consideration or enquiry may be warranted in order to better align with the evidence
- How treatment-based orders are delivered and supervised in practice, and the extent to which this appears to reflect good practice, and whether further consideration or enquiry may be warranted in order to better align with the evidence
- The characteristics of people in the Scottish justice system who use drugs

1. The role and aims of sentencing in Scotland

The role of sentencing is complex. Most scholars agree that any working approach to sentencing must hybridise retributive and utilitarian approaches to sentencing – that is, that they must find a balance between responses driven by the person's past criminal actions and punishing them for those actions, and those driven by decreasing future harm by reducing the person's likelihood of reoffending or deterring others from committing crimes.

In Scotland, this balance is sought through the Scottish Sentencing Council's (2018) Sentencing Guideline: Principles and Purposes of Sentencing, which apply to all sentencing decisions in Scotland. This guideline states that a sentence should be the one best suited to "achieve the purposes of sentencing that are appropriate to the particular case" – suggesting that different cases may warrant prioritisation of different purposes. The purposes they specify are:

- Protection of the public via preventative measures and deterrence
- Punishment
- Rehabilitation of offenders, to reduce their risk of reoffending and allow them to change and move past offending
- Giving an opportunity to make amends, acknowledging the harm caused to both victims and communities
- Expressing disapproval of the behaviour and reflecting society's concern about it

The guidance also states that in achieving the appropriate purpose of a particular sentence, the efficient use of public resources may be taken into account.

2. Sentencing and substance use

However, the role of a person's substance use in judicial decision-making further complicates things. Sinclair-House et al (2020) note that in both the liability and sentencing stage, sentencing guidelines consistently characterise intoxication as aggravating and mental illness as mitigating.[7] Where an offender presents with a substance use disorder, potentially involving elements of both mental illness and intoxication (or, at least, historic intoxication), sentencing guidance is lacking. In their survey of sentencers in England and Wales, they found that sentencers gave significantly lighter prison sentences to people described as having a particular neuropsychiatric profile due to disease, than if an identical neuropsychiatric profile was due to heroin dependency. Moreover, they found that belief in the person's choice to acquire the dependency was a key component of this effect, and that evidence of dependency was more likely to evoke punishment considerations than rehabilitation.

While the above research took place in the English and Welsh system, the Scottish Sentencing Council's (2021) Sentencing Guideline: The Sentencing Process raises a similar dilemma. In this Guideline:

- The offence being committed "whilst under the influence of alcohol or drugs which were consumed voluntarily" is listed as a possible **aggravating factor**

[7] It is worth noting that section 26 of the Criminal Justice and Licensing (Scotland) Act 2010 states that voluntary intoxication of alcohol is not to be seen as a mitigating sentencing factor.

- The person having a “mental illness or disability, especially when linked to the commission of the offence” is listed as a possible **mitigating factor**
- Having “demonstrated a willingness to address their personal problems and to change their offending behaviour, including addressing any drug, alcohol or mental health issues” is listed as a possible **mitigating factor**
- Sentencers are advised “Cases may have both aggravating and mitigating factors. Whether any factor has an aggravating or mitigating effect will depend on all of the circumstances of the case.”

This guidance gives individual sentencers discretion to interpret:

- How important each factor is in relation to one another
- The meaning of substances being “consumed voluntarily”, especially in the context of dependency
- The extent to which substance use constitutes a “mental illness or disability” in its own right, and the extent to which this affects the commission of offences
- The extent to which mental illness may cause a substance use problem, or a substance use problem may mask an underlying mental illness
- How a person may “demonstrate a willingness to address their personal problems”, how far that willingness must extend, and how much the sentencer must share some belief in their likelihood of success

Additionally, a further implicit goal for sentencing has guided changes in sentencing frameworks in Scotland over recent decades: the Scottish Government’s policy priority of shifting the balance between use of custody and justice in the community , has led to changes including:

- the legislative presumption against short sentences (of three months or less) in 2010
- the advent of Community Payback Orders from 2011
- the creation of Community Justice Scotland and local Community Justice Partnerships from 2017
- the extension of the presumption against short sentences to 12 months or less in 2019 – although it should be noted that sentences under 12 months have still been imposed each year since

While judicial decision making is driven by the specific circumstances of each case, rather than population level considerations such as reducing

the number of people in prison, these policies and laws shape the context in which sentencers decide which available sentence will best serve their intended purposes in each case.

Despite the measures listed above, it is worth noting that Audit Scotland concluded in 2021 that the aims of reducing imprisonment and increasing community sentences have not yet been achieved, with Scotland's incarceration rate still amongst the highest in Western Europe.

Studies exploring judicial decision making are very rare in Scotland. However, the Scottish Sentencing Council recently published an Issues Paper on judicial perspectives of community based disposals (2021). While not specific to people with substance related problems, it is informative to note that this report found that:

- Some sentencers perceive a need for greater consistency in provision of community-based programmes and services
- One of the greatest challenges to judicial confidence in community-based disposals concerns limitations of resources to support their management and delivery
- Judicial awareness of available services in each area could be improved
- Sentencers have noted that breach proceedings have the potential to take significant periods of time, and some would desire earlier reporting of breaches to the court
- Sentencers generally desire greater flexibility to impose what they see as an appropriate sentence for each specific case
- Some sentencers see Covid-19 pandemic related disruptions as having negatively impacted the efficacy of community disposals, and in some instances this has affected sentencing practice

These findings appear consistent with Garrett et al's (2019) work on judicial decision-making in the US. They report: "our findings support the "treatment resource hypothesis" as one explanation for variation among courts and judges in the extent to which alternative sentences are offered to low risk offenders… providing these resources will be crucial in reducing mass incarceration." The authors found that all measures of treatment resources were strongly related to the frequency with which judges gave out non-custodial alternative sentences. Similarly, Monahan et al (2018) also found that most judges in their Virginia, USA study

supported the principle of alternative, treatment based sentencing, but felt alternatives to custody in their jurisdiction were “inadequate at best.”

The Issues Paper mentioned above followed an earlier report published by the Sentencing Council (2019) on a discussion event amongst members of the judiciary and representatives of various health, social care and justice stakeholders regarding sentencing people with mental welfare issues. It noted that:

- Participants perceived systemic challenges in information sharing, which, if overcome, could increase the amount of information available to the courts at sentencing
- In some cases a defence solicitor may be the first person in a position to consider whether the person has a mental health difficulty that should be brought to the attention of the court. This may have an impact on what assessments the court orders, and consequently which sentencing options are available
- Sentencers expressed a desire for more detailed information from community justice social workers about interventions and programmes available, for example more on what is involved, how long they take, and waiting times, so that they could have more confidence that a community sentence would be effectively implemented
- Long waits for psychiatric, psychological or Mental Health Officer reports seem to be more likely to delay sentencing than waits for Criminal Justice Social Work Reports. Participants “noted that many offenders may have a cluster of issues – for example a personality disorder, substance use issues, and adverse childhood experiences – and that additional resources might be required to investigate and obtain information in relation to each.”
- In relation to which issues or conditions might constitute a “mental disorder” for the purposes of sentencing, “some attendees noted that the inclusion of ‘substance use disorder (drugs/alcohol)’ would risk bringing a very large number of offenders within the scope of any such guideline, and that it may be preferable not to include this.” The reasons behind this view are not enumerated in the report
- Participants felt that “the level of resources and support available to offenders through Drug Treatment and Testing Orders, together with the multidisciplinary approach of such orders, is not generally available to offenders with mental welfare difficulties.”

For sentencing people with mental welfare issues, “a package of measures similar to those available under drug treatment and testing

orders was favoured, adopting the same multi-disciplinary approach, and providing the same type of care and support. The Structured Deferred Sentence court was suggested as a model of the type of monitoring and support that the court – with the appropriate level of support from the local authority and social work – could seek to provide in appropriate cases. Again, the provision of the necessary resources for such an approach was recognised as being outwith the Council's remit."

3. Sentencing options and details of orders

Sentencing options

Currently in Scotland, courts have a range of sentencing options they can impose for offending behaviour, including a prison sentence at the most restrictive end, and a spectrum of community orders with various degrees of restriction or requirement on the person's movements or behaviour. The range of sentencing options available in a given case may depend on a number of factors, including the offence being prosecuted and the level of court in which the case is being heard.

Some features of the current landscape include:

- A legislative presumption against prison sentences of less than 12 months[8]
- No person under the age of 21 may be sent to prison. The only custodial disposal available (whether by way of sentence or otherwise) in the case of persons other than children who are not less than 16 but under 21 is detention under section 207(2) of the Criminal Procedure (Scotland) Act 1995

The introduction of Community Payback Orders from 2011, and the subsequent creation of Community Justice Scotland and local Community Justice Partnerships from 2017

- Efforts to develop more opportunities for people to be diverted from the harms of the justice system at earlier stages, including:
    - the Recorded Police Warning system, which provides police officers with a means of dealing with certain less serious offending behaviour[9]

[8] Presumption Against Short Periods of Imprisonment (Scotland) Order 2019, via Criminal Justice and Licensing (Scotland) Act 2010.

[9] Lord Advocate's Statement on Diversion from Prosecution (2021) Lord Advocate statement on Diversion from Prosecution | COPFS

- diversion from prosecution, where an accused person is referred to local authority justice social work (or a partner agency) for support, treatment or other action as a means of addressing the underlying causes of the alleged offending and preventing further offending

However, despite these measures, Audit Scotland concluded in 2021 that the aims of reducing imprisonment and increasing community sentences have not yet been achieved, with Scotland's incarceration rate still amongst the highest in Western Europe.

Geographically, courts and the community sentences they impose operate within slightly different administrative bureaucracies. The court system has six Sheriffdoms, which break down into 39 district Sheriff Courts, and each person will appear in the court for the area where the offence was committed. However, community sentences are served in the area where the person lives, and are primarily delivered by justice social work teams who are typically employed by local authorities (of which there are 32), and work with Community Justice Partnerships (of which there are 30), regional NHS Boards (of which there are 14) and local Alcohol and Drug Partnerships (of which there are 31). This is a complex bureaucratic landscape, and, notably, one that means sentencers may have different disposals or interventions available to them in each case, depending on where the person being sentenced lives.

The two main community orders options specifically aimed at people with substance use problems are a Drug Treatment and Testing Order (DTTO) or a Community Payback Order (CPO) with a drug treatment requirement. For both orders, the person must confirm that they are willing to comply with the relevant requirements before the order is made – although it is important to note that a prison sentence is a possible alternative, so the voluntariness of such consent may be contested.

The two orders have slightly different legal definitions – a CPO *is a sentence* of the court, while a DTTO is an *order instead of a sentence*. This creates a technical distinction in the person's status, with CPO recipients being convicted and sentenced, while DTTO recipients are convicted with no sentence passed. However, the orders function in broadly the same way. For both orders if the person fails to comply the court may vary or revoke the order, or impose any sentence competent for the original offence, but should take account of the time spent on the previous order. Both orders are also listed in Section 5D(2) of the

Rehabilitation of Offenders Act 1974, and consequently have the same disclosure periods in respect of the person's criminal record.

The next section characterises each of these orders in more detail.

4. Characterising DTTOs

A Drug Treatment and Testing Order (DTTO) is a disposal given instead of a sentence. DTTOs operate under s234B – 234K of the Criminal Procedure (Scotland) Act 1995 (inserted by s89-95 of the Crime and Disorder Act 1998), and are supported by Scottish Government "DTTO Guidance for Schemes" (2011).[10]

As first conceived, the DTTO drew heavily and consciously on the principles of the US Drug Court model (Collins, 2019) – focussing primarily on drug treatment and rehabilitation, while using the authority of the court to encourage compliance.

Main features of a DTTO

- The key legislative criteria for a DTTO are that it may only be imposed where the court is satisfied that:
    - the person is dependent on or has a propensity to use drugs and
    - their dependency or propensity to misuse drugs requires and may be susceptible to treatment and
    - they are a "suitable person" for the order

- Additionally, there should be a suitable justice social work team in place to supervise the order, and local services that will meet the person's drug treatment needs, which they can access within a short timeframe

- While not a legislative requirement, practice guidance suggests that the person should be "facing the likelihood of custody" due to the seriousness, frequency or pattern of offending

[10] This guidance is now somewhat out of date – having been published before some significant social work practice changes, but remains generally applicable.

- The order is considered intensive and ‘high tariff’ due to its use of resources and the demands it makes on the person’s time. On the order, the person will be expected to:
    - Attend scheduled drug testing, as frequently as specified by the court in the order
    - Regularly submit to random unscheduled drug testing
    - Enter residential drug treatment, if required as part of their treatment plan
    - Regularly attend drug treatment appointments and engage with drug treatment
    - Regularly maintain contact with their supervising justice social worker so they can monitor treatment engagement and progress
    - Attend court for review every month, where the judge will consider their testing results, treatment engagement and progress, and determine whether they may continue on the order

- The order is intended to focus solely on treating substance use, and legislation specifically limits the social worker’s role to only facilitating this. Therefore, the person is not required to engage with, and the officer is neither required nor allowed to expect the person engage with support or interventions for any other criminogenic or wellbeing needs they hav

DTTOs are widely, but not universally, available across Scotland. In order for DTTOs to be available, local authorities need to:

- provide assessments and supervision of orders, through a justice social worker (the “supervising officer” in the legislation’s language). Guidance states this should be a specialist DTTO team, or designated DTTO staff, within a wider justice social work department
- develop arrangements for people on DTTOs to receive multi-disciplinary assessment and rapid access to treatment and testing. There is no prescriptive guidance on how this should be structured or managed, and different areas currently take different approaches

5. Characterising CPOs

Community Payback Orders (CPOs) replaced community service orders, supervised attendance orders and probation orders in 2011. They are a sentence, and operate under s227A-227ZO, and schedule 13 of the Criminal Procedure (Scotland) Act 1995.

A CPO is a general order, not necessarily focussed on addressing a specific need for the person convicted. The legislative eligibility criteria are only that the person is convicted of an offence punishable by imprisonment, and the court is of the opinion that the offence (or combination of offences) is "serious enough to warrant" such an order.

Additionally, there must be a "responsible officer" (in practice, a justice social worker) in place to supervise the order.

Main features of a CPO

- Each CPO is centred on a requirement that the person either attend supervision appointments with a justice social worker, perform unpaid work or another activity, or both. In addition, the court may add other requirements in order to tailor the sentence to the person's needs. The additional requirements may be for the person to:
    - pay compensation
    - attend a specific programme
    - reside at a specific address
    - engage with agreed mental health treatment
    - engage with agreed drug treatment
    - engage with agreed alcohol treatment
    - engage in any particular "conduct" the court specifies in the order
    - restrict their movement (which may or may not be electronically monitored).

- In order to impose a drug treatment requirement as part of a CPO, the legislative criteria are very similar to a DTTO: the person must be "dependent on", or have a "propensity to use", drugs, and be "potentially susceptible to treatment". Additionally, there needs to be local services that will meet the person's drug treatment needs, which they can access within a short timeframe. Drug treatment requirements can only be imposed with supervision.

- Due to their flexibility, the intensity of a CPO can vary widely. They are considered relatively high tariff, in that they are an explicit alternative to a prison sentence. However, for people with substance use problems, when compared to a DTTO, some aspects of the CPO may be seen as less intensive or demanding. Practice guidance suggests that CPOs with a drug treatment requirement should be considered for those whose offending history is not high tariff enough to warrant a DTTO.

- On a supervised CPO, the person will be expected to:
    - Regularly attend supervision appointments with their justice social worker, and engage with the interventions they instruct to address their criminogenic needs
    - Receive unannounced home visits from their justice social worker
    - Only attend court for review if required

- On a supervised CPO with a drug treatment requirement, the person will be additionally expected to:
    - Enter residential drug treatment, if required by their treatment plan
    - Regularly attend drug treatment appointments and engage with drug treatment

CPOs are available in all areas across Scotland, and delivering them is one of the major functions of all justice social work departments.

6. Eligibility, targeting and assessment

Eligibility criteria

At a macro level, CPOs and DTTOs are available for similar populations. Both are for people whose offending is sufficiently severe that they have not been diverted from the justice system earlier, are imposed in situations where the person might otherwise receive a prison sentence, and can provide (and require compliance with), drug treatment for people who use substances problematically.

However, being a more flexible and general-purpose order, a CPO is potentially both available and suitable to a wider range of people. For example:

Offending seriousness: DTTOs and CPOs have similar "maximums" for offending seriousness, being determined by the point at which a court feels it is necessary or appropriate to imprison the person. However, in practice CPOs may, on average, have a lower "minimum" offending severity, giving them a wider range overall. This is because DTTO practice guidance recommends them only for circumstances where the person is "facing the likelihood of custody" because of the seriousness, frequency or pattern of their offending. For a CPO the person needs to have been convicted of an offence punishable by imprisonment, and for the court to consider the offending "serious enough to warrant" a CPO (s227B(2) of the 1995 Act). DTTO IIs were brought in with the intention of encompassing people whose offending is not sufficiently high tariff to warrant a full DTTO, but these are not widely available across Scotland.

Substance use: In relation to imposing drug treatment through either order, both a DTTO and a CPO Drug Treatment Requirement have the same eligibility criteria: that the person has a "dependency on or propensity to use" drugs, and that this behaviour may be susceptible to treatment. However, the practice guidance for each order encourages social workers conducting assessments to consider DTTOs as being suitable for people with more severe or complex drug issues.

Readiness for change: The legislation only requires, for both orders, that the person consents to the order being made. However, practice guidance indicates that CPOs may be more appropriate when "the person is earlier in developing readiness to change". The practice guidance for DTTOs also suggests that motivation to comply with the order may be a factor in considering whether the person meets the additional requirement that they be a "suitable person".

Wider needs: Eligibility is potentially affected by the requirement to be a "suitable person" for a DTTO. There is no legislative definition, but the practice guidance indicates that this includes the person's motivation to comply with the order, and also that schemes may not be suitable for people with co-occurring mental health problems or insecure housing.

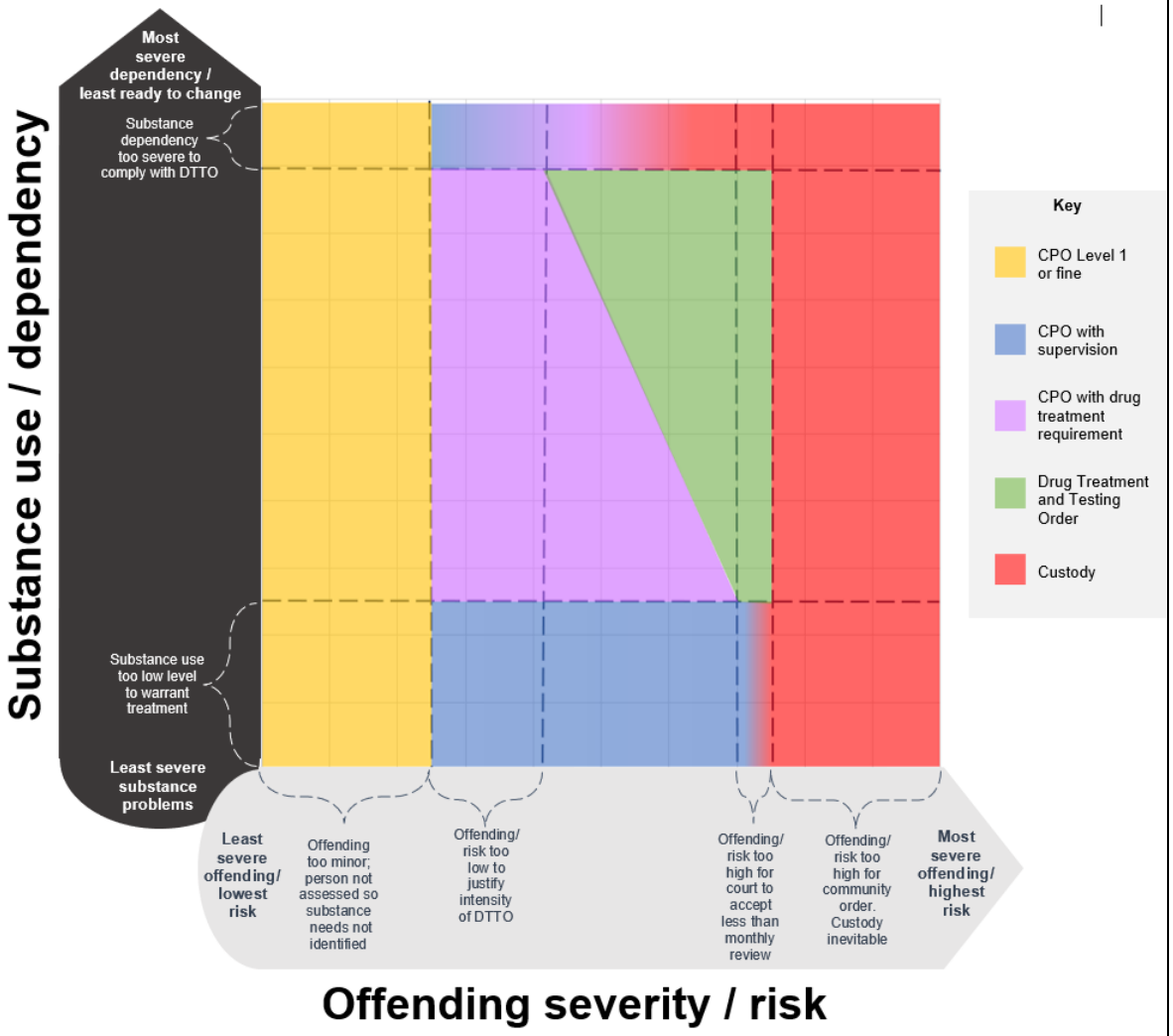
Eligibility for each order in relation to the other

The figure below is highly reductive, but seeks to illustrate, broadly, where the eligibility criteria for the different Orders sit in relation to one another, based on the two main factors governing court and social work decision-making in relation to DTTOs and CPOs:

- offending related considerations such as severity and risk, and
- substance use related considerations such as degree of dependency and motivation to change.

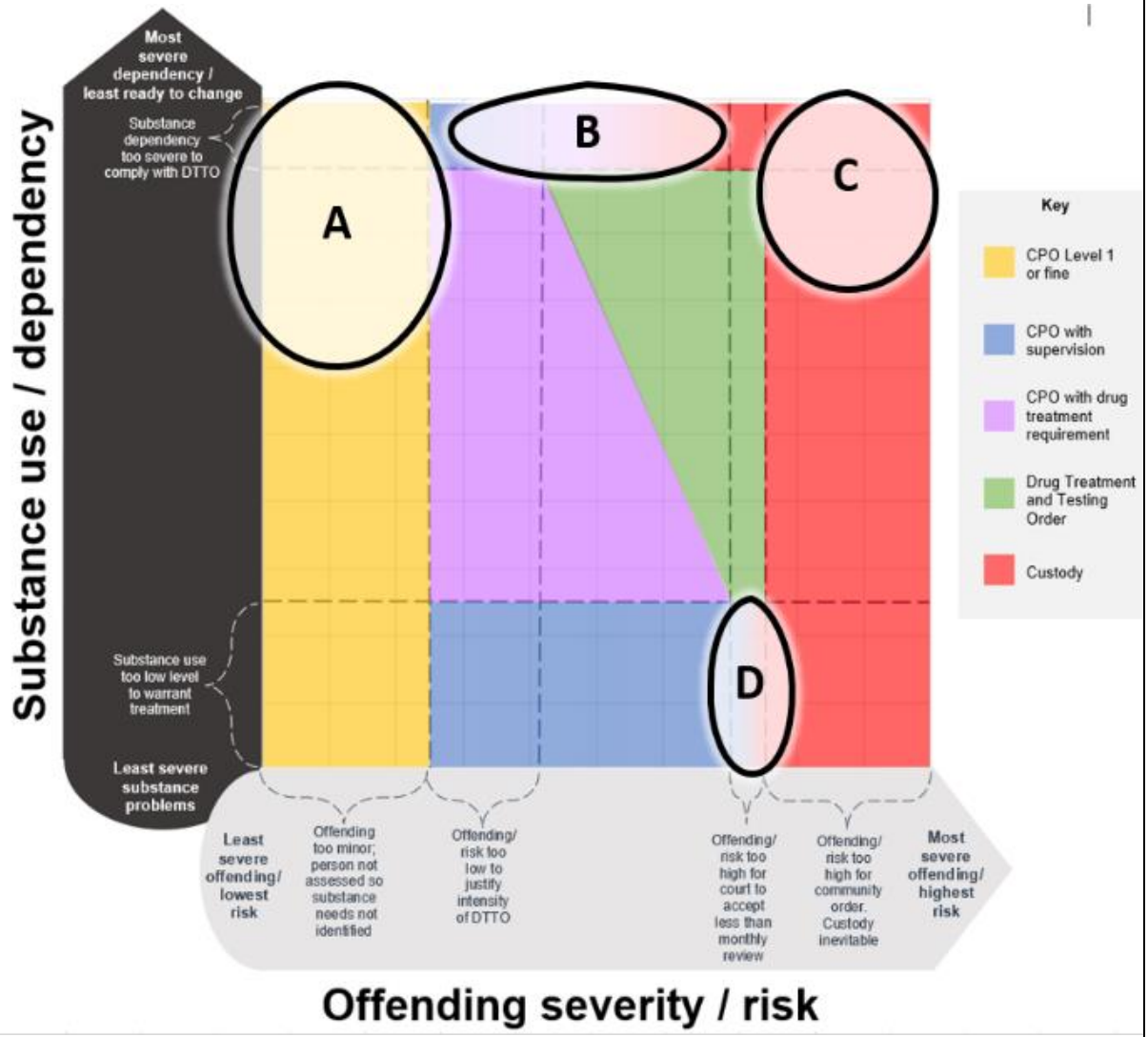
It is based on interpreting the logic and thresholds of the legislation and guidance, **not** on data about the number of orders or distribution of the population. It is presented here only to show how the orders' criteria relate to one another in who they are intended for, and does not reflect the actual size of the relevant populations. Additionally, the boundaries presented are based only on the judgments that are made in the process of applying the legislation and guidance. In reality, these are not strict lines, but threshold ranges that would vary based on the other factors not presented in this chart.

Figure 1: Approximate relationship between substance use and offending severity as criteria for community orders



While this diagram does not show the number of people in each population, it does help to highlight some particular types of situation that may either not be well served, or pose difficulties in tailoring an appropriate response. In particular, the areas of the chart circled on the smaller illustration below:

Figure 2: Approximate relationship between substance use and offending severity as criteria for community orders, with groups A to D shown



A. These people have relatively high substance related problems or severe dependency, but whose offending is too low level to trigger a social work assessment

Their needs are therefore not identified or made known to the court. While a treatment-based order would not be appropriate to most people in this category because it would reflect up-tariffing, by not assessing them the opportunity is missed for social workers to support them into voluntary treatment or refer them to harm reduction interventions if they are open to this. The Care Inspectorate (2021) found, across the 5 local areas they inspected, that approaches to

identifying risk and need for this group varied, and that areas where a local process was established were more consistent in identifying, escalating and recording concerns and responses to this group's risks and needs.

B. These people have very high substance dependency or complete unreadiness for change, and may struggle to comply with a treatment order

In these cases, there is no obvious alternative sentence, and the social worker and court will both need to consider carefully the best way to address the person's needs. This could result in a wide range of different outcomes including:

- **SDS** (Structured Deferred Sentence)**:** If available in the area, a structured deferred sentence would provide an opportunity to develop the person's readiness to change and gather more information on which to base the judgment about their ability to comply.
- **CPO:** If the court is willing to accept a CPO with treatment as adequately intensive for the offending, and the person may be better able to comply with this than with the testing and monthly monitoring of a DTTO, a CPO with treatment requirement might be given.
- If the court is willing to accept a CPO with requirements addressing other criminogenic needs as adequately intensive for the offending, a CPO with other requirements may be given.
- The CPO can also be tailored to the specific case, for example by scheduling reviews. However, as this group is defined by their difficulty complying and engaging, the more oversight the court gives itself the more likely it may be that the person ultimately cannot complete the order.
- **Custody:** If the court does not feel that there is a community based option that is both sufficiently intense to be proportionate to the offending, and possible for the person to comply with, a custodial sentence is likely.

C. These people have high substance dependency and severe offending behaviour

This group are unlikely to be suitable for community based orders, but also unlikely to benefit from, or make progress during, a prison sentence. Additionally, a prison sentence reduces the treatment

options available, and may increase their chances of a drug related death on release, and/or of further offending. Other models of secure treatment may be more appropriate to this population, although availability of these in Scotland is limited.

D. These people have relatively low level substance related problems, but high level offending

For this group, their substance use may not warrant the intensity of a treatment order, but the court may not be comfortable to leave them in the community without frequent monitoring. The most likely outcomes for this group are either:

- **Custody**: If the court considers the severity of offending to be the main consideration in the case, or the person's reoffending risk too high, custody may be inevitable.
- **CPO**: With requirements to address other criminogenic needs, and tailored with extra review hearings. This order may provide social work an opportunity to support the person to engage voluntarily with drug treatment or harm reduction.

Assessment and sentencing procedure

The specific procedures and assessments used will vary depending on local court practice, local authority social work arrangements and local health board and ADP arrangements. However, generally speaking, the following describes a simplified, typical process for someone with a substance use problem facing sentencing.

Step 1 – Assessment

All people convicted of a crime will have a date set for their sentencing. The process for arriving at either a DTTO or a CPO with a treatment requirement begins the same way – with the court requesting a justice social work report before sentencing.

Sentencers do not have to request a report in all cases (further information is available in the Scottish Government's 'Justice social work reports and court-based justice social work services' practice guidance).

A report is, however, usually requested where a community sentence is being considered.

The court cannot impose a CPO unless it has obtained, and taken account of, a justice social work report (an exception to this is a CPO with a Level 1 unpaid work requirement only).

How are people assessed?

The Justice Social Work Report is an important source of information that the court will consider when sentencing the person, but not the only source. It is intended to complement a range of other considerations, including victim information or impact statements, and narratives from the Procurator Fiscal. Justice Social Work Reports appear to be generally high quality sources of information – the Care Inspectorate (2021) rated most they reviewed (across 5 local areas) as good or better, and very few as weak, and noted that Sheriffs viewed them as helpful to their decision-making regarding community disposals. However, stretched workloads and time pressure do appear to reduce the quality of these reports, with the Inspectorate noting that "a higher proportion of assessments we rated as very good or excellent had been completed in accordance with the 20-day threshold than those we rated adequate or weak, where almost half were outwith the 20-day timescale".

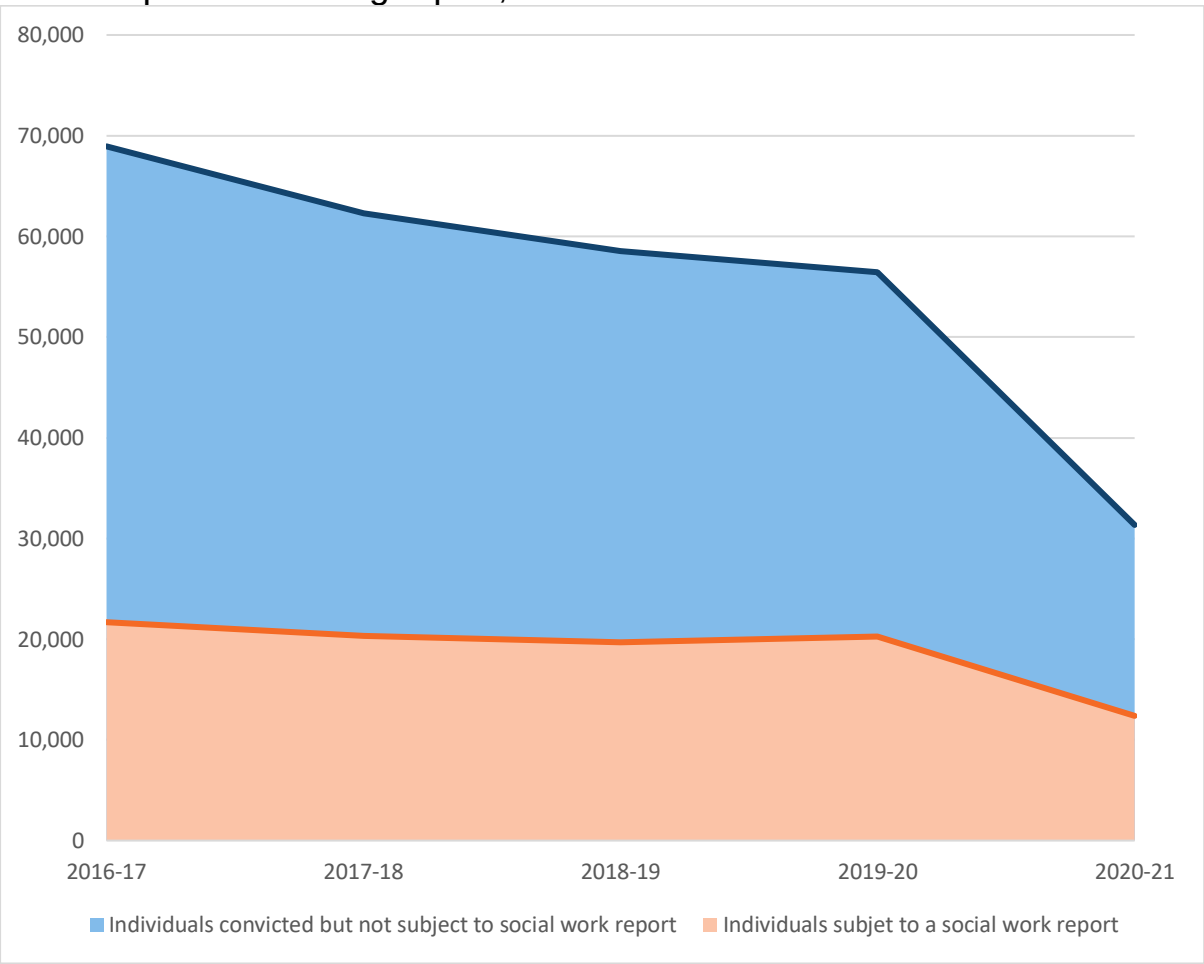
Who gets a Justice Social Work Report?

It is important to note, in relation to understanding people's drug use, that no data are available for people who are not assessed.

Criminal Proceedings statistics show that 31,344 individual people were convicted in 2020/21, while Justice Social Work statistics show just 12,383 individual people were subject to Justice Social Work reports in the same year. This leaves 18,961 people who were sentenced without a social work report (or, potentially, relying on an older social work report), and about whom no data is available in relation to their drug use. Moreover, 2020/21 is an anomalous year in the data as the LS/CMI IT system was offline from March 2022 to August 2023, and assessments were done offline during that time period. It should be noted that in preceding years the gap between people convicted and people receiving social work reports is even larger.

In Figure 3 below, the blue line shows all people convicted, with the orange shaded area reflecting the proportion receiving a pre-sentencing social work assessment. It shows that between 2016/17 and 2019/20, around one third of people convicted have typically received a social work report before sentencing.

Figure 3: Number of people convicted, and assessed by justice social work for pre-sentencing report, 2016-2021



How is the Justice Social Work Report compiled?

If a report is requested, a Justice Social Worker will interview the person and review documented sources of information such as their file and Offender History Form. Guidance on conducting these interviews and writing justice social work reports (2023) suggests that where relevant 'the context of trauma in their life – including the presence and impact of mental health issues, substance misuse and any current treatment plan'.

During the interview, if the person discloses that they have a problem with any kind of substance use, the social worker will then seek more

details about their usage, their perception of its relationship to their offending, and their interest in treatment or making change. These details will then be summarised in the report to the court, and will inform the social worker's recommended sentence.

- If the person does not disclose their drug use, the social worker will not be able to make the court aware of it. They cannot receive a sentence with specialised drug treatment.
- If the person does disclose that they use drugs (and/or have mental health difficulties), the social worker may request additional time from the court to do a full drug needs (and/or mental health needs) assessment.
    - If the court agrees to this, the additional assessments take place and detailed information from them can be taken into account at sentencing, enabling the court to impose a sentence with specialised drug treatment, if they wish
    - If the court does not agree, the additional assessments do not take place, and at sentencing the court will be informed in the Justice Social Work Report of the person's disclosures, but no more detailed information will be available for the court to take into account. Without a detailed assessment, they cannot receive a sentence with specialised drug treatment

The Practice Guidance for delivering DTTOs states that for the purposes of identifying people who may be suitable for a DTTO via the social work report process, the service should develop its own clear criteria for the target group, and ensure social workers have access to both consultation and line management input to assist assessment and decision-making.

Data on those who may have a drug problem

Background on data presented

The assessment and reporting structure uses an abbreviated form of the LSIR (Level of Service Inventory - Revised). LSIR is a validated and widely used assessment tool for understanding a person's context, offending and criminogenic needs (Raynor, 2007).

Data on the items in this tool are recorded in the LS/CMI database held by the Risk Management Authority. However, quantitative data relating specifically to drug use at this assessment stage is very limited. The social worker's report should draw the court's attention to

any specific concerns in relation to drug or alcohol use, but this is generally recorded as part of a narrative about the person's circumstances and offending.

The only quantitative variables recorded in the LSCMI database for this stage of assessment are:

- Whether the person has any drug crimes in their offending history (i.e., convictions for offences such as dealing or possession)
- A variable called "alcohol or drug problem: school/work", which is selected if the person has disclosed that their relationship with alcohol or drugs is having a negative impact on their ability to maintain a healthy or functional relationship with their work or education.

These two variables are not ideal proxy measures for identifying people with drug dependency in the data set. This is because:

- The first variable relates to detected, proven offending history, not the person's relationship with substances.
    - People may be charged with drug crimes regardless of whether they have a dependency or problematic relationship with drugs, while many people with drug problems may never be charged with drug crimes. This means this variable may capture some people whose relationship with drugs may not be problematic, while missing others. Consequently, it could be **higher or lower** than the "true" rate.
    - Moreover, past offending may relate to a period of dependency that the person has now recovered from. This means this variable may capture some people who should no longer be classed as having a problem with drug dependency. Consequently, it could be **higher** than the "true" rate.

- The second variable conflates alcohol and drug-related problems.
    - This means the number it captures will be **higher** than the number of people whose problems specifically relate to drugs, or to codependency on both drugs and alcohol.

- The second variable also limits substance-related problems to the person's relationship with work or education. While this item has been validated as a criminogenic factor for assessing risk of reoffending, it may exclude people whose substance use primarily impacts other

domains such as their relationships or physical health. Consequently, it could be **lower** than the “true” rate.

Notwithstanding these limitations, as the best measures available, these variables are presented here to give some idea of the order of magnitude of people who may have a drug problem identified at this stage.

Numbers of those who may have drug problem

Between 2017 and 2021, 7,163 people met one or both of the criteria outlined above, and therefore may have a drug problem, this averages 1,433 per year.

For this group any information about their relationship with drugs that the social worker gathers in their initial interview is likely to be provided to the court in a narrative form as part of their social work report. This means that the court can take this information into account in their sentencing decision. However, no more detailed data is recorded in a format suitable for analysis at this stage. For the majority of this group, more detailed data about their drug-related problems is not available: 4,660 (65%) do not go on to receive a more detailed social work assessment. Typically, this will be because they receive a low-tariff disposal such as a fine or Level 1 CPO, which does not require supervision.

Outcomes for those who may have a drug problem

Compared to the remainder of the population receiving initial assessments, between 2017 and 2021 people potentially likely to have drug related problems are:

- More likely to be identified as requiring supervision or intervention (83%, compared to 67% for those with no indication of a drug problem), but only slightly less likely to be identified as feasible for community disposal (94%, compared to 96% of those with no indication of a drug problem)
- Slightly more likely to be identified as being on a trajectory of worsening offending (47%, compared to 43% for those with no indication of a drug problem)
- Somewhat more likely to be identified as meriting fuller assessment (7%, compared to 5% for those with no indication of a drug problem)

Additionally, LS/CMI data suggest that people with drug related problems are more than twice as likely to be assessed as having motivation as a barrier – this is marked as a potential responsivity issue for 48% of people with drug related problems, compared to 23% without drug related problems. This pattern also holds for denial/minimisation, although the discrepancy is not as great – 55% of people with drug related problems have this recorded as a potential responsivity issue, compared to 46% of those without. Women with drug related problems are also more likely to have gender-specific responsivity issues noted than women without drug related problems (7% compared to 4%).

Step 2 – Additional Assessments

If the court agrees to delay sentencing for additional assessment[11], they can request either:

- A specialist medical report. This will enable the court to impose a Community Payback Order with a drug treatment requirement if they wish at sentencing
- A full multi-disciplinary assessment. This will enable the court to impose a Community Payback Order with a drug treatment requirement or a Drug Treatment and Testing Order if they wish at sentencing. However, such an assessment is not a requirement
- An assessment for a Structured Deferred Sentence (if available in the area)

The Practice Guidance for DTTO schemes recommends that to improve reliability, these assessments should be carried out in the community if at all possible, although decisions on bail and remand are matters for the court.

Step 3 – Justice Social Work recommendation

Once the assessment is complete the social worker will determine with health colleagues whether or not there are suitable services in the local area to meet the person's needs.

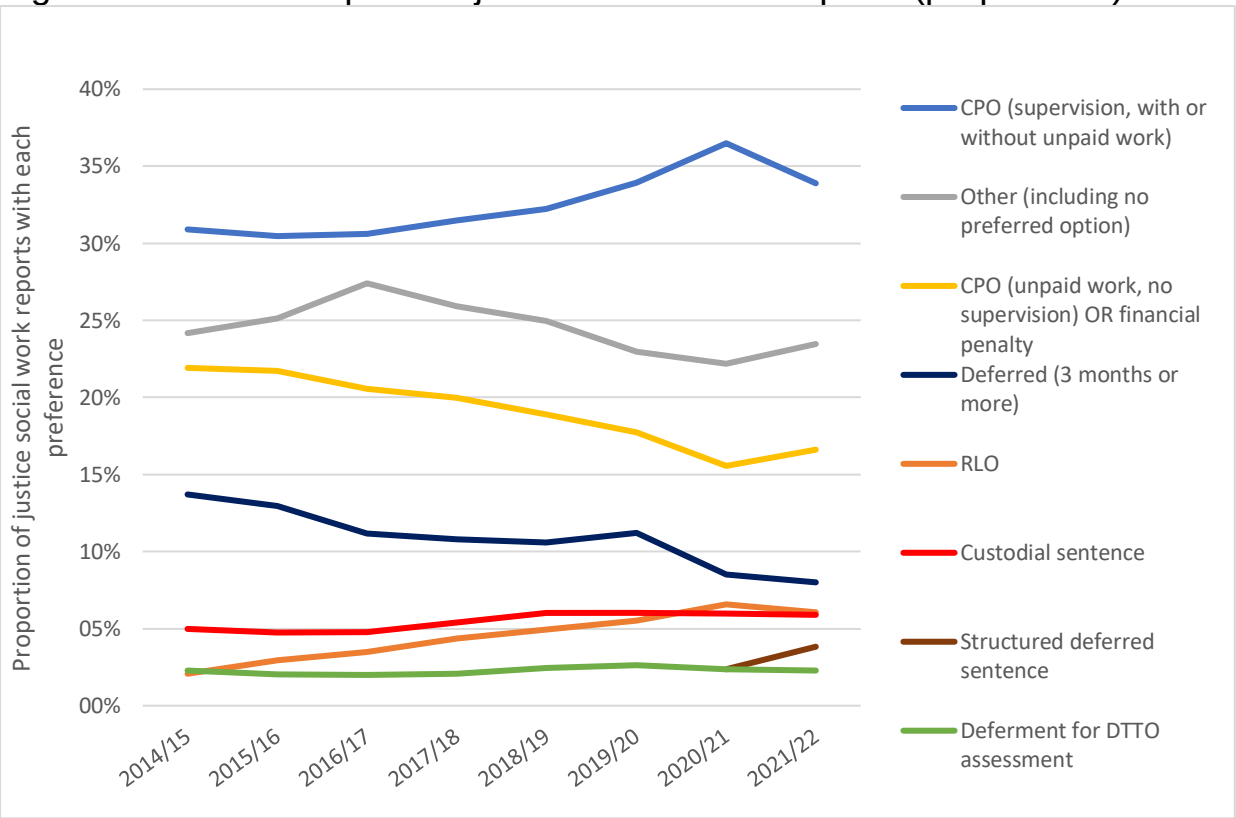
- If the person's needs are not severe enough to warrant treatment, the social worker will recommend the sentence that they feel would best address the person's other criminogenic needs and risks.

[11] See page 5 of the 'Justice social work reports and court-based justice social work services' practice guidance for more information.

- If there are no suitable treatment services for the person, the social worker will provide all reports and information to the court, and recommend what they view as the most appropriate alternative sentence to the court.
- If there are suitable treatment services for the person, the social worker will develop a treatment plan or plans with health colleagues, and all the relevant documentation is shared with the court.
    i. If only a specialist medical report was requested, the recommended treatment plan will be general, and suitable for a CPO with a drug treatment requirement.
    ii. If a multi-disciplinary assessment was requested, the social worker may recommend a treatment plan suitable for either a CPO or DTTO depending on their professional assessment of what would best serve the person's needs. If recommending a DTTO they must also present a more detailed and complete treatment plan, and an alternative option that can be implemented as a CPO if the court is not minded to support the DTTO.

As noted above, data is not available on the specific population of people who have substance use problems in the justice system. However, the chart below summarises the data on options recommended to the courts following all social work reports:

Figure 4: Preferred option in justice social work reports (proportions)



Step 4 – Sentencing hearing

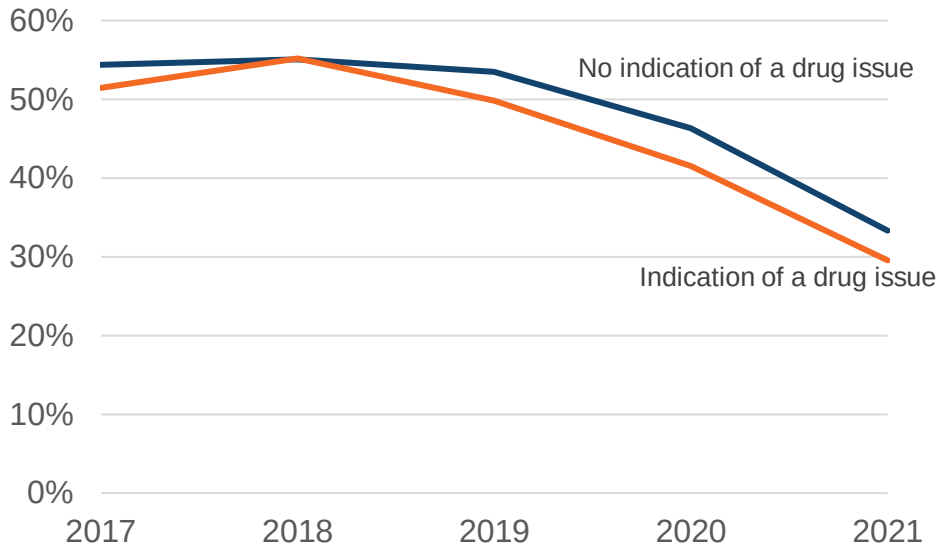
At the sentencing hearing, the court will apply the purposes of sentencing (see Scottish Sentencing Council's 'Principles and purposes of sentencing' guidelines) and proceed through the required steps to arrive at a decision. The steps involve:

- Assessing the seriousness of the offence, based on the person's culpability and the degree of harm caused
- Considering any aggravating and mitigating factors. Committing the offence under the influence of substances voluntarily consumed is a possible aggravating factor, while mental illness is a possible mitigating factor, as is demonstrating willingness to address drug problems.
- Considering the principles and purposes of sentencing, and how the different purposes should be weighted
- Considering which sentence option will best serve the chosen purpose(s) while being fair and proportionate in light of all the facts and circumstances of the offence[12]

[12] Please refer to Scottish Sentencing Council guidelines for a comprehensive outlines of steps required to arrive at a decision: The sentencing process | Scottish Sentencing Council

Compared to the remainder of the population receiving initial assessments, between 2017 and 2021 people potentially likely to have drug related problems are slightly less likely to receive the disposal that social work recommend to the court (47%, compared to 50% for those with no indication of a drug problem). It is also notable that the disposals recommended by social work, and those imposed by the courts, appear to have diverged over time. The chart below shows the proportion of people receiving the recommended disposal for both people with and without indications of potential drug related problems:

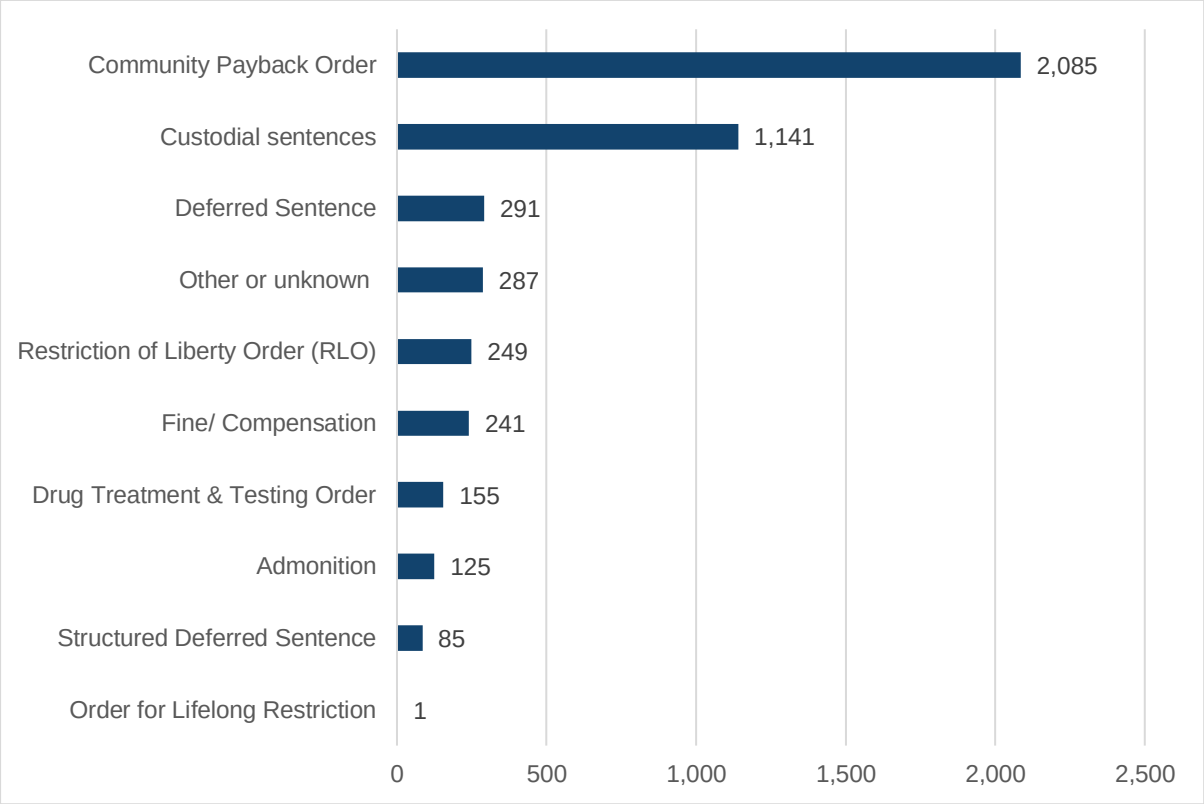
Figure 5: Percentage of cases receiving the disposal recommended by social work following pre-sentence assessment



Disposals for those who may have a drug problem

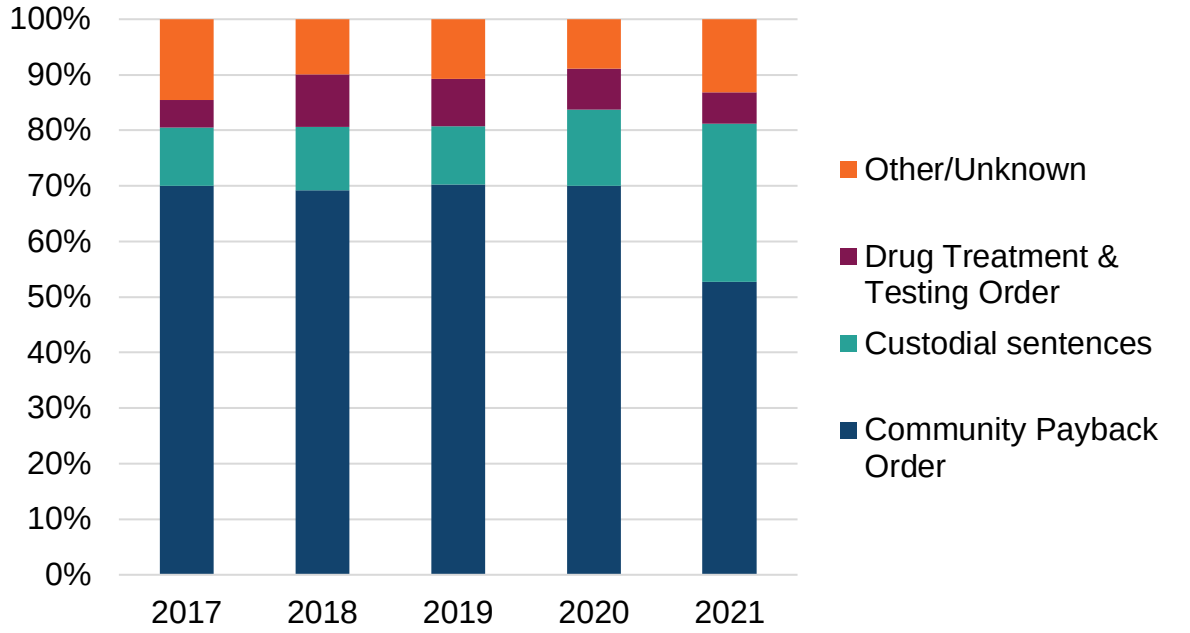
For this group (whose initial assessment shows they may potentially be likely to have drug related problems, but who do not have a more detailed social work assessment recorded), the most common disposal is a CPO, followed by custody. It is notable that a proportion of DTTOs also fall into this category each year, and the reasons that someone may be recorded as receiving a DTTO but not have a more detailed assessment recorded in the LS/CMI database may warrant further exploration with stakeholders. The full distribution of disposals for this group is shown in Figure 6 below.

Figure 6: Disposals given to people who may potentially be likely to have drug related problems, but who do not receive a more detailed assessment following sentencing (2017-2021)



Between 2017 and 2021, the most common outcome for people who may have a drug problem has been Community Payback Order (68%), followed by custody (13%) then Drug Treatment & Testing Order (8%). However, as Figure 7 below shows, there has been a shift away from CPOs in favour of custody for this group in 2021. The reasons for this cannot be easily inferred, but could possibly be related to prioritisation of the most serious cases during the Covid-19 pandemic.

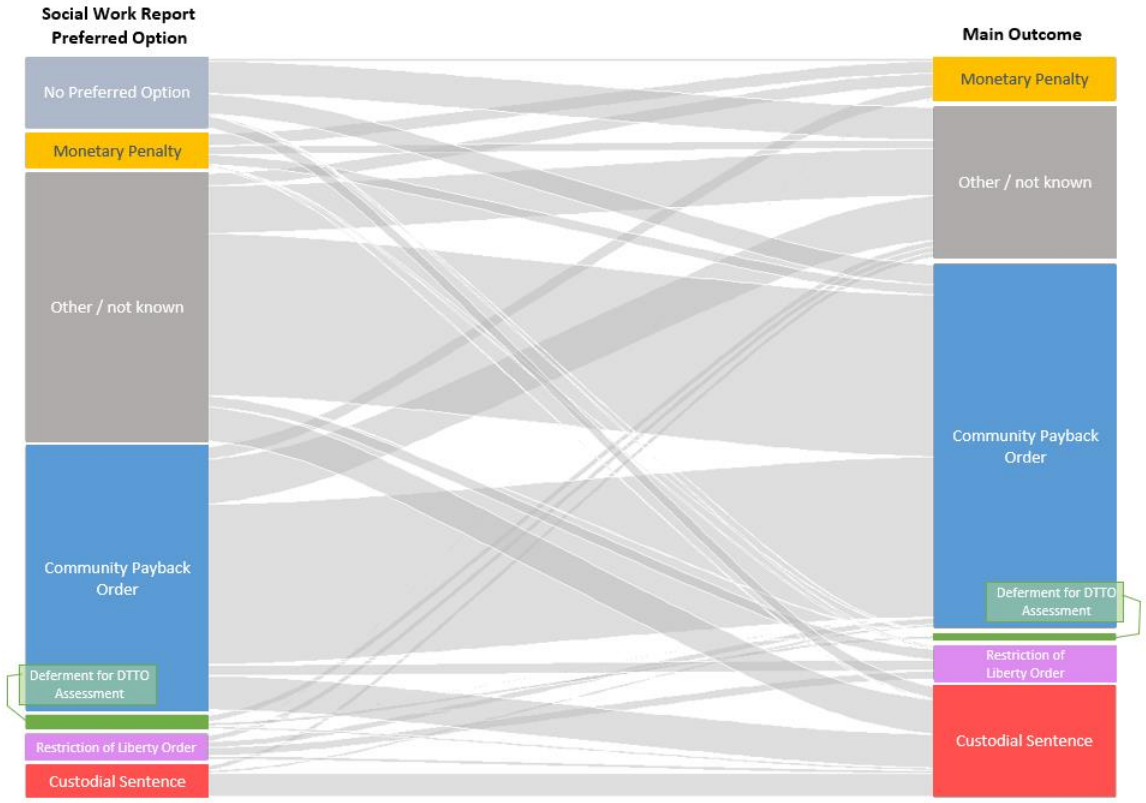
Figure 7: Disposals for potential drug related cases, 2017 to 2021



Preferred option vs main outcome

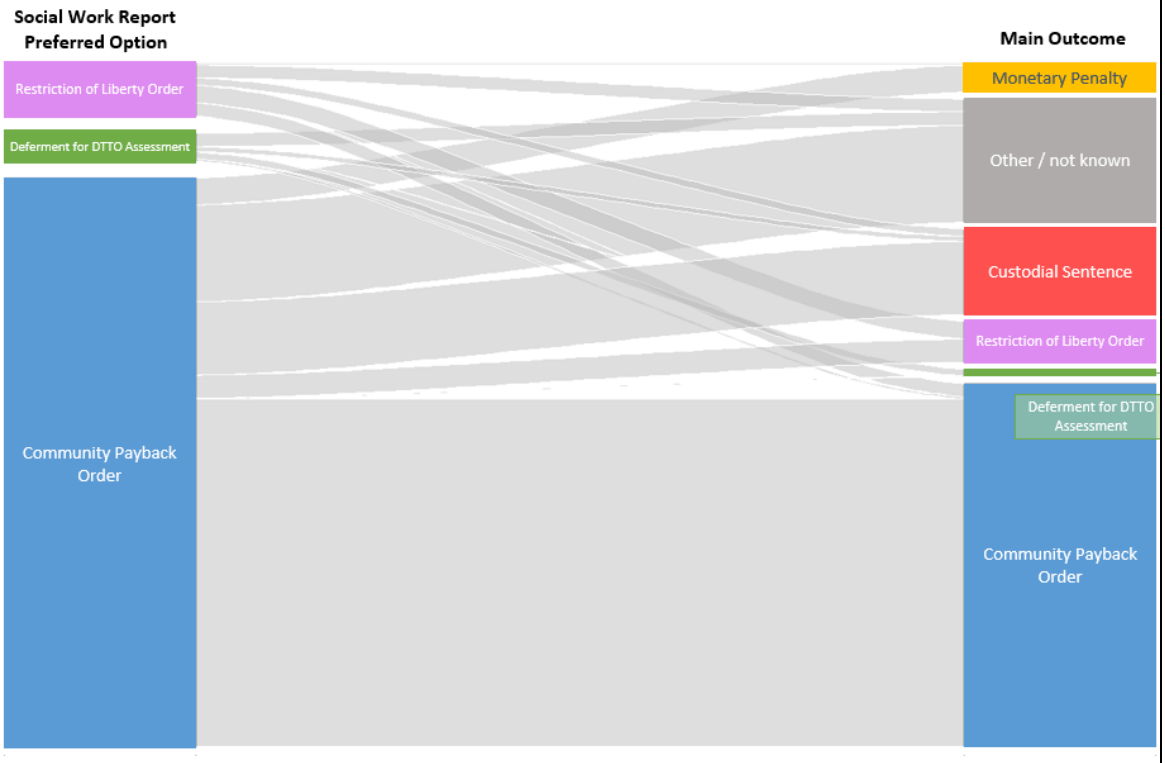
The data on social work reports' "preferred option" and the "main outcome" imposed by the court are imperfect measures for understanding the relationship between recommendations and judicial decision-making, but are all that is available to this review at this time. The chart below is based on all cases, not just those where the person may potentially have drug related problems and while challenging to interpret, shows the complexity of the pattern in the overall data as well as the significant number of cases in the "other" and "unknown" categories. To note, for both main outcome and preferred option, the 'other' category includes deferred sentences, structured deferred sentences as well as actual 'others'. In addition, for main outcome, admonition, warrant for apprehension/recall and absolute charge are also included. The chart also shows that where the outcome differs from the (known) recommendation, the biggest flow is made up of people whose social work report recommends a CPO, but who receive a custodial sentence instead.

Figure 8: Social Work Report Preferred Option and Main Outcome 2014-22



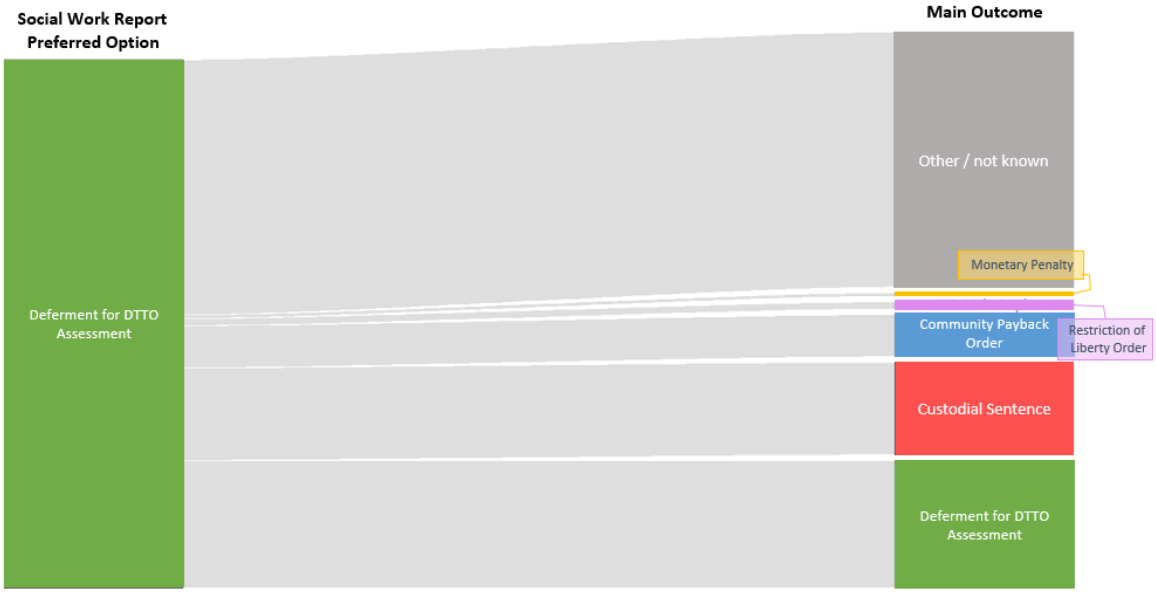
If we limit the analysis to just those cases where the social work report's preferred option is known, and they have recommended an option that involves some form of supervision within the community, we see that where the preceding recommendation is known, almost all CPOs follow a recommendation for a CPO. Where the court decides not to follow the recommendation for a CPO, this is usually in favour of a higher tariff sentence – where the outcome is known, a significant proportion of cases ultimately resulted in custody or, less commonly, a Restriction of Liberty Order, while a much smaller proportion of CPO recommendations result in a monetary penalty:

Figure 9: Social Work report preferred option where option involves some form of supervision within the community, and main outcome



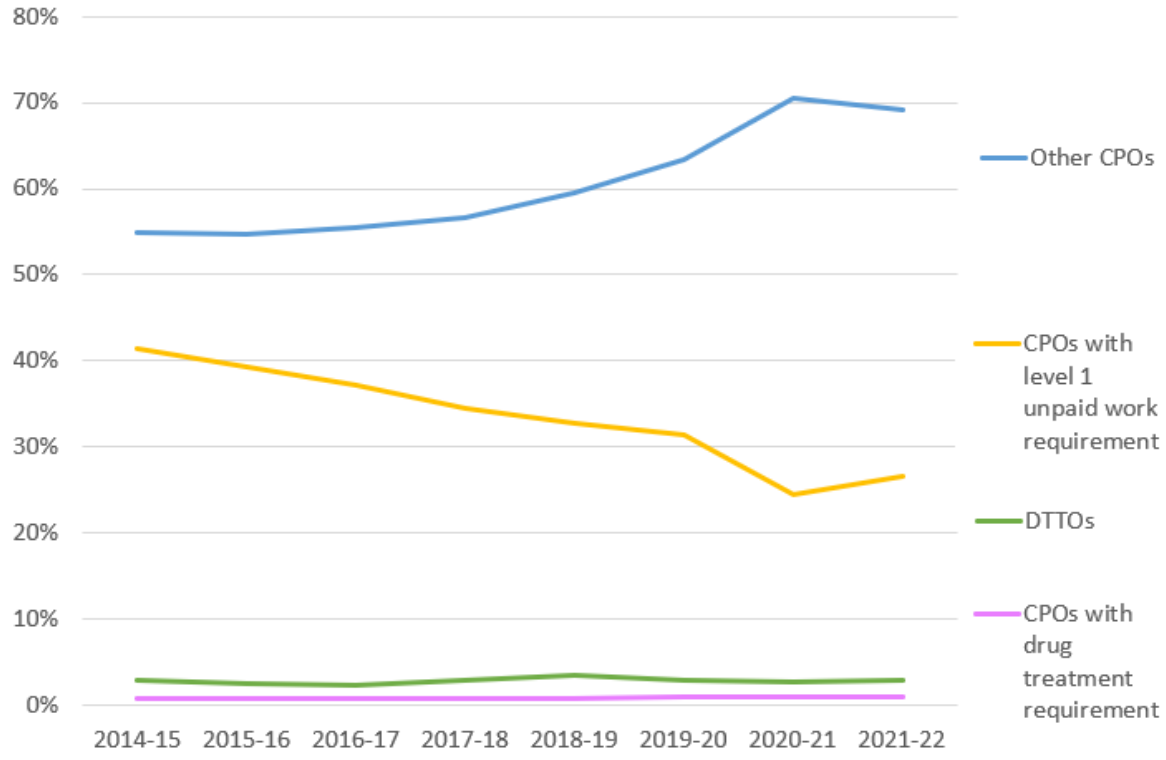
Zooming in even closer, to look specifically at those for whom a DTTO assessment is recommended, we see that there is a particularly high rate of “other” or “unknown” outcomes for cases with this recommendation. Where the outcome is available, less than half of social work reports recommending deferment for DTTO assessment have this as their outcome, and one third result in a custodial sentence.

Figure 10: Social Work report preferred option and main outcome for those for whom a DTTO assessment is recommended



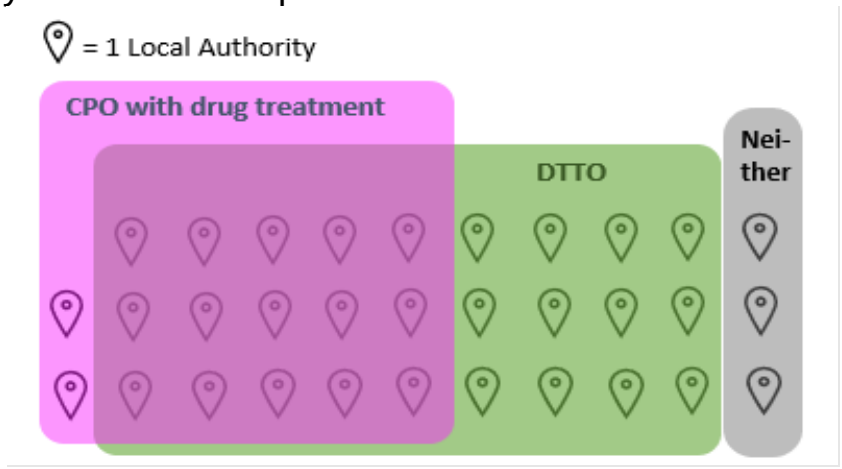
Due to limitations in the data, we cannot look specifically at the outcomes of assessments for CPO drug treatment requirements, or which recommendations tend to lead to them being imposed. However, we can place the number of drug treatment requirements in the context of the total number of CPOs imposed – which shows that only a very small proportion of all CPOs have a treatment requirement, and their rate is consistently lower than that of DTTOs. Overall, CPO alcohol requirements constitute just over one percent of all CPOs issued in 2021-22, and drug treatment requirements just under one per cent.

Figure 11: Proportion of social work orders 2014-15 to 2021-22



Looking across the regions, it is also clear that there is some variability in the rates with which different types of order are made, although it is impossible to tell from the data how much this is caused by local variation in offending and substance use patterns, and how much may be attributable to differences in local service provision, professional practice or sentencing preferences. In 2021/22,17 (out of 32) local authorities delivered at least 1 CPO with a treatment requirement, with 110 imposed in total. By contrast, 27 local authorities delivered at least one DTTO, with a total of 361 imposed.

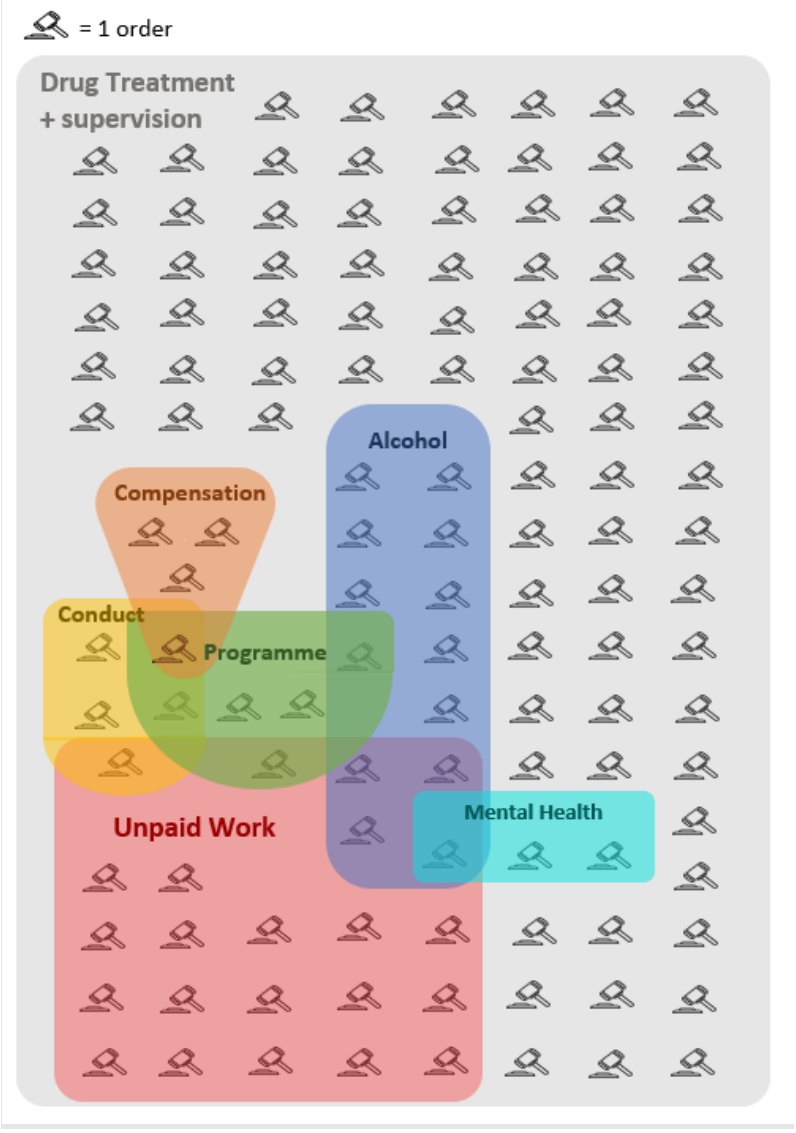
Figure 12: Number of local areas where drug treatment based community orders were imposed 2021-22



All Community Payback Orders must have either unpaid work or supervision. Apart from a small reversal due to the effects of the pandemic, recent years have seen a general trend towards increasing use of supervision and reducing use of unpaid work. Apart from these core requirements, the most common additional requirements for all CPOs are Conduct or Programme.

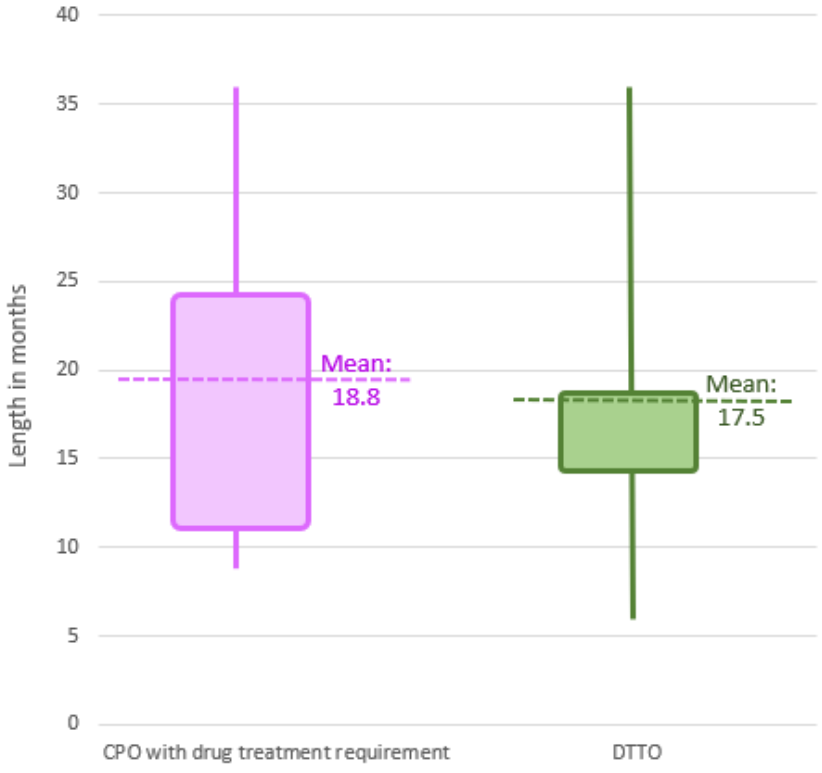
In 2021/22, 125 CPOs contained a drug treatment requirement. All those who receive a drug treatment requirement will also have supervision. Over half of all 125 drug treatment requirements in 2021/22 were made without any additional requirements being imposed. A further 34 had one additional requirement, most commonly unpaid work, followed by alcohol treatment. The distribution of all requirements added to CPOs with a drug treatment requirement is shown in the figure below.

Figure 13: All requirement combinations on CPOs that included a Drug Treatment Requirement in 2021/22



In terms of order length, both CPOs with treatment requirements and DTTOs tend to be imposed for similar lengths of time – the average is 18.8 months for CPOs with drug treatment requirements, and 17.5 months for DTTOs. DTTOs show a slightly wider range in lengths, but also a notably greater tendency to cluster near the mean, while CPOs are more distributed across their range of lengths.

Figure 14: Length of drug treatment based orders imposed in 2021-22



Step 5 – Structured Deferred Sentences

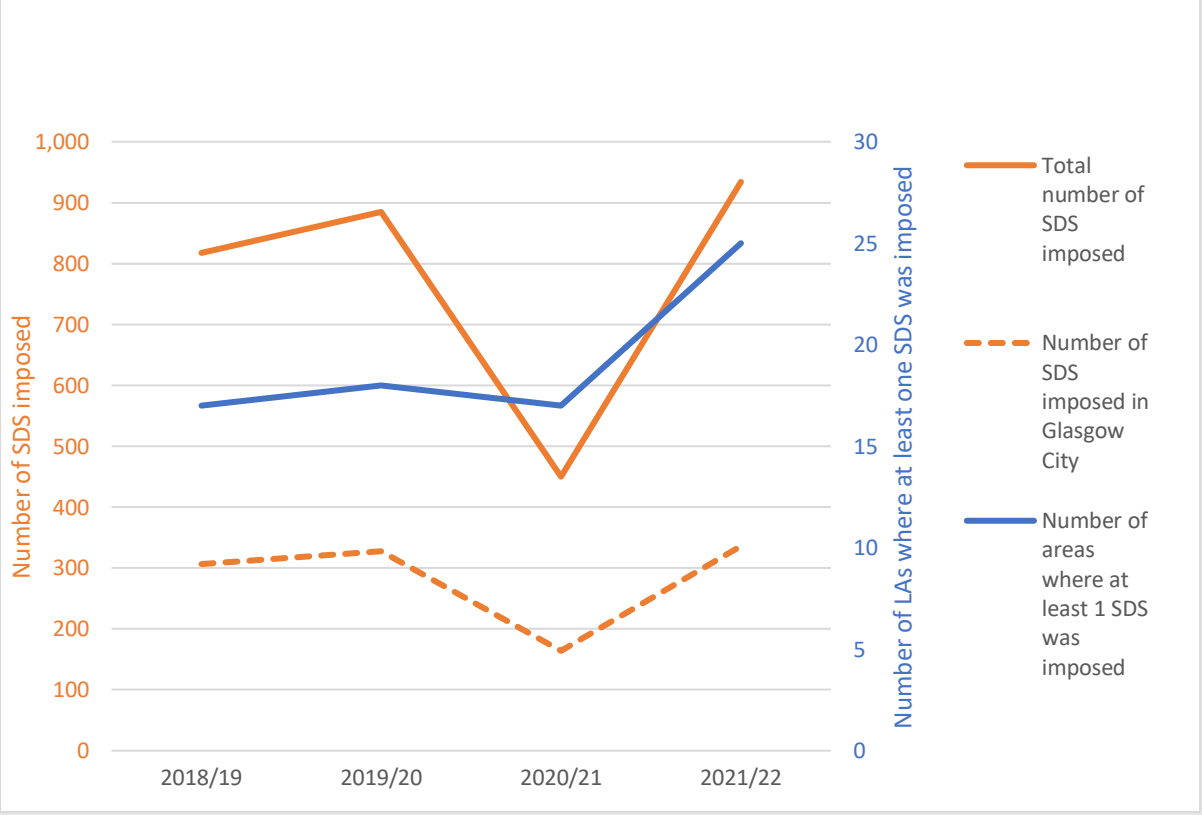
If the court is unsure whether the person is likely to comply with a community based order, or with treatment specifically, in some areas it is possible to defer the sentencing decision in order to allow the person to engage with a Structured Deferred Sentence (SDS). This means that instead of giving a sentence, the court orders the person to engage with justice social work support for a specific period of time before returning to court for sentencing. During that time, their ability to comply and engage will be assessed. When the person returns to court, the same options are available to the court as at the time of conviction, but they have additional information on which to base their decision.

- In some specific schemes like the Aberdeen Problem Solving Approach, the SDS can be used to support people into treatment and then, if the court is satisfied with their progress, avoid the harms of high tariff criminalisation by admonishing the person instead of imposing a more intensive disposal.

- In other areas, SDS might be used to support the person into treatment and assess their ability to engage and comply. If the court is satisfied with their progress, this may make them willing to impose a treatment based community order instead of a prison sentence, or a less stringent community order than they would otherwise have given.

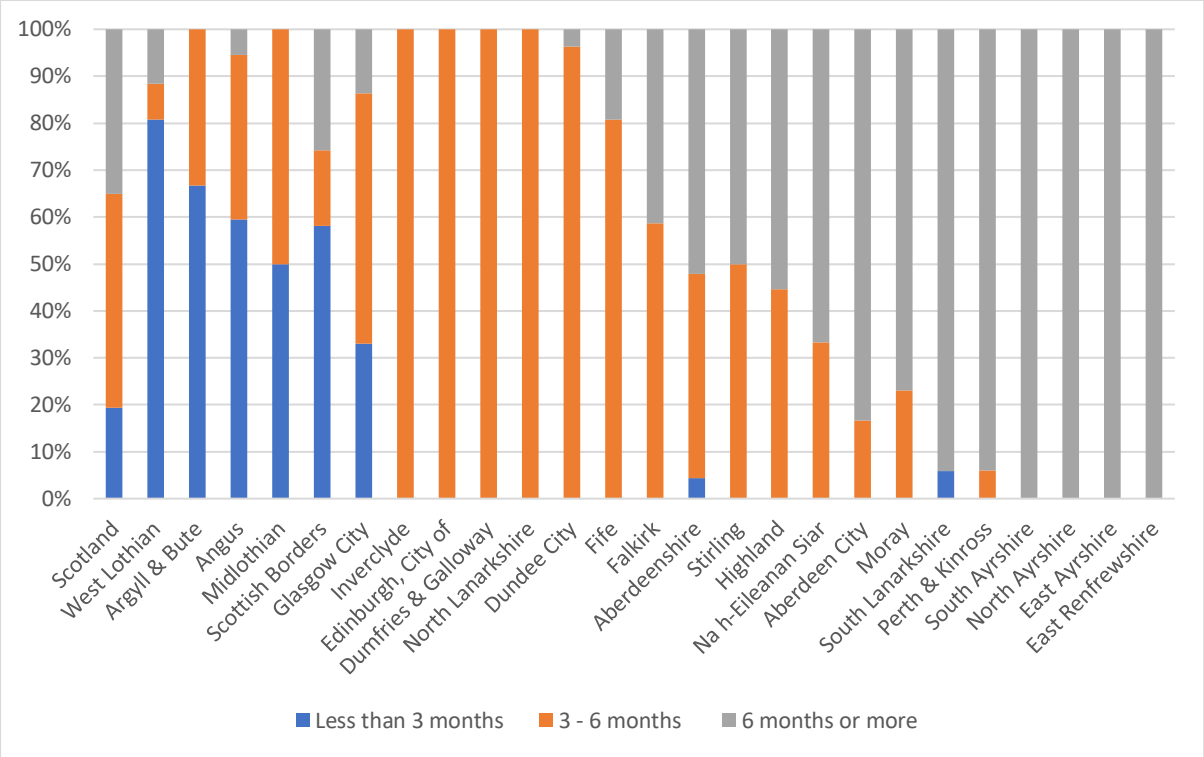
In 2021/22, the highest number of SDSs to date was recorded, with 934 SDSs imposed, and 882 individual people receiving at least one SDS. 2021/22 also saw the highest number of areas offering SDSs, with 25 areas providing at least one SDS in 2021/22, compared to 17 in the first year of data. Glasgow City consistently provides the highest number of SDSs, and accounts for over one third of all SDSs in all years.

Figure 15: Number of Structured Deferred Sentences imposed, and number of LAs where SDS were provided, since 2018/19



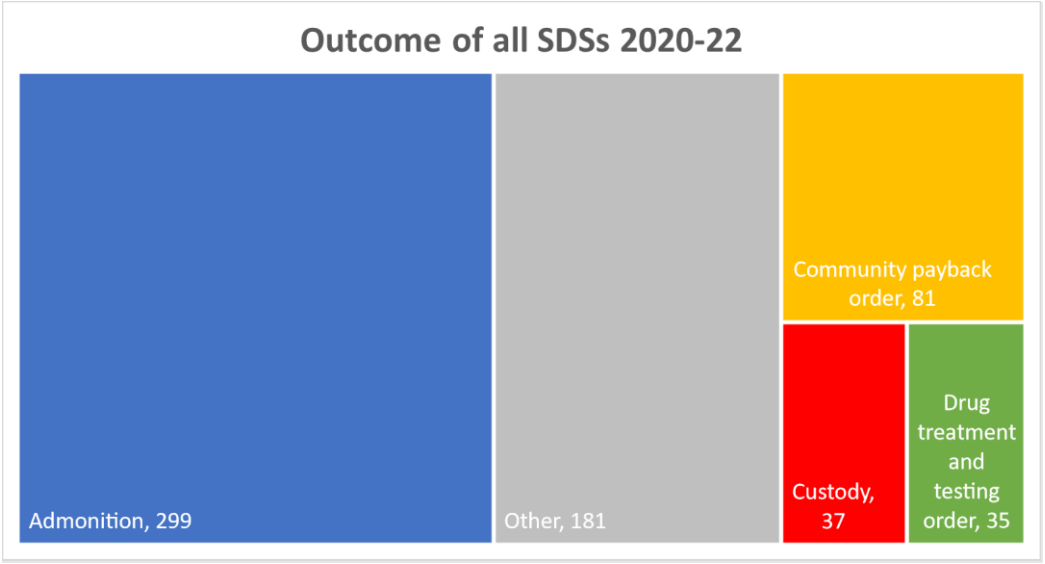
In 2021/22, just under half of all SDSs were for between 3 and 6 months. Both the typical length, and the variability of length, varies significantly between areas.

Figure 16: Length of Structured Deferred Sentences across Local Authority areas where available



Following a Structured Deferred Sentence, when the person returns to court for sentencing, the most common outcome in 2020/21 and 2021/22 was for the person to be admonished – this happened in around 50% of all SDSs. Again, the main outcome, and variability in outcomes, vary significantly across areas – which is to be expected, since SDS schemes may operate in different ways, and with different purposes, depending on local need and resource.

Figure 17: Outcome of all Structured Deferred Sentences 2020-22



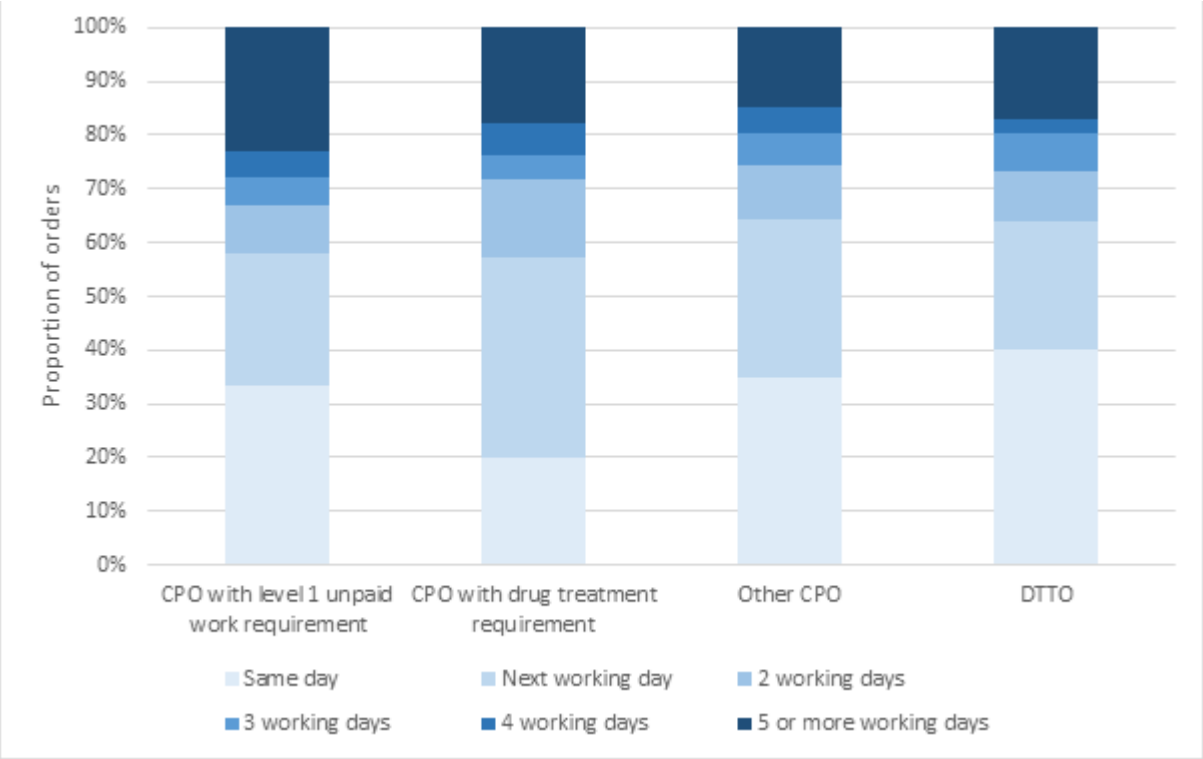
Step 6 – Delivery of the order

Once the order has been imposed:

- If the court imposes a Drug Treatment and Testing Order, the person will begin working with their justice social worker and treatment provider(s) in line with the treatment plan presented to the court.
- If the court imposes a Community Payback Order with a drug treatment requirement, the person will continue working with their social worker on their full needs assessment and treatment plan, then once this is complete they will begin working with treatment providers (or their social worker if appropriately trained), in line with the agreed plan.
- If the court imposes a supervised Community Payback Order with no drug treatment requirement, the person will begin working with their justice social worker to complete the order, and as part of this work their social worker may use their supervision appointments to deliver some drug-related interventions (if they are appropriately trained to do so), or encourage them to access third sector support.
- If the court imposes a custodial sentence, the person will enter custody and their health and treatment needs will fall under the prisoner healthcare system.

The chart below shows the length of time taken between an order's imposition and the person's first contact with justice social work. Level 1 unpaid work requirements have the longest waiting time, at 7.2 working days. Other CPOs, with or without treatment requirement, average 3.9 days, and DTTOs average 2.7 days.

Figure 18: Number of days from imposition to first social work contact 2020-22



7. Assessment of practice against the evidence base: conclusions and areas for exploration in relation to eligibility, targeting and assessment

Overall, the process established by legislation and practice guidance is complex, containing multiple pathways and many key decision or transition points – each of which reflects a potential opportunity for someone with substance related problems who needs treatment to "fall off" of the pathways to a treatment-based community order. That is not to say that these are problematic process steps that should necessarily be considered "holes" in the system – there are many factors that need to be balanced in each decision, and not every person with substance related problems would benefit from a treatment based community order, so these opportunities to exit the pathway to one may be entirely appropriate. What is important is that, at each point, the best decisions possible should be made in order to offer and retain those who would benefit on a treatment based pathway, and channel those who would not, to other pathways without up-tariffing them.

Eligibility and targeting

Overall, it is clear that the sentencing system does include options which can keep people out of prison – however, without detailed data on the people passing through the courts, it is difficult to say what impact these options have on outcomes. One area which may benefit from further exploration is the apparently high number of people in prison who have substance use problems, and the relatively low number of people who receive DTTOs or CPOs with a treatment requirement. The data demonstrates a mismatch between the proportion of people recommended for community based sentences, but receiving a custodial sentence instead. This would seem to indicate that social workers generally assess more people as appropriate for community based rehabilitation (based on the person's risks and needs) than the judiciary considers appropriate for sentencing that way (based on applying the purposes of sentencing to the specific facts of the case). However, without further details regarding the nature of the index offences or the person's criminal history it is not possible to draw any firm conclusions, but further research in this area may be merited.

Assessment

The community sentencing process in Scotland is largely based on individualised assessment, uses a well-validated tool (the LSIR or LS/CMI) to assess Risk, Need and Responsivity (RNR), and aims to tailor the sentence and interventions a person receives based on RNR principles – all of which are generally supported by the evidence. The most common community order, the CPO, can be tailored by the court in terms of length, intensity, requirements and activities, and frequency of review. The treatment offered in a DTTO or CPO drug treatment requirement is also based on the individual's assessed needs, but the fidelity between needs and treatment received may be higher in CPOs with treatment requirements than DTTOs, because the treatment details are not specified by the court. The advent of Structured Deferred Sentences provides an additional opportunity for even more detailed individual assessment and tailoring, although these are still used infrequently and in variable ways.

However, while this general approach is consistent with the evidence, there remain questions about whether this approach is implemented in optimal ways. For example:

- **Timing and coverage of assessment**: Some people who would benefit from receiving an assessment may not be assessed. This is most likely to happen if their offending is relatively low level, or they have been to custody before – meaning opportunities may be missed to engage people in treatment earlier in their offending careers, or to engage some people who have been harmed by prison sentences already instead of returning them to custody. Whether there may be opportunities for earlier assessment or triaging of cases is a question worthy of exploration with stakeholders.

- **Criteria for orders**: Although the legislative criteria for substance dependency are the same, it is justice social workers who assess people's risk and needs, and make recommendations to the court about the most appropriate sentence. Taking a more detailed look at the practice guidance for each order, there are some potential tensions that may be difficult for social workers to negotiate. For DTTOs, social workers are advised to prioritise those with high-risk use patterns, such as poly drug use (especially in "chaotic circumstances"), injecting, high frequency, worsening chronic long term use, and the most harmful substances such as opioids, benzodiazepines, cocaine and crack (DTTO Guidance for Schemes, 2011). However, they are also advised that CPOs may be more suitable for people if complex social circumstances might impede their focus on treatment, there are additional issues related to the offending that would not be addressed, or the person requires medium to long term residential treatment. One possible reason for the low rates of DTTO usage, is that it is unlikely that there will be many, if any, people whose substance use is sufficiently problematic to make them eligible for a DTTO, who don't also have the kind of co-occuring problems that then exclude them. This may be a significant factor in the low numbers of DTTOs issued – there are simply not many people with the relevant needs profile of very high substance use and offending behaviour, but no other issues that may interfere with treatment or need to be addressed to reduce their risk of reoffending.

- **Assessment tools**: while the LSIR and LS/CMI are well validated and widely used tools, they are not specialised for exploring substance use. As noted earlier, the two main items of relevance are simply binary variables about whether the person has a substance use problem currently, or has had one ever. Beyond this, the discussion will be driven primarily by the Justice Social Worker's professional training, along with any specific local guidance or supplementary assessment tools. There are benefits to the flexibility and rapport-building of unstructured discussion, but also potential risks in practice variability causing some

people to be missed. Whether the appropriate balance is currently struck in this area should be explored with stakeholders.

- **Resources and time required**: It is not possible to tell from the available data what impact (if any) is caused by the different levels of assessment required for each order, but there are obvious considerations in relation to: court resource involved, acceptability of delayed justice outcomes, social work capacity/case-loads and health colleagues' availability to contribute to assessment.. How these factors are balanced against one another, and against the value courts place on detailed information, warrants further exploration with stakeholders.

DTTOs and CPOs vary in the extent to which they might be considered to take a realistic approach to recovery that recognises goals other than abstinence and accommodates the need to build the person's motivation and readiness to change. CPOs with a treatment requirement generally provide more flexibility for these factors, as the order only requires the person engage with treatment. This leaves more room for the person and their treatment provider to develop goals and tasks together, potentially incorporating harm reduction as appropriate, or changing approach as the person's needs change. However, DTTOs include the specific treatment activities and testing frequency that must be adhered to. This means a gradualist approach is harder to take; the goal of treatment is often set (or at least strongly implied) by the court's expectations about testing results, and treatment is less flexible in terms of providing harm reduction alongside other treatments, or adapting to the person's changing needs. This is understandable if one takes the perspective that the increased monitoring is necessary in order for the court to be comfortable keeping people with higher reoffending risk levels in the community instead of custody. However, it is less aligned with the perspective that people with the highest risks and needs are also those who may be slowest to make progress, and require the most flexibility and accommodation in order to remain engaged in treatment. The way both orders and expectations are calibrated for different target groups may therefore also warrant further exploration with stakeholders.

The complex geographical arrangements in the court, community justice, and health systems may mean that in cases where a person is convicted in an area other than where they live, the court may have less information about, understanding of, experience with, or trust in, the community services they can receive. While the court can still request a report from the justice social work department in the person's local area,

this reduced familiarity may have an impact on the decision to request an assessment, and about what sentence is believed will best serve the intended purpose.

8. Delivering orders and treatment

Overall, both treatment based orders provide a similar framework, based on accessing treatment relevant to the person's assessed substance-related needs, while keeping them in the community. However, DTTOs may be seen as offering less flexibility in how they are delivered. This is for because:

- The treatment details are specified in the order, making it more difficult to respond flexibly if the person's circumstances or needs change over time.

Although the treatment provided is needs based, the order itself is only focussed on substance use. Whilst this limitation exists in legislation, we are aware that social work practice has evolved over the years, and many areas undertake a holistic approach, working with the person on addressing other criminogenic needs. It should be noted that it may however be desirable to exclude these areas of the person's life from their order, because enforcement action or judicial scrutiny linked to their progress can arguably be a means of de facto criminalisation of need.

On the other hand, a CPO with a drug treatment requirement may offer less formal scrutiny of the person's progress in drug treatment (because tests are not reported to the court, and court reviews are less common). The supervising officer's role and scrutiny applied should however be noted here. CPOs can also involve support and more scrutiny of progress in other domains of life. Depending on the person and their circumstances, and the court's and social worker's expectations, this could either be an enabling factor or a barrier to successful completion of the order. As noted above, such scrutiny and enforcement may have the unintended consequence of de facto criminalising need, but on the other hand it may also be a necessary level of control to hand the courts in order for them to be willing to keep the person out of custody. This dynamic, and the legislative framework in relation to the social work's role in supporting people on DTTOs, may therefore warrant further exploration.

While DTTOs may offer less flexibility in the delivery and management of individual cases, Justice Social Work departments and Alcohol and Drug Partnerships have a wide degree of flexibility in terms of how they

structure and deliver services for their local area, which is described in the following section on service structures.

9. Service Structures

Because community orders are delivered by each area's justice social work department (and health services or local ADPs), service provision, structure and approach vary across the country and there is no standard model. Orders are delivered within a complex organisational landscape. Additionally, provision can change depending on local resourcing, policy and sentencing practice. Notwithstanding this, recent work by Social Work Scotland (McPartland, 2022), and triangulated by additional information gathering carried out by Scottish Government and Health Improvement Scotland in 2023, provide an indicative snapshot.

Across these three surveys of local areas, only one area was not represented in at least one of the samples. Combined, the samples indicate that the majority of areas provide DTTO services, however:

- A number of areas report being unable to take on new cases, or being able to take on only a tightly capped number.
- Some areas reported that people on existing DTTOs were receiving only a partial service.
- Some areas reported no current DTTOs, but the ability to deliver them if required.
- One area reported currently offering a service, but that it was "not sustainable".
- One reported not offering a service because of lack of local demand.
- One area had been forced to suspend its provision due to prolonged staffing shortages, preventing new DTTO orders from being made in their own area and neighbouring areas where they also provide delivery.

Both service and funding structures appear to vary significantly between areas, and some areas reported being in the process of either reviewing their model, or rolling out changes. The below is based on the snapshot in the data available, and is not necessarily an exhaustive list.

The following approaches appear to be used to **fund** DTTO delivery:

- Justice social work s27 ring-fenced funding is used to employ non-clinical staff who provide social work and wrap-around support, while the

NHS employ clinical staff who are co-located and work together to assess and deliver cases.

- Justice social work service s27 ring-fenced funding may be used to employ non-clinical staff, and also to buy in or second clinical staff from the local NHS service, who work in a multi-disciplinary team to deliver cases.
- Formal working partnership between a separate justice social work team and local Drug and Alcohol services.
- Justice social work s27 ring-fenced funding is supplemented by local ADP funding, in order to employ additional staff, to make it possible to provide a service for people in remote and rural areas.
- No official model or formal working arrangements, due to DTTO not having been ordered in a number of years.

The following observations can be made about variations in **service structure**:

- Most Justice Social Work services are within a local Health and Social Care Partnership, but not all.
- Most Justice Social Work services partner with local NHS drug dependency services to provide treatment for people on DTTOs, however some others may:
    - Employ their own clinical staff in order to provide a more bespoke and intensive intervention than the local NHS can provide
    - Partner with other, third sector organisations to provide treatment
    - Partner with a different local area's service to access treatment
- Some Justice Social Work services facilitate fast-track access to drug treatment and/or mental health services including residential rehab, but people in other areas will access services at whatever the mainstream wait time is locally.
- Some Justice Social Work services facilitate access to, or directly provide, various additional services or groups not offered to the mainstream population in NHS drug treatment. Examples include acupuncture, dental, groupwork programmes, overdose prevention interventions, peer support, and blood borne virus clinics. Other services only facilitate and supervise access to mainstream NHS services.
- Most Justice Social Work services reported positive relationships with their partners for treatment provision, although some reported that communication, limited resources and personnel could be problematic. Most, but not all, have transitional or follow up support to improve transfer into mainstream services.

- Some Justice Social Work services have dedicated DTTO staff, while in other areas DTTOs fall in the general caseload of criminal justice social workers.
- Some services utilise only mainstream services that would be available to any person presenting for treatment, regardless of their involvement in the justice system, while others provide a dedicated or additional service specifically for people on DTTOs.
- In addition to justice social workers, a range of different staff roles and titles may be employed in the service, including support workers, community justice assistants, drugs workers, resource workers, doctors, nurses, specialist drug treatment nurses, nursing assistants, medical officers, and admin assistants.
- Some areas co-locate clinical and non-clinical staff.
- Some areas have collaborative arrangements in which one area provides DTTO services for neighbouring areas. This can mean that, if an area providing services to other areas experiences difficulty in resourcing or otherwise delivering DTTOs, the result can be their suspension in multiple areas at once.

The following **issues and challenges** have been noted by services:

- Small and highly variable numbers make it hard to plan and resource services appropriately.
- Inadequate funding for both social work and clinical services, and funding not keeping pace with rising costs.
- Increasing complexity of cases over recent years makes each one more time consuming for staff to deliver, reducing capacity and contributing to staff burnout.
- Lack of staff, especially specialist staff, and lack of access to psychiatry and psychology.
- Lack of the full range of NHS services they would hope for clients to access, particularly psychosocial interventions.
- DTTO Guidance, and the service model it implies, are outdated in relation to current practice, and that it requires revision, particularly in light of changes in both community justice and substance use trends since it was published.
- The benefits of a dedicated, bespoke service can be undercut if transition into mainstream services on completion of the order does not have a clear pathway and strong communication.
- There is no standard set of outcomes that services all measure, and a range of different health board and social work systems are being used

to record activity. Most services report partially meeting their identified outcomes.

Some local case studies can also be highlighted as demonstrating specific challenges, and potential innovations or solutions being tested in local areas. These are from Community Justice Scotland's 2021/22 summary of CPOs, except where otherwise stated. Because many of these relate to areas of active development work, the facts below may now be out of date, but nonetheless may be worthy of further exploration:

- One area appointed an 18-month post, shared between Justice Social Work and the Alcohol and Drug Partnership, to develop a "shared care" model between substance use services and JSW. At the time of reporting, they stated that mental health services continued to be hard to access, but learning was being shared through the local Forensic Pathways Review Group, and staff training was being sought.
- One area identified a disconnect between Sheriffs' understanding of local treatment orders, and what was actually being delivered – specifically, that Sheriff's believed that by imposing a drug or alcohol treatment requirement, they were enabling the person to access additional support they otherwise would not have access to, but in fact the services accessed to deliver these requirements are the same as those available to the general public. Whether such misunderstandings exist in other areas too, and whether it can be addressed through improved communication channels or additional training, may be a question that warrants further exploration.
- The same area detailed that substance use assessment is not carried out until an order had been imposed and the referral then made, which has been problematic in cases where the court imposes a treatment requirement on someone who, upon detailed assessment, does not meet the usual thresholds for accessing these mainstream treatment services. This issue, compounded by communication challenges between social work and the treatment service, can result in people being provided with inadequate or suboptimal treatment and support. At the time of reporting, a proposal had been put forward to recruit two specialist workers to be based within the mainstream treatment service, but work specifically with people subject to drug and alcohol treatment requirements.
- The Care Inspectorate (2021) report that in some local areas, specific case manager or social work assistant roles have been created to provide additional support to people with Level 1 unpaid work requirements. These orders do not include supervision, and so the

people on them do not typically receive support to address criminogenic needs. However, the roles mentioned above have provided capacity to offer such support, without the strict enforcement of engagement, and has helped to increase engagement particularly for people with complex needs. The Inspectorate report that "This helped to reduce the need for community payback orders to be returned to court due to non-compliance. People welcomed these additional arrangements and made effective use of the supports available to attend appointments, address housing and benefits issues and improve their general life circumstances and sense of wellbeing". This type of arrangement may be one worth exploring, as a model for providing support to address wider needs, without making progress on them enforceable, and thereby criminalising need.

10. Addressing drug use

Treatment services vary locally

Suitable services must be available locally that can meet the person's treatment needs. In each area, Alcohol and Drug partnerships provide a forum for partners to come together to plan, develop and deliver alcohol and drug services.

The vast majority of treatment services are not directly linked to the justice system, but rather are NHS, social care or third sector services, which someone on a treatment order would be required to engage with. In some places the treatment available via DTTOs is additional to that which can be accessed by other routes, while in others, DTTOs only utilise the same services that can be accessed by anyone in the community who needs them.

Each NHS Board and Integration Authority may develop or commission the services they consider are necessary in their area. There is no detailed map of the types of services available across areas in Scotland, or centralised evidence on their quality or evaluation. Services are regulated and guided by a range of different sources and organisations. Most notably for this review:

In relation to service design and development:

- Service design advice and recommendations are developed by Health Improvement Scotland for policy makers, NHS Boards and Integration Authorities to take into account in planning their services.
- Specific standards for delivery are also developed by Health Improvement Scotland, with an expectation that Boards and Integration Authorities meet all standards. This includes the Medication Assisted Treatment Standards for substance use, which were developed collaboratively with several partners in the sector, with an implementation programme hosted by Public Health Scotland.
- Public Health Scotland further support service quality through provision of data and intelligence and monitoring and evaluation support.

In relation to front-line delivery:

- Front line health professionals are mostly regulated at the UK level: doctors by the General Medical Council, Nurses by the Nursing and Midwifery Council, and allied professionals by the Health and Care Professions Council.
- Practitioners are guided by evidence-based clinical guidance developed by the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium. Independent professional Royal Colleges and Faculties also provide specialty-specific information and advice to practitioners.
- Justice social workers are regulated by the Scottish Social Services Council. They utilise accredited risk assessment tools, and work within national practice guidance.
- Premises are inspected by the Healthcare Environment Inspectorate and the Care Inspectorate.
- Justice social work and wider support services are inspected by the Care Inspectorate.

In this context, there is no consistent model across Scotland in terms of which services are available, how they are delivered, what eligibility criteria are applied, or how quality is monitored and assured. Additionally, the sector is currently in a phase of rapid change and some expansion, as the new Medication Assisted Treatment Standards are gradually implemented and additional funding linked to the drug deaths emergency is used to implement new services, approaches and research.

Consequently, it is not possible to provide a clear or straightforward idea of which services might be offered to someone on a treatment-based community order. Some impressions can be gleaned, however, from Public Health Scotland data, annual reporting on ADP activity and implementation of the MAT standards, in the sections that follow.

Sectoral capacity, access and quality

- Although **variation** in clinical policies and practices in relation to the MAT standards has decreased significantly as implementation has progressed, some variability remains. In particular the proportion of people being prescribed long acting injectable buprenorphine and the number of days to receive opioid substitution therapy are noted as having wide ranges.
- The sector faces challenges to ensure services remain **consistent and resilient**. In particular recruitment and retention of staff.
- An Audit Scotland update on drug and alcohol services in 2022 noted that the sector has only recently begun to recover from previous gradual declines in funding: “Overall funding to alcohol and drug partnerships reduced over several years, but by April 2021 it returned to around the level it was six years ago in cash terms, but with no real terms increase in funding.” The announcement of the National Mission on Drugs and the supporting additional £250 million made available in 2021 by the Scottish Government, mean the real terms increases in funding from 2014/15 were a 16 per cent increase in 2020/21 (total funding was £98.2 million) and a 67 per cent increase in 2021/22 (total funding was £140.7 million). Recent uplifts in funding mean that ADPs now receive the highest level of funding on record, a continued 67% increase in real terms to £161.6m in 2023/24. Audit Scotland raised in their 2022 report that it was difficult to track how spend was distributed, spent and monitored. Since then Scottish Government have taken action to improve financial transparency primarily through the publication of two annual reports (21/22 and 22/23) which set out how funding was distributed across Scotland. ADPs are now also required to submit bi-annual financial reporting which monitors spend in services. ADP funding allocations are published annually on the Scottish Government website.
- The justice system relies on multiple data systems that are not set up to record the data required to enable implementation and measurement of the MAT standards, and that do not communicate across the justice system or community systems. Mapping work carried out to support MAT standards implementation identified no capacity for data collection and analysis within the current workforce.
- The MAT standards implementation review (Public Health Scotland, 2023a) found that despite operating procedures – including pathways

between secondary care, justice, housing and primary care – the proportion of referrals from these sources is very low, indicating “a lack of effective operational pathways and data sharing agreements between some partners and the need for stronger links with hospital admissions.” Particularly in support of assertive outreach (MAT Standard 3), there is a need to develop guidance aimed at ensuring consistent multi-agency risk assessments and assertive outreach whenever someone at risk of drug harm is identified by any agency.

- The MAT Standards Implementation Review also identifies a number of risks to the sustainable success of the MAT Standards, including:
    - that unsustainable and under resourced systems may prevent improvement work from happening;
    - that funding uncertainties could lead to a decrease in the quality and quantity of care that can be provided;
    - that small ADP teams will be overwhelmed;
    - that senior and intermediate management support will wane; and
    - that an overemphasis on achievement of RAGB scores will undermine the focus on ensuring that there is meaningful benefit to people as a result of the changes implemented.

Treatment types

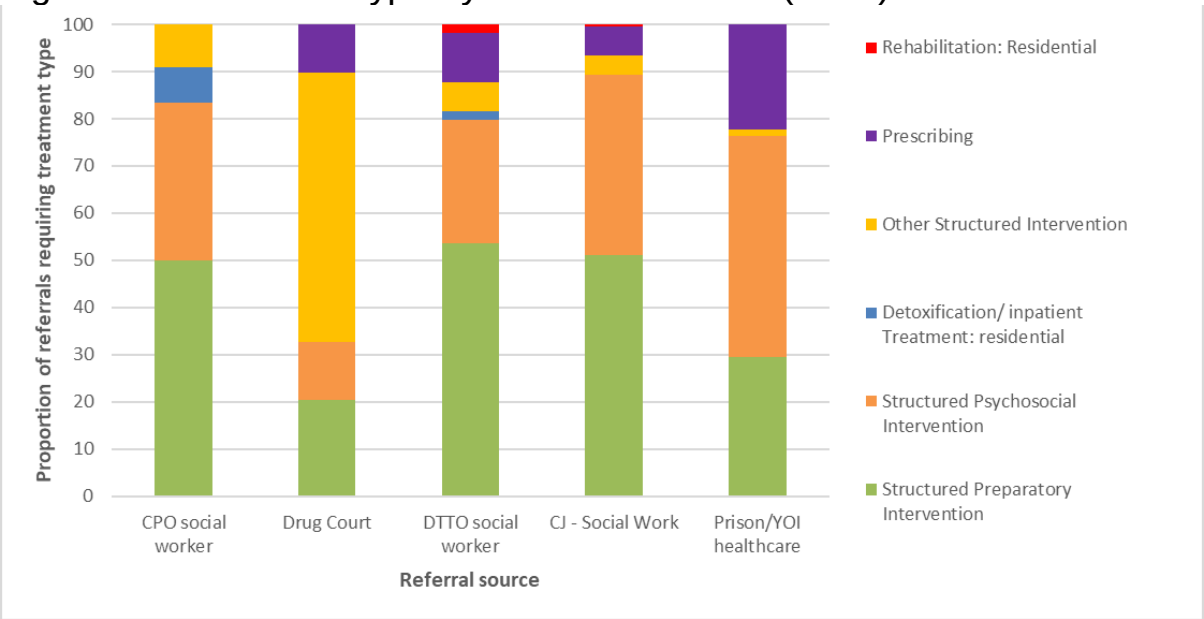
The figure below shows Public Health Scotland data on the treatment types that people are referred to from different justice services in 2021/22. Caution should be used when interpreting this data, particularly because:

- Individuals may be recorded in the dataset for multiple episodes of treatment, each treatment episode may involve multiple referrals, and each referral may result in multiple types of treatment. Consequently, the counts below reflect referrals to each treatment type, rather than the number of individual people.
- The treatment type is recorded at the point that a person receives a treatment start date, and due to challenges with the implementation of the new DAISY database, a large number of cases are either missing this data, have no treatment type recorded because they are on an ongoing waiting list, or have ultimately ended their engagement without commencing treatment.
- Treatment type is determined by both the person’s needs, and what is available locally for them to be referred into. This data is therefore not an accurate measure of the service needs for this group, as it does not record unmet treatment needs, or cases where someone is referred into

a sub-optimal treatment type because it is the only option available for them.

- Additionally, this data covers only Tier 3 and 4 treatment services. There is some variation in how the treatment tiers are defined for data collection purposes in different areas, but broadly speaking: Tier 1 and 2 services include information, advice, risk screening, brief psychosocial interventions, harm reduction interventions, needle exchanges and aftercare. These are not reflected in the data, but such services can still play an important role in minimising harm, promoting wellbeing, engaging people in the earliest phases of contemplating or seeking help to recover (Smith and Massaro-Mallinson, 2010).
- Not all residential facilities (Tier 4) submit data to DAISY, so residential treatment may be under-represented.

Figure 19: Treatment type by source of referral (2020)



With the caveats above in mind, the following observations may be made about the data presented in this chart:

- Amongst community justice based referrals (ie those coming from a justice social worker), the most common treatment type was **structured preparatory interventions**. For all three of these groups, the rate is around or just over 50%, which is the same as for the general public referred from non-justice related services.
    - While the evidence on mandated recovery suggests that, generally, those entering mandated treatment might be expected to be earlier in their contemplation of change, and therefore more in need of preparatory interventions than the general population,

some features of the justice system may contribute to the rate remaining similar across populations. These features include:

- Social work's incentive to support people likely to succeed, and avoid setting people up for failure, may mean that people who are early in their readiness for change are not recommended for treatment based orders.
- Faced with the prospect of custody, people being assessed may have an incentive to overstate their readiness for change, or understate the severity of their drug problems, and consequently be referred directly to more intensive services before they are ready for them. While social workers are trained to consider this possibility and have tools to aid discernment, this is a process of individual human judgment and it is inevitable, in the context of an incentive as strong as avoiding custody, that some misalignment between need and treatment type may occur.
- Structured Deferred Sentences may be used in some cases to assess a person's readiness for change, rather than referring into a preparatory intervention. During the deferment, the social worker may utilise techniques like motivational interviewing to try to move the person through the early phases of readiness to change, without referring to a formal preparatory programme.

- Because of the large proportion of preparatory interventions, it is worth considering whether reporting test results to the court is appropriate in these cases, particularly before the preparatory work for change has been completed. At this stage, it is not generally expected to see significant reductions in usage, and so the purpose of reporting test results to the court can be questioned.

- People referred via CPOs appear highly unlikely to be referred for **Prescribing or Residential Rehab**. The rates of prescribing for DTTO and Drug Court referrals (10.5% and 10.1% respectively) are only slightly lower than for non-justice related referrals (11.3), while referrals from custody-based health teams have almost twice the rate of prescribing (22.3%).

- **Detoxification / Inpatient Residential Treatment** is significantly more common for people referred via CPO (7.5%), than either general non-justice related referrals (2.5%) or people referred via DTTO (1.8%).

This may appear counter to expectations, since both DTTOs and residential treatment tend to be aimed at only the most entrenched drug problems. However, it likely reflects the paradox, highlighted in the section on eligibility criteria, that beyond a certain threshold of severity the person is likely to struggle to comply with a DTTO and social work or the courts may consider a CPO more appropriate in order to avoid the person being "set up to fail".

- There are additional categories of treatment in the data set – specifically **structured day programmes and community-based detoxification** – that are used occasionally in the wider population, but have no recorded cases of people entering via a criminal justice related referral in this time period.

The specific details of service types and delivery modes are not collated anywhere, so it is not possible to assess the extent to which people in Scotland have access to the comprehensive "matrix model" that reflects gold standard service for people in mandated treatment. Drawn primarily from reporting on the implementation of the MAT Standards (2023a) (unless stated otherwise), findings that provide a partial picture are:

- **Range of services**: In 2022, the Scottish Parliament's Criminal Justice Committee reported on the need for urgent justice sector reforms. Witnesses before that committee indicated that "there is a need for a wider range of community services for people for whom prison should not be an option", and for treating "the reasons for drug use, such as trauma, poverty, neglect and abuse".

- **Harm minimisation**: In the most recent annual returns, all ADPs reported that they have drug services that supply Naloxone, and the majority offer Hepatitis C testing, injecting equipment and wound care in community health care services, pharmacies, and/or third sector drug services. All ADPs also reported undertaking activities to support the development of recovery communities in their area, such as mutual aid groups, Self-Management And Recovery Training (SMART) groups, recovery cafes, recovery support groups, family support groups, and kinship care support. The groups reflect a variety of organisations, including delivery partners, churches, community interest companies and third sector organisations.

- **Retention:** OST treatment services appear to be effective at retaining people in treatment, with a reported 91% retained for at least six months.

However, a two month sample showed that the majority (63%) of discharges were defined as “unsupported”.

- **Residential facilities**: Recent analysis of residential rehabilitation facilities carried out by the Scottish Government’s Population Health Directorate highlighted a number of issues with access to residential rehabilitation. Of particular relevance to the community justice population is the lack of structured preparatory work to ensure people enter treatment with the best chances of success. As noted earlier, people entering treatment via the justice system are likely to be less advanced in the process of change than the general population of people entering treatment, making preparatory work especially important. This work highlighted a need for more preparatory work to be available to people, and a challenge in the current variability of programmes offered, agencies involved, and ease of access.

- Similarly, the report also highlights a lack of suitable detox services, and of structured pathways between detox and rehabilitation services. This is particularly the case for people who use benzodiazepines, or who require a complex detox. Issues highlighted include:
    - Lack of funding for residential rehab spaces, and a wide variety of different funding arrangements in different areas.
    - Substantial barriers to accessing rehab for people who use benzodiazepines, potentially caused by clinical staff shortages and difficulty accessing in-patient detox.
    - Lack of appropriately trained staff for supporting people with severe and enduring mental health conditions, and low staffing levels meaning such people cannot be managed safely within facilities.

- **Mental health:** Most ADPs report that mental health support is available for people who use drugs but do not have a diagnosed co-occurring mental health problem. This is mainly done through multi-disciplinary team working, and practices like colocation of drug treatments and mental health staff. However, most areas did not yet have protocols for referring people with co-occurring problem drug use and mental health problems, and a variety of formal and informal referral procedures appear to be used across the country. As covered earlier in this report, co-occuring mental health issues are particularly prevalent in the population of people who both use drugs and commit offences.

- **Non-opioid substances**: While OST has seen rapid expansion, insufficient progress has been made in the care and treatment of people

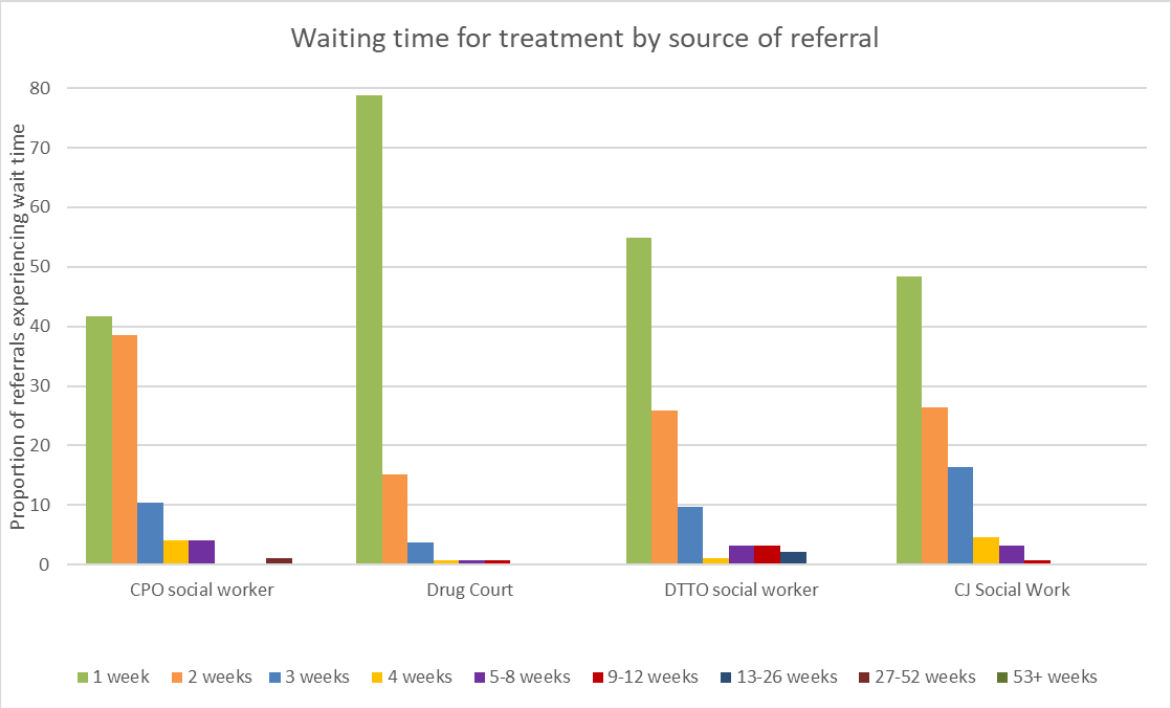
using benzodiazepines, stimulants and gabapentinoids. The MAT standards implementation report discusses a 2 month sample from October-November 2022, in which a quarter of post-mortem toxicology reports detected no opioids, while 63% did detect benzodiazepines. Additionally, there has been a large increase in cocaine deaths in recent years: between 2015 and 2020 the number more than quadrupled from 93 to 459. Also of concern is that the injection of stimulants is particularly destructive, and a factor in recent HIV transmission, putting this population at particular risk.

- While medication itself has limited evidence in relation to stimulants and benzodiazepines, people suffering from the problematic use of these substances can benefit from many of the other features of the MAT standards, in particular: psychological therapies (MAT standard 6), mental health support (MAT standards 9), trauma-informed care (MAT standard 10) and harm reduction (MAT standard 4) interventions. While the growing diversity of drug-use in Scotland is a general concern across the sector, the growing use and danger of street benzodiazepines was highlighted by those in the justice sector who contributed to the Drug Deaths Task Force's Report on Drug law Reform (2021), and is worth highlighting considering the historical focus on opioids amongst DTTO services in particular.

Wait times

According to Public Health Scotland data from 2021/22, the majority of people accessing treatment through a criminal justice referral pathway have a wait time of two weeks or less. It is notable that Drug Court referrals have a substantially larger number waiting just one week or less. Whether other services can learn from the approach that enables this would be worthy of further exploration.

Figure 20: Waiting time for treatment by source of referral



Role of testing

Testing is likely to form a part of many treatment programmes, regardless of what type of order the person is on, however it is only a mandatory and integral part of the order for DTTOs.

People who are tested regularly as part of treatment accessed via a CPO treatment requirement will generally have the frequency of tests set by the treatment service, and the results are used only to monitor their progress and facilitate honest engagement within the therapeutic relationship. Depending on the treatment type and policies of the programme, some people accessing treatment via a CPO may not be regularly tested at all.

In contrast, testing is an integral part of all DTTOs. The minimum testing frequency is set by the court, and the social worker must report all test results to the court. This requirement has received some criticism for limiting the treatment provider's and social worker's ability to engage flexibly with the person in response to failed tests. Professionals contributing to the Drug Deaths Taskforce's work on drugs and the law noted, for example, that a person may be engaging well with treatment and support but still test positive for drugs – for example, if their treatment is focused on preparatory work and building readiness for

change, if they are managing to cut back on their drug use but have not yet fully stopped all consumption, or if they experience a lapse after a period of abstinence. Knowing that a failed test will be reported to the court, these people may sometimes choose to miss a testing appointment, which interrupts their regular contact, putting them at risk of disengaging from treatment, as well as then being reported for breach. The Taskforce notes that the level of compliance expected of people may often be unrealistic. Courts' expectations about levels and pace of progress and compliance, coupled with their access to all testing results, may be one reason for DTTOs' high rates of revocation at review.

Additionally, the purpose of regular testing in drug treatment is generally to enhance treatment and the therapeutic relationship by facilitating completely frank disclosure to the treatment provider, and creating opportunities for the person to experience an understanding and non-judgmental response from the treatment provider, regardless of the testing results, so that trust, confidence and self-worth is built up over time. Bringing the court, and its enforcement role, into this process may therefore harm the therapeutic relationship rather than supporting it.

The role of testing warrants further exploration, in order to better understand people's lived experiences of testing during mandated treatment, how the results are regarded by courts, and whether the mandatory reporting of results to courts strikes the best balance between incentivising people to continue engaging with treatment, while maintaining the courts' willingness to keep people out of custody wherever possible.

11. Addressing offending and social support needs

Access

As explained in detail in earlier sections, the legislation and guidance give DTTOs and CPOs different levels of focus and resource for addressing needs other than drug treatment. Social workers will develop case plans for the people they supervise, based around supporting the person to address their various criminogenic needs – both directly, in supervision meetings and home visits, and indirectly, by referring them to services and activities.

These services and activities are typically provided by either public or third sector organisations. Since 2017, community justice has operated under the Community Justice (Scotland) Act 2016, which places duties on a group of statutory partners to engage in community justice planning, and many of the services and activities will fall within the local Community Justice Partnership arrangements. These arrangements are intended to create systems that are highly tailored and flexible to local needs, but require a high level of effective communication and close partnership working to be successful.

All DTTOs and CPOs with treatment requirements will have a supervising social worker, and may receive some support from them in the course of supervision.

Practice Guidance for the delivery of CPOs, for example, includes the suggestions that:

- The case plan should be collaboratively developed with the person and, where appropriate, family members or other agencies. “The case management plan should take account of both criminogenic and other needs to meet the specific goals of the individual on their unique journey towards desistance. This may involve improving significant relationships, restoring health and well-being, securing sustainable/stable accommodation, achieving financial stability or maximising benefits, taking advantage of meaningful learning opportunities and developing new employment skills.”
- Delivering CPOs is likely to require involvement from “community justice partners and […] individual mainstream agencies, such as Jobcentre Plus, the health service and local authority housing departments” as well as “voluntary and private sector organisations”.
- Individual Engagement Contracts could include “a wide range of issues, including: education and training; help with family issues & parenting; advocacy – benefits and housing; participation in offending behaviour programmes; participation in drug and alcohol programmes; constructive use of leisure time; and physical and mental health.”
    - Literacy and numeracy needs, in particular should be assessed and addressed if necessary.
    - Providing practical help to people who lack settled accommodation should be considered part of the normal duties of a social worker supervising a CPO, because suitable accommodation helps people to stabilise their lives, and improves their prospects of engaging with other interventions aimed at reducing the risk of re-offending.

The role of the supervising social worker in a DTTO is, uniquely, limited by statute. Section 234C, sub-section (8) of the Criminal Procedure Scotland Act 1995 states that "supervision by the supervising officer shall be carried out to such extent only as may be necessary for the purpose of enabling him to:

a. report on the offender's progress to the appropriate court;
b. report to that court any failure by the offender to comply with the requirements of the order and;
c. determine whether the circumstances are such that he should apply to the court for the variation or revocation of the order."

It should also be noted that social work practice has evolved over the years . Many areas have developed a holistic approach adopting the Recovery Model for their DTTO teams. This provides additional wraparound support, without adding compulsion to engage. This, along with the current legislative framework, is worthy of further exploration.

Variety and quality of support offered

The Community Justice Scotland's Annual Report on Community Payback Orders reported that areas were attempting to use contact with the justice system as an opportunity to identify and address wider needs, and many were taking active steps to help people into services (although, as with health treatment, devolution to local areas means services and approaches are not consistent across all areas). For example:

- Many areas described providing practical assistance to people, such as food parcels, toiletries, mobile phones and travel support. The report notes that this indicates a significant basic unmet need within the justice-involved population.
- Some areas have bespoke local approaches to mentoring, particularly involving people with lived experience. An example cited is the Edinburgh and Midlothian Offending Recovery Support Service, which has recruited a "recovery motivator" with lived experience to support people with both recovery and desistance.
- Some areas report using Housing First or Rapid Rehousing approaches, although it remains unclear how well integrated these are with community justice, and success is limited by structural challenges such as housing availability and the complexity of justice-involved

clients. One example that does appear to be specifically integrated with justice services is Highland's Rapid Rehousing project, which targets complex cases that are not eligible for the local Housing First programme. However, overall, the CJS annual report on CPOs found that "Securing suitable housing for people subject to CPO continues to be problematic for some local authority areas, particularly for a cohort that generally requires single occupancy and flexible tenure options."

- Some areas provide interventions focussed on mental health for those in the justice system, which take various forms including community psychiatric nursing contact, specialist psychiatric assessment, crisis suicide prevention, and broader wellbeing and resilience interventions. However, Community Justice Scotland's Annual Report on Community Payback Orders also found that "A dual diagnosis of mental health and addiction difficulties continues to act as a barrier to services for individuals, often due to how service criteria is linked to funding." One area has partnered with their local Autism service to commission training for all justice staff on awareness and bespoke interventions, with longer-term practitioner forums being developed.
- Some areas have approaches intended to engage people with employability services. In one example, one-to-one employability support is offered, intending to address people's individual needs.

While attempts to identify and address the underlying needs of people in contact with the justice system is positive from the perspective of both addressing offending and connecting vulnerable people with the support they need, the context that makes this necessary should also be considered. In the report Hard Edges Scotland (2020) "a standout finding across all six case study areas was the extent to which the criminal justice system was used as the last resort 'safety net' for people facing SMD whom other services routinely failed to provide with the help they desperately needed."

The relationships between Community Justice partner services and Alcohol and Drug Partnerships vary across the country, although CJS's annual report on CPOs found that "Many areas report excellent links with their local Alcohol and Drug Partnerships in supporting people subject to CPO who have a substance use issue." Local recovery communities are cited as a valuable and commonly available resource, and a smaller number of areas collaborate with residential rehabilitation services. In one practice example, an 18 month post was created for a development officer to develop a "shared care" model between substance use and justice social work.

In terms of outcomes and effectiveness of community justice, Audit Scotland highlighted that improvements should be made in its 2021 report on Sustainable Alternatives to Custody. A revised Community Justice Performance Framework was published in March 2023, and work is ongoing to improve relevant data access and reporting. The Community Justice Performance Framework sets out nationally determined outcomes which are to be achieved in each local authority area, and national indicators which are to be used in measuring performance against these. Assessment of progress towards these national outcomes is examined by statutory partners acting jointly at a local level, and by Community Justice Scotland.

Justice social work services are also subject to scrutiny by the Care Inspectorate, and its evidence suggests that justice social work services tend to be of high quality.

The Care Inspectorate's overview report on Justice services (2021) drew on findings from inspections of 5 local areas. While not necessarily nationally representative, it's findings are informative. In particular, that:

- **Relational working**
    - Most people on community payback orders were positive about their relationships with community justice social work staff, felt treated with respect, and felt that the relationship encouraged them to attend regularly and engage with their requirements. The highest quality relationships had a transformative impact on people's lives. These were characterised by continuous, consistent contact with compassionate and trauma-informed staff who individualised the person's support.

- **Accessing support**
    - People on CPOs valued the opportunity to be connected with third sector agencies such a Turning Point, Venture Trust and Shine Mentoring. Access to women's centres or hubs was also valued, although not all areas inspected provide these.
    - A range of national and third sector agencies provide various forms of support, although some concerns were noted about diminishing local services, and in some cases a need for more clarity and communication on which agencies are responsible for which roles.

    - Generally, people had access to the required interventions during their community payback order. Offence-focussed work was particularly evident where services had invested in, or ensured access to, a range of structured interventions and resources.
    - Referrals to other support agencies were generally prompt and made as early as possible, and collaboration between community justice social work and service providers was generally positive.
    - Where a comprehensive, strategic needs assessment is available, it usefully supports services and partnerships to direct resources to where they will have the greatest impact.

- **Service culture and policies**
    - "There was a high degree of correlation between an individual's identified risks and needs and the intensity of supervision. Staff management of non-compliance and the use of discretion was an overall strength."
    - Services are appropriately flexible in respect of accommodating people's personal commitments, responsibilities and travel constraints.
    - Greater consistency is required in community justice social work practice in relation to the frequency and focus of reviews and home visits.

- **Reporting**
    - Overall the standard of reports prepared by community justice social workers is "a strength".

While the evidence suggests these are generally quality services, resources are necessary to ensure that quality is sustainable. Justice social work statistics show evidence that the labour required of social workers to deliver each case may be increasing over time. For example, over the last decade the number of same-day reports requested by courts has increased, and courts are now significantly more likely to request these be written reports rather than presented orally. Similarly, since 2015/16 the proportion of community payback orders requiring supervision has increased, while the proportion requiring only unpaid work has decreased. Audit Scotland's 2021 report also noted that impacts from the Covid-19 pandemic, "including court backlogs, pressures on finances and a delay in offenders being able to complete unpaid work hours, will add further stress to the system".

12. Enforcement and outcomes

Opportunities for revocation

There are three main ways a community based order can come to an end: the person may successfully complete the order, the court may revoke the order due to a breach by the person, or the court may revoke the order at a review hearing, if they no longer view the order as appropriate for the person or their circumstances. If the order is revoked, it will be replaced with an alternative sentence. Orders may also be terminated within the dataset if the person moves to a new area or dies.

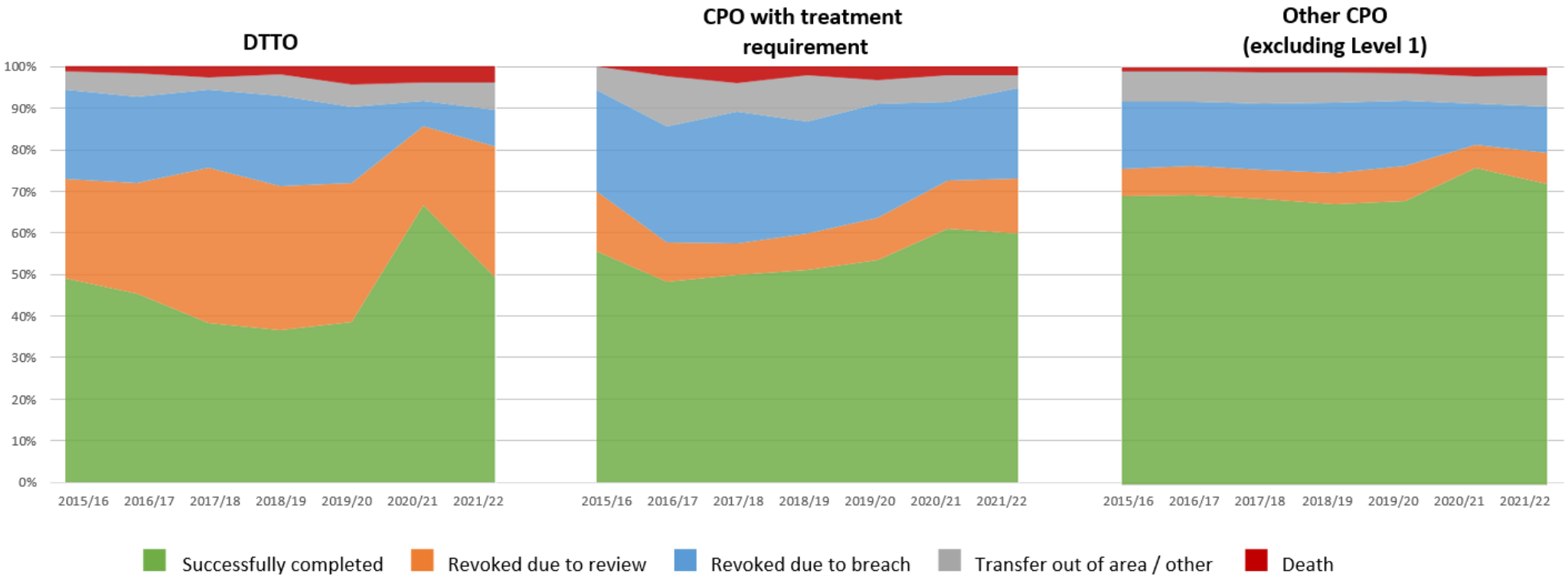
The chart below provides an overview of the proportion of orders with each of these outcomes between 2015 and 2022. It is notable that the successful completion rate for DTTOs is lower than for either CPOs with a treatment requirement or other types of CPO. This is to be expected, since the people who receive DTTOs are likely to be, on average, those with the most serious / entrenched drug problems. Amongst orders that are revoked, DTTOs are significantly more likely to be revoked at review, while other orders are more likely to be revoked due to breach. There are a number of ways to interpret this finding, but some possible factors are:

- People on DTTOs may be complying with their treatment order in a way that their social worker finds satisfactory, but that their Sheriff, upon review, considers inadequate in terms of the progress made in their drug use or other behaviour. People on CPOs of any sort are less likely to face court review, and to face it less frequently, than people on DTTOs - reducing their opportunity for revocation due to review.
- On some occasions when a social worker perceives that a person may have breached their order, they may not consider it necessary to submit a separate breach report if the person has a regular review hearing in the near future, as they can alert the court to the breaching behaviour at that review. Such cases may be recorded in the data as revocation due to review, but are, at least in part, triggered by the breaching behaviour. Again, because of the higher frequency of reviews for DTTOs, this may be more likely to happen in a DTTO than a CPO.

Additionally, it is noteworthy that, although completion rates for all the orders shown below increased during the pandemic, this increase was particularly substantial for DTTOs. The reason for this cannot be inferred from the data available, but some relevant factors may have been:

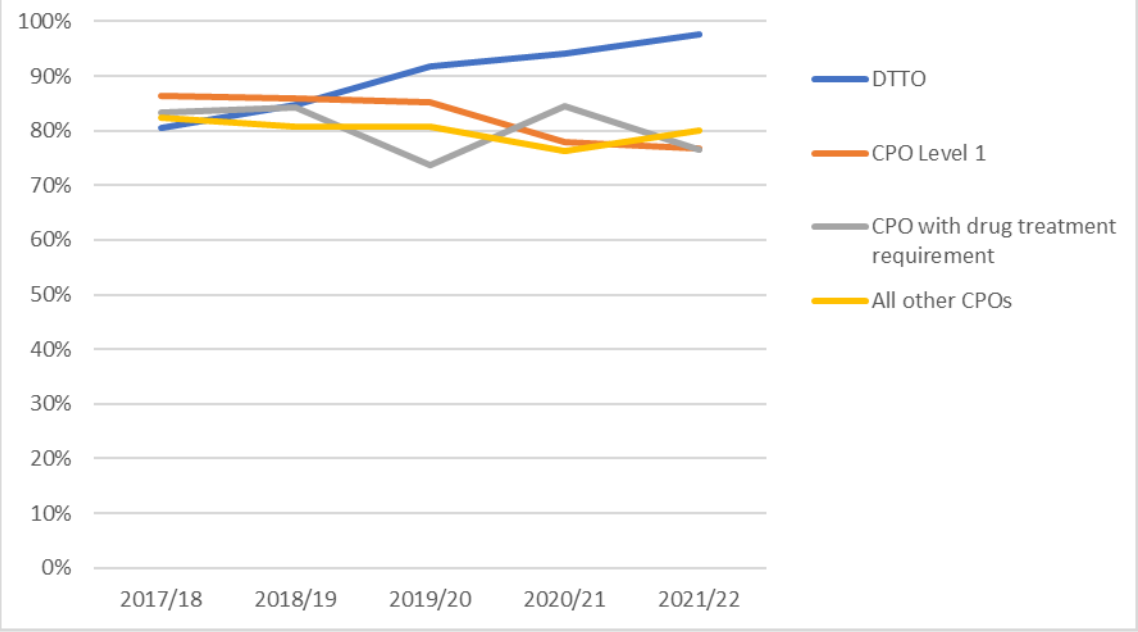
- the decrease in socialising, nightlife and time outside the home making it harder for some people to access or use drugs, or to commit other offences or breaches;
- the significant reduction in testing carried out, since this can only be done in-person;
- the significant resource put into accommodating homeless people, and making tenancies more secure, during lockdown measures; and
- the shift to virtual contact with supervising social workers removed the need for most people to attend at an office, which may have made it easier for people to consistently attend supervision.

Figure 21: Order outcomes, 2015-2022



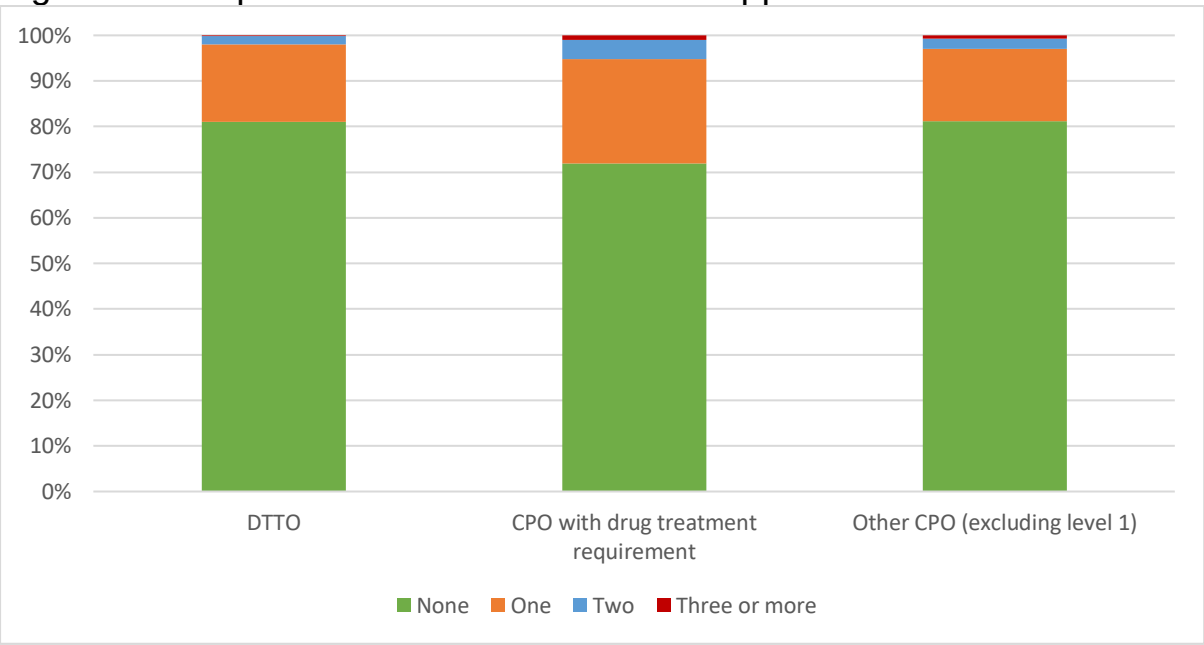
Breach applications should be lodged as promptly as possible once the social worker has decided it is necessary report a breach to the court. Over the last 5 years, the proportion of breach applications lodged within 5 working days has steadily increased for DTTOs and is now at almost 100%. In this time, all other categories of CPO have fluctuated around a lower mean.

Figure 22: Proportion of breach applications lodged within 5 working days



The chart below shows the proportion of each type of order that have one, two, or 3+ breach applications made to the court. The proportion of orders that proceed without any breach applications being made is relatively similar across the three types of order: the rate varies from 81% for both the DTTO and “other CPO” category to 71% for CPOs with a drug treatment requirement.

Figure 23: Proportion of orders with breach applications made

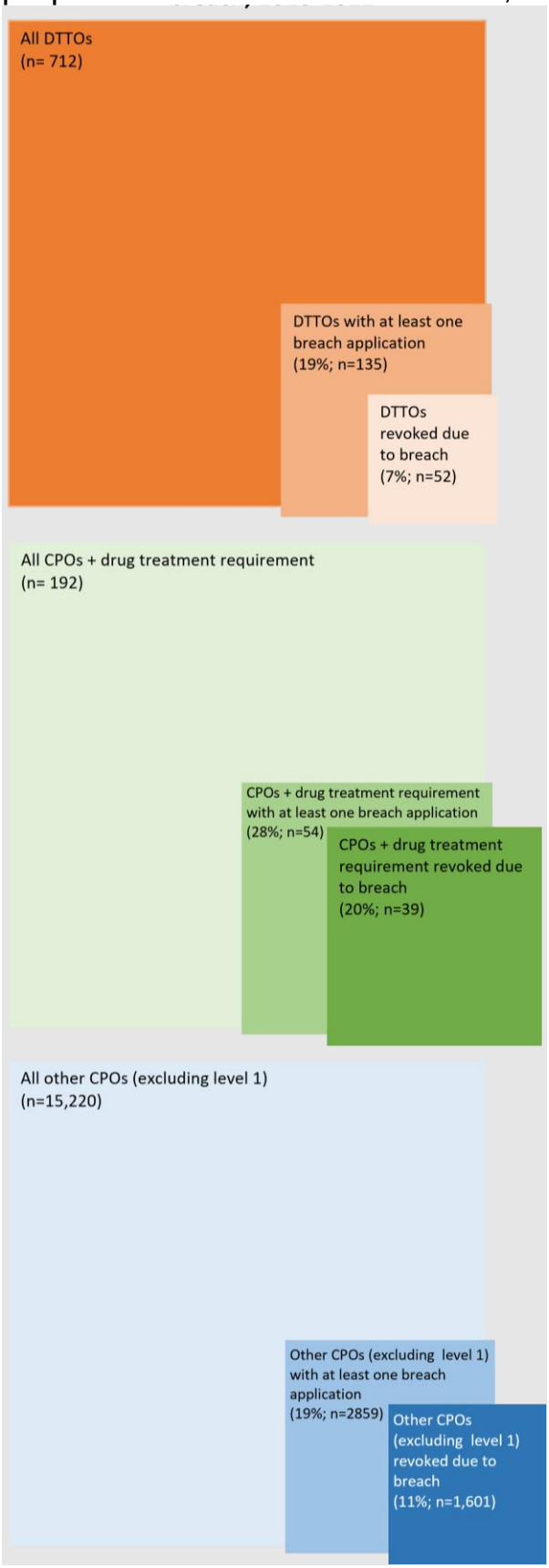


However, the proportion of cases with a breach application that are ultimately revoked due to breach is more variable. Looking only at those cases with at least one breach application, we see that:

- 39% of DTTOs with at least one breach application are ultimately revoked due to breach
- 72% of CPOs with a drug treatment requirement, that receive at least one breach application, are ultimately revoked due to breach
- 56% of other CPOs (excluding Level 1 orders) that receive at least one breach application are ultimately revoked due to breach.

Again, the reason for this is not readily inferred from the data. One possibility is that the court may be more likely to allow a person to continue on their order, despite a breach, if they know they will review the person again soon. Consequently, the frequency of review hearings for DTTOs may make the court more confident in allowing the person a second chance after a breach, knowing that they will have another opportunity to revoke the order relatively promptly if the person does not change their behaviour.

Figure 24: Proportion of orders with at least one breach application, and proportion revoked due to breach, 2020-22



Outcomes following revocations

The chart below shows DTTOs, and CPOs with a treatment order, alongside all other CPOs (excluding level one orders) for context. It shows the break down in terms of completion, mode of revocation and alternative outcome once revoked. It is notable that:

- DTTOs and CPOs with a drug treatment requirement have, over the past two years, had similar overall completion rates. While they differ in terms of whether a revocation is more likely to come about due to breach or review, the probability of revocation itself does not vary between the two groups. It should be noted, however, that this is influenced in part by the unusually large spike in completions caused by pandemic measures (discussed above), and that in the years prior, DTTO completion rates were generally slightly lower than those of CPOs with treatment requirements. It remains to be seen how this pattern will proceed over subsequent years as the pandemic recovery continues.

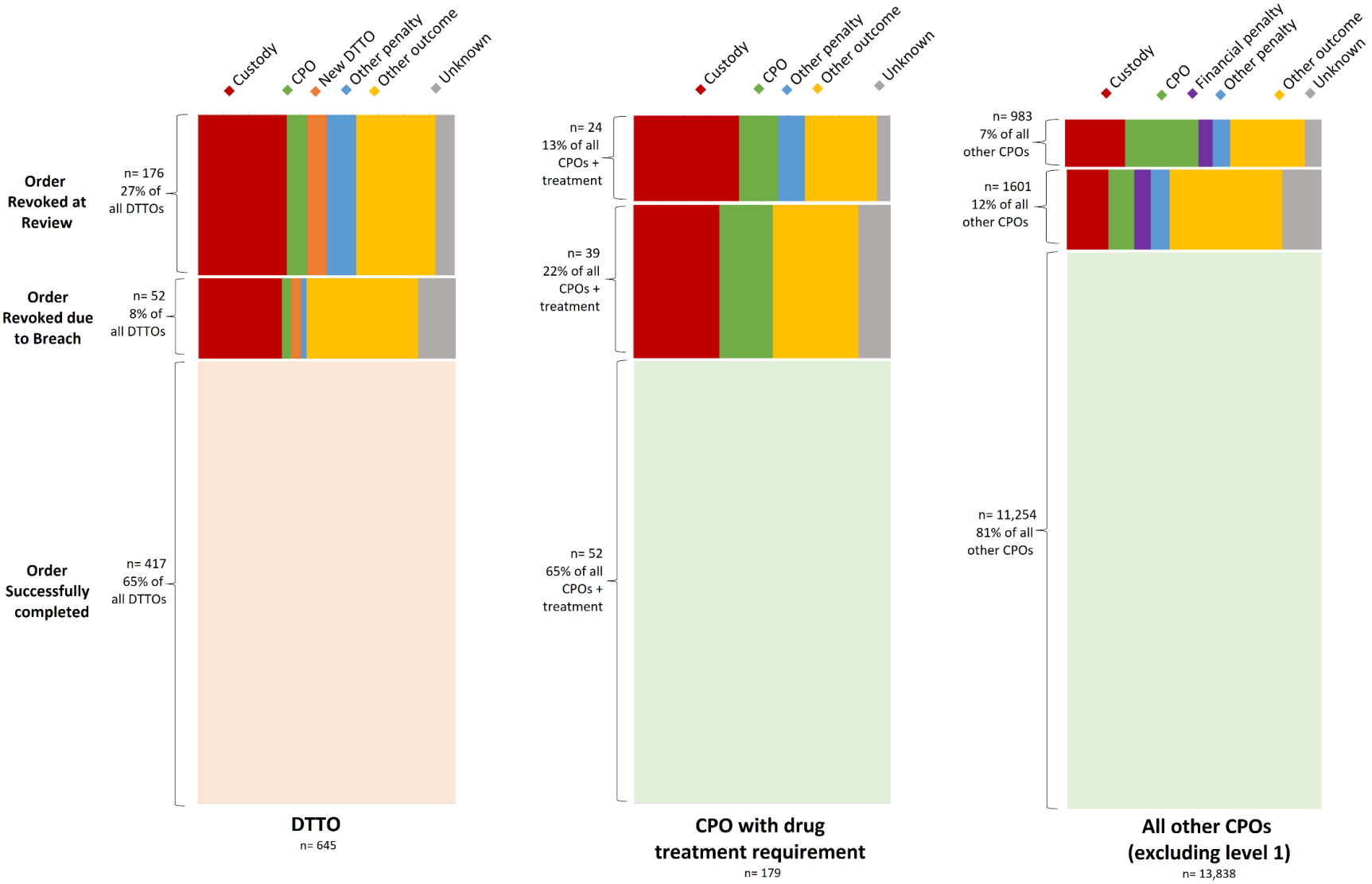
- This is in contrast to the “all other CPOs” category (which excludes Level 1 orders), which has a notably higher completion rate at 81%. This is to be expected, since substance use is a significant criminogenic need in itself, and also tends to be correlated with, or even compound, other criminogenic needs.

- Additionally, rates of “other penalty” and “other outcome” categories are also similar between DTTOs and CPOs with a treatment order.

- Custody is slightly more common for orders revoked at review than for those revoked due to breach, across all order types. Overall, 33% of revoked DTTOs, and 38% of revoked CPOs with a drug treatment requirement resulted in custody. The higher rate for the latter category is mostly accounted for by a greater proportion of custodies following review. Only 21% of all other CPOs (excluding Level 1 orders) revoked resulted in custody – as above, this is to be expected because this group is likely to have, on average, less severe criminogenic needs.

- The number of unknown outcomes is consistently higher for revocations due to breach, compared to revocations at review. This may indicate an issue in data recording or flow in the breach process, which may warrant further consideration.

Figure 25: Main outcome following termination of orders 2020-22



Reconvictions

Before considering reconviction rates for DTTOs, some important limitations of this data must be borne in mind.

- Data on reconvictions are only available for the 12 months following sentencing, so long term reconviction trends are not available and it cannot be known whether differences between different orders persist beyond 12 months.
- Reconvictions data looks at the first time a person is given a disposal in a specific time period, and whether they reconvict within a year. It is possible that they may have received other disposals prior to this time period.
- Additionally, since most DTTOs and CPOs with treatment requirements are made for more than 12 months, most people reconvicted in this timescale will still be on the order at the time of the new conviction. This fact, coupled with differences in the ways cohorts are recorded in the data sets, means it is not possible to look at whether successful completion of a treatment based order is associated with any difference in reconviction rates. Consequently, the reconvictions data that is available must be interpreted with significant caution.
- Finally, reconvictions data does not disaggregate the different requirements attached to a CPO, so it is not possible to compare DTTOs to CPOs with a treatment requirement. Because of the significantly wider breadth of offender characteristics and offense types represented in the general CPO group, this is not an appropriate or informative comparator.

With these caveats noted, the data show that people given a DTTO have the highest likelihood of being reconvicted within 12 months, and the highest number of new convictions within 12 months of any disposal, varying between 58% and 67% over the last decade. This is to be expected, considering that people receiving DTTOs will have, on average, the most entrenched drug problems and some of the highest criminogenic needs in the community-sentenced population. Consequently, as noted in the National Statistical Bulletin on Reconviction Rates, this should not be interpreted as indicating a particular lack of effectiveness for these orders. Over time, both the reconviction rate, and number of reconvictions per offender, have fluctuated with no clear directional trend.

After receiving a DTTO, if a person is reconvicted within a year they are relatively unlikely to receive another community based sentence. Over the last decade, the proportion of such people receiving a second DTTO has never exceeded 3.6%, and at times has dropped below 1%. Due to the time

required to complete a DTTO, it is unlikely for a person to receive another DTTO within a year. Most people in this position will receive a custodial sentence, with about half as many receiving a CPO. These high rates of custodial sentences likely reflect the fact that to have received a DTTO in the first place, the person's offending record must already be sufficiently severe to put them at risk of custody. However, whether the low rates of offering a second DTTO (or a CPO with a treatment requirement) reflect good practice may warrant further exploration.

It is also notable that, over the last decade, the number of custodial sentences for reconvictions following a DTTO are significantly higher than the number of individual people receiving them, indicating that people sent to custody for a reconviction following a DTTO often receive multiple short sentences within a 12 month period. While this indicates relatively prolific offending, it suggests that the relevant offences are not necessarily severe. This pattern is less strong in the data for the 2019-20 cohort than for preceding years, likely due to the pandemic affecting all parts of the justice system. It may also reflect an impact from the presumption against short sentences.

Considering that it is normal to require multiple attempts at treatment and recovery, people who struggle or falter either during or following a treatment order may not necessarily be "set up to fail" if given another one. The first DTTO can arguably serve as a learning experience for both the person, and the professionals supporting them, so that on a subsequent order they can derive more benefit from, for example, beginning treatment with more preparatory intervention than previously, working with treatment providers or modes that suit them better, and drawing on the perspective and adjusted expectations they may have gained from the first experience. Current legislation does not prevent this from taking place, so the low levels of DTTOs (or other community based disposals) for reconvictions following a DTTO should be explored with stakeholders to better understand the reasons for current patterns and whether they are considered to reflect good practice.

13. Assessment of practice against the evidence base: conclusions and areas for exploration in relation to delivering orders and treatment

Again, the evidence reviewed in this chapter shows a complex system and a high degree of local variability. While limitations in the data make it difficult to

draw a complete picture, in general the evidence suggests that justice social work services tend to provide quality assessment and support, while drug treatment services can be more variable, but are working through a period of implementing change and are aware of key challenges the sector faces.

There are some findings from this review that suggest specific pieces of work that may be necessary.

DTTO guidance

The guidance for DTTO schemes is now significantly out of date: having been published in 2011, it pre-dates the current Community Justice structures that have been in place since 2017, as well as the current crisis of drug deaths. It also refers to a number of outdated features in the justice system, including Probation Orders (replaced by Community Payback Orders) and Social Enquiry Reports (replaced by Justice Social Work Reports). Other elements of the guidance appear to be inconsistent with current day practice or service structures, and the advice it contains on both mental health and homelessness are ambiguous. To make the practice guidance fit for purpose in the current context, consideration of review and update in line with current evidence and best practice is warranted.

Reviewing the current delivery of support and treatment through these orders also highlights a number of areas that warrant further exploration with stakeholders (including people with lived experience) and consideration by policy makers. In particular:

The balance between support and enforcement

The dynamic between the offer of support, and the enforcement of engagement with that support, is a nuanced one. This is particularly true in the context of the present legislative limitations on supervision in DTTOs. The evidence review found that one feature of effective mandated community drug treatment is responding to multi-problem clients with an integrated and comprehensive care package. Compared to a DTTO, a CPO with a drug treatment requirement may offer less scrutiny of the person's progress in drug treatment (because tests are not reported to the court, and court reviews are less common), but also involves both more support *and* more scrutiny of their progress in other domains of life. Depending on the person and their circumstances, and the court's and social worker's expectations, this could

either be an enabling factor or a barrier to successful completion of the order. Such scrutiny and enforcement may have the unintended consequence of de facto criminalising need, but on the other hand it may also be a necessary level of control to hand the courts in order for them to be willing to keep the person out of custody. This dynamic, and the legislative limitation on social work's role in supporting people on DTTOs, may therefore warrant further exploration. Some areas have developed models where additional, voluntary support is offered to people on Level 1 CPOs (who are not required to engage with supervision). This may be one model worth considering within the bounds of the current legislation for providing additional support to people on DTTOs as well, and indeed this Review was made aware that some areas may already be doing this. Considering the generally positive findings regarding the quality of justice social work services, there is reason to believe they may be a valuable asset to many people on DTTOs.

Therapeutic alliance and harmonising expectations

The crux of designing effective approaches to mandated treatment is balancing the justice system's need for accountability and enforcement with effective treatment's reliance on a compassionate and patient therapeutic alliance. Whether this balance is appropriately struck by current approaches is worthy of deeper consideration, particularly from the perspective of people with lived experience of court mandated treatment. For example, how can the justice system's intrusion into the treatment provider's therapeutic alliance with the person be minimised? How can the social worker's relationship with the person be made as therapeutic as possible, notwithstanding their enforcement role? How can courts and sheriffs learn from models of therapeutic alliance to interact with the person in a way that minimises the potential criminogenic harms? Some potential answers to these questions have been identified in the evidence review, but the experiences of people both subject to, and working within, the justice system will be paramount to identifying practices that will work in the Scottish context specifically.

Within this general theme, some areas that may be fruitful to explore are:

- the role professionals and sheriff's see drug testing results as having in their current practice, and whether the current levels of test reporting are necessary to achieve an order's goals.
- how to deliver the specialist training on substance use, sub-conscious stigma and the skills of therapeutic alliance building that this evidence review has found to be features of an effective mandated treatment system.

- ways that judicial, social work and health providers' expectations of people on orders might be better harmonised around a realistic, public-health oriented model of recovery journeys, with a view to reducing the need for revocation, and potentially increasing the possibility of additional opportunities in the community for people who do not complete their order, or are reconvicted.

Service structures and funding

This review has found a high degree of variation in service structures and funding, the appropriateness of which may warrant consideration. The delegation of community justice and health care is intended to provide flexibility to local needs, and it is a natural consequence of this model that community sentences and drug treatment will vary in different areas. However, the high variation in arrangements presently observed, coupled with the grave seriousness of both the public health emergency and the prospect of using the state's coercive power to mandate drug treatment, raises questions about what consistency might reasonably be expected, and in turn about equality before the law. It may be appropriate to consider whether more should be done to standardise provision, or to facilitate systematic learning between services so that over time we might expect to see more convergence on models that are most effective.

Relatedly, consideration should be given to the specific resource and logistical challenges highlighted by services, and experienced in key parts of the social work and health sector work forces. The evidence review suggests that adequate specialist staff, co-location of justice and treatment staff, pre-review meetings, dedicated coordination roles, and joint training and awareness raising are all features likely to improve service quality. Services that are delivering these features may be useful sources of learning. Additionally, the notably shorter waiting times for entering treatment via a drug court, compared to other community justice referral sources, may also be something that can be learned from.

Service available

Generally, more work is needed to better understand the range of treatment types available in each area, and whether they reflect a model that is, per the recommended "Matrix Model" sufficiently:

- Intensive (model recommends 4-5 days per week)
- Extensive (model recommends minimum 18 months)
- Comprehensive (incorporating multiple approaches)

The literature reviewed suggests that, in particular, there may be gaps in terms of integrated mental health support, treatments for people who use stimulants or have complex poly-drug use patterns, availability of residential rehabilitation, and intensive structured day programmes.

Consideration may be warranted in relation to whether the interventions offered are sufficiently ambitious in terms of engaging people early in the process of considering change, and whether current standards of motivation and readiness for change being applied in assessments are appropriate. These vary locally depending on the specific eligibility criteria for each programme, and are not laid out in the guidance. While people should not be "set up to fail" on community orders, any opportunity to engage someone in potentially life-saving treatment should be taken seriously. It may be possible that interventions could be developed with a greater role for preparatory drug counselling utilising evidence-based techniques like motivational interviewing and motivational enhancement therapy, aimed specifically at overcoming the engagement challenges of "mandated, coerced or concerned" patients. Similarly, facilitation of 12-step programme engagement, peer support, and early access to harm reduction, are all known to support eventual engagement with for formal treatment. On the other hand, the need to direct scarce specialist resources where they can make the most difference must also be borne in mind.

Ensuring that sheriffs also accurately understand the support and treatment available, both in each area and on each order, is also essential.

Opportunities for, and following, revocation and reconviction

A key difference between DTTOs and CPOs are the opportunities they present for revocation. While this consideration should not be overstated, due to the similar completion rates for DTTOs and CPOs with a treatment requirement, the CPO model is arguably closer to that which the evidence canvassed in this review supports. Consequently, it is worth exploring the

role that each opportunity for revocation plays in an order overall. In particular, how important do sentencers consider the monthly DTTO review to be in their decision about whether they are comfortable keeping someone in the community? A more tailored, and evidence-based, approach may be achieved through the CPO model, where reviews are scheduled only if the court feels they are necessary. Similarly, how important do sentencers consider the monthly testing results to be in their decision to maintain or revoke an order? A more evidence-based approach recognising that people can engage well with treatment but still test positive for drugs, may be for justice social workers (collaborating with health and social care professionals) to interpret the meaning of testing results within the context of the person's broader engagement – and raise the results with the court if they consider them a cause for concern.

Relatedly, it may be valuable to explore the factors that affect decision-making when a person either has a treatment-based order revoked, or is reconvicted after serving one. Current legislation does not prevent multiple treatment-based orders from being made, so the low levels of DTTOs (or other community based disposals) for reconvictions following a DTTO should be explored with stakeholders to better understand the reasons for current patterns and whether they are considered to reflect good practice.

Finally, the gap in the quality of care between community and custody settings, and disruption to treatment in transitioning settings, is concerning, particularly for the significant number of people receiving a custodial sentence following revocation or reoffending. While not a primary focus of this report, these findings form an important part of the context in which sentencing decisions are made, and custody is the most likely counter-factual for many, if not most, people on mandatory treatment orders.

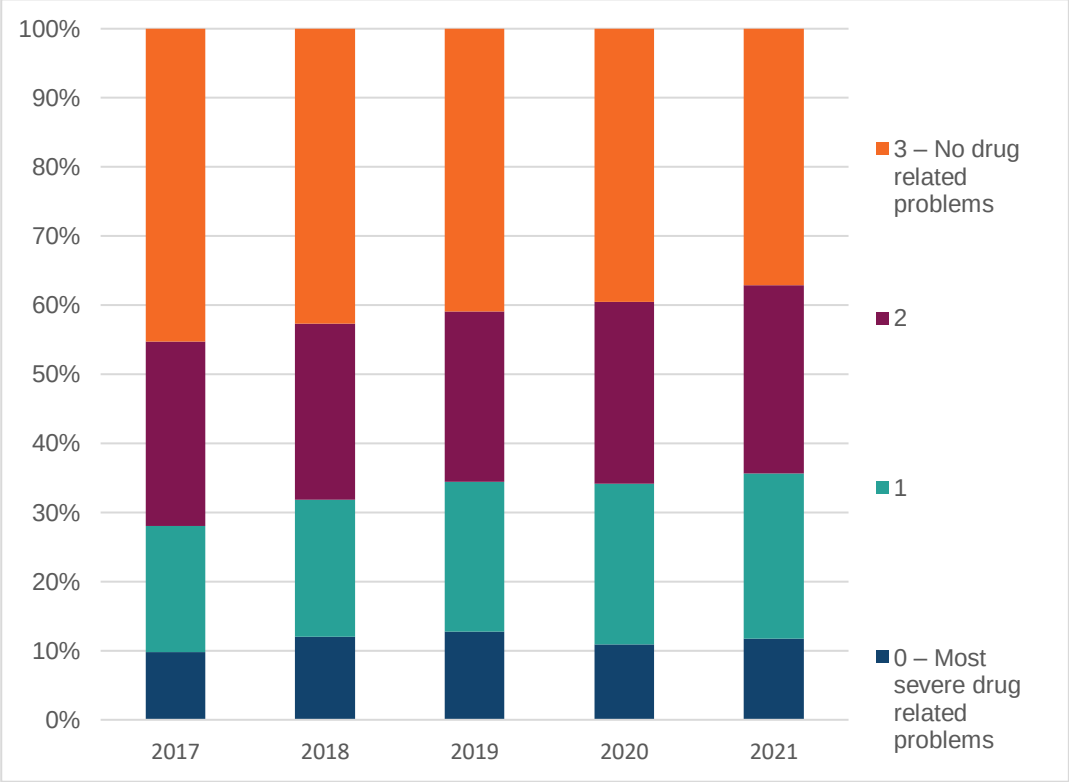
Characteristics of the relevant populations

The data presented below are based on LSIR data, an explanation of the variables is given above in section 3.2.1.

Data on those who receive a full assessment after sentencing

More detailed data on people with drug related problems is available for those who receive a full assessment after sentencing. This generally takes place if they have received a sentence that requires supervision, or some custodial sentences. In these assessments, social workers assign a score based on the extent of the person's "current drug problems", where 0 = "substance abuse seriously interferes with maintaining a prosocial lifestyle", and 3 means the person does not have drug related problems. The figure below shows how these scores have been distributed in the last 5 years, including a gradual downward trend in the proportion who are recorded as having no drug problem:

Figure 26: scores for the variable "current drug problem", in full LSCMI assessments



For the purposes of this analysis, people scoring 0 or 1 (on a scale from 0-3) on the LSCMI variable "current drug problem", meaning those with more than

minor drug related problems, have been compared to the remainder of the population receiving the same assessments. For ease, these groups will be referred to as “people with drug-related problems” and “people without drug related problems” in this section of the analysis.

Demographics in the populations of interest

Sex

Amongst people receiving initial assessments to inform pre-sentencing justice social work reports, men are slightly more likely to fall into the group that is potentially likely to have drug related problems, than show no indication of drug related problems. Between 2017 and 2021, 84% of those in the “no drug related problems” group were male, while in the group potentially likely to have drug related problems, 86% were male.

The most recent release of justice social work statistics (data up to 2021-2022) shows that over the preceding 5 years, around 80% of DTTO recipients have been male – suggesting that men with drug related problems may be less likely to receive a DTTO than women with drug related problems (although the analysis did not control for other factors that may influence this outcome such as offending type or severity).

In the same time period, 85-86% of CPO recipients have been men (although this does not separate out those with drug treatment requirements).

Amongst referrals into treatment services in 2021/22, Public Health Scotland data records that between 80 and 86% of referrals made by community-based justice professionals were for males, as were 93% of referrals from prison or YOI health teams. Across all justice referral sources, DTTOs had the highest proportion of females, at 20%.

Age

Amongst people receiving initial assessments to inform pre-sentencing justice social work reports between 2017 and 2021, people who are potentially likely to have drug related problems tend to be clustered towards the middle age brackets, with 72% falling between 30 and 49 years of age. There is a particularly large difference in the proportion of people aged 40-49, compared to those with no indication of a drug problem. A higher proportion of those with no indications of drug problems are either older or younger, with 20-29

year olds and those over 60 both significantly more likely to fall into this group.

The most recent release of justice social work statistics (data up to 2021-2022) shows that over the preceding 5 years, people aged 31-40 have been the most likely to receive a DTTO. In relation to Scotland's population, two people per 10,000 for this age range got a DTTO in 2021-22. Compared to the other age ranges, those aged 25 and under and over 40 were the least likely to receive a DTTO (both 0.6 people per 10,000 population in 2021-22).

The average age for someone receiving a CPO has been gradually increasing – from 30 to 35 over the last 10 years. Those aged over 30 accounted for just over half of orders in 2017-18 but now account for 60 per cent in 2021-22 (although again it should be noted that this applies to all CPOs, and those with a drug treatment requirement have not been separated out).

Amongst referrals into treatment services in 2021/22 from justice sources, Public Health Scotland data records that people referred to treatment by a CPO supervisor are, on average, slightly younger than those referred via a DTTO. Over 46% of CPO referral episodes in 2020 were for people under 30, but only 26% of DTTO referrals.

Insights into needs of the populations of interest

In Community Justice Scotland's Outcome Activity Across Scotland Annual Report (2023), “partners reported that service users were presenting with needs linked to alcohol and substance use, physical and mental health, wellbeing, employability, housing and more. Many individuals were experiencing more than one issue concurrently.” Data on the extent of the different issues people in the justice system face remains limited, but this section provides a snapshot of available insights from justice social work and Public Health Scotland data.

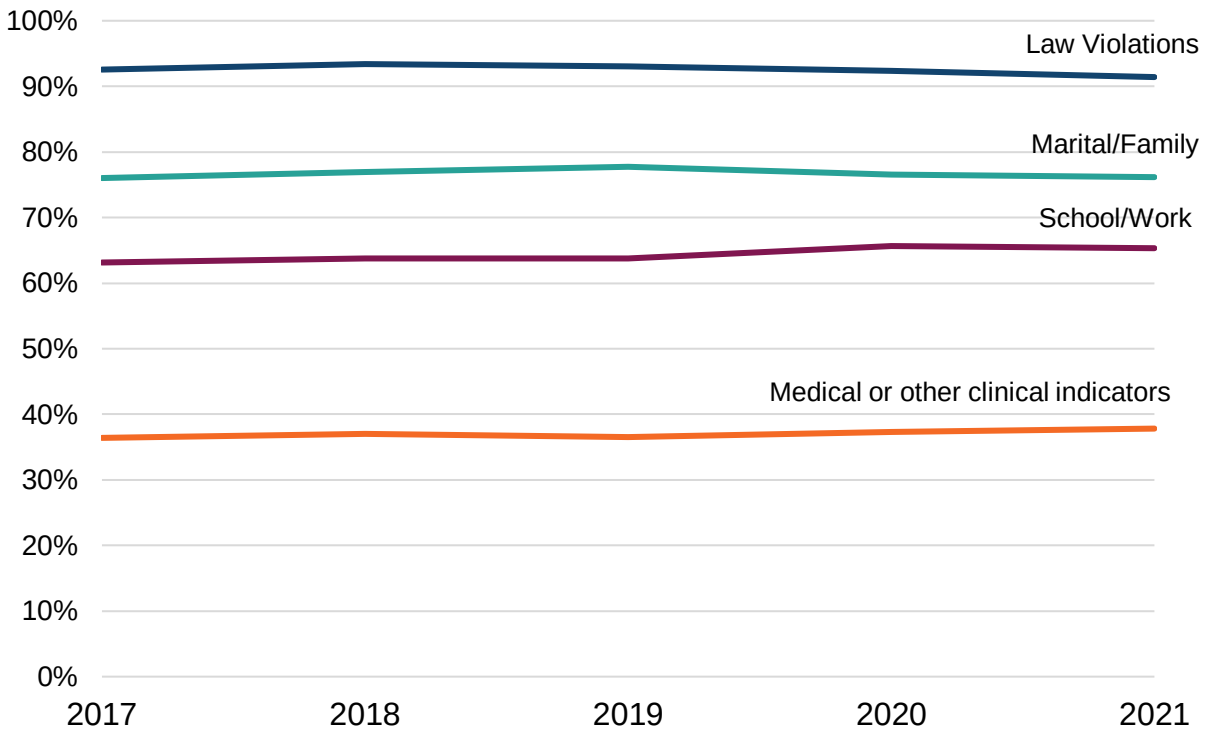
Public Health Scotland data on treatment episodes in 2021/22 show that people referred for treatment are disproportionately from the lower SIMD brackets. Amongst justice referral sources, this pattern is most pronounced in CPO referrals, where 35% of people are from the 10% most deprived areas. Similarly, 28% of DTTO treatment referrals are for people from the 10% most deprived areas. This is comparable to the rate for all non-justice system related referral sources, which is also 28%. Notably, police referrals are

significantly less concentrated in the most deprived areas – only 16% of police-referred treatment episodes in 2020 came from the 10% most deprived areas.

Amongst people who receive a full assessment, 55% of those with drug related problems have been imprisoned following a conviction, while only 34% of those without drug related problems have. It is important to note that this analysis does not control for other factors that may contribute to this pattern, or follow individuals longitudinally, so it is not possible to infer the extent to which this pattern is influenced by factors like severity of offending patters, and how much may be attributed to the experience of having been in custody before. However, it is relevant to consider here that the biennial Scottish Prisoners' Survey most recently found that 12% of respondents reported that they started using drugs in prison for the first time.

Additionally, in full LSCMI assessments four main areas that may be affected specifically by drug use are recorded. Amongst these, shown in Figure 27 below, the most common issues people with drug related problems face are related to law violations (93%). Medical / clinical indicators of dependency are the least frequently identified issue, but still affect over 1/3 of this group (37%). This is notable particularly in light of the relatively low proportion of people identified as warranting further assessment in the initial screening process. While these are different populations and the proportions cannot be directly compared, there may be merit in further work exploring what processes are triggered, referrals are offered, or assertive outreach occurs, for people who social work assess as showing medical / clinical indicators of dependency.

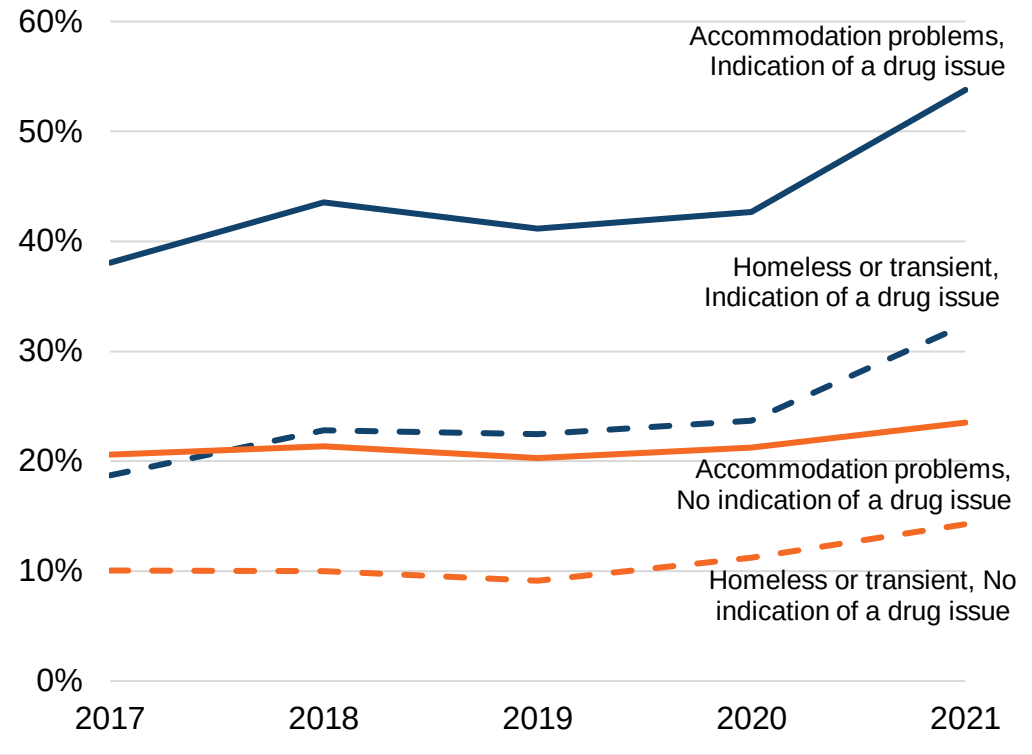
Figure 27: Percentage of people with drug related problems in full LSCMI assessments, and where it impacts their lives, 2017 to 2021



Accommodation and homelessness

Amongst those receiving detailed assessments, people with drug related problems are more likely than those without drug related problems to face **housing issues**. For example, as shown in Figure 28 below, between 2017 and 2021, they are more than twice as likely to be recorded as “homeless or transient” (23% compared to 10%), or to be recorded as having “accommodation problems” (42% compared to 21%). Notably, this gap has increased over time as housing issues appear to have grown more rapidly amongst those with drug related problems than those without.

Figure 28: Percentage of cases with a housing issue, 2017 to 2021



Public Health Scotland's data on referrals into drug treatment from criminal justice sources are incomplete and should be interpreted with caution, but amongst those for whom it exists, people on CPOs and DTTOs appear about equally likely to be recorded as homeless.

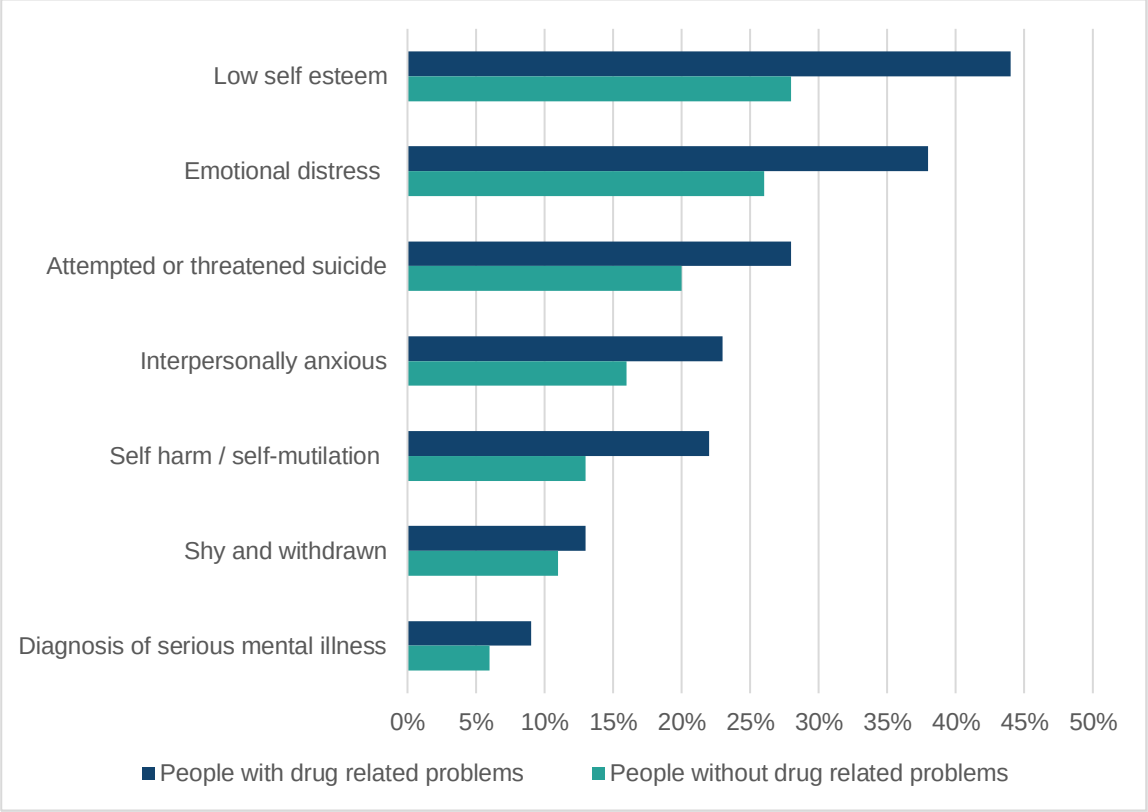
Mental health

Amongst people receiving detailed assessments, people with drug related problems show indications of significantly **poorer mental health** than those without drug related problems, as shown in Figure 29. For example, they are recorded as having:

- Higher prevalence of attempted or threatened suicide (28% compared to 20%)
- Higher prevalence of self-harm and self-mutilation (22% compared to 13%)
- More likely to show low self esteem (44% compared to 28%), being shy and withdrawn (13% compared to 11%), being interpersonally anxious (23% compared to 16%) or showing signs of emotional distress (38% compared to 26%)

This group also has a higher likelihood of being diagnosed with a serious mental illness (9% compared to 6%). However, it is notable that these rates are significantly lower than might be expected considering the much higher rates of markers that are strongly indicative of serious mental illness, such as suicidality. The fact that this population has a rate of attempted or threatened suicide of 28%, yet only 9% are diagnosed with a serious mental illness, raises questions that may warrant further consideration regarding whether this population is accessing the mental health diagnosis and treatment they need, whether information about diagnosis and treatment is adequately available to social work assessments, and whether there are adequate opportunities for referral pathways from justice social work assessment to the mental health services these people may need, regardless of the disposal imposed.

Figure 29: Mental health indicators amongst people receiving detailed assessments following sentencing (2017-2021)



Relatedly, a survey of mental health needs amongst over 250 clients at one Scottish Justice Social Work service found that over 70% had some kind of mental health issues, and that “there is little point in asking solely about mental health without asking about drug/alcohol use and prescribed medication” (Community Justice Scotland, 2021).

Whilst mental health and trauma are different for these two sub-populations of those assessed, it should be noted that this does not mean that those with drug related problems have greater cognitive or intellectual challenges. For example, learning difficulty and communication barriers are equally prevalent for those with and without drug-related problems (both measure 4% in both groups). Cases where “low intelligence” is recorded as a responsivity issue, where the person is recorded as having a cognitive impairment, or where specific literacy difficulties are recorded, all have just one percentage point difference between those with and without drug related issues.

Co-dependency

Public Health Scotland’s data on referrals into drug treatment from criminal justice sources suggests that rates of alcohol co-dependency appear to be higher amongst those receiving a CPO than a DTTO. In 2021/22, 48% of referrals via a CPO social worker were for co-dependency, but only 17% of referrals via a DTTO social worker, and only 6% of referrals via a Drug Court.

Data on alcohol co-dependency should be recorded in the LSCMI database for those receiving detailed assessments, but could not be accessed in sufficient time for this review. This may be a useful area for future analyses of this data to look at.

Drug types

While significant gaps in Public Health Scotland’s data on referrals into drug treatment from criminal justice sources make analysis of detailed measures like specific substance types difficult, some general patterns can be noted from the data that are available. Across all criminal justice referral sources, opioids, stimulants, depressants and cannabinoids appear to be the most commonly used substances. While the data are not adequate to confidently differentiate trends, they suggest that stimulants and cannabinoids may be more prevalent amongst those referred via CPOs, while opioids may be more prevalent amongst those receiving DTTOs. Opioids also appear to be even more prevalent amongst those referred into treatment from custodial settings. Again, this analysis does not control for any other factors that may contribute to this pattern.

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The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

This report is available on the Scottish Government Publications Website (http://www.gov.scot/Publications/Recent)

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-83521-302-5
Published by the Scottish Government, August 2023

Produced for the Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS1347882 (08/23)