FULL REPORT

Drug Education as Diversion

A mixed methods evaluation of the Avon & Somerset Drug Education Programme

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1.0 INTRODUCTION

This evaluation was undertaken on behalf of the Office of the Avon and Somerset Police and Crime Commissioner to evaluate Avon and Somerset Constabulary's Drug Education Programme (DEP). The DEP is an education programme that has operated in South West England since 2016, initially in Bristol before it was extended across the Avon and Somerset Force area in 2019. The programme provides people caught in possession of illegal drugs with an alternative to criminal prosecution or conviction. It is a preventive education programme to which people caught in possession of illegal drugs are referred. Its overarching aim is to reduce drug-related offences in the Avon and Somerset Police Force area, to reduce the burden on the criminal justice system and to build improved relations between local communities and the Police. The aim of the DEP is to educate participants about the health, social and legal effects of drugs and to encourage attitude and behaviour change towards desisting from further drug misuse or drug-related offending. This report presents an evaluation of the DEP using mixed research methods and provides recommendations for its future development. The evaluation was undertaken between October 2020 and November 2021.

2.0 BACKGROUND & CONTEXT

2.1 The Drug Education Programme

The Drug Education Programme has been commissioned on behalf of Avon and Somerset Constabulary since 2016 by NHS England and the Avon and Somerset Police and Crime Commissioner's Office (OPCC) on a five-year contract.. From 2016-19, it was delivered by Swanswell Drug and Alcohol Recovery Service within Bristol, and from 2019 by Avon and Wiltshire Mental Health Partnership NHS Trust and extended across the Avon and Somerset Force area. It operates as a partnership between the OPCC, Avon and Somerset Constabulary, Avon and Somerset Custody and Courts Service and Avon and Wiltshire Mental Health Partnership NHS Trust.

The programme offers an alternative to arrest and potential conviction, offering adults aged 18 years and over who are caught in possession of illegal drugs with the opportunity for diversion away from a criminal justice outcome. Individuals who are referred to the DEP participate in an educational session, either face-to-face or online, led by trained drug education facilitators employed by Avon and Wiltshire Mental Health Partnership NHS Trust. The programme aims to educate participants about health impacts, social harms and legal implications of using or possessing illegal drugs. Individuals who are caught in possession of drugs may be referred to the DEP by an arresting police officer; the decision to make the referral is at the discretion of the police officer but is aligned with PACE (Police and Criminal Evidence Act 1984) codes of practice that regulate police powers. The individual offender must admit culpability at the time of the suspected offence and be willing to attend the DEP. Referral can be offered irrespective of the type of drug an individual was found to be in possession of or the extent of any previous offending. However, individuals can only attend the DEP once, so those who successfully complete the DEP but who are subsequently caught in possession of drugs are not permitted to re-attend the programme and will likely receive a criminal justice outcome (a caution or charge for possession). On successful completion of the DEP, participants receive a letter and certificate of attendance that states that no further action will be taken and that the incident will not show up on future criminal record checks.

2.2 Drug Education Schemes

Drug education programmes are essentially diversion – or "arrest referral" – schemes that offer an alternative to a criminal justice outcome (arrest, prosecution or conditional caution). Arrest referral was introduced in England and Wales in 2002 as a technique for engaging with users but not as an alternative to prosecution or due process. Referral would occur in the police custody suite at a police station once an individual had been detained and assessed by a healthcare provider or independent specialist drugs worker (Hunter et al, 2005). It would involve providing arrestees with information about drug misuse and, where appropriate, intervention by healthcare or drug services during custody (Sondhi et al., 2002). With the publication of the Bradley Report in 2009 into liaison and diversion services for people in the criminal justice system, referral and diversion shifted the emphasis towards health and welfare outcomes for individuals presenting with drug and alcohol problems, with criminal justice agencies, health providers and drug treatment services working in partnership to provide tailored solutions, and thereby diverting arrestees into more appropriate treatment and support (Home Office, 2011). Contemporary diversion schemes therefore tend to be partnership initiatives established between police, local healthcare organisations and drugs services that use the point of arrest to divert individuals into drug treatment, harm reduction initiatives or drug education services before an individual is formally charged with an offence. This is most commonly used for individuals caught in possession of illegal drugs for personal use or involved in minor supply or cultivation offences. Police diversion schemes have proliferated across England and Wales, including by the police forces of Avon & Somerset, Bedfordshire, Cleveland, Derbyshire, Devon and Cornwall, Durham, Dyfed-Powys, Hampshire, Hertfordshire, Humberside, Kent, Leicestershire, North Wales, Thames Valley and the West Midlands,.

Debate on alternatives to criminal justice outcomes for drug related offending remains prominent on the policy agenda, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA 2015) presenting two main lines of argument in favour of drug education as a diversion mechanism:

1. The argument that education is effective in changing behaviour and thereby reduces the impact to individuals and to society of drug misuse; and
2. The argument that education can reduce the structural burden on criminal justice systems and agencies by diverting non-problematic drug misuse towards health and welfare services.

However, the success of drug education as an effective diversion strategy is contested. Effectiveness and efficacy depend on a range of factors including educational methodology, funding and resources, social and cultural contexts, demographic character of target populations, and so on. Drug education is nonetheless recognised as a key prevention objective within the EU Drugs Strategy, which states that:

> *"In order to prevent crime, avoid recidivism and enhance the efficiency and effectiveness of the criminal justice system while ensuring proportionality, the EU shall encourage, where appropriate, the use, monitoring and effective implementation of drug policies and programmes including arrest referral and appropriate alternatives to coercive sanctions (such as education, treatment, rehabilitation, aftercare and social reintegration) for drug using offenders"* (Council of the European Union, 2012)

The United Nations has for more than 40 years recommended that people who misuse drugs should be offered appropriate and effective alternatives to conviction or punishment measures, such as "*treatment, education, aftercare, rehabilitation and social reintegration*", essentially rehabilitative measures rather than deterrent or retributive responses (United Nations 1961, Article 36(1)(b)). It also recognises that these need not be exclusively delivered by criminal justice agencies but via "*bridges between the criminal justice system and the treatment system*" (UN 1998a, para. 3.108).

The EMCDDA (2015) suggests that alternatives to punishment or coercive sanctions can address five key objectives:

- A proportionate response to drug-related offending behaviour;
- A reduction in drug-related crime and offending (Holloway et al. 2006);
- Reduced communicable and non-communicable disease prevalence;
- Reduced societal impact, particularly on social and welfare systems; and
- Reduced pressure on criminal justice system resources and infrastructure.

Avon and Somerset Constabulary's DEP is a pre-arrest diversion programme for people caught in possession of any illegal drug. It involves deferring a summons to court, with no further action taken if the person attends the DEP, similar to a speeding awareness course. If the individual attends and successfully completes the DEP, prosecution is not pursued and an offence is not recorded against the individual. This avoids the potential disruption and stigmatisation associated with having a criminal record. However, individuals who are referred and then do not attend or successfully complete the DEP are subsequently charged with an offence and summoned to court. Most referrals to the DEP are for those commonly identified

as "non-problem" drug users. These are individuals whose behaviour the police would consider to be non-problematic in terms of health and societal impact, but who can bring a disproportionate burden to the criminal justice system should formal arrest and prosecution ensue. "Problematic" drug users, on the other hand, tend to be those with a history of drug misuse, addiction or possession; these are not necessarily excluded from the DEP provided that a referral has not been made before and the police perceive that this could achieve a potentially beneficial outcome.

2.3 Behaviour Change Approaches

Most health behaviour change theories and models have evolved since the 1960s from within social psychology. These primarily identify the individual as the locus of behaviour, placing greater or lesser importance on external societal and environmental factors, but placing significant emphasis on individual agency. Others have focused either on the behaviour exclusively or on the relationship between the behaviour, the individual and the environment. Most models of behaviour change that focus heavily or exclusively on individual knowledge and understanding underestimate the impact of social context on human agency. In this vein, the convention for many drug education programmes has been to employ interventions that singularly aim to build knowledge and understanding on the nature and harmful effects of illicit substances. This approach assumes a common sense causal link between knowledge, attitudes and behaviour (Goodstadt 1978; Stoker 1992); it also assumes that individuals can and will take personal responsibility for their behaviour once they are know and understand the harms associated with drug misuse. However, this sole focus on individual agency can either ignore or underestimate significant normative cultural, social and economic factors that influence attitudes, behaviours and individual choice. It also assumes that increased knowledge and understanding about drug misuse will foster a negative attitude towards drugs and bring about positive behaviour change.

Darcy (2021:91) plainly states that "*drug information refers to just that, the provision of information about drugs*." This may include descriptions of drugs, information on their chemical consistency and their effects, it can take the form of didactic talks or presentations, leaflets or posters, awareness campaigns, and so on. On the other hand, drug education is "*a systematic process of teaching and learning that involves imparting and acquiring knowledge about drugs to achieve understanding*." Moreover, it should be age appropriate, developmental and have achievable learning outcomes, and empower the learner to cope with and manage social contexts where drugs are available or commonly used (Darcy 2021).

Most drug education programmes, however, use a combination of information-based education (knowledge and understanding), life skills or "resistance" training and normative education (Allot et al 1999); "normative" here refers to learning about normative belief systems, social norms and peer relations. This approach was derived from the social influence model introduced by McGuire (1964), which evolved through the 1970s (Bandura 1977; Evans, 1978; Fishbein and Ajzen 1974). It assumes that drug misuse primarily manifests as a social phenomenon; individuals are initiated into drugs through social pressure from a variety of sources including mass media, peers and significant others. Behaviour change is facilitated through exposure to counter arguments (knowledge and understanding) supported with practical or life skills training and peer education. An example of this approach was the DARE (Drug Abuse Resistance Education) project in the United States, a police education collaboration based on Evans' (Evans 1976) social influence model. This emphasised the use of resistance skills training and normative education, and was introduced to the UK in the mid-1990s. However, evaluations of DARE produced conflicting results, suggesting that while participants showed increased knowledge of illicit drugs, more positive attitudes towards police officers and were more able to resist peer pressure (De Jong 1987; Clayton et al 1991), longer term behaviour change effects were not observed. Allot et al (1999), moreover, argued that peer influence can be overstated, assuming that individuals who use drugs are indeed persuaded to do so by their peers in the first place.

The Transtheoretical Model of behaviour change, also known as the Stages of Change Model, was developed by Prochaska and DiClemente in the 1980s to explain the process of intentional health behaviour change (Prochaska and DiClemente, 1984; Prochaska et al 1985). It proposed that individual behaviour change can occur in six stages:

- *pre-contemplation* - the individual does not intend to take action and may be unaware that their behaviour is problematic;
- *contemplation* - the individual intends to take action and recognises that their behaviour may be problematic but may feel ambivalent towards changing their behaviour;
- *preparation* - the individual is ready to take action and to start to take small steps toward the behaviour change;
- *action* - the individual has changed their behaviour and intends to keep moving forward;
- *maintenance* - the individual has sustained their behaviour change and intends to maintain the behaviour change going forward;
- *termination* - the individual has no desire to return to their unhealthy behaviours and is sure they will not relapse.

While the model has limited utility in terms of its effectiveness (West 2005), importantly it proposes that people do not change their health behaviour quickly or decisively but may

move through these stages, often regressing as well as making progress. Since health behaviour change requires conscious decision-making – or free choice on the part of the individual – this process is greatly impeded when individuals exhibit longstanding habitual or addictive behaviour that is entrenched and semi-automated through repeated reward and punishment (West 2005). Despite extensive criticism of the model and a lack of clear evidence to support its effectiveness, it is still widely used for drug education interventions (Dupont et al 2017). Motivation for change is likely to be an important trigger for reducing or resisting drug misuse. Indeed, Dupont et al (2017) have argued that interventions that seek to motivate individuals to change their behaviour when they are at the stage of *contemplation* may be successful for some individuals. They conducted a study with 131 young people aged 14-24 years, who had a clear relationship with cannabis, associated problems at school, work or with social relationships, and who were at risk of developing problematic drug misuse. Using a programme of drug education based on motivational interviewing, they concluded that an education intervention that keeps participants too long in the contemplative stage may do more harm than good. In other words, more talking and thinking about drugs without an accompanying 'nudge to action' and a strategy for dealing with ambivalence, may lead to more rather than less drug misuse. Hence, a well-intentioned and theoretically sound intervention may bring more disadvantages than benefits (Dupont et al 2017). This implies that less emphasis should be placed on contemplation and more should be given to actions or skills that enable individuals to make changes to their behaviour. Furthermore, because a participant shows some degree of motivation to engage in an education programme (e.g. by agreeing to participate and then attending the programme), this does not mean that they necessarily want to or intend to change their behaviour.

Vasiliou et al (2021) have suggested that ill-conceived drug education programmes can be narrow in focus, principally addressing what are misperceived as knowledge deficits, problematic social norms and low motivation for behaviour change; in other words, the educator will assume the student has a knowledge deficit, a social network or peer group that condones drug misuse and is not motivated to reverse their drug misuse behaviour. Also, they have pointed out that drug education programmes commonly adopt a one-size-fits-all approach, involving participants from diverse cultural and demographic backgrounds with different levels of drug misuse and different health behaviour patterns. Thus, while such interventions can show a short term benefit, they may be less effective at addressing broader contextual social, cultural, environmental and economic factors that may influence individual behaviour. Also, they will vary in their ability to support individuals' health, social, welfare and developmental needs. Drug education that is therefore contextually driven – and therefore relevant to participants' lives – is likely to achieve greater traction towards sustained behaviour change given that it will attempt to address social, psychological and situational

determinants of drug taking behaviour (Hansen et al 2017; Zhang et al 2018). It is unrealistic to assume that drug education will address complex socio-cultural and environmental factors that contribute to illicit drug use. This is not to suggest that drug education is ineffective but that it should not be set against unrealistic aims and expectations. Certainly, published evidence shows that soundly conceptualised and rigorously implemented programmes can influence drug using behaviour in positive ways and can produce net social cost savings to society (Midford et al 1999).

2.4 Evaluating Success of Drug Education

Referral schemes aimed at producing positive criminal justice or health outcomes are challenging to evaluate, especially where there are multiple complex objectives. These reflect the often varied values and goals of partner agencies or stakeholders, or indeed of society and of individuals who participate in these schemes, which make it difficult to establish reliably whether an intervention 'works' or is effective. Essentially, there are different ways to measure success. For instance, the desired outcome of drug education could be for participants to:

1. Attend the programme;
2. Actively engage with the learning;
3. Show measurable changes in knowledge, understanding and/or skills;
4. Feel the programme has benefited them personally;
5. Show potential to desist from (mis)using drugs in the future;
6. Actually desist from (mis)using drugs in the future;
7. Demonstrate measureable improved health and wellbeing in the future;
8. Desist from offending or re-offending.

Such outcomes can be measured subjectively (using qualitative research) or objectively (using quantitative research). Over extended time periods, these can be difficult to measure, especially if participants are transient, hard to access and/or reticent about taking part in research. Therefore, measuring success is contingent on the questions asked and the quality of data available; conclusions must be drawn carefully with awareness of the limitations of what can be measured.

A Europe-wide evaluation of non-criminal justice disposals for drug using offenders found that large numbers of individuals were diverted into treatment or education without systematic follow-up or review of effectiveness of these alternative disposals (EMCDDA 2015). Hayhurst et al (2015), in their international systematic review of effectiveness of diversion

programmes for Class A drug users, found that high quality evidence on effectiveness of diversion schemes was sparse, identifying lack of clear programme outcomes and limited evaluation methodologies. There is a paucity of robust evidence of effectiveness of drug referral programmes, which partly stems from unclear primary objectives for most programmes, for instance whether they seek to reduce imprisonment, treat addiction, reduce drug-related crime, reduce pressure on justice systems, etc. This lack of robust evidence in turn brings into question the credibility of rehabilitative or educational schemes, which can lead to loss of political support and loss of funding potential. High quality evaluation is therefore essential to be able to evidence the effectiveness of drug education programmes. In this regard, an important key to success is to ensure that drug education programmes are designed to meet realistic objectives rather than idealised outcomes.

3.0 EVALUATION METHODOLOGY

3.1 Aims and Objectives

The aim of this evaluation was to explore and review the impact of Avon and Somerset Police's Drug Education Programme using a mixed methods approach. More specifically, Police and commissioners were keen to review the use of the programme as a diversionary approach in terms of reducing drug related harms and understand whether the approach was making a difference for those going through the DEP. The evaluation comprised an analysis of anonymised secondary DEP referral data for the period November 2018 to January 2021 (two years and two months) and a qualitative analysis of interviews involving a range of key stakeholders and DEP providers.

The quantitative phase had the following objectives:

- To identify and interpret significant demographic features of the data.
- To review and identify significant DEP referral, uptake and completion patterns.
- To investigate the extent to which completion of the DEP *may* impact drug misuse or drug related offending, arrest or conviction.

This third objective must be qualified since there could be a variety of reasons why an individual shows a change in their behaviour. Police records cannot provide this level of insight but can only show whether or not there *may* have been a change of offending behaviour in the short term from which one *might* infer that the DEP was a trigger to behaviour change. Essentially, the data would only show if an individual had not come into contact with the police again, rather than infer that the DEP had resulted in a change of behaviour.

The qualitative phase had the following objectives:

- To explore how DEP participants (referrals) and stakeholders perceived and interpreted the DEP in terms of meeting personal and professional objectives.
- To understand the merit and utility of the DEP as an educational process.

Again, to qualify, this qualitative phase of the evaluation would examine subjective perspectives (expressed values, opinions, beliefs, experiences, etc.) of those involved directly and indirectly with the DEP, with the purpose of gleaning insight into the DEP to inform future

debate about its efficacy and appropriateness. Qualitative data cannot provide evidence of effectiveness of behaviour change interventions.

3.2 Research Ethics & Governance Requirements

The project was granted full research ethics approval by the University of the West of England's Research Ethics Committee in September 2020 (UWE REC REF No: HAS.20.07.199). Access to secondary data from the anonymised records from Avon and Somerset Police's NicheRMS365 Integrated Records Management System (referred to hereon as 'Niche') was provided in December 2020, following a Data Protection Impact Assessment (DPIA). The ethical approval granted permission to undertake online one-to-one digitally recorded interviews in Microsoft Teams with DEP participants, DEP facilitators and key stakeholders. All data storage and transfer – of quantitative Microsoft Excel data and qualitative interview recordings – was undertaken in compliance with UWE Bristol's Data Protection Regulations, the Data Protection Act 2018 and the General Data Protection Regulation 2018. Consistent with these, all research data were transferred to an encrypted Microsoft Outlook OneDrive folder to which only the evaluation team at UWE Bristol and the data provider from Avon and Somerset Police had access, the latter only to the anonymised excel data. Before transferring the Niche data to the UWE OneDrive, Avon and Somerset Police anonymised these data tagging each offender with a unique alphanumeric code (e.g. P0036) so that individuals could not be identified from the data. No hard copy research materials were used and all stored electronic data were destroyed on completion of the project. Individuals who were invited to participate in the evaluation as interviewees were asked to provide their informed consent. As part of the consent process, participants were advised that their involvement would be entirely voluntary, that they could ignore or decline to take part, or withdraw their consent and participation at any stage without adverse consequences. Potential participants were sent a Participant Information Sheet for reference and asked to sign and return an electronic consent form. The relevant documentation relating to consent, privacy and participant information are appended to this report.

3.3 Quantitative Phase

The evaluation team were supplied with 12,681 anonymised records from Avon and Somerset Police's Niche System, which comprised DEP referral data for the two year period November 2018 to January 2021. These were available as a series of excel spreadsheets that provided data on 3,659 offenders. The final combined dataset provided demographic details on each offender and information about their offending histories; these included offence group and

offence description for the offences that triggered the DEP referral. The data required intensive 'cleaning' to bring eight separate data sheets together in a coherent form, matching individuals across and removing duplicates or non-relevant records.

Table 1 provides a summary of the categories of data that were available from the original Niche data sheets, with brief explanation of key terminology. This is followed by some explanation of the offence codes and outcomes.

Table 1. Data categories from the Niche Integrated Records Management System

Variable	Explanation
Person ID	Anonymised alphanumeric code..
Person Flag Date	Date individual was added to Niche as record of a 'Positive Outcome'.
Age	Age at the time the DEP positive outcome was recorded (18 years and above).
Sex	Male or Female.
Ethnicity	IC1 (White, North European); IC2 (White, South European); IC3 (Black); IC4 (South Asian); IC5 Chinese, Japanese or Southeast Asian; IC6 (Arabic or North African); IC7 (mixed ethnicity).
Local Authority (domicile)	South Gloucestershire, Bath and North East Somerset, Bristol, North Somerset, Somerset, out of force area.
Positive Outcomes pre-DEP	Number of previous positive outcomes recorded (prior offending history).
Positive Outcome Categories pre-DEP	Offence Categories recorded as Positive Outcomes (all offences).
Positive Outcomes pre-DEP (drug-related)	Number of previous drug-related crimes recorded as Positive Outcomes (drug offending history).
Positive Outcome Categories pre-DEP (drug-related)	Drug-related offence descriptive categories as Positive Outcomes
Beat Code/Location of offence leading to DEP referral	Location of offence within one of 123 neighbourhoods in the Avon and Somerset Force area spanning five local authorities: South Gloucestershire, Bath and North East Somerset, Bristol, North Somerset, Somerset.
Outcome Classification (for DEP referral)	Outcome Code (OC1-OC22), describing the category of the outcome used by the attending police officer.
Offence Code	The Home Office numerical code attributed to the 'offence group'.
Offence Group	The Home Office 'offence group', i.e. police recorded 'victim-based crimes' (violence against the person, sexual offences, robbery, total theft offences, criminal damage, arson), and police recorded 'other crimes against society' (drug offences, public order offences, miscellaneous).
Offence Description	Home Office subgroup of the offence group.
Drug-related Offence Description	Home Office subgroup within Drug Offences group.
Positive Outcome after DEP	Police outcomes occurring post DEP (successive offending).
Positive Outcome after DEP (drug-related)	Drug-related police outcomes occurring post DEP (successive offending)

Police forces supply data to the Home Office using a broad outcomes framework that covers the range of possible 'disposals' available to the police, including the option to charge, caution, dismiss or divert an individual if there is suspicion that a crime has been committed. A 'positive outcome' refers to the decision or judgement the attending police officer makes and records – for example, to 'charge' the individual, to give a 'caution' or to divert them to a non-criminal justice intervention. Table 2 shows the full range of disposal outcomes available to the police. Police officers exercise their professional judgement in accordance with PACE to determine the most appropriate outcome (Home Office 2021). Outcome 22 is used for diversionary, educational or intervention activity purposes where further criminal justice action is deemed not to be in the public interest; this outcome would normally be used to refer individuals to the DEP. However, as Outcome 22 was introduced in April 2019, referrals to the DEP prior to this were recorded as Outcome 10 (not in the public interest).

Table 2. Outcomes Framework (Home Office 2021)

Outcome	Descriptor
1	Charge and or Summons
2	Caution - youths
3	Caution - adults
4	Taken into consideration
5	The offender has died (all offences)
6	Penalty Notice for Disorder
7	Cannabis warning
8	Community Resolution
9	Prosecution not in public interest (CPS) (all offences)
10	Formal action against the offender is not in the public interest (police decision)
11	Prosecution prevented - named suspect identified but is below the age of criminal responsibility
12	Prosecution prevented - named identified suspect identified but is too ill (physical or mental health) to prosecute
13	Prosecution prevented - named suspect identified but victim or key witness is dead or too ill to give evidence
14	Evidential difficulties victim based - named suspect not identified but the victim declines or is unable to support further police action to identify the offender
15	Evidential difficulties - named suspect identified and the victim supports police action, but evidential difficulties prevent further action
16	Evidential difficulties victim based - named suspect identified - the victim does not support (or withdraws support from) police action
17	Prosecution time limit expired - suspect identified but the time limit for prosecution has expired
18	Investigation complete - no suspect identified. Crime investigated as far as reasonably possible - case closed pending further investigative opportunities becoming available
19	National Fraud Intelligence Bureau field (NFIB only). A crime or fraud has been recorded but has not been allocated for investigation because the assessment process at the NFIB has determined there are insufficient lines of enquir1 to warrant such dissemination

20	Further action, resulting from the crime report, will be undertaken by another body or agency subject to the victim (or person acting on their behalf) being made aware of the action to be taken.
21	Further action, resulting from the crime report, which could provide evidence sufficient to support formal action being taken against the suspect is not in the public interest - police decision.
22	Diversionary, educational or intervention activity, resulting from the crime report, has been undertaken and it is not in the public interest to take any further action.

As mentioned previously, it was necessary to combine and 'clean' the different data sheets to create a single dataset that could be analysed. The following steps were therefore taken to do this:

- Each case (individual offender) was tagged with an anonymous alphanumeric ID.
- Eight data sheets were combined manually in Excel to create one comprehensive spreadsheet.
- The final dataset was imported to SPSS (Statistical Package for the Social Sciences) for analysis.
- The total database of 12,681 records represented 3,659 individual offenders.
- 2822 individuals had been referred to the DEP as either Outcome 22 (1,667) or Outcome 10 (1,155).
- Of the 3,695 individuals, 2,461 were discarded leaving 1,198 for analysis.
- Of the 2,461 that were discarded:
  - 1279 were duplicates or had missing data;
  - 1,015 had no drug offences against their record;
  - 166 were under 18 years at the most recent entry date on Niche;
- For individuals with consecutive offences (positive outcomes), the most recent drug offence was identified as the reason for the DEP referral.
- For individuals with concurrent offences (positive outcomes), the drug offence with the highest count and then severity was used as the reason for the DEP referral.
- Individuals who had committed a historical drug offence but whose recent offending was not drug related were removed.
- The final dataset was checked in consultation with the Avon and Somerset Police data team.

After the dataset had been cleaned in this way, 1,198 individuals aged 18 years and over had been identified as having committed drug offences and referred to the DEP during the 26 month period. For this final sample, data were available for the following variables:

- Age at time of DEP referral
- Sex (male or female)

- Ethnicity (IC1-IC7 or unknown)
- Local Authority area (domicile)
- Offence Group (at time of DEP referral)
- Offence Description (at time of DEP referral)
- Age Range from age of first offence*
- Number of recorded offences since first offence*
- Number of recorded drug offences since first offence*
- Number of recorded other offences since first offence*
- Post-DEP Re-offence Description

  * earliest possible recorded date of first offence was 10 years consistent with the age of criminal responsibility.

SPSS was used to undertake basic descriptive and inferential statistical analysis. This enabled the basic features of the data to be summarised numerically and visually, and to measure potential relationships between variables in terms of frequency distribution, central tendency and variability within the dataset.

3.4 Qualitative Phase

The expectation was that one-to-one qualitative interviews would be undertaken with individuals who had successfully completed the DEP and with various key stakeholders including DEP facilitators and Police representative. Limitations caused by the COVID-19 pandemic meant that that interviews had to take place online and, despite repeated efforts by the DEP team, DEP attendees did not volunteer to be interviewed to be interviewed. The interviews were therefore confined to key stakeholders and conducted in Microsoft Teams. These were digitally audio recorded to enable thematic analysis and each interview lasted between 45 and 60 minutes. These explored individuals' knowledge, understanding, interpretations and opinions of the DEP, focusing particularly on its perceived impact on participants.

The Police and OPCC supplied contact details for individuals who either delivered the DEP or had a good working knowledge of it. They comprised employees of Avon and Wiltshire Partnership NHS Trust, volunteer facilitators and peer mentors and various ranks of police from across Avon and Somerset Constabulary. Each participant was invited by email to participate in an online interview. This was a modest convenience sample of nine interviewees. The intention was to select participants on the basis of their experience. In the case of police participants, these were individuals who were either involved in establishing the DEP or who

had employed Outcome 10 or 22 to divert offenders to the DEP. The other group of interviewees comprised individuals who had first-hand experience of running the DEP and working with those who had been referred to the DEP. The interviews were designed to explore in depth these stakeholders' knowledge, understanding and experience of drug education and of the opportunities and challenges the DEP presented. The interviews took a conversational style, exploring participants' insight, experiences and opinions. They were subsequently transcribed verbatim and then thematic analysis was employed to elicit themes across the data.

4.0 QUANTITATIVE FINDINGS

4.1 Introduction

As stated in the previous section, 12,681 records were retrieved from Niche, which represented 3,659 individual cases for the period November 2018 to January 2021. Police Force Area data show that for the Avon and Somerset Force Area (ONS 2021), 10,456 drug offences were committed during this period, an average of 3,485 per year. The 1,198 referrals to the DEP that formed the final dataset for this analysis therefore represented approximately 11% of drug offenders in the region. The large number of initial records (12,681) reflected a prolific history of offending for some individuals and therefore a level of complexity that had to be managed carefully to ensure accuracy. Evidently, large numbers of individuals were referred to the DEP with consecutive and/or concurrent offences.

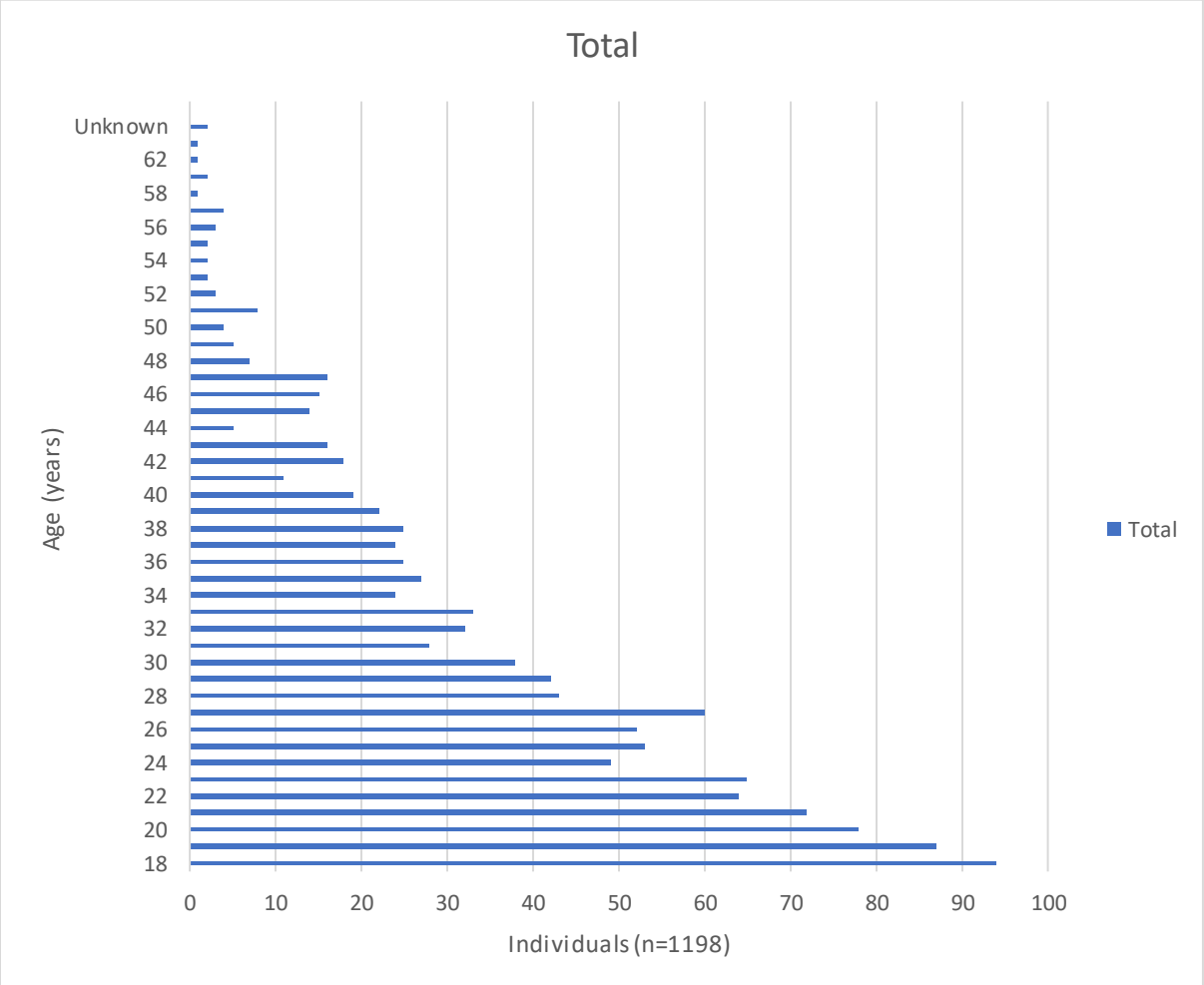
This section begins with an overview of the demographic characteristics of the individuals referred to the DEP, with reference to age, sex, ethnicity and local authority area. It then examines the offending profiles of individuals including their offending histories, types of drug offence that led to the DEP referral and prevalence of re-offending. It must be emphasised that due to the small overall sample size, inferences or trends are identified in the data which do not necessarily translate into reliable or generalisable findings, especially where small numbers within subcategories are discussed.

4.2 Demographic Features of DEP Referrals

Age Distribution

Of the 1,198 cases, the age range of individuals at the time they were referred to the DEP was 18 to 68 years as illustrated in Figure 1. The mean age was 28 years with a standard deviation of 9.105. This infers that while most individuals tended to be young (in their late teens and early twenties), there were significant numbers of individuals across the age range, suggesting that cohorts who attended the DEP were diverse in terms of age distribution. These age variations likely reflected diverse backgrounds of individuals who attended DEP sessions, especially in terms of stage of life-course, educational and occupational background, socioeconomic status and offending history. Most attendees were young with a minority of older participants.

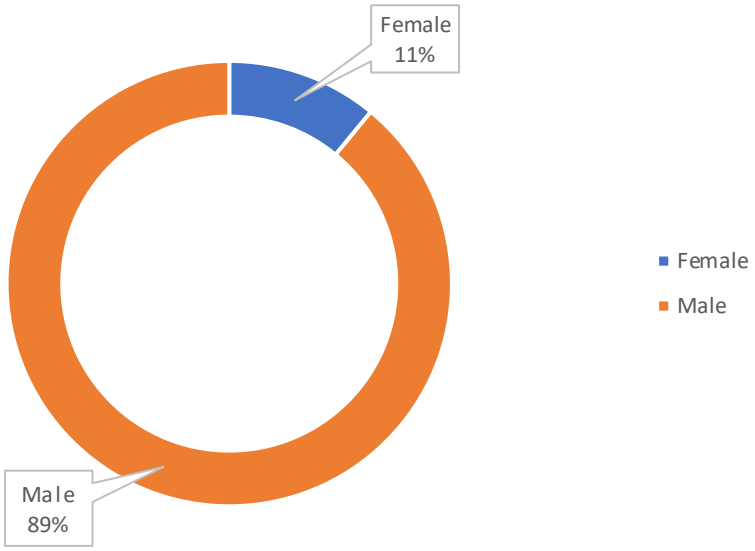
Figure 1: Age of DEP Referrals (n=1,198)



Sex

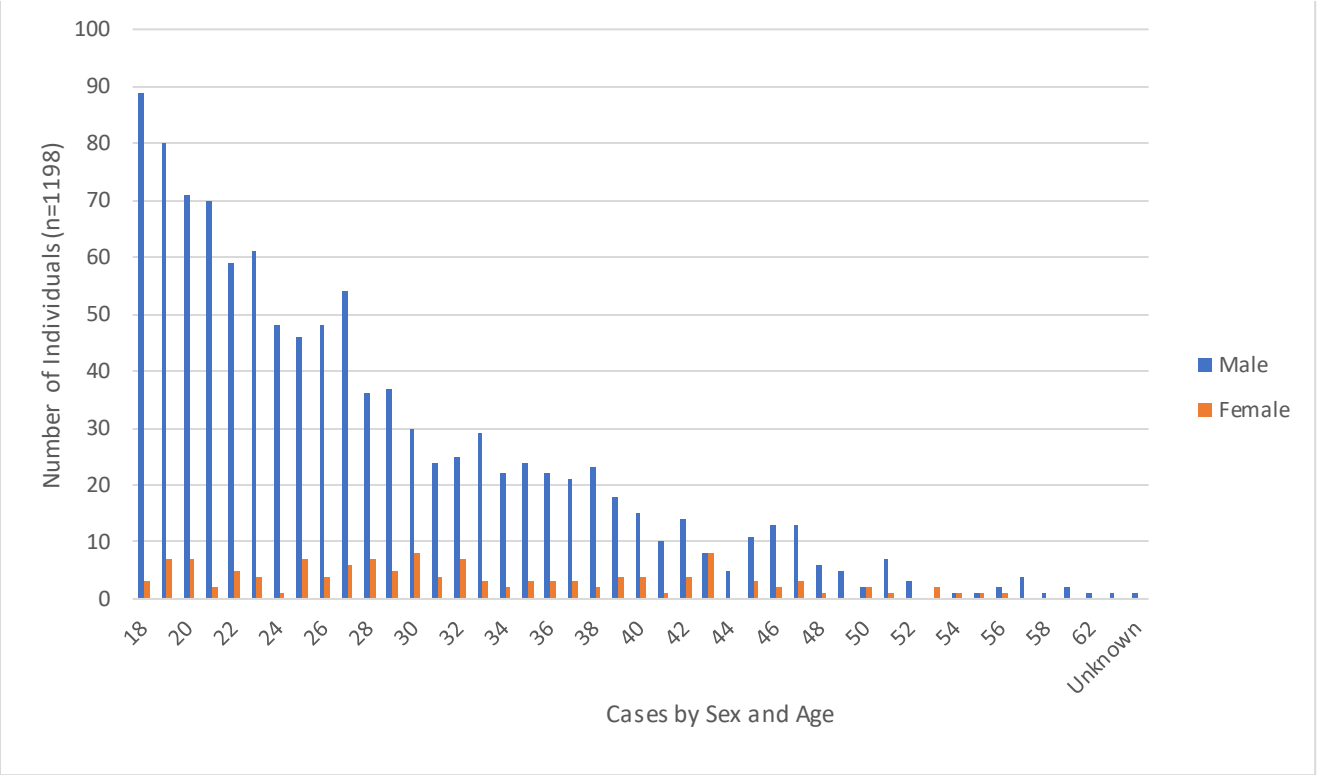
Of the 1,198 cases, 1,063 (89%) were male and 131 (11%) were female (4 unknown). Most individuals who were diverted to the DEP were therefore male (Figure 2).

Figure 2. DEP Referrals by Sex



The mean age of females was 32 years with a standard deviation of 9.5, and for males, 28 years with a standard deviation of 9. As Figure 3 illustrates, however, for males there was a strong skew towards the youngest age range, with 18 years being the most commonly occurring age (the mode), whereas for females the most commonly occurring age was 30 years. The standard deviations for both groups suggest quite a broad spread across the age ranges although it can be seen from the histograms that males were significantly younger while females were more evenly distributed across the age range. It is not clear how these were distributed over time or the proportions that attended each DEP session, but females were significantly underrepresented, although equivalent to the national average for female arrests for notifiable drug offences, with the proportion at 88% for males and 12% for females (Allen and Kirk-Wade 2020:10). In terms of DEP referrals, this would suggest an average of 5.5 female participants per month compared with approximately 44 male participants per month (ratio of 1:8). Given the relatively small numbers of women, it may be worthwhile reviewing the appropriateness of running mixed gender groups.

Figure 3. DEP Referrals by Age and Sex



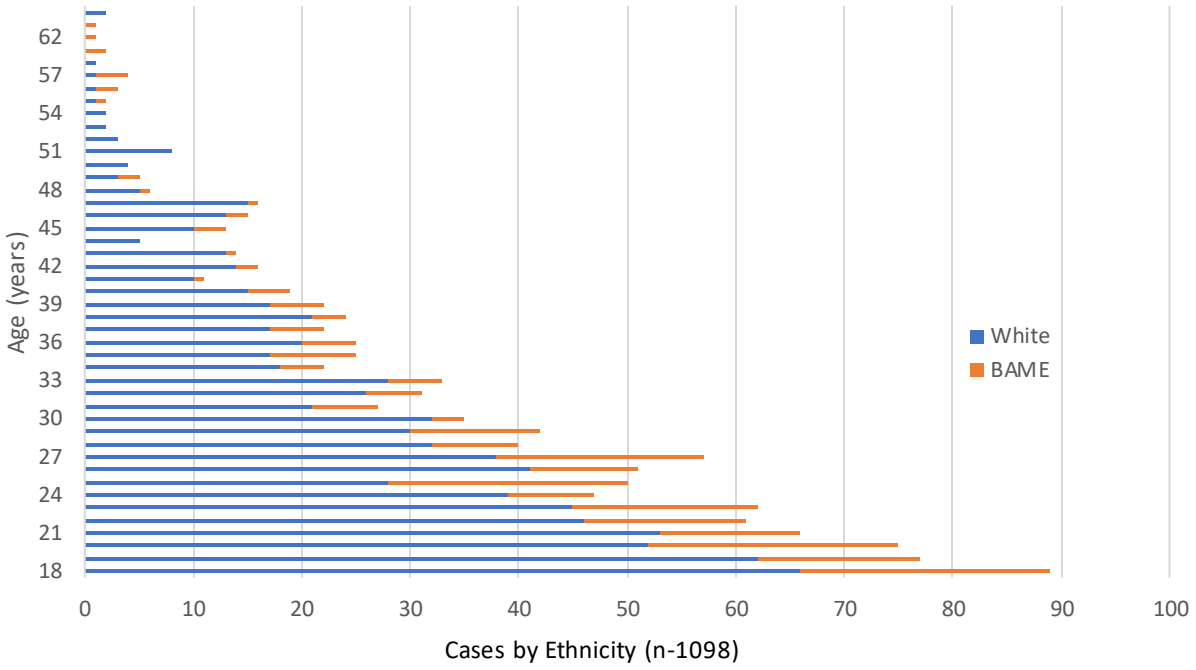
Ethnicity

Table 3 shows the numbers and proportions of individuals by ethnicity classification (IC1-IC7) referred to the DEP during the 26 month period of data collection. The majority were North European white and the second largest group were black. Of the 1,198, 73% (877) were, moreover, identified as white and 22% (261) as being black or from a minority ethnic group, as illustrated in Figure 4.

Table 3. Ethnicity of DEP Referrals (n=1198)

Home Office Ethnicity Code	Number	Percentage
IC1. White - North European	862	72.0%
IC2. White - South European	15	1.3%
IC3. Black	158	13.2%
IC4. South Asian	42	3.5%
IC5. South-East Asian (Chinese, Japanese, SE Asia)	2	0.2%
IC6. Arabic/Middle Eastern/North African	4	0.3%
IC7. Mixed	55	4.6%
Unknown	60	5.0%

Figure 4. DEP referrals by ethnicity and age

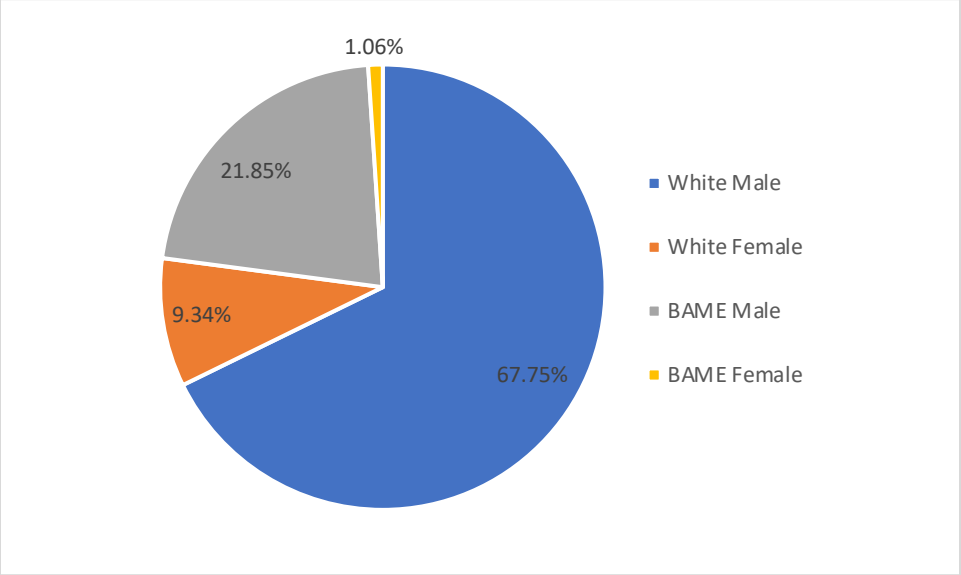


The sample is too small to provide a reliable interpretation of these proportions. Nevertheless, for the Avon and Somerset Force area, the proportions of people from a black or ethnic minority group make up 6.8% of the population, with a higher proportion (16%) concentrated in Bristol (Avon and Somerset Constabulary 2017). From these small numbers, it appears that, for the force area as a whole, proportionally more people from a black or ethnic minority group were referred to the DEP relative to the white population, which mirrors the greater likelihood that a person from a black or ethnic minority background will be stopped and searched by Avon and Somerset Police compared to people who were white, which is currently reported to be 4.2:1 (Avon and Somerset Police and Crime Commissioner 2020). Additionally, despite this apparent higher proportion of DEP referrals of people from black or ethnic minority backgrounds, absolute numbers of referrals to the DEP were small, with an average of 20 per month compared with 82 white referrals per month. Ethnic or racial mix within drug education programmes, however, may have some effect on participation levels and group dynamics that could be further investigated.

When ethnicity was examined by sex for the DEP sample (Figure 5), this reveals that only 1.6% (n=12) of DEP referrals were female and black or from an ethnic minority background, whereas one fifth (248) were males and black or from an ethnic minority background. The majority (68%) were therefore white males, followed by males who were black or from an

ethnic minority background (22%), then white females (9%) and then females black or from an ethnic minority background (1%).

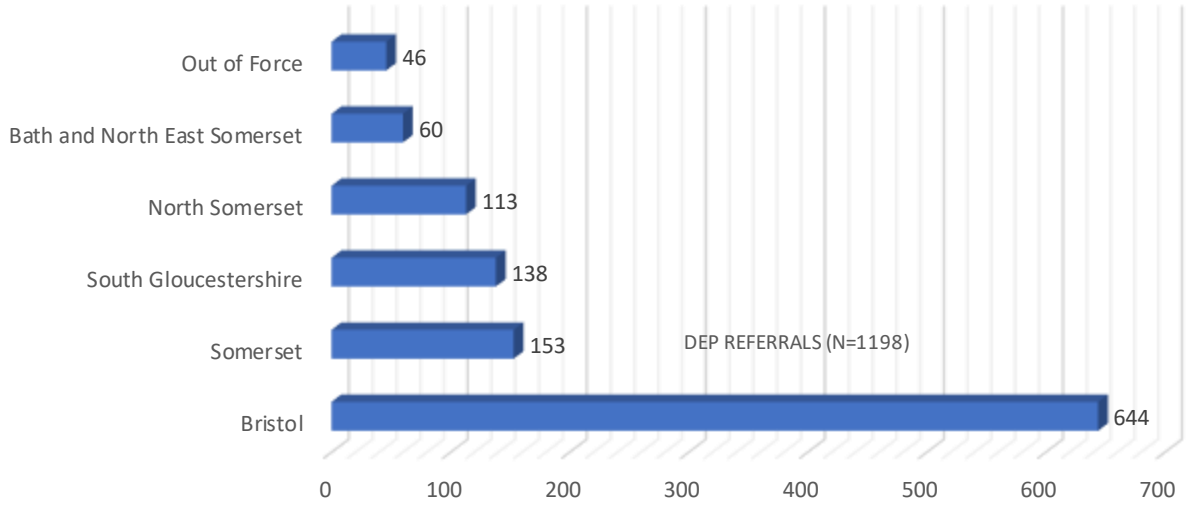
Figure 5. DEP Referrals by Sex and Ethnicity



Local Authority Residence

Residence information for the 1,198 individuals referred to the DEP was available at the local authority level (see Figure 6). Around half of referrals came from Bristol, which has 27% of the force area population. This suggests that more people were referred to the DEP per capita than for other local authorities. This could infer a range of possible determining factors; for instance, Bristol may have proportionally more people who become involved with drugs either for the first time or as a longstanding problem; Bristol also has a larger proportion of younger age groups relative to more rural counties and a large student population. The higher population density may also result in a greater likelihood of being caught in possession of drugs, along with higher detection rates and higher overall crime rate. Furthermore, the DEP has been in operation in Bristol for the longest period, which may suggest that beat officers were more likely to be aware of it as an OC22 disposal.

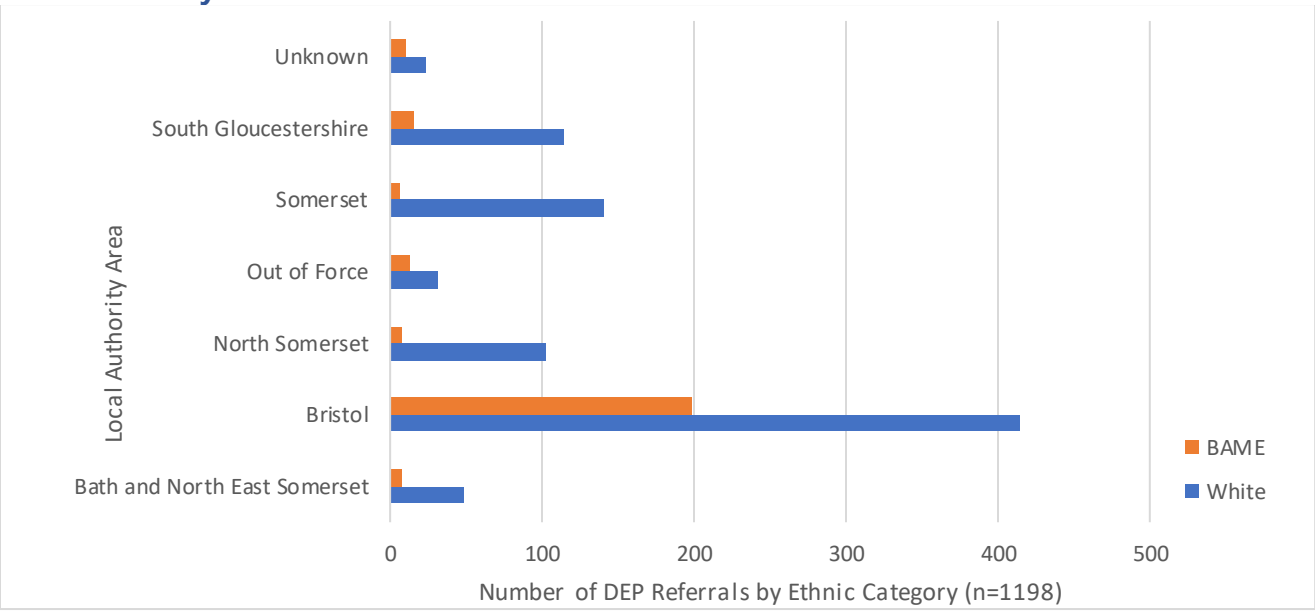
Figure 6. DEP Referrals by Local Authority Residence



	Bristol	Somerset	South Gloucestershire	North Somerset	Bath and North East Somerset	Out of Force
Total	644	153	138	113	60	46

When ethnicity was examined in relation to local authority area, this shows that a larger proportion of DEP referrals in Bristol were black or from an ethnic minority background. This was markedly different to the other local authority areas as represented in Figure 7 below.

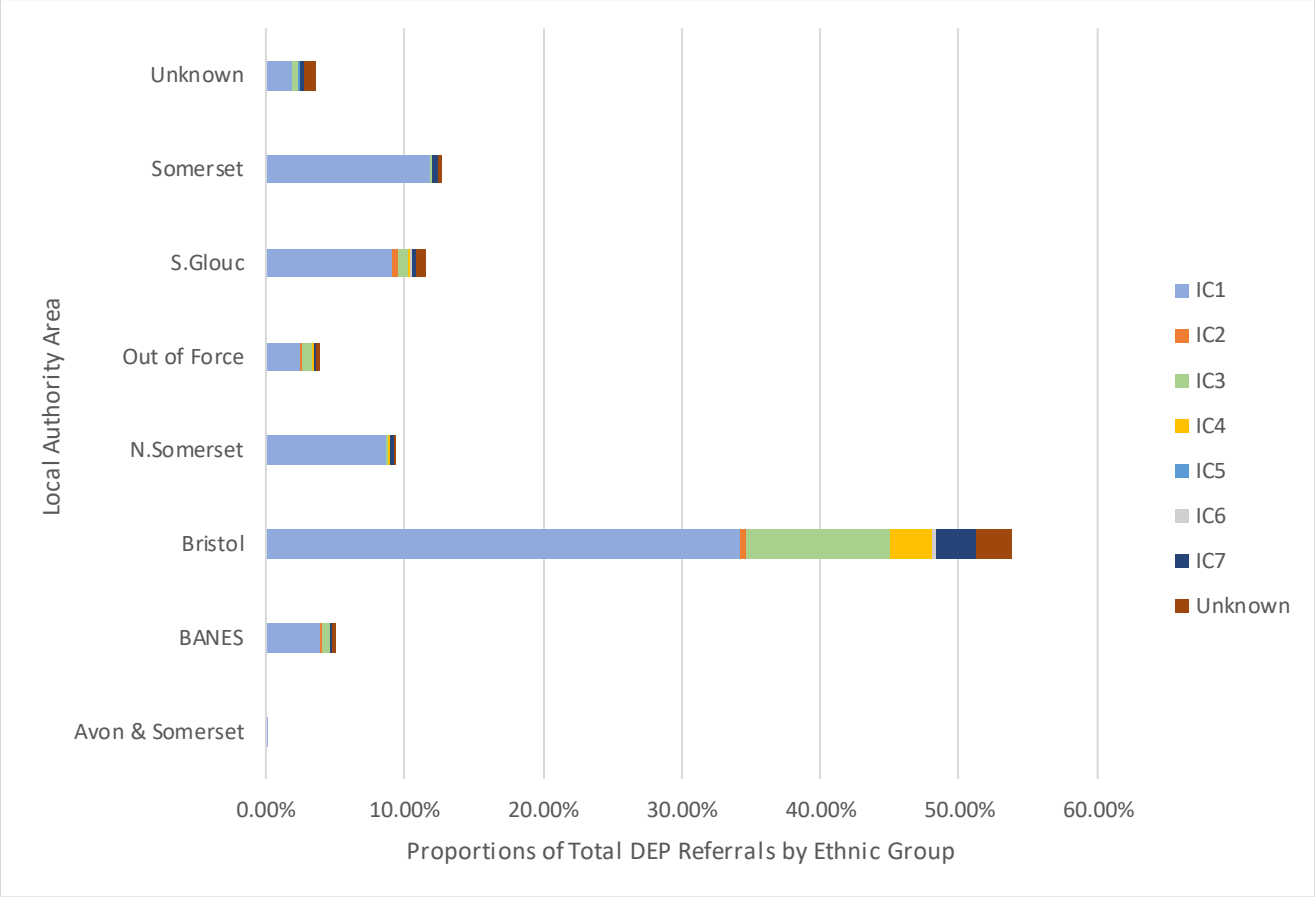
Figure 7. Comparison of DEP referrals from white, black and ethnic minority backgrounds by Local Authority Area



DEP referrals for the Avon and Somerset Force Area as a whole comprised 73% white and 22% from black or ethnic minority backgrounds (with 5% unknown). However, Bristol has 54%

(n=644) of all DEP referrals of which 35% (n=415) were all the white referrals for the region and 19% (n=199) were all the referrals in the region from a black or ethnic minority background; of the latter, 125 were black or IC3, as shown by the green bar in Figure 8 below.

Figure 8. DEP referrals by local authority area and ethnic group



4.3 Demographic Characteristics & Offending Profiles

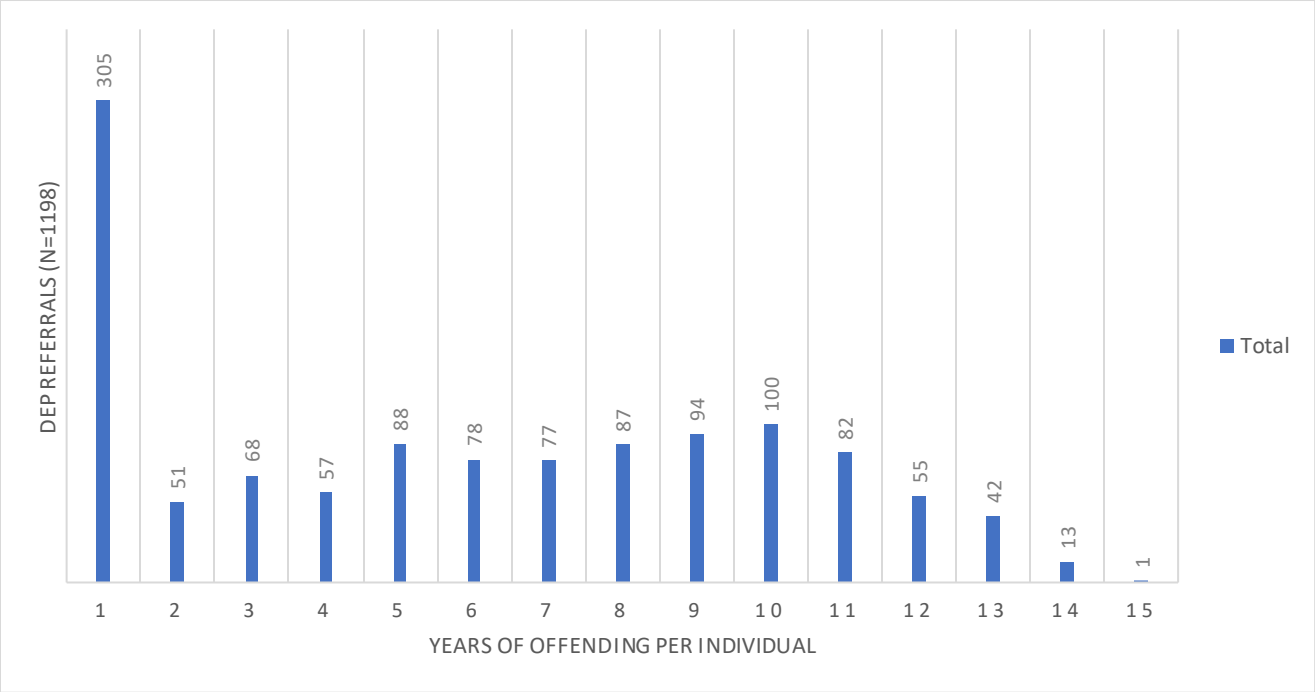
This subsection combines the demographic data described above with the data available from the 1,198 individuals' offending profiles. Specifically, it describes and compares previous offending histories (i.e. pre-DEP positive outcomes), pre-DEP offending types and categories across the sample, drug offending categories at the point of DEP referral, and post-DEP re-offending. Given the relatively small sample, only limited statistical analysis was possible.

Age and Offending History

Many individuals had evidently committed multiple offences leading to positive outcomes over several years. This is illustrated below in Figure 9 that shows years of offending for all

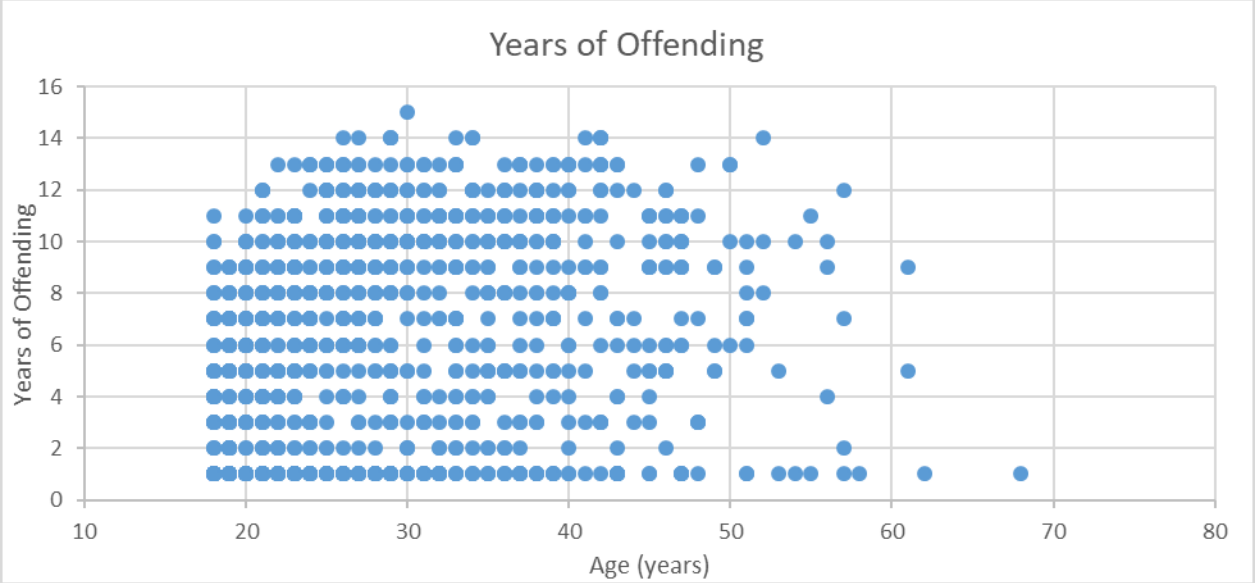
DEP referrals. The majority (n=305) had committed an offence with a positive outcome within a single year, while the remainder of the sample (n=893) had histories of offending (positive outcomes) ranging from 2 to 15 years. As can be seen below, there was no particular pattern across the sample except that 75% of the sample had offended prior to the offence that triggered the DEP referral.

Figure 9. Individuals Referrals to the DEP by Years of Offending (History)



When years of offending were examined against age (see Figure 10), there was no significance attached to age and likelihood of presenting with a long or a short offending history. However, this does suggest that individuals were referred to the DEP irrespective of whether they have a history of re-offending.

Figure 10. Distribution of Individuals by Age and Years of Offending



Ethnicity and Offending History

When examined against the ethnicity of DEP referrals, there were no obvious differences in long term patterns of offending either. For white, black or other ethnic minority group referrals (total=1,138), around 23% of each group had 1 year of offending history, as shown in Figure 11, which reflects the general ratio of pre-DEP offending. This corresponds with 206 white 1-year offenders and 60 1-year offenders who were black or from an ethnic minority background. When white (IC1&2) ethnicity was compared with black (IC3), this shows no marked difference in the distribution of the data either as shown in Figure 12.

Figure 11. Proportions of DEP referrals by ethnicity and years of offending.

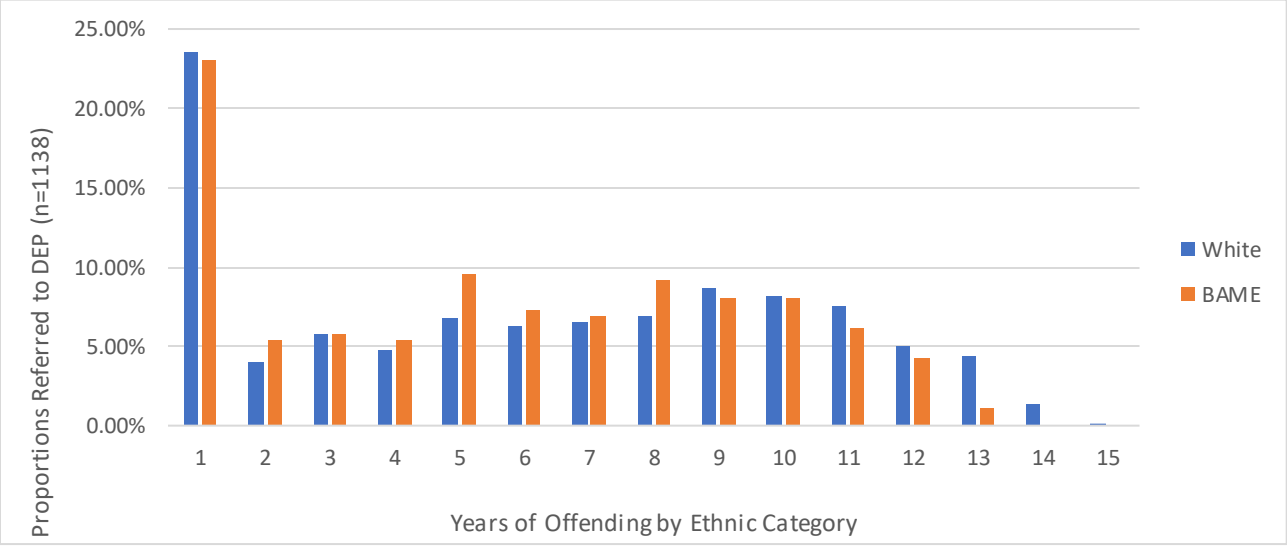
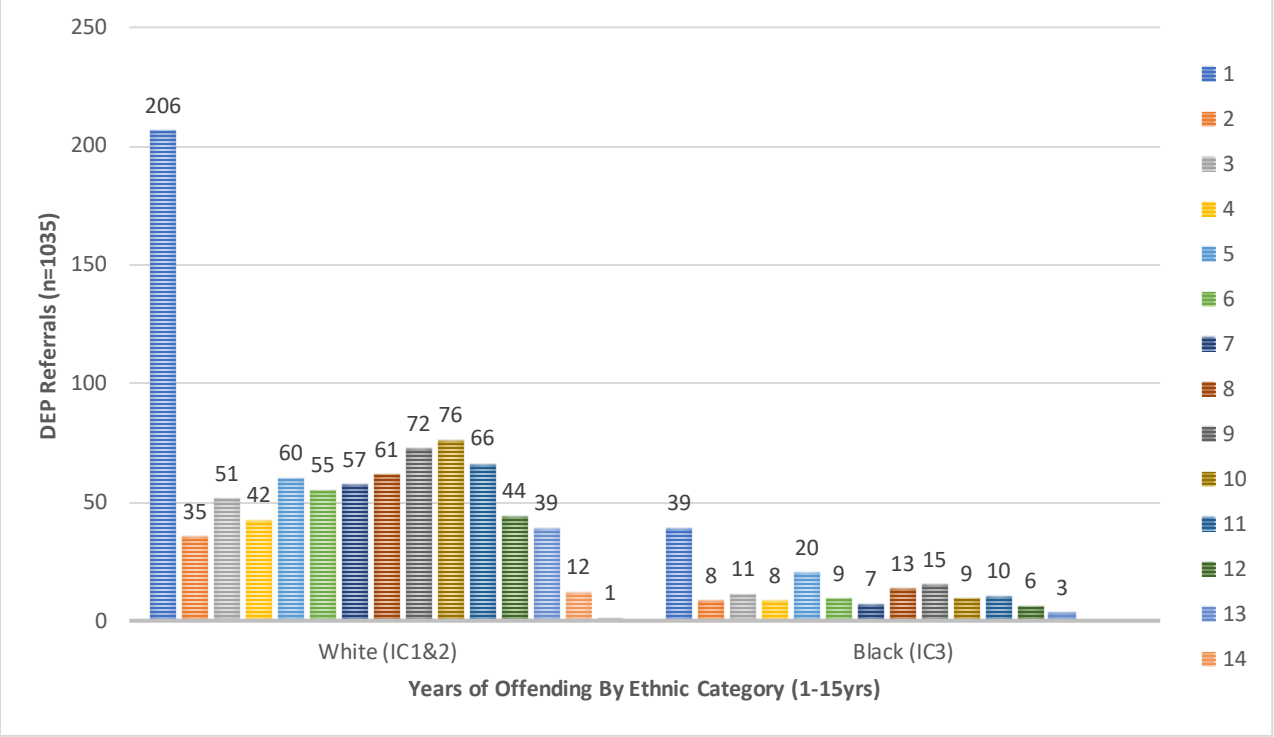


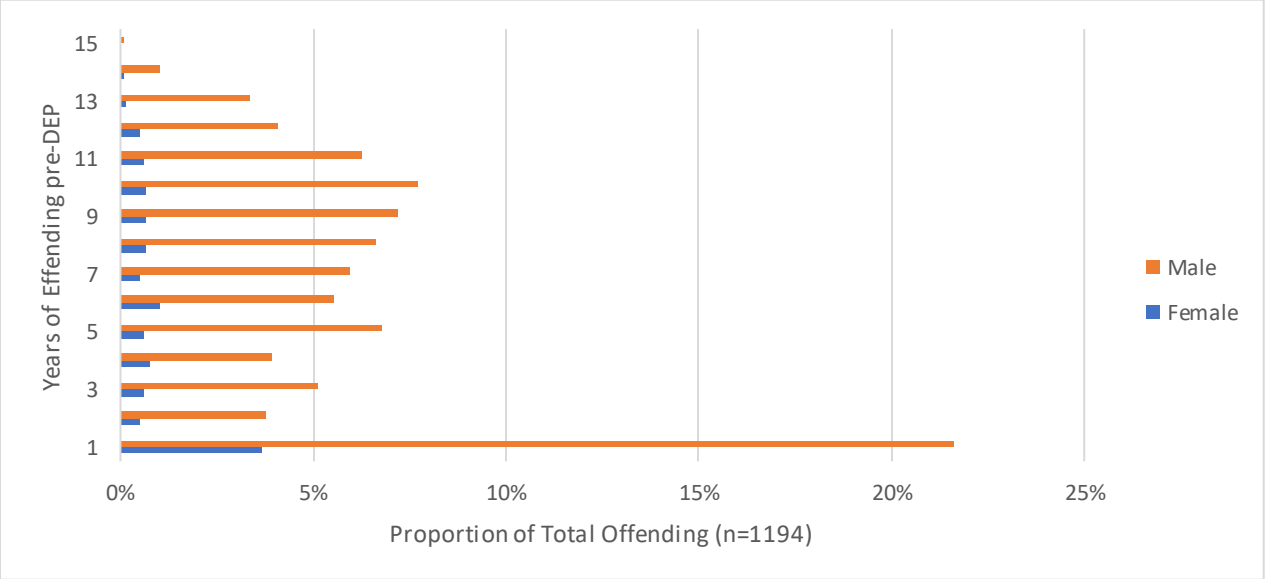
Figure 12. Comparison of years of offending between white and black referrals



Sex and Offending History

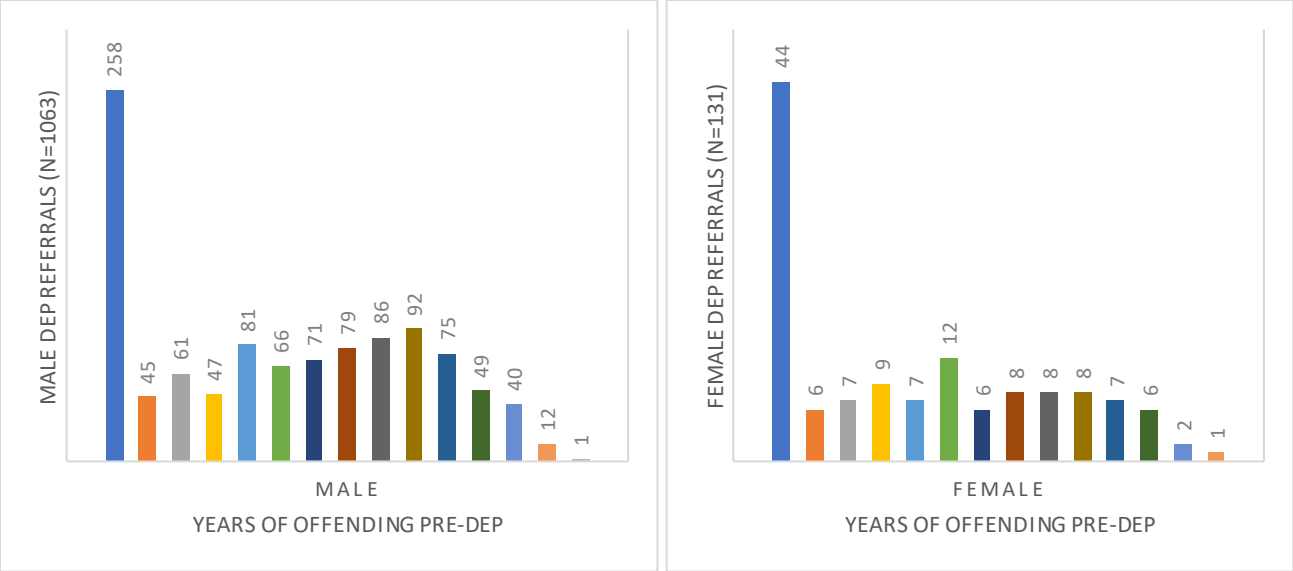
When years of offending were examined against sex (Figure 13), for total DEP referrals the majority (25.3%) of males and females have offending histories of one year. There was a significant proportion of males and females who have received positive outcomes pre-DEP over 2-15 years.

Figure 13. Pre-DEP Offending for males and females as a proportion of the total



When examined proportionally by sex, of all the males in the sample, 24% (n=258) have a pre-DEP offending history of 1 year and for females this was 34% (n=44), as shown in Figure 14, suggesting that the women in the sample were less likely to have long offending histories. The sample sizes were too small to draw any significant interpretation from this.

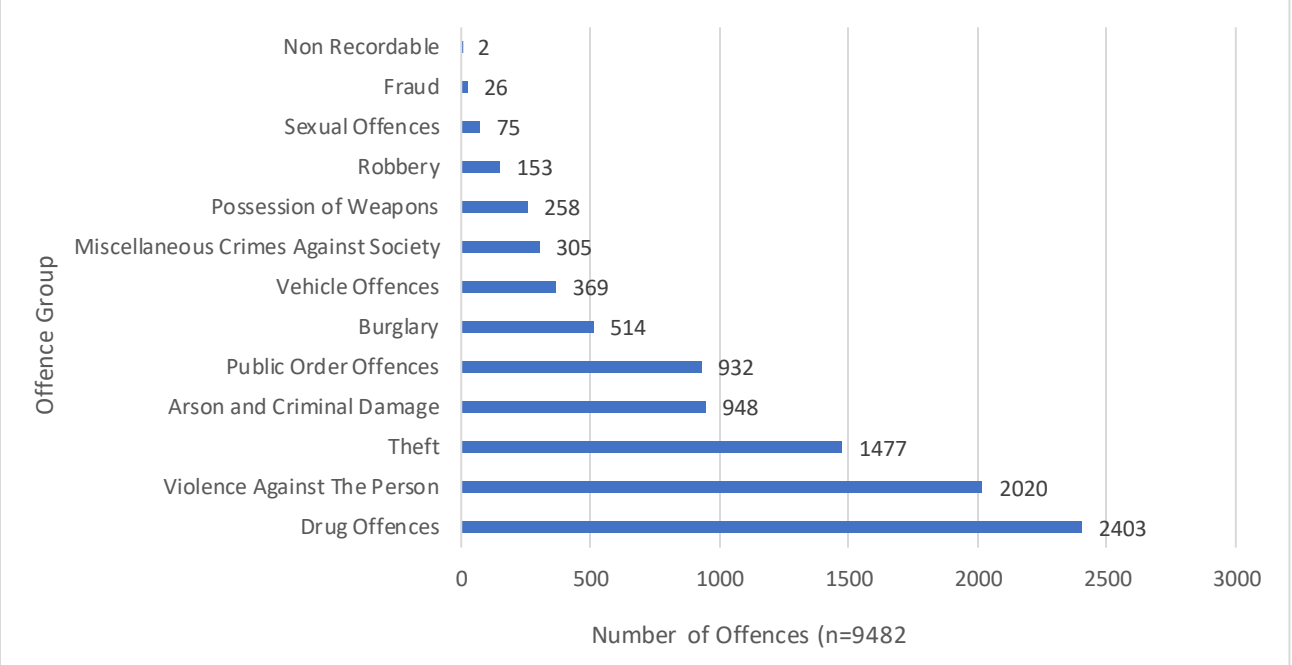
Figure 14. Pre-DEP offending histories by sex



Offending History and Type of Offending

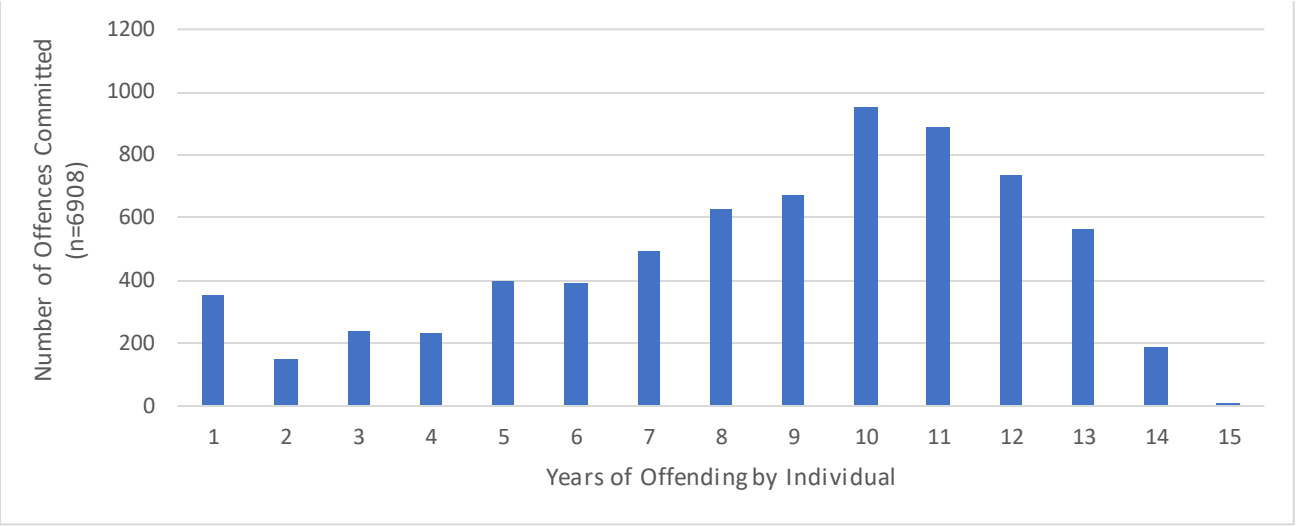
The data for the 1,198 DEP referrals showed that across the whole sample there were 9,482 recorded offences, of which 2,403 were drug offences. As stated previously, these reflected between 1 and 15 years of offending history. The range of offence groups is illustrated in Figure 15. The dataset revealed that many individuals had complex offending histories that included a range of offence types, of which drug offences formed part of the picture.

Figure 15. All Offences committed by DEP referrals



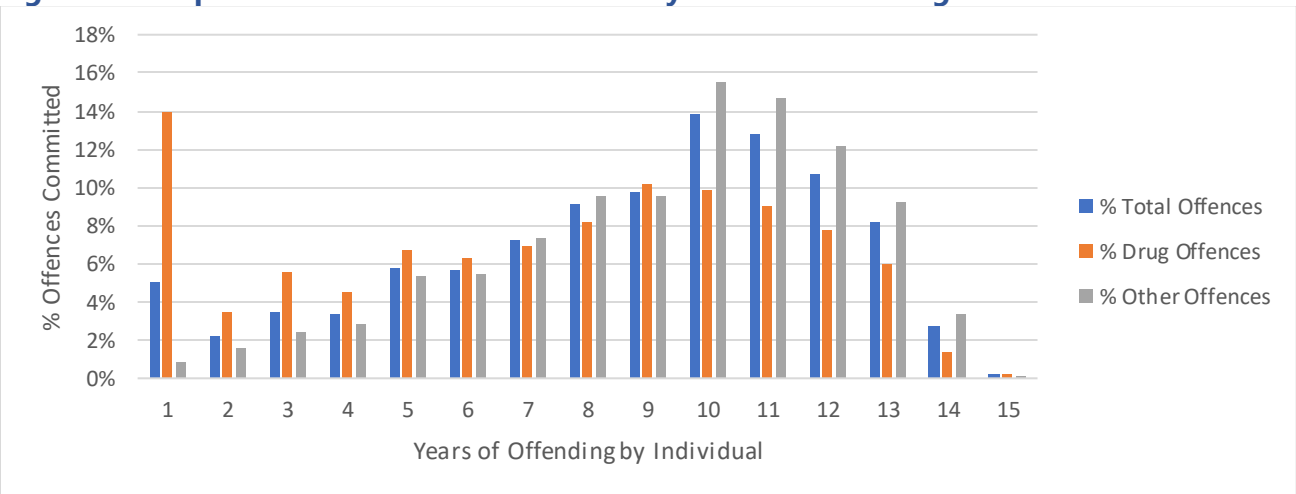
Combining the data was an intensive manual process given the complexity of many individuals' offending histories and duplicate or missing data within the original data sheets. Across the sample of 1,198, therefore, 6,908 offences were recorded with positive outcomes pre-DEP referral, committed over between 1 and 15 years as illustrated below in Figure 16. Of these, 2,240 were drug offences and 4,664 were non-drug offences. The highest count in the chart shows that 953 offences were committed by individuals who had offending histories of 10 years, while 352 offences were committed by individuals with offending histories of just one year. The chart shows that by far the majority of the sample had extensive offending histories. All 1,198 had received a referral to the DEP although a proportion of these were for non-drug related offences; this reflected the fact that some individuals had committed concurrent offences at the time of the DEP referral and the non-drug offence was flagged against the positive outcome.

Figure 16. All Offences Committed by Individuals' Years of Offending (n=6908)



When total offences, non-drug offences and drug offences were compared, as shown in Figure 17, there was a close similarity in the proportions of drug offences committed against non-drug offences committed, regardless of an individual's offending history, apart from those with just one year's history of offending. Essentially, 14% of drug offences were committed by this group of 'new' offenders who contribute 5% of total offending and less than 1% of other offending. Conversely, 86% of drug offences were committed by previous offenders with the most prolific drug offending (29%) occurring among those with offending histories of between 9 and 11 years. For those with other offences running over periods of between 10 and 14 years, drug offending appears to be a small proportion of their total offending (shown by the grey columns).

Figure 17. Proportions of Offences Committed by Years of Offending



It was also evident that 223 of the 1,198 individuals had more than 10 offences, with between 10 and 46 positive outcomes over a period of between 3 and 15 years. By far the majority of these had more non-drug related offences than drug related offences that were indicative of complex and chaotic offending histories. To illustrate this, the entry for P0330 is shown below in Table 4:

Table 4. Offending Profile ID P0330

ID	Age at offence	Sex	Ethnicity	Local Authority	Offence Group	Offence Description
P0330	26	Male	IC1	Bristol	Theft	Theft from shops and stalls
P0330	27	Male	IC1	Bristol	Theft	Theft from shops and stalls
P0330	28	Male	IC1	Bristol	Drug Offences	Possession of a controlled drug - Heroin
P0330	28	Male	IC1	Bristol	Theft	Theft from shops and stalls
P0330	29	Male	IC1	Bristol	Drug Offences	Possession of a controlled drug - GHB
P0330	29	Male	IC1	Bristol	Drug Offences	Possession of cannabis - a class C (recordable)
P0330	29	Male	IC1	Bristol	Possession of Weapons	Having an article with a blade or point in a public place
P0330	29	Male	IC1	Bristol	Theft	Theft of a pedal cycle
P0330	29	Male	IC1	Bristol	Theft	Theft from shops and stalls
P0330	29	Male	IC1	Bristol	Vehicle Offences	Theft of a motor vehicle
P0330	30	Male	IC1	Bristol	Drug Offences	Possession of cannabis - a class C (recordable)
P0330	30	Male	IC1	Bristol	Public Order Offences	Racially or religiously aggravated harassment, alarm, distress
P0330	30	Male	IC1	Bristol	Theft	Theft from shops and stalls
P0330	31	Male	IC1	Bristol	Arson and Criminal Damage	Other Criminal Damage, Other - valued under £5000
P0330	31	Male	IC1	Bristol	Possession of Weapons	Having an article with a blade or point in a public place
P0330	31	Male	IC1	Bristol	Public Order Offences	Causing intentional harassment, alarm or distress
P0330	31	Male	IC1	Bristol	Public Order Offences	Fear or provocation of violence
P0330	31	Male	IC1	Bristol	Theft	Theft from shops and stalls
P0330	32	Male	IC1	Bristol	Drug Offences	Possession of a controlled drug - Cocaine
P0330	32	Male	IC1	Bristol	Drug Offences	Possession of cannabis - a class C (recordable)
P0330	32	Male	IC1	Bristol	Theft	Theft from shops and stalls
P0330	33	Male	IC1	Bristol	Theft	Theft from shops and stalls
P0330	34	Male	IC1	Bristol	Drug Offences	Possession of cannabis - a class C (recordable)
P0330	34	Male	IC1	Bristol	Theft	Theft from shops and stalls
P0330	35	Male	IC1	Bristol	Theft	Theft from shops and stalls
P0330	36	Male	IC1	Bristol	Public Order Offences	Fear or provocation of violence

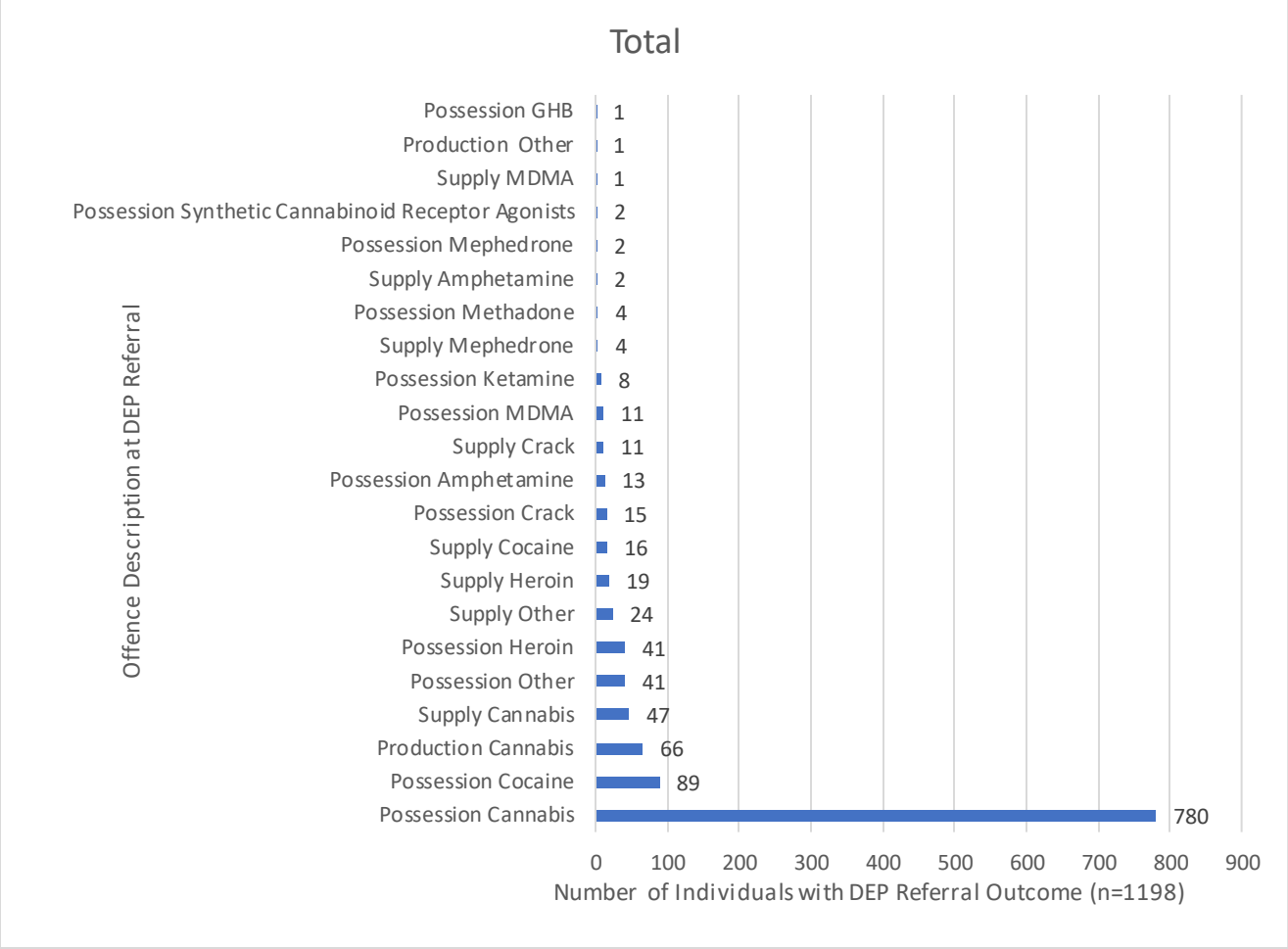
P0330	36	Male	IC1	Bristol	Theft	Theft from shops and stalls
P0330	37	Male	IC1	Bristol	Possession of Weapons	Possession of an offensive weapon without lawful authority or reasonable excuse
P0330	37	Male	IC1	Bristol	Theft	Theft of a pedal cycle
P0330	37	Male	IC1	Bristol	Drug Offences	Possession of cannabis - a class C (recordable)

The most prolific offender in the sample (P3261) was a 27 year old white male from Bristol with 46 offences over 14 years, of which only one was for possession of drugs leading to the DEP referral. Many of the most prolific offenders had multiple entries for offences other than for drugs, commonly for acquisitive crime – theft or burglary – damage to property or violence. The data only reveal what the individual was arrested for but does not indicate whether the offence was due to drugs. For many individuals, therefore, the DEP referral came in the wake of a significant offending history. Conversely, there were 268 cases with just the one offence that triggered the DEP referral and 168 with two offences.

To illustrate further, when examining the offence details within the offence groups, one male (ID P0013) had 26 entries under 'previous offence details', 21 of which were drug offences that included possession of Cannabis, Heroin and Cocaine and supplying or intending to supply Heroin and Crack. The additional four non-drug offences were for violence (two for 'assault occasioning actual bodily harm' and one for 'common assault and battery') and one was a public order offence ('use of threatening/abusive words/behaviour or disorderly behaviour likely to cause harassment, alarm or distress'). The DEP flag indicating the Positive Outcome (referral to the DEP) showed 16 entries on Niche for supplying or offering to supply Heroin, Crack and Cocaine, and four entries for possession of Heroin and Cannabis. After completing the DEP, this individual subsequently committed a drug offence; he was caught in possession of Cannabis. This individual evidently had a chaotic offending history largely involving controlled drugs. By contrast, around half of all cases referred to the DEP as Outcome 10 or 22 showed one or two relatively minor offences, the majority having been caught in possession of Cannabis and with no previous offending history; these tended not to re-offend following the DEP as it discussed shortly.

These data raise a number of questions about the types of 'offenders' referred to the DEP. Evidently, the majority were people caught in possession of drugs yet who have a history of offending. Commonly, the trigger for the DEP as the choice of disposal is a relatively minor possession charge that can mask a more serious offending history. This was evident when comparing the drug offence types that triggered the DEP referral. Figure 18 shows the offence description for each individual that led to the positive outcome of DEP referral.

Figure 18. Offence Descriptions leading to DEP Referral as Positive Outcome

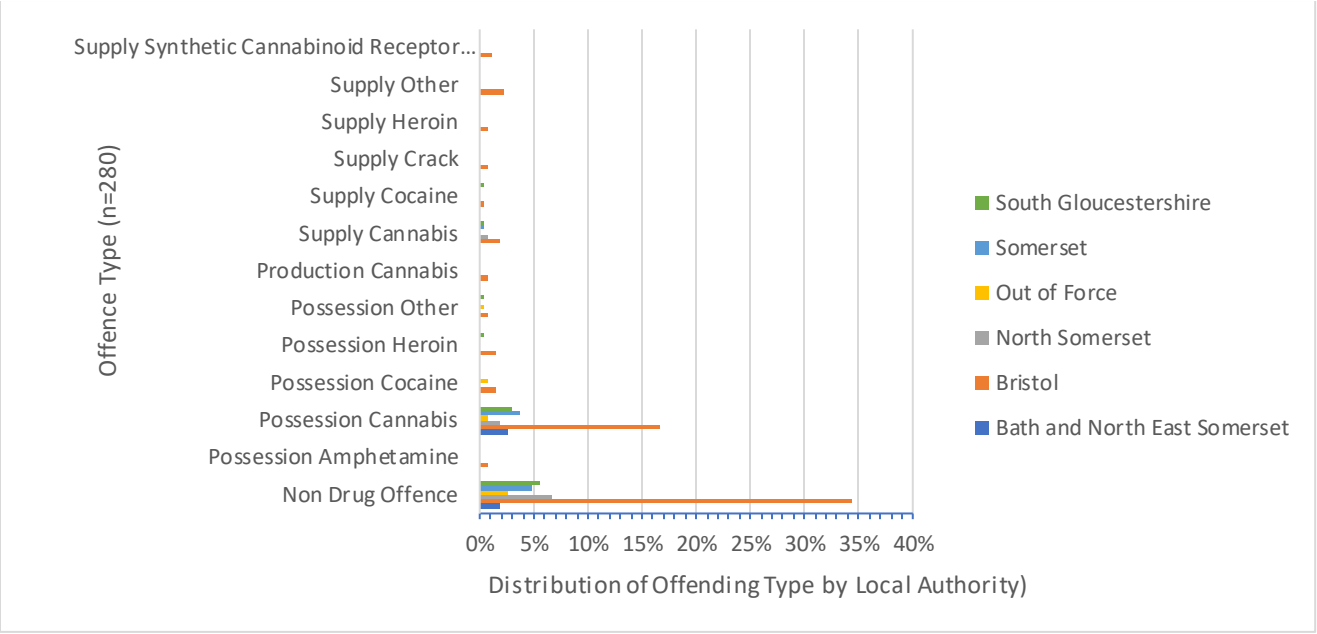


By far the most common offence was possession of Cannabis, which constitutes 780 or 65% of referrals.

Reoffending following the Drug Education Programme

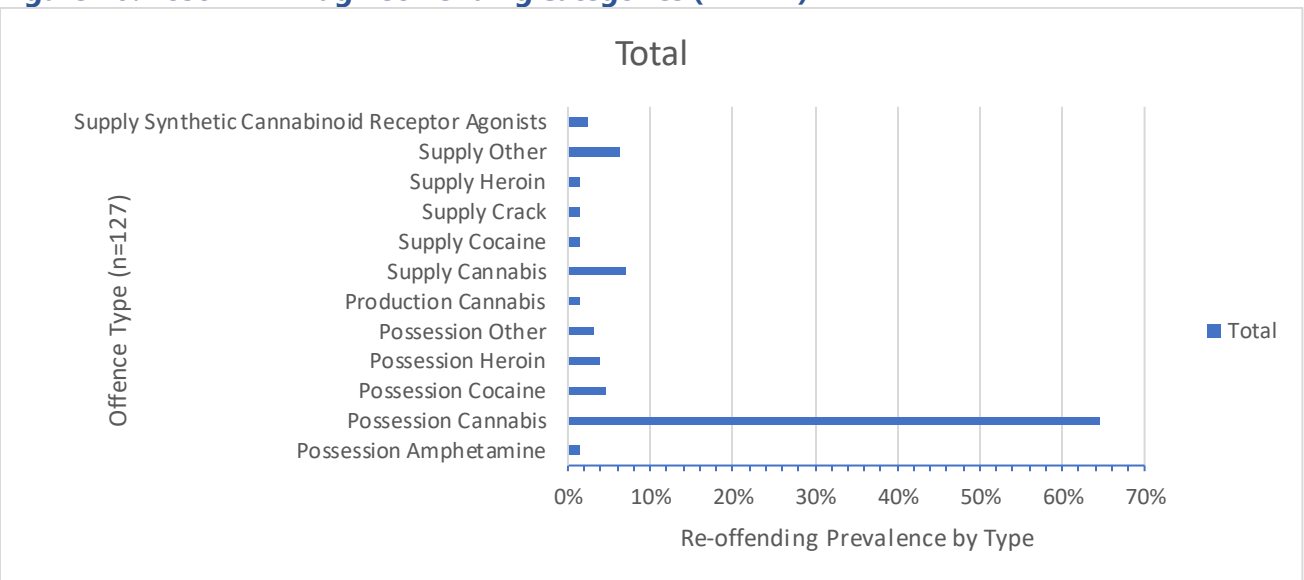
280 (23%) of individuals who attended the DEP reoffended. While these data are really too small to make significant statistical conclusions, the proportion is interesting since 127 (45%) of these committed drugs offences post-DEP and 153 (55%) committed non-drug offences post-DEP, as shown in Figure 19.

Figure 19. Reoffending Types as Proportions by Local Authority



235 (84%) of those who reoffended post-DEP had been referred to the DEP for possession of cannabis. Subsequent to the DEP, 97 (41%) of these committed non-drugs offences while 53 (22.5%) were caught in possession of cannabis again. For repeat drug offending only, cannabis possession was the most common category representing 65% of the 127 drug re-offenders, as shown in Figure 20.

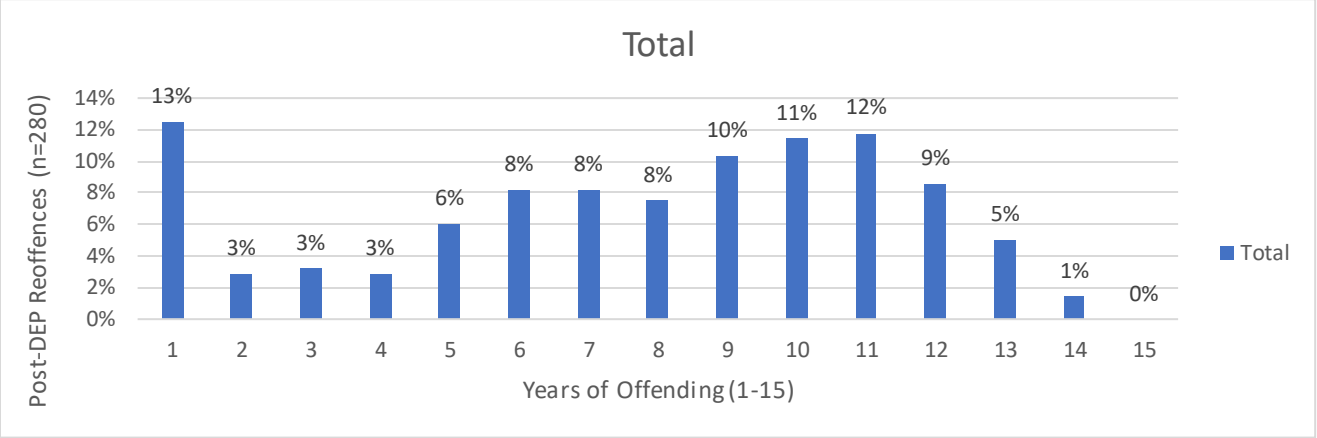
Figure 20. Post-DEP Drug Reoffending Categories (n=127)



Evidently, a greater proportion (87%) of re-offenders had histories of multiple offending over 1-15 years, as shown below. This mirrors the 86% of drug offending committed by individuals

with offending histories of more than 1 year (from the full dataset of 1198) as illustrated in Figure 21.

Figure 21. Post-DEP reoffending by Individuals' Years of Offending (n-280)



One significant feature was that these 280 individuals who re-offended post-DEP shared between them 2,681 previous offences constituting 39% of all offending for the 1198 cases (see Table 5). The majority of reoffending appears to be for non-drug-related offences, which probably reflects a legacy of offending over several years.

Table 5. Pre-DEP Offences committed by Post-DEP Reoffenders (n=2681)

Offence Types	Sum of Other Offences	Sum of Drug Offences	Total Offences
Non Drug Offence	1241	316	1557
Possession Amphetamine	9	3	12
Possession Cannabis	473	188	661
Possession Cocaine	33	8	41
Possession Heroin	27	15	42
Possession Other	47	8	55
Production Cannabis	4	6	10
Supply Cannabis	44	33	77
Supply Cocaine	35	3	38
Supply Crack	11	6	17
Supply Heroin	3	5	8
Supply Other	78	31	109
Supply Synthetic Cannabinoid Receptor Agonists	46	8	54
Totals	**2051**	**630**	**2681**

5.0 QUALITATIVE FINDINGS

The data from the qualitative interviews with stakeholders are discussed from two perspectives or standpoints, that of the police as the referring agents and that of the representatives of the DEP. The number of interviews was small and the findings should therefore be interpreted with caution as they cannot be used to provide overarching conclusions about the effectiveness of the DEP. Rather, they provide rich insight into the processes surrounding the DEP and into stakeholders' opinions and interpretations of the DEP.

5.1 THEMATIC ANALYSIS

Key themes that arose from the interviews with Police and Drug Education Programme representatives were extracted through intensive line-by-line thematic analysis. The interviews were analysed in an inductive comprehensive way thereby including data irrespective of its immediate relevance to the DEP. This provided a broad picture that eventually formed three categories or subsections: [1] Characterising the 'Drug Problem'; [2] Policing Drug Related Offending; and [3] the Drug Education Programme. The verbatim words of participants (quotes) are used throughout to illustrate the themes and subthemes, which reflect their perspectives, opinions and knowledge relating to the DEP and to wider drug related offending. As stated previously, there were nine interviewees made up of five police representatives and four DEP representatives. The latter were employed by the NHS, two as salaried professionals and two as paid peer mentor facilitators with extensive lived experiences of longstanding drug abuse; both consented to share their lived experiences given their pivotal role with the DEP. Despite the small sample, the interviews were rich, contextual and extensive, each lasting in excess of 60 minutes and yielding deep and insightful data. To ensure confidentiality and anonymity, participants are not personally identified but a code is used to denote whether the individual was a police (Px) or DEP (Dx) representative. Unfortunately, as was stated previously, it was not possible to interview 'clients' who attended the DEP although it is recommended that further research is undertaken with clients; this could be introduced as voluntary one-to-one interviews following scheduled DEP sessions, perhaps as part of a follow-up programme of support.

5.2 CHARACTERISING THE 'DRUG PROBLEM'

At the beginning of each interview, interviewees were invited to discuss their understandings, experiences and opinions of drugs in society, exploring the social context of drug misuse and

the drug-related policy context as a warm-up tactic and to establish some context and perspective for discussing drugs related policing and the Drug Education Programme.

5.2.1 Proliferation and Complexity

According to the participants who represented the police, two extremes of street level drug-related crime tend to manifest:

- "*… the people who've been drug users for years – you can spot them a mile off … For them, obviously, the health impacts are huge and so unfortunately they're quite easily identifiable as prolific drug users. But there are also the students – there will be some who are really struggling with addiction but, for the majority, it's that social aspect, a couple of times a week if that, and sometimes they're probably not using it that much*." (P4)

Overwhelmingly, participants mentioned how the 'drugs problem' has proliferated in recent years with the advent of multiple combinations of substances, a rapidly changing scene and increased uncertainty and trepidation associated with the provenance and impact of many new substances in circulation. This was captured by D1:

- *"There's ever changing needs and an ever changing picture. Drugs have always been dangerous but they've undoubtedly become more dangerous. There's so much more stuff available now, there's a lot of new synthetic substances out there and drugs like Fentanyl … and there's Acetone which goes into Spice and which we know as varnish remover. Back in the '70s and the '80s, the main cutting agent was Paracetamol or something else like that. So although there were dangerous elements going into drugs then, that was nothing compared to what it is now. It's become a massive problem."*

Spice (synthetic cannabinoids) is widely recognised as a game changer for police and drug agencies given its potent and unpredictable effects. Being made up of a mix of shredded plant material, laboratory-made chemicals and sometimes other contaminants, it can have the appearance of 'weed' or Marijuana but has very different and more dangerous short term and long term effects. As D2 stated:

- *"There's a lot of spice around. Back in 2017 I think it was, a cannabis factory was discovered in Weston-Super-Mare where a load of plants were seized that had all been sprayed with liquid Spice. I knew a couple of people that smoked Spice who smoked Cannabis and it just wiped them clean out."*

The consequences of Spice were summarised well by P5:

- *"Spice is making our job really unpredictable. It can be quite terrifying. It can make people incredibly violent, almost uncontrollable, and can take many officers to get hands on to stop the person hurting themselves, let alone us … It's the general rot that it does to people, this particular drug, it's incredibly addictive and it's probably the one that whenever I hear it come up on a job and suspected Spice is involved, it definitely makes me concerned and changes my threshold for how we're going to be dealing with it."*

Likewise, P3 spoke at length about the proliferation of the drugs market, also making reference to Spice:

- *"Anything from basic cannabis, to heroin, crack, cocaine, amphetamine, and everything in between. When I was growing up it was weed, coke and heroin; that was it. There's so many different ones now. All the Spice stuff that was legalised before that's now being sold on the black market. And with Spice we've had people dying. There was massive problem with a bad batch of Spice going around Bristol, and people who regularly smoked it and who were hooked on it were literally dying in the street. There's prescription drugs as well … like the really strong painkillers." (P3)*

The proliferation of drugs in prisons is seen to reflect that occurring in the community but to a greater extreme, especially with the increased risk of contamination, as D1 highlighted:

- *"The problem in prisons is that drugs like heroin – which at the moment averages around 45 to 50% purity on the streets in the southwest – in prison you're lucky if you get 3% because it's mashed up with brick dust and drain cleaner and stuff like that. So it brings a lot more dangers." (D1)*

D3 also spoke about the use of Spice in prison:

- *"Spice is a massive problem in the prisons. It is a nasty, nasty drug. People get messed up on that stuff. I tried it when I was in prison and I couldn't move for five hours. I was shaking and sweating, and I had to wait for it to pass. And then I was smoking it again later because that's the addict in me. I just went on smoking it like it was weed. And I was like, "Whoa, what's going on?" But then you have a little bit more and leave it and have a little bit more and leave it."*

P2 referred to Zanax, a benzodiazepine usually prescribed for anxiety and depression, which has become a problem in the South-west region:

- *"We had a really bad batch of fake Zanax in Weston, with people making their own or buying them off the dark web and either cutting them or getting the powder and making it into*

tablets. A lot of people were going off the rails. And then we had two die in a day who we'd had regular dealings with and who we all knew by name. We came into a briefing and heard they'd died and we couldn't believe it. You hear about people dying but you don't really believe it until it actually happens. Even in my relatively short time as a police officer, I've known at least ten people quite well who have died, and that's just in one small area." (P2)

P5 referred to the use of Nitrous Oxide, a legal substance that can be purchased online:

- *"We've got a massive problem with Nox canisters. They litter the streets everywhere and we have no powers because they're completely legal. There was a very tragic incident this week where there was a young man out enjoying the sun with some friends, drinking and probably taking a bit of class A. He's gone and done a Nox balloon on the water's edge, toppled backwards, gone under the water and drowned."*

These examples by no means give a full picture of the prevalence of drug misuse within the South-west region but they illustrate what is often uppermost in the minds of police and drugs agencies and infer that police forces and prisons are having to deal with the acute end of a dangerous phenomenon. As P2 suggested, "drugs is one of the main issues that we deal with." He also said, "*… a lot of the time, we are dealing with the users, the sort of aftermath, what happens afterwards …*" Likewise, P3 said that as a response police officer in Bristol, most of his time is taken up with drugs-related offences. And, as P4 put it, "*We probably get a slightly skewed view of drug taking because we tend to see the worst of it, the most extreme cases.*"

5.2.2 Legalisation / Decriminalisation

Given the complexity of the illicit drug scene, there were mixed views among interviewees about the legal status of some substances, particularly given the association between cannabis and synthetic cannabinoids (Spice). Most shared the view that cannabis is significantly less harmful than most other substances, some suggesting it is less harmful than alcohol or tobacco. One police interviewee said:

- *"You can buy cigarettes at 16 and cigarettes are more harmful than cannabis. Alcohol is more harmful than cannabis. We go to a lot of domestic violence and fights on the weekend because of alcohol. We've not done anything to curb that, have we, really, if you look at it? So why are we still fighting it? I don't understand it." (P3)*

The comparison with alcohol was echoed by D3:

- *"Some people will go out at the weekend, get wrecked and end up fighting … and that's due to alcohol. And when they're drinking, they're just losing their inhibitions. Alcohol's one of the worst ones out there, but it's socially accepted. Yet there's so many people that smoke cannabis on a daily basis, who'd rather do that than go out and have a drink, possibly because drink doesn't agree with them and they don't like the person they are when they drink. Everyone's got their vice, everyone's got their thing."*

P3 argued that because cannabis had become so widely used it was impossible to police, in terms of both possession and supply:

- *"We've been trying for too long and it's not working. So legalise it, control it, control the strength of it, and direct the money from selling it into drug rehabilitation programmes, into other things that will help society." (P3)*

P3 also argued:

- *"I can't see that 'gateway' argument, I just can't. It doesn't make sense to me. It obviously depends on why the person is smoking it. If it's to get smashed out of their face, they'll most likely skip cannabis and go straight to cocaine as a recreational drug. Heroin's a different ball game altogether … When you start talking intravenous drug use, sticking a needle in yourself and injecting, that's nothing like smoking a joint, you know? The physical act of rolling a cigarette with some cannabis in it and smoking it, rather than burning something in a spoon, sticking it in a syringe and injecting it, that's entirely different. But I know that's an argument that some people have, but I can't honestly see the relevance. I've spoken to many people while doing this job who've smoked cannabis for years, and that's all they've done. They don't drink alcohol, they don't smoke cigarettes, they don't do crack cocaine, they don't do methamphetamine, they don't do heroin. They do cannabis and we're criminalising them for that." (P3)*

Other reasons were given for legalising cannabis by police and DEP representatives, which included its perceived benefits for positive thinking, reasonable and non-aggressive behaviour, relaxation and stress management, safe and regulated production and the use of revenue from sales for safe manufacture and for drug treatment and support.

D3 suggested that legalising cannabis could make prisons calmer and more productive:

- *"When people smoke weed in prison they chill out. They just get on with their thing and then it's quiet in the prisons. If you talk to the screws [prison officers], that's all they want because they're outnumbered two screws to sixty inmates. The inmates are running the prisons. So*

when they want to kick off no one can do a thing about it unless they're locked up all of the time. So you could allow a certain amount per person, maybe give them vapes or edibles. It could be so different. The screws would be up for it because it'd make their job easier." (D3)

P4, on the other hand, argued that legalisation of cannabis will not remove the problems associated with its use, especially with regard to mental health. Moreover, "*Your little bit of cannabis that you think is not really a big deal actually makes some people a lot of money. And where there's a lot of money to be made, there's going to be a lot of nasty stuff going on behind the scenes.*"

There were mixed views about the efficacy of cannabis as a 'gateway' drug. D2 said, "*I know loads of people that started smoking cannabis and they've end up on crack and heroin, or being alcoholic.*" Equally, it was acknowledged that everybody's experience of drugs was different:

- *"In my experience, cannabis is not necessarily a gateway drug for everyone, but what it certainly does do is introduce you to people who can get other substances. And in my experience, the majority of people I've known with a problematic drug problem have been in that position because of unscrupulous drug dealers who have said, "Look, I haven't got this at the moment, but I have got this," and they get introduced to it. So that's a massive problem. I wouldn't want to see it decriminalised, but, on the flip side of that, I would like to see more support being offered." (D1)*

5.2.3 Drug Misuse as the Basis of Most Offending

A key theme that transcended the interviews was the notion that most crime the police deal with involves drugs, whether this be at the level of serious organised crime – production, distribution and supply – or at the street level of possession, public nuisance, violence and theft. In this respect, drug addiction and dependence were perceived to be at the root of most offending. As P2 argued, "*Drugs are more of what you'd call a precursor, something that pushes people into crime, same as alcohol.*" Similarly, the quotes below are all from police representatives who collectively shared this perspective:

- *"Drugs are behind a very high proportion of all crime. I would say that for upwards of 80% of the crime we deal with drugs are involved at some point, especially stealing to fund a habit. So a lot of the low level shop theft is to fund a drug habit. Burglary is the same – they will go and burgle or steal cars to fund their drug habit." (P3)*

- *"Believe me, everybody in the police knows that if we took away heroin and its use, then people wouldn't need to break into houses. The number of people who break into houses who aren't drug users is minimal. Nobody does that anymore. The desire and need for your drugs and your money overrides all. So people generally don't commit burglaries just for the fun of it. So if we didn't have people that used drugs, we wouldn't have robberies, we wouldn't have shoplifting, we wouldn't have burglaries. So the easiest way to reduce burglaries, robberies, knife crime, serious assaults and even murders is to reduce the availability of drugs or the need for drugs." (P1)*

- *"The prolific drug users are trying to fund a habit and are therefore arrested for shoplifting and theft. And when you look into their home and family life, quite often they had children who aren't with them anymore and it's really upsetting for a lot of them. They can't get themselves out of the situation they're in." (P4)*

D3, who had a long history of addiction admitted:

- *"Most of my crime was caused around using a substance. If I wasn't using a substance, I wasn't getting into trouble. If I was clean or I was sober it probably wouldn't have happened. I wouldn't have lost it, I wouldn't have been in fights. I would have walked away. But if I was off in my face, I'd head butt them because I was under the influence."*

5.2.4 Drug Misuse as a Multi-Causal Phenomenon

Varied reasons were cited by interview participants to explain drug misuse, particularly from those more directly involved with the DEP or with significant histories of drug addiction. These ranged from peer pressure and social acceptability to a range of 'coping' responses to challenging or adverse circumstances and life events. These are summarised and then deeper insight is explored based on data from individuals with extensive lived experiences.

Peer pressure and social acceptability

Across all the interviewees there was the view that 'fitting in' and conforming to social norms is a common reason for young people from adolescence through to young adulthood to participate in recreational drug misuse, usually involving cannabis and sometimes cocaine. Recreational drug taking was distinguished from heavier dependence or addiction to Class A drugs and to supply or dealing in illicit drugs. Social pressure to fit in was one factor that was emphasised:

- *"Without sounding too negative, the world is a difficult place to live in at the moment … It puts pressure on people to be in a group, it puts pressure on people to follow a certain line. And, you know, when you put that pressure on people, the only way to fit in is to do what other people are doing." (D1)*

Moreover, social acceptability fosters a level of tolerance and cognitive dissonance whereby certain substances become sanctioned and legitimised by the peer group such that the health and legal risks are perceived to be low or insignificant:

- *"With the 18 to 25s, the problem there is peer pressure. In the '80s, when I was going to the pub, it was a pint and a bag of pork scratchings. Now it's a pint and a line of coke, you know? It's become socially acceptable … It almost seems to be that culture of, "Okay, I'm out with my mates, I've got to fit in, they're all doing it. So, that's what I'm going to do to fit in." I think there's a huge amount of peer pressure." (D1)*

There was also a clear distinction between the 'student' experience of experimentation with drugs and recreational drug use away from home and that which manifests among friends within one's own home community. The student experience of drug taking was considered to be very different to the more entrenched drug taking behaviour that developed within the cultural context of a local neighbourhood often involving school aged children:

- *"I think, in terms of a student perspective, it is very different. A lot of it is kind of peer-based. And, you know, when you're at uni, you're wanting to try new things." (D4)*

By contrast:

- *"I was on Methadone, Subutex, Heroin, Crack Cocaine … If you name every drug there is the possibility that I've taken it. I started at about the age of 11, smoking weed and if anyone had anything I'd try it. I didn't think it was a problem. Everyone that I knew was doing it. I was just in that circle. I'd sniff gas at school. We'd get glue and put it in a bag and do that. Little things like that. Everyone was doing it and having a laugh and that. And then I'd go home and do it – I'd get home, get some glue and sit there and do it. And then I'd sniff petrol because that makes you high as well, and I even set myself on fire sniffing petrol pouring it all down myself. And then I went through the party scene, taking Cocaine and Ecstasy, Amphetamines. And everyone was doing it and they'd go to work in the week but I'd still be doing it all week. And then I was selling drugs so I could still carry on and do it. And they'd come back at the weekends and we'd all go partying again." (D3)*

The latter scenario was considered by interviewees to be a far more serious concern, more dangerous and connected to wider criminogenic factors, as illustrated by D3:

- *"We've got kids running around with knives who think they're little gangsters … And at that age you just stab someone and don't think about it until you find yourself in a cell and you've got to deal with being locked up and you're only 17 years old." (D3)*

Drug misuse as a coping strategy

All participants identified drug misuse as a societal phenomenon that manifested for various reasons but that is essentially fuelled by different contributing factors or 'social determinants'. In most instances, drug misuse was considered to be a coping strategy many young people exhibit as a response to adverse or challenging circumstances. As suggested previously, this can include an individual's cultural context where drug misuse is normalised alongside other pressures to conform or fit in.

Psychological stress was one perceived contributing factor, drug misuse being considered a response to stress – either acute stress caused by a disruptive life event or change of circumstances or longstanding exposure to a toxic stressful environment or situation. Drug misuse was therefore recognised as a 'symptom' of underlying dis-ease rather than being the root cause of a person's circumstances *per se*. This was illustrated by D3 who referred to the impact of the COVID-19 pandemic on individuals, where drug misuse was interpreted as a response to fear and loss of control:

- *"With COVID, they have scared everyone to death and it's created anxiety in people … caused people to suffer with anxiety and depression who've never had it. So referrals are coming in just from the lockdowns, with people being stuck in, people who've never really struggled with their mental health or had the taste of that."*

Likewise, D4 argued that:

- *"Quite often, drug use is the result of trying to cope with complex mental health or social difficulties. So trying to explain that and get that across is important because people don't often think about drug misuse from that angle."*

Linked to this was the subtheme *lack of ambition*, which was identified particularly as a driver for a long term history of drug misuse for some individuals. This was perceived to result from 'lost opportunity' during childhood in terms of growth, development and education, and was identified by several police and DEP participants. For example, D1 acknowledged that he grew up in a small market town "*… where there was not a lot going on but it's always had a massive drug problem*." He believed he could quite easily have taken the '*crime and drugs route*' himself, as several of his school peer group had done. P1 likewise stated:

- *"You've got people with nothing to do, no job, living in poor neighbourhoods and you've got others who are fulfilled with plenty of things to do in their life – a job, a nice environment and they don't need to take drugs. Obviously, addiction has multiple causes but it's much more common among those with nothing to do."*

D1 identified the economic strains on young people that can reduce both their aspirations and their confidence; in this regard, drug related offending could become a realistic option:

- *"There is tremendous pressure on young people at the moment. They can't get on the housing ladder, they're finding it difficult to get employment … There's a lot of stresses on young people and so I just think that drugs have become the go-to coping mechanism."*

The link with deprivation was explicit in some participants' accounts, most drug misuse and drug related crime perceived to occur among more disadvantaged communities, and drug misuse and crime being viewed as consequences of living within criminogenic neighbourhoods:

- *"People from poorer backgrounds are more likely to have a criminal history, I believe, without looking at statistics I couldn't say 100%. But a lot of the people that we deal with, as response officers and police community support officers, they are the lower socio economic group that are perpetrating crimes." (P3)*

Likewise, D1 stated:

- *"There's a huge amount of poverty, job losses and things like that … It's therefore a coping mechanism. People aren't happy in their environment, with the way they live – they're not happy with their life, so it's a way of coping."*

The social context described by these participants extended to an intergenerational pattern observed among families known to be involved with drugs and crime, as P1 described:

- *"I've been in the business long enough now to see children, parents and grandparents all involved in the same drug supply business in their area. And it's almost like a family business that goes on. That's not right. The kids of these people shouldn't have to aspire to continue in that business, you know?" (P1)*

D3 reflected on his personal experience of addiction in his family that captures this rather poignantly:

- *"Over the years, even through my addiction, I've always looked after my mum [with her alcoholism], even when I was using heroin … because she's my mum, she's the only person who's ever really stuck by me through everything. That's a big thing about addiction – it's also trying to get the parents clean and getting them to understand that what they're doing is going to affect their children, that maybe they'll end up using when they're older because of that, or maybe they'll end up having mental health problems." (D3)*

Most interviewees linked problematic drug misuse with *adverse childhood experiences*, whether in terms of the lack of boundaries afforded though parental/guardian ambivalence or neglect, unrecognised clinical problems such as ADHD, or through more active domestic violence or abuse. *Lack of boundaries* during childhood and adolescence was considered to be significant for some interviewees. D1 reflected extensively on this in relation to his own situation:

- *"Life is a routine: we get up, we go to work, we come home, we have dinner, we go to sleep, eat, sleep, and repeat. And if we don't have that structure, if we don't have that routine, when there are no guidelines everything falls apart. In my opinion, that's where we've gone wrong as a society."*

Furthermore, he argued:

- *"I don't think we give young people the coping strategies anymore to deal with things … to understand the consequences of letting people down and letting their family down. And I think a lot of that is because coping mechanisms have been taken away from young people or not given to them in the first place. There are no consequences anymore, no clear boundaries. We live in a society where the world has become fake, where you get trophies for coming last in a race and things like that. I think if you've not done particularly well at something and you've come last, it's important to be told that, that this means you <u>haven't</u> done your best. Everything has become kind of acceptable and there's a lack of consequences … I think that's what's missing from life. It's that definite kind of guidance. And that's why younger people are turning to other things as a coping mechanism." (D1)*

Reflecting on his own parenting, D1 said:

- *"I'm seeing it with my daughter at the moment. She's 18 and all she wants to do is get tattoos, take drugs and bum around. And I'm trying to say to her, "That's not life. You're not going to get the nice car that you want, you're not going to get the nice house that you want because at the moment you're not applying yourself." And from my perspective that perhaps should*

have been explained earlier, much earlier. And that's my fault. That lies with my generation. All of these things that are happening now are a result of me saying, "Yes, that's okay."" (D1)

The following excerpts from D2's interview, where he reflects on his own situation, illustrate how lack of stability at home as young child, probably combined with undiagnosed ADHD, predisposed him to a chaotic upbringing that led to many years of illicit drug misuse and criminal behaviour. This kind of lived experience is considered to be a valuable ingredient for the success of the Drug Education Programme as it provides real world context for drug taking behaviour that can be reassuring for those with histories of drug misuse and can act as a deterrent to those who have experimented with drugs or used them recreationally. These issues will be discussed more fully later on.

- *"I did have a bit of a bad upbringing. I seen a lot of stuff that happened to my mum from my dad, and I resented my dad … And he did a lot of stuff to me that shouldn't have happened to me. And I carried that all the way through. And I was angry, like, I was 'hatred', like […] I always blamed my mum and my dad, because it was chaotic where I lived. My mum tried her best. I've got two brothers and a sister and my dad was like a flat out drinker. My mum drinks as well – it's in my family. One of my uncles passed away from alcohol and my other uncle's in a home because he's got dementia – "wet brain" from alcohol. And my mom still drinks every single day. So in my resentment I blamed them both. I'm like this because of them […] So, I weren't ever comfortable with myself as a kid. I had an obsession with collecting spiders. I used to take them in my mum's house and she was allergic to 'em, yeah? And then I had to have loads of them. And it got to a stage where I would go about and throw stones at people's windows. I was like 11 … And then I would want the police to chase me and because I was fast, they would never catch me. I was always chasing something else to get out of my own head. When I picked up the drinking and drugs, it was like, Oh, this is what I've been missing to fill that void inside me […] Then nearly three years ago, the doctor said to me that I've got ADHD – and I'm still waiting for an assessment, mind. I've always been 100 miles per hour. It probably makes sense of what I was like when I was younger, my behaviour when I was in school: I could never sit still, I'd always be out of my seat misbehaving, locking teachers in cupboards, nicking people's bikes, bunking off, know what I mean? I was just running riot all the time […] I started tooting my deodorant in the bathroom and then I started tooting gas. And then my friend used to nick motorbikes and I used to toot the petrol. I got that bad on it that I used to go round breaking into people's cars and putting hose pipes down there and tooting on it. I was real, real bad on it. So I started off, like, tooting petrol and tooting gas, and then, like, nicking cigarettes and drinking alcohol, and quite quickly it drifted into like Class A drugs. I don't know whether it was the addict in me or whether the gas or the petrol were just not good enough. The buzz of throwing stones or*

getting kicked out of school was good enough at the time! Smoking cannabis was really, really good at the beginning but then when I took to drink it was like, "Oh my God! That's so much better!" That would blank me out. And then when I started taking ecstasy and sniffing cocaine and doing trips and mushrooms and all that sort of stuff, that was stronger again. So, for me it was always chasing that strongest drug I could get that would take me away from reality [...] So, by the time I was in my mid-20s, I was drinking nearly every single day. And towards the end of my using, I was smoking crack cocaine and being an absolute nuisance [...] I didn't really know what was wrong with me. We used to go out on a Thursday and my friends would then go home and I'll still be drinking and using drugs through to the following Tuesday and Wednesday. And my friends just used to turn around and say to me, "You're mental," and I'd just reply, "You're just light-weights, you can't drink like me." And it took me like nearly 15 years to admit that I was wrong. Every single time I put a drink or a drug in me, I had no willpower to stop. I had this thing in my head that was telling me to keep doing it and that it was going to be okay." (D2)

D3 gave a very similar scenario based on his lived experience, identifying features of his early childhood as precursors for his longstanding drug addiction:

- *"I didn't have the skills and I never had a father figure. When I was younger, my dad never taught me anything. He just got aggressive. He was aggressive the whole time and my step mom was mentally abusive – she abused us physically, yes, but mentally and emotionally as well. So it was the mental scars, you know? It was childhood trauma. And then it would creep in: 'Am I good enough?' Because I was told for a long time when I was younger that I wasn't going to do anything and I'd never be anything. That's what my step mum said to me, those words exactly: "You'll never be anything, you're just trouble. You're just a bad kid." [...] I can accept that that was her projecting her insecurities onto me, that that wasn't a reflection on who I am, I was just a child. How <u>can</u> I have been bad? I'd just come into the world. I was just learning, you know, and I didn't have a father figure."*

So when rationalising his drift into drug addiction, D3 explained:

- *"I was just escaping, I was escaping a pain. And I didn't know that at the time, because you don't really know what's going on inside. Obviously, I had things instilled in me that I didn't realise were there and I was masking that pain. I was self-medicating ... I think I was always self-medicating. And now I've got a diagnosis of bipolar personality disorder which might have been from child trauma but it might equally have been a chemical thing that was made worse when I was younger. Or maybe the drugs induced that, I don't really know. I was always off my head and the life and soul of the party."*

Essentially, these perspectives suggest that while it may be recognised that some individuals may choose to use drugs recreationally, albeit within a permissive or persuasive social environment, for others the social and familial context is really key, which can involve a combination of adverse childhood experiences and social deprivation, suggesting that drug misuse is less a choice and more an coping strategy. P1 for instance stated:

- *"I know from talking to lots of people over the years that nobody wants to take drugs. Nobody wants to be addicted to heroin or to have to take Crack all the time. These people don't want that. They've generally done that to block something out of their life or, you know, to get rid of the pain that they're feeling about some situation in their life." (P1)*

Furthermore, P5 said that adverse childhood experiences and other safeguarding issues are always uppermost in the minds of police officers when encountering people involved in drug-related offences or who are exhibiting clear drug dependence: "*Those are the questions I'm asking myself when I've got a young person in front of me … 'What do we know about this person?'*" He stressed that all front line officers should have an understanding of safeguarding issues, adverse childhood experiences and trauma as potential underlying factors:

- *"ACEs probably features in most officers' heads. If we've got a young person that's been caught with drugs we've got to be asking, 'What's the home situation like?' We've got to be thinking about that. If they're 15, 16 years old is there something going on at home? What's their background? Are they known by social services, etc." (P5)*

Drug misuse can therefore be an indicator of underlying disruption within an individual's life, which is likely to be a complicating factor for the police who have to assess a situation very quickly when they encounter a potential offence being committed. Some of the accounts above illustrate how drug misuse may be interpreted as a form of escapism for individuals who have experienced traumatic life events – acute or prolonged. In this regard, it should arguably be interpreted as a 'symptom' of underlying psychological and social factors rather than the root cause *per se*. This perspective is commonly echoed within prison research where drug misuse is interpreted as a coping strategy for prisoners who may use drugs to 'numb' the mundanity as well as the stress of imprisonment. This was articulated by D1 and D3 who had both experienced prison:

- *"In prison I spoke to plenty of people that spent most of their day off their tits. They said it was because it killed the bird. When they say they're killing bird, they mean they're killing time. And that's no different to what people are doing in society that aren't happy with their lives, they're just killing time but not actually achieving anything." (D1)*

Similarly, D3 described the drug Spice as a "*bird killer*":

"*You don't remember the days then, the days just go by and you ain't got to worry about it, you're totally out of it … You're out of the prison in a way, because you're flying high. You're not really there at all. And that's what it's all about, really, the drug problem.*" (D3)

5.2.4 Lived Experiences – Reaching the End of the Road

A key theme that arose from the two DEP representatives, whose lived experiences have featured in this discussion so far, is the sense of 'reaching the end of the road' or 'hitting the buffers'. For both, this involved break down in their close relationships and near death experiences as a consequence of their drug abuse. D3 said he reached this point when he was sent to prison, which he admitted was also a 'wake-up call':

- *"It all started for me when I went to prison. I was using drugs, I had a chaotic lifestyle. It happened for me at the right time really. I was at rock bottom, I'd hit rock bottom. I lost my children, I lost my partner, I lost everything in my life. And I was sat there in an eight by four cell with just me and my thoughts. And I had to look deep inside, and decide: 'Where am I going to go with this? What do I do now? Do I go and close this show, end it all', like? Because it was all too dark. 'Or do I like get up and dust myself off again', like I'd done numerous times in my life? I always seemed to just get back up and carry on as before. But this was probably the toughest time. I attempted suicide but it didn't work. I planned it quite well and I timed it – I knew the regime, I knew when the officers wouldn't be there and I made a good attempt of it, but it didn't work. So then it was like, 'Right, well, that's not going to happen, that's not your destiny, it's time to do something." (D3)*

Evidently, he had reached this crisis point on previous occasions:

- *"I've had some really, really horrible nasty times, the pits of the pits. And when you're depressed and you're on drugs and you're psychotic and you're taking yourself to the hospital because you feel like your head's going to explode or your brain's falling out – literally, you're holding your head … I've been in a psychosis I don't know how many times, thinking people were after me. It's a horror. It's horrible to be in that situation." (D3)*

Moreover:

- *"I was nearly dead … I did die and came back … because I've overdosed and I've been brought back to life three or four times. So, I feel really lucky to be here." (D3)*

D2 had been in similar situations and uppermost in his mind was the trauma he had caused his family, with the loss of his partner and children:

- *"As a result of my using, I haven't seen my kids for six years. I've got two kids who'll be eleven and nine this year and I haven't seen them for six years, and that's eaten away at me. It just escalated when she took my kids away from me. I understand why she did it … and she didn't even see me at my worst. And I've had to stand up in court and admit to all this stuff that I've done – taking money off of her and saying horrible things to her. That's a really hard thing to swallow when I'm sober. I know a lot of that was from my own making, from going out drinking, not coming home and not being present. I wasn't a very nice guy to their mother. So obviously it's a really, really sour situation. … And it's not going to be an easy road because of that six years I've been out of their lives. I'm going to have to sit down one day and explain to them why I wasn't in their life. There's a lot of trust to rebuild and I've got to make amends to their mother at some point. And she's still bitter at me." (D2)*

This preliminary section of the findings has illustrated that drug misuse and addiction are complex and multi-causal. Even for the least prolific 'offender' there is likely to be a back-story that should be appreciated when considering how to manage drug misuse. Often the problem will be dealt with legally or clinically depending on perceived severity, threat and potential harm, but usually drug misuse is symptomatic of deeper seated societal, cultural or welfare issues that warrant intervention, and the perspectives of ex-users or clients can be valuable in seeking alternative courses of action.

5.3 POLICING DRUG-RELATED OFFENDING

This section examines perspectives on drug-related policing based on the qualitative evidence. The views of police representatives are more prominent here given their roles and experiences in this area.

5.3.1 Responsive Policing within Limited Resources

All the police representatives asserted that much of their time is spent reacting or responding to the acute end of drug-related offending rather than investigating the production and supply of drugs. Those in 'front line' roles acknowledged that this was essentially their function as response or beat officers, as P5 stated, "*We spend a lot of time in the reactive space, particularly on response, because that is the nature of the job*." (P5) Much of this work, especially in urban localities, entails street level encounters involving individuals who are incapacitated, endangering themselves or others, or involved in theft related to their drug dependency:

- *"As police officers, we see a lot of people who are high on drugs, off their face and who make bad decisions because their judgement is impaired, whether it's stealing off someone, robbing someone, or being a nuisance in town." (P2)*

As P3 described, "*they'll basically do anything for a hit. And if they can't get the hit they want, they'll get the hit that they can afford*." Furthermore,

- *"I think it just becomes the norm for them; they just keep taking it and taking it, and become addicted to it. So when they try to stop, their body shuts down and it becomes immensely painful until they have another hit of whatever it is, and then that's all they can think about. So, they ruin their life." (P3)*

What also emerged was the volume of these cases with what appears to be the majority of policing time taken up dealing with street level crime associated with drug misuse, illustrated by this account:

- *"Residential streets, high rise flats, things like that, it's all over the place. There's little pockets in places, but they're all over really, since there's so many people doing it. And there's nowhere near enough of us to police it. It's impossible to police effectively." (P3)*

D1 suggested that this reactive stance is characteristic of the criminal justice system overall:

- *"There's nearly 100,000 people in the prison system at the moment. The prisons are literally just a place to keep people who are deemed unfit and unsafe to be in the community. For me, that's not what it should be about. The criminal justice system is a temporary fix because what you're doing is taking these people out of society. And that's only a temporary fix for society. It's not a temporary fix for prisons though. It's easier to get drugs in prison than it is out on the street. So it removes the problem for society and just puts it somewhere else." (D1)*

He continued, "*We've tried the 'stick' method for years and years and years, and it doesn't work. In my opinion, it doesn't work*" (D1), which suggests that drug misuse requires much more than a criminal justice approach.

Front line police officers evidently spend a lot of their time responding to street level disturbances that can be frustrating when this is perceived not to be tacking the root causes of drug-related offending. This was summarised by P2, who suggested that:

- *"Finding the dealers is the best way to get on top of the drug problem – and targeting the suppliers – because obviously if you get them out of the game you're having a larger impact, instead of going out and arresting a load of people for using. Then you've taken out the distribution network."*

This was combined with the fact that the large organised crime groups are perceived to be several stages ahead of the police:

- *"The OCGs are clever, they're becoming more and more aware of the tactics we use because these get disclosed as part of the court process. So they change their standard operating procedures and we quickly become out of date. So, unless you get really lucky, you're constantly chasing and trying to have that light bulb moment and work out how that network is operating." (P5)*

In this regard, there was enthusiasm among front line officers to undertake more investigative policing:

- *"There are long periods, especially at night, where we don't have people calling 999 believe it or not, so we'll spend a lot of time doing proactive stuff, sometimes operating in plain clothes and responding to ANPR [automatic number plate recognition] hits. We'll basically be going after cars that have some kind of intelligence marker against them. For instance, if*

we want to focus on a specific area where drug dealing is common, we'll get out in plainclothes and have a poke about and see what we can see." (P5)

Investigative policing was considered to be a favourable strategy for tackling the root causes of drug-related offending, even at the street level where officers can use their experience and judgement to identify, distinguish and investigate the more significant offenders as opposed to the 'low level' offenders found to be in possession or involved in street dealing. So, on the one hand, there is the need to respond to low-level offending – "*… searching individuals, finding drugs and dealing with them for that offence*," and, on the other hand, "*… investigating the large scale enterprises and conspiracies*." (P1) While the bulk of intelligence and detective work does not ordinarily involve front line patrol officers, they play a key role at street level in terms of encountering criminal activities linked to the larger dealing enterprises such as the County Lines networks. To illustrate, P3 described the kinds of scenarios where patrol offices can come into contact with a dealer network:

- *"On the supply side, you've got vehicles, one or two people, sometimes more, in the vehicle with drugs in the vehicle and usually a weapon as well. And they'll be ferrying the drugs all over the place, and that's likely to be large quantities of drugs. You've also got large quantities of drugs that are individually wrapped, so maybe not as much quantity but they're still dealing. Also, there are the street dealers – you're talking about the guys on foot, kids on bikes … More often now it's the younger kids that have been groomed into selling drugs on the street for very little profit themselves, but they see it as a gang thing, kudos, whatever. And then with that comes the stabbings and the territorial fights and all the rest of it … There's the violence aspect to it as well, where they're fighting, stabbing and murdering people in turf wars to sell drugs. So we're first on the scene with stuff like that."*

With County Lines, patrol officers might encounter 'cuckooing' where a dealer network "*takes over a vulnerable person's address and sells from there. They'll literally dish it out to kids and the kids will go and sell it. It's very rare you'll see the big dealers getting their hands dirty anymore. Too risky for them*." (P3)

Prisons are considered to be the least resilient part of the organised crime network for illicit drugs:

- *"I know guys who get into trouble just to get sent to prison so they can run a business for someone on the outside. They've got phones in there and they're sending the drugs and all*

sorts over with drones, it's a business. They quadruple in price: an ounce of weed out here might be £140 pounds and in there it's £380." (D3)

A consistent view across the policing representatives was that workload is unprecedentedly heavy at all operational levels, which was felt to have been exacerbated by overall reductions of operational police staff in the wake of national cuts in policing numbers and the impact of the pandemic on policing. In general, drugs-related policing was viewed as a huge problem that demanded much more resource than police forces are able to provide. As P1 emphasised:

- *"Staffing in the police is an ongoing problem – trying to provide the services required of us with the staff we've got. Two years ago we had a Drug Squad created with 100 staff divided into two – fifty based in Bristol, fifty in Bridgwater to cover Somerset. The impact of those two teams was massive, the extra work they generated equivalent of one and a half members of staff working full time. When you try and present that to the decision makers – that we need more staff – it's difficult, it really depends on what the bosses think." (P1)*

5.3.2 Engagement with Drug-Related Offenders

The interviews with police representatives provided insight into the engagement tactics front line officers use with suspects. 'Stop and Search' is evidently a major preoccupation for the police given its political and societal profile and the fact that it is an important instrument for the police. It is routinely used with drug-related offending often being the first option available to patrol officers when they suspect someone to be in possession of illegal drugs. There was acknowledgement among interviewees that Stop and Search is useful as a deterrent for first time or low-level offenders but that it can be problematic with more serious or 'resistant' offenders or suspects. For the former, just being stopped can de-escalate a situation, as P2 suggested:

- *"Being searched by someone and getting caught with drugs on you, I can't imagine what that's like. It's quite something for them, especially the first time. I can imagine it shakes them up quite a lot. I remember being at school and being told off and it does shake you up, it really does put you down for a while." (P2) He added, "The vast majority of the time, those who we stop and search have probably never been in trouble with the police before, like those we're stopping in car parks smoking cannabis … They'll actually comply straight away because they're scared of what's going to happen to them. It's like they're stunned, like a deer in the headlights, and straight away they'll say, "Yeah, I've got stuff on me, here it is," or they'll just freeze and you'll find the stuff in their jeans pocket." (P2) He also equated this with*

being caught speeding: "We'll tell them not to speed again and we might not give them a ticket, but we will give them some strong words of advice. Then you'll see them driving around at 30 everywhere because it really it does rattle them." (P2)

Acquiring a sense of perspective and proportion is therefore important for an officer in each policing scenario and apprehension associated with the encounter is a natural response:

- *"It's one of those things you don't really take in until you come across it. So when you first come across that sort of low level of drug taking, when you're first a police officer, and you first come across someone smoking cannabis or whatever, you feel the anxiety go up a little bit, the adrenaline goes up and you're thinking, 'How am I going to deal with this?' especially when it's quite low level … It's still an offence and people are obviously scared of police finding drugs on them and you've got that public perception you've got to take forward." (P2)*

On the other hand, there are those more challenging situations where a suspect will resist being stopped or searched or try to evade arrest:

- *"Literally last night, we came across a massive bunch of kids aged 12 to 16 walking around the streets lobbing water balloons, and then they started chucking rocks. We went to talk to them and there was a strong smell of cannabis, but then they all ran off … which then just makes it worse." (P3)*

Stop and Search is undeniably a politically sensitive tactic that has been associated with institutional racism and disproportionate policing, which was partly reflected in P2's suggestion that "*You can get the really, really 'anti-' ones who hate being stop searched*" (P2). The following account indicates how sensitivities among minority ethnic communities can play out in practice, where a police officer described a stop and search scenario:

- *"In this particular instance, one of them got out of the car and he immediately stuck his hands out behind his back. We were engaging with him really pleasantly, having a good chat, but he turned around and put his hands out to the rear for me to cuff him. I had to say to him, "What are you doing? Let's keep this nice and friendly here. You're not going anywhere." Straight away, it struck me that we need to be thinking about what's going on here. We've used the controversial tactic of Stop and Search and we've straight away been met by a really odd behaviour with this guy assuming that I'm going to put handcuffs on him. And that's something we encounter on a daily basis now, particularly with the BAME community." (P5) He added: "We've already got a barrier, as in culture, you know … This particular young lad*

has probably been told by loads of his mates before that the police can put you in cuffs and that then they're going to beat you up … And that could be generational throughout his family, or it could be his peers and so on and so forth." (P5)

P5 referred to another occasion in police custody where a detainee anticipated that the police would use violence on account of their ethnicity:

"I had a young lad in custody the other day who said, 'Do you know the reason why you officers turn your body worn cameras off?' And I went? 'Yeah, I do, but go on, I'm interested to hear what you say …' 'Well, it's because you're going to beat me in the cell'. So, I'm like, 'Mate, you're 16, you have absolutely no idea. You've just been brought in for GBH. That camera up there is your protection. That doesn't happen. So, no matter what anybody tells you, that doesn't happen. I guarantee you, by the end of this shift, you and I are going to be talking to each other like normal people. And you're actually going to think I'm a relatively okay bloke'." (P5)

A clear message from the police interviewees was that in scenarios where they respond to a call or suspect that a crime is being committed, it is essential to use discretion and judgement and to weigh up the situation with sensitivity. P5 spoke at some length about this:

- *"Officer discretion forms a massive part of being a police officer, whether it be a traffic stop or just engaging with somebody in the street and deciding how you're going to resolve the situation. Our decision making revolves around the threat-harm-risk that is being posed in a particular situation. If there's clearly no threat-harm-risk whatsoever, there's no need to take any sort of further immediate action." (P5)*

Here he was referring to the Thrive Matrix (Threat > Harm > Risk > Investigation > Vulnerability > Engagement) used in policing to guide an officer's investigative decision making. Police officers use this framework at a scene to rationalise, understand, de-escalate and endeavour to remove as much risk as possible and, where appropriate, refer individuals to alternative non-criminal justice disposals should this be deemed appropriate. This is essentially a harm reduction approach to policing that requires front line officers to:

- *"… think on our feet about how we best do this, and how we best deal with the situation. We need to be asking ourselves, 'What is it we're trying to achieve?' We're looking for a positive outcome that doesn't put more pressure on the courts system. We're asking ourselves whether it's proportionate for us to put someone through the courts, especially for a bit of cannabis. It's partly our responsibility not to overload the services and to just do the decent thing."*

P5 also asserted that an important stage post-intervention is to reflect and learn from the experience:

- *"When I come away from a job I will reflect on what happened and I could come away and think, 'Actually, referral to another service could have been a better solution.' While it may not be appropriate or possible to go back and change the pathway we took, at least I've identified that." (P5)*

Another feature identified as a crucial theme of the police encounter with a suspect is communication – the manner and conduct of the police officer when approaching and engaging with suspects. P5 identified conversational technique as an important de-escalator tactic. He spoke about the "*30 to 40 minute bubble*" when the officer has to approach, stabilise, de-escalate and manage the situation to the best of their ability, and reflect on situations where poor communication skills have been exhibited by fellow officers:

- *"I've been on a number of jobs where there've been police officers who are either really young or come from very different backgrounds and personality types, and the way they speak to people is not good."*

This officer asserted that communication technique is paramount:

- *"We can be dealing with very dangerous people. And one of the things I learned in Conduct after Capture Training is to humanise yourself to your captor. You're there with your body camera, your ASP, your Parva, your PPE, your cell phone […] Even though I'm flapping myself internally in certain situations, people can be intimidated and don't want to talk to you. Or they can cast aspersions on what I'm like before they've even spoken to me. So it's really important to be able to engage and speak to people … For me, it's therefore about gaining control of my subject, albeit in conversation or handcuffed, to establish first of all if they're a threat to themselves or a threat to me." (P5)*

Added to this, he argued that it is essential to be able to explain coherently what is happening and why, partly for legal reasons but also to establish a level of trust and rapport:

- *"Whether it be for a possession charge or for a DEP, you need to be able to explain to people what the process is, because good explanation will guarantee that better engagement with people and actually getting them to take up the help that is being offered." (P5)*

5.3.3 Supportive and Empathic Policing

In addition to this measured, deductive and reflective approach to evaluating and managing particular policing scenarios, participants described how policing requires an empathic and supportive stance. D1 described this in terms of

- *"… walking a very fine line between enforcement and support. There have to be consequences, but there needs to be support along with that where we can say, 'Okay, look, you've messed up, you've done this, you've done that, this is what we're going to do to support you'."*

This was inferred by P2 who argued that such an approach can feel positive and affirming for both perpetrator and police officer:

- *"In all honesty, we do try to help people as much as we can. A lot of our job is perceived as being on the 'punishment' side with people generally disliking us. But I've been to so many situations where they will thank you and they will hug you after you've offered them an alternative to arrest and potential prosecution, because you're not punishing them. You're still giving them a disposal but you're also trying to help them. So after that they're thanking you and sometimes they'll be crying and saying how much they really appreciate what you've done for them. That then really boosts your morale. And that's one of really good sides of this job, you <u>can</u> really help people and you can actually feel like you're doing something good. So, it really does boost your morale that little bit when you can actually help someone." (P2)*
-

P5 argued that for him:

- *"It is about doing the right thing. We have long moved past target driven approaches and, certainly on my team, that is not what we do. But I have encountered conversations with others who've said they're been looked at for the number of arrests they've done and the number of Stops and Searches they've carried out and so forth, which is not how we should be doing business."* He added: *"I would hazard a guess that not everybody thinks the same way, no officer thinks in the same manner. But I think everybody should be aware of what the best practices are and how we could best go about things."*

One police representative reflected on how his stance has shifted significantly over his years of service:

- *"As a drug squad officer, I spent my time researching drug dealers, kicking off their doors, invariably fighting with them, chasing after them, and then ultimately locking them up. And during that period of time, it gave me great pleasure to see someone go to prison for six years for selling drugs, you know, causing the harm that they did. As I've matured, I've recognised that by locking up drug dealers I'm not solving that problem. People go on about "losing the war on drugs" – I don't consider it a "war", I consider it a job to prevent the harm that's caused to people that choose to use drugs. My passion now really lies with changing things as opposed to locking people up. I want to see people who use drugs have the opportunity to stop using drugs, I'm passionate about changing that. I know that if we lock up a drug dealer then another one will pop up immediately, it's a never ending story." (P1)*

From an ex-offender perspective, D3 echoed this perspective, suggesting:

- *"'Okay, so we have to punish you, but we're going to punish you in a way that's going to benefit you and help you. We'll put you on a course for anger management to help you learn how to deal with your stress.' Not: 'We're going to stick you in a cell and make you more stressed and fucked up'."*

5.3.4 Alternatives to the Criminal Justice Pathway

P1's account above indicates a cultural shift in drugs policing where a zero tolerance, tough policing stance has been replaced by an arguably more progressive approach based on harm reduction and health improvement:

- *"Back in the early days, the police generally didn't have an interest in anything beyond if someone used drugs, that was a crime. So they were arrested, sent to prison, full stop, no questions. And then in probably around about 2000, the treatment agencies started to pop up and become trendy and receive funding to help people." (P1)*

It is evidently frustrating for front-line police officers who encounter situations where offenders have committed a recordable crime but clearly have welfare issues that have precipitated the offence, yet where the police are legally required to charge the suspect:

- *"A lot of stuff we do is PACE derived, so it's legal. So you have to arrest them and it's straight into police custody. There's not much care then and a lot of stuff we can't refer. And in some*

cases it's very sad because we'll have to say, 'Well, this isn't our department.' 'If you're homeless, it's not our department, it's someone else's.' They might have broken in and stolen food so, we have to deal with that, with the criminal damage, robbery, burglary, whatever they've done. We can't refer them elsewhere." (P2)

The opportunity to refer or divert suspects away from a criminal justice outcome was viewed as a really positive asset for the police, especially when handling low level drug-related offences:

- *"It's really refreshing that we can actually use that power of referral instead of just punishing them. It's nice to actually be able to say, 'Well, you need the help, you need to go and get help, so we're going to make you go and get help, we're not going to punish you.' It's very rare that we get to do that. I wish there were more ways to do that instead of going down that punishment route." (P2)*

Likewise, P1 said:

- *"I'm a big fan of helping people who use drugs to stop. And I'm a big fan of diverting people who are heading down the drug dealer route to go somewhere else and do something."*

P2 acknowledged that a range of alternative referral options are available to the police that reduce the severity of an outcome and avoid the necessity for prosecution via the courts; these include community resolutions and conditional cautions:

- *"With community resolutions you can get people to write apology letters or to pay for damage, things like that. Conditional cautions are almost the same and mean you can, for instance, say they have to attend an anger management course. They're still going through the criminal justice system, so it's still an arrest …" (P2).*

Such outcomes, suggested P4, act as "*… a reminder that actually, no, it is still illegal and this could affect you in the future. If you carry on and you get caught again, it will have significant implications for you … And they'll admit, 'Okay, right, I don't want to get caught again'*."

Building upon these perspectives, it was clear that police representatives recognised that many scenarios they encounter are essentially health or welfare issues that surface once a crime has been committed. P3 acknowledged that front line police officers are often the first emergency service at a scene:

- *"We'll get a 999 call – someone lying down the middle of the road. That's an ambulance job, isn't it? But we'll go anyway. Someone's suffering from a mental health crisis and they're going to kill themselves. It's really a medical emergency but we're the first ones there. We can detain people under Section 136 of the Mental Health Act and take them to a hospital based place of safety; that's our responsibility."* He added, *"Our building block is to protect life. So if you speak to a lot of cops and ask them why they joined the job, they'll say it's to help people. Obviously, yeah, it's to catch bad guys, drive fast cars and do whatever, but it's to help people essentially. And if someone needs help, whether it's because they've taken too many drugs or whatever, then we'll go and we'll help. And then we'll ask the questions later."*

P5 echoed these thoughts:

- *"As a response officer, we are responding to escalating mental health events. So having an understanding of what to do in these situations, you basically have to have a toolbox, a tool for every situation and, you know, your "experience box" as well, basically."*

5.4 THE DRUG EDUCATION PROGRAMME

5.4.1 Introduction

This section examines the qualitative findings relating specifically to the DEP. The DEP operates essentially as a liaison and diversion service supported by a team of mental health practitioners employed by Avon and Wiltshire Mental Health Partnership NHS Trust.

5.4.2 Perceived Objectives of the DEP

From the perspective of the DEP team, the DEP is aimed at people who are in a position or have the capacity to think about and reflect upon their drug taking behaviour; in other words:

- *"… those that can still be reached and to whom we can still say, 'Start thinking about your drug use, start thinking about the impacts that it has on you, on your health, on your family and on society'." (D1)*

D4 described the DEP as an "*early intervention*" that is "*harm prevention based*" and that introduces participants to knowledge and information about drugs whilst drawing on lived experiences of participants and of facilitators. D4 expanded:

- *"It's not so much a drug reduction strategy, more about harm reduction, trying to keep people safer and more aware … Being safe is one of the main outcomes I would hope for and avoiding any form of prosecution … It's about being able to help them make informed decisions and keep themselves safe, and being aware of how this can impact their future and other people's futures."*

The intention is therefore that the DEP is principally targeted at low level or first offenders to prevent them from becoming dependent or experiencing further deterioration in their drug misuse. The majority of participants will have been caught in possession of cannabis:

- *"They've probably just smoked cannabis … They may not have tried cocaine or heroin but they could be on that pathway. So by getting that message across to them we might just put them off of trying it." (D2)*

Likewise,

- *"A lot will just be there for cannabis use. But I think it's really, really important to make people aware of the dangers of other substances. They might have friends or know people who use other substances. They might have tried them themselves or have an interest in doing so. So making them aware of the risks around all these other different kinds of drugs is definitely going to be helpful in preventing further harm … So it's more an early intervention for getting people who are maybe just starting drug use at a very low level to become aware of the risks they might not have been aware of." (D4)*

Furthermore,

- *"It's definitely more of a preventative measure. We discuss the physical health risks and then the mental health risks with every substance that we talk about. None of the people that we would see would actually be in that state." (D4)*

All those involved in the DEP emphasised that the programme is orientated towards reducing harm through the sharing of knowledge and experience rather than it being purely didactic or "top down":

- *"We're not there telling people: 'Don't do drugs.' We accept the fact that people use drugs, but we want to try and help them to do it in the safest way possible." (D4)*

5.4.3 Making a DEP Referral

The DEP referral process requires police officers to have a good knowledge and understanding of the Police and Criminal Evidence Act (PACE) 1984, which governs police powers to stop and search, question, detain, arrest: "*You need to know the legislation, you need to know that inside and out, and you need to be able to put it across.*" (P5). PACE then determines whether the police officer has the legal justification to stop and search individuals and to proceed further with other measures. Under PACE, therefore, if a police officer decides to stop and search an individual under the Misuse of Drugs Act and finds a prohibited substance, they are required to proceed down the legal route with an arrest. However, as P1 explained:

- *"Previously, PACE allowed us to investigate and question people on the street in relation to Cannabis and Khat … to give them a caution or street warning for possession. This would involve taking the drugs off them if they admitted to possessing them for their own use. They'd get a street warning and then nothing more was heard about it. This was brought in*

to try to stop people going into the system, and that's what sort of led to the DEP: previously we'd be taking drugs off people and sending them on their way with no education, no chat, nothing. And then all we'd do is cost them money, because they'd go and buy some more."

P1 explained that this more lenient approach had evolved with the introduction of the Psychoactive Substances Act 2016, which states that while it is an offence to supply, import and deal in psychoactive substances, it is not an offence to possess them:

- *"As far as possession goes, we don't even have the power to take the drugs off them. We may have to take them for testing, though, if we can't identify them, but we don't prosecute for possession of a psychoactive substance. So that's almost like a continuation of what we do now with the DEP – we don't prosecute people for possession of drugs."*

In this respect, as several officers affirmed, Avon and Somerset Police do not actively investigate and intervene with individuals suspected of taking drugs for personal use. Indeed, P1 said:

- *"I can guarantee you, and I can say with hand on heart, that in Avon and Somerset we do not go after people for possession of drugs, we do not go out and stop people with the intention of finding drugs on them for personal use."*

It was emphasised nonetheless that where Class A substances are concerned, or in cases where it has been necessary to undertake a PACE Search or a Misuse of Drugs Act Search and then drugs are discovered, the legal process must proceed and there may then be a conviction for possession. This was explained further by P1:

- *"When Class A drugs are involved they have to be arrested and interviewed in the normal way. We must explain their rights to them including the opportunity to have a solicitor present. But you can't proceed down that path and interview them on the street; under PACE, you can't interview for possession of a Class A drug on the street and the person has a legal right to be interviewed. Even if they are caught in possession of cannabis, under PACE we are expected to explain their rights to them and give them that opportunity to speak to a solicitor and to be formally interviewed. If that's what they then decide they want to do, we have to then arrest them and take them to a police station or arrange for them to voluntarily attend for an interview."*

The introduction of diversionary schemes for low level offending – offered to suspects at the point of arrest during a stop and search – brought with it a complication with PACE; a police officer cannot approach or apprehend a suspect and question them about a suspected offence without first offering them their right to be interviewed in the presence of a solicitor. Questioning a suspect at the point of apprehension on a voluntary basis without legal representation must occur with their unequivocal consent. And therefore to offer the DEP to a suspect as an alternative to being arrested means conducting a voluntary interview at the point of stop and search to enable the police officer to make an informed judgement. So, as P1 explained, when the DEP was first introduced as an alternative disposal for police officers:

- *"… the question of breaching PACE was considered to be an acceptable breach that was underwritten at the time by the Chief Constable. It was introduced purely to benefit the person caught in possession, to avoid being arrested."*

He emphasised that if a suspect is adamant that they want to be questioned in the presence of a solicitor, then they can be arrested in compliance with PACE:

- *"If the person you're stopping and searching says, 'Hang on a sec, you can't question me about heroin, that's a breach of PACE," then the officer will say, "No problem, you're under arrest, we'll go back to the police station and do it under PACE properly'." (P1)*

Essentially, therefore, for an officer to make a DEP referral the suspect must be fit to consent to a voluntary interview at the point of stop and search and waive their right for an interview with a solicitor present. As P3 suggested, "*It depends on their demeanour, they have to be open to it*." Therefore, in situations where a serious crime is committed, officers must apprehend and arrest the suspect and then the full PACE protocol applies. P1 explained that police officers must therefore use their discretion to decide whether or not to offer the DEP as an alternative to arrest. Furthermore, there may be occasions where the extent and type of possession is unclear, or where individuals may have been involved in an offence where the evidence is inconclusive. For example:

- *"There are occasions where we'll provide someone with the opportunity to go on the Drug Education Programme even if they've been found to have heroin in their possession. We'll be breaching PACE because under PACE we're not supposed to interview people on the street for Class A drugs. But for an individual to agree to go on the DEP they have to answer some questions around their possession, so we have to breach PACE by doing that." (P1)*

Similarly:

- *"Someone that's been using heroin for 25 years, who's found in possession of a wrap of heroin and who's been to prison for six years for various drug offences, and been stopped and searched 55 times and found in possession of heroin, they can still have a DEP. Those are people who've failed in every aspect and we want them to have this one chance as well. If we can stop them taking drugs or at least help them down that road … the DEP is an opportunity to trigger a change." (P3)*

There are clearly exceptions where individuals with histories of offending will be referred to the DEP at the discretion of the police officer as an alternative to making a formal arrest:

- *"I used the DEP with a guy I brought in for affray under suspicion of GBH. While we were at the custody suite, he admitted to me in the holding cell that he'd got some Spice on him. Now this particular individual had a long history with drugs but because he admitted it and he hadn't had a DEP referral before, and because he was already being dealt with for the other offences, we used the DEP as a solution." (P5)*

All the police representatives interviewed nevertheless viewed the judgement to use the DEP as a referral option as a straightforward decision:

- *"Generally, the line between who we give the DEP to and who we don't is very, very clear. One the one hand, there's the kids who are out with their mates drinking a can of beer and smoking in the park and then there are the people who are with the OCGs or who have proper problems with drugs. They're two very, very different groups." (P2)*

A clear distinction was perceived between low level possession and more serious drug related offending:

- *"It has to be a possession amount of drugs and that they haven't been on the Drug Education Programme before." (P1)*

- *"If I stop someone on the street and they've got a small amount of cannabis, rather than giving them a criminal record, they will obviously qualify for the DEP." (P3)*

The process of referral using a short voluntary interview was described by several of the police interviewees. P3 described this:

- *"I'll go through the DEP interview with them there and then. They'll have to admit to possessing it and then I'll return to the station, write up a crime report and complete the DEP programme referral; and that's basically my involvement in it. If they don't turn up for the DEP programme, then it will come back to me and then I'll have to put a case file together and it'll go to court for a possession charge." (P3)*

P5 pointed out that in order to comply with PACE:

- *"You've got to be very careful with the questions that you're asking. In fact, the questions have got to be minimal. So you need to do the checks first without alerting the subject to the DEP option, because if we're going down the arresting route, we don't want to give it away." (P5)*

Body worn camera was considered a valuable tool to provide the evidence that the process is conducted ethically and appropriately:

- *"… being able to show good examples of body worn video, which is really important in telling the good stories out there and being open and transparent" (P5).*

P5 elaborated, saying:

- *"You ask them a series of questions as a voluntary interview, there and then using the body worn camera, and we're looking for them to admit to possession. Once that's done, you can raise a crime report and write it all up later."*

P2 explained that use of a body cam could save valuable time:

- *"I helped out on a job with a team in Weston-Super-Mare. The sergeant on that team found some drugs on this guy and the guy was kicking off a bit. But then he offered him this alternative disposal. He pulled out the DEP form and read through it on body cam … and that's such a great idea, because then there's not the hassle of trying to get him in for an interview. This guy lived in Bristol, so it was great to get it done then and there, instead of having to get him to come all the way back from Bristol for that voluntary interview …"*

Examples of the Stop and Search process were described by police representatives as summarised below:

- *"We'll go into a Stop and Search, which allows us to get "hands on", to go through their pockets and seize anything that we find, and also for us to do some checks on them. And that's really where the DEP process starts for me [...] We'll then ask for an intelligence check to be done through our client system to see if there's a DEP flag against them [...] Now if they're a habitual drug user then there's no point in doing a DEP referral because they'll have had loads of street charges before for possession, more than likely [...] But if they've got nothing on them from previously in relation to drugs, then we can go down that route and make the DEP referral." (P5)*

- *"We'll conduct a PNC [Police National Computer] check. If they've got no drug convictions they may be eligible for DEP. We'll check the local police record, Niche, and if they've got no previous DEP referral or out of court resolutions then they're eligible. They have to comply basically, they have to agree to it. If they're saying, 'No, I don't want to do it', then it's 'Well, okay, then I can't offer it to you and if you don't want to do I can't go through it with you'. [...] If their last conviction was a fair few years ago and they've been out of trouble for several years then they might be eligible for the DEP, because it wasn't an option a few years ago. So if you take into context that the Drug Education Programme was created to educate and to stop reoffending, even if they've got extensive history it might work for them. I think it very much depends on when they last offended and how open they are to the idea of the programme." (P3)*

Typically, making the initial decision whether to refer to the DEP depends upon what an officer encounters at the scene and any background intelligence that is available on the suspects. Detailed accounts were provided by P2, P3 and P5 where the DEP had been used to divert suspects:

- *P2 explained that it was relatively common to come across a group of young people parked in a car smoking cannabis: "We searched a car in an abandoned industrial estate. The lights were on, all four windows were down and there were four kids inside. And it absolutely stank as well. My partner took the lead as I was new in service. We searched them all and found a little bit of cannabis on one of them in the back. And my partner explained to them that since there was only a small amount they could come to the police station for a voluntary interview and be referred to the Drug Education Programme. He explained the whole thing to them and then brought them in for the voluntary interview where he then went through all*

questions on the DEP form with them. I thought this was a really, really good process and I started observing how other people were doing it."

- *P3 described a similar occasion: "There was a rear light out on a car so we stopped the car. There were four males inside and a very strong smell of cannabis. They were all compliant and they were clearly student types. They'd never been in trouble with the police before, no criminal records, nothing on our local police computer for any of them. So it didn't make sense to arrest all four of them and take them into custody. It was a small bag of cannabis, probably worth only ten to fifteen pounds. So we went through their options with them. And on that occasion, because there were so many of them and so as to control the situation, as soon as I found the drugs I arrested the individuals with the cannabis for possession. That gave me the additional power to get hands-on if I needed to. But I didn't need to because they were compliant to go ahead with the search. Two of them actually had possession and the driver admitted that he'd smoked some earlier in the day. So we sat them in the police van and ran through their options with them – 'If you take part in the drug education programme you won't get a criminal record. You'll go on this course and then basically there's no need to go to court and it won't go on record.' And they were incredibly thankful and cooperative then and gave us their details, took part in the voluntary interview, and then we were able to let them go."*

P5 described a stop and search involving two university students:

- *"There were a couple of young Somali lads parked up in a Vauxhall Corsa at three o'clock in the morning. I couldn't actually see them because of all the smoke in the car – it was impossible to see through the windows. So we did our checks on the vehicle before approaching them and we decided to do a Stop and Search on Section 23 of the Drugs Misuse Act. And it's very, very important that we get that right as Stop and Search is, as you'll know, a political hot potato. So in this instance our rationale was that it was three o'clock in the morning, we've got a strong smell of cannabis coming from the car and one of them is holding a joint in his hand. The intelligence also suggested this was an area known for drug dealing. So when we were going through the car we found a couple of university prospectuses and these turned out to be two young lads both with acceptance letters to go and study computer science at university in London. Taking them to court would not have been proportionate. So we went through the DEP process with them. And they've never come to note again."*

P2 described a situation with a man in his 60s who was growing cannabis for his own use:

- *"There was this guy whose neighbours called 999 because they hadn't seen him in ages and he lived alone and they were worried about him. So we were called to his house and his car was still there and his dogs were outside. The back door was closed and the dogs had been outside for a couple of hours according to the neighbours. So we were wondering if maybe he'd had a heart attack or something. Eventually we decided to enter the house under Section 17 of PACE, which allows us to enter a premises to save life … So we entered the house thinking he was going to be dead and that we'd go in and find him on the floor. When we got in there we found stuff everywhere – he was a hoarder. And then we found a load of cannabis plants he was growing … We found twelve plants altogether but you could see that they were for personal use. There were no small snap baggies, no scales, nothing like that. He had books on how to do it and a special calendar on when to clip and dry the leaves, stuff like that. But it was very obviously for his personal use. It turned out that he'd actually been out at the time and then he came home while we were in there. We had to seize the cannabis plants and we had to take him into custody, but then we were able to offer him the DEP, which was a great outcome. He'd never been in trouble with police before, he was a nice neighbour apparently and he just smoked a little bit of cannabis every now and again. So he wasn't criminalised for it."*

P2 described another instance:

- *"There was this one guy who fell off a wall behind a pub into someone's garden. They called us and we turned up and he was still breathing and conscious but slurring his words. We waited for an ambulance and while we were waiting two tiny bags of cannabis fell out of his pocket. When we got him to the ambulance, he was talking about his job and he was crying … He'd been on a night out, he was barely 19 and he was in a real state. He was really worried about his mum finding out and he was smartly dressed and had his BMW keys. He was torn up over losing everything. His BMW was on finance and he was in a real state believing that his whole world was crashing down around him. So he was really scared by what he'd done […] So when we offered him the DEP, he was jumping at it, he was crying, he was saying "I'll take that, I'll take that." … I think he realised that he'd make a bad decision and that was probably enough of a scare to prevent him doing it again."*

5.4.4 When the DEP is Not Used

Four specific instances were cited where a DEP referral would not usually be made:

[1] The offence might necessitate an active police response to control a situation, especially where the Thrive assessment indicates a level of threat and perceived harm that warrants an

active police response. These are cases where arrest and prosecution are likely to be inevitable: "*With a lot of the heavy drug users, we're normally finding drugs on them because of something else. We may have arrested them and be searching them for a knife because we caught them committing another crime. We can't offer them the DEP because they're going into custody. A drugs charge might then get tagged on with whatever they're being arrested for. If, say, they've threatened someone with a knife, then you'll find the knife and then you might find some drugs on them. So it would just get bundled all together and they wouldn't get that help afterwards, that's not in our control. They're then with the custody team and the DIP – the detainee investigation team – who take over after we've brought them in.*" (P2)

[2] The drug-related offending is clearly linked with mass production, supply and organised crime (e.g. county lines). This was summarised by P2: "*With a lot of the organised crime groups, a lot of the harder criminals, they will try and divert your attention and they'll start stashing stuff before you can get there. And they're the ones where there's much more involved and there'll be a knife or a gun in the car, they'll be driving without insurance and driving in a vehicle that's not registered to them, things like that.*" (P2) Similarly, P5, referring specifically to the supply of Spice and other Class A drugs, "*People are really getting hurt. We're seeing a lot of knifepoint robberies and there are a number of jobs in the force area at the moment where kids are dealing and a DEP would 100% not be suitable. That's about dealing with a much bigger problem*." (P5)

[3] When encountering large groups, such as crowd situations, the police have very little power to actively engage in instances where it is suspected that drug related offending might be taking place. Use of alternative disposals is not always possible in these situations simply due to scale. P2 suggested that in such situations where there was no doubt that drugs were either in people's possession or being used, police officers would might resort to confiscation and NFA [no further action]: "*When there's a lot of people around, most officers will just NFA the job. They'll take the drugs off them and send them away … that's all you can do really. If you NFA'd a lot, your sergeant would soon look at it and go, 'You need to chase that up'. But I do know some officers who will just NFA the job*."

[4] It is deduced that the suspect or detainee will not benefit from a DEP referral. A lot of opinions were expressed about this group. Essentially, an individual with an active and chronic drug addiction would neither be ready nor able to commit to a Drug Education Programme: "*At the end of the day, they're still going back into the same situation." (D4) Likewise, "An education programme would be wasted. First of all, they wouldn't turn up, and then they wouldn't engage in it. Even if they did, it wouldn't change their behaviour. They're too far down the rabbit hole*." (P3) P2 provided a more extensive account: "*With the heavy drug users, they*

know it's bad for them. A lot of them have teeth falling out, some of them are really skinny – six or seven stone – and they know what it's doing to them. And, to be honest, you don't trust them to turn up for it … Their whole life is devoted to drugs and they will steal to fund that, that's all they care about. They're not eating properly, they're not getting help, they're not getting a job … They won't benefit in that respect."

5.4.5 Perceived Advantages Afforded by the DEP

[1] A key advantage of a DEP referral for the police is that it saves a lot of time and administrative workload associated with the full arrest and prosecution route: "*The overriding factor for the police on the ground was that they could spend five minutes doing a DEP referral and then carry on with what they were doing, rather than spending five hours in custody. That was a massive factor and one of the main reasons why we introduced it, to save police time. It was a way that we could reduce the workload massively of the guys on the ground*." (P1) Likewise, D3 said, "*If you talk to the police, they're snowed under with people coming in for stupid little things – caught again for possession, caught again for this and for that. And that makes their job harder because they can't go out and get the real criminals, the people who need to be taken off the street*."

[2] DEP referral was also referred to as a de-escalation tactic: "*Initially, if it's been quite a hostile encounter to start off with, the DEP can actually be a really good tool for de-escalation*." (P5)

[3] The voluntary interview as part of the DEP referral process can be a good tactic for intelligence-gathering in that it can open up dialogue between the police officer and the suspect and may then provide information about supply. This was inferred by P5: "*It's a way of identifying supply, where it's coming from, to enable us to explore the bigger problem. That voluntary interview includes the question: 'Where did you get it?' and then that becomes evidential. I'll always have that conversation off camera as well as it's part of our responsibility to ensure that there's going to be no blowback on them. And on occasions they've given me the dealing line number or they've given me a car or something like that that's linked to a supply chain. So, as a grassroots officer on the ground these are very small things, but for that intelligence investigator back at HQ it is phenomenally important*." (P5)

[4] The DEP referral option is also attractive to the police because it gives them a 'positive' positive outcome – or olive branch – to offer people as an alternative to the punitive route: "*The DEP gives us that tool to engage with our communities better and to not be seen as this authoritarian uniform that is out to get them … For me as a front line officer it's about having*

a positive outcome for the individual. We're not pulling them through the courts system which is already overburdened." (P5)

[5] Participants also perceived the DEP as a proportionate response to low-level offending, and therefore a more prudent use of resources. P5 argued: "*A bit of cannabis should not ruin somebody's life. It doesn't look good on a DBS check*." D1 asserted that having come originally from an enforcement background, he could see the benefits of supporting people with a drug problem rather than criminalising them, "*on the proviso that they will access the support and go on to lead drug free lives*."

[6] A DEP referral was perceived by all the police representatives to be viewed in a positive light by individuals they apprehended, particularly given how they responded to the offer of the DEP as an alternative to arrest and potential prosecution. P2 said: "*A lot of them will absolutely jump at the chance to do the Drug Education Programme, they absolutely jump at it. And then they are so apologetic, they become really, really polite and jump at that chance*." This was echoed by P4: "*Almost all of those caught in possession get referred to it and they are very happy to take part in it. They seem very grateful that they've been given this chance and are very happy to do it for obvious reasons*." (P4)

5.4.6 Education as a Core Value

Education was universally viewed as an essential route out of drug misuse and drug-related offending. More specifically, life skills education was considered to be instrumental in terms of early years' childhood socialisation and development and for older youths and adults seeking a route out of drug dependence. P1 argued:

- *"They say you must teach your kids to add up. Adding up's useful but we need to teach kids about how to live, teach them life skills. Until we start teaching people how to live, and the dangers of alcohol, smoking and drug use, then I don't think we're going to have any impact on that kid's growing up. They'll see their parents take drugs, so that's what they're going to do, take drugs and steal things." (P1)*

Similarly, P3 emphasised the importance of education as an early years' crime prevention strategy:

- *"It's important that we educate or give the opportunity of education before we give someone a criminal record that could potentially ruin the rest of their life through not being able to*

get a job for a drug conviction from when they were 18. Did I do drugs when I was younger? Yes … I probably shouldn't say that but I did that before I joined the job. Would I have benefited from education? Absolutely. I think, in schools, if they taught you about cannabis and the effects it has, and all the rest of it, then, yeah, maybe we'd have less people smoking cannabis."

As a police officer, P3 viewed education as an important part of the role:

- *"I think there is a responsibility elsewhere to provide education, whether through schools and colleges or even with the police. The first building block of policing is to protect life … so we have a responsibility to educate and do what we can to either stop people taking drugs or to educate people on how to do less harm through taking drugs." (P3)*

5.4.7 Personal Responsibility

Personal responsibility is often considered to be a core value associated with health behaviour. Health promotion theories emphasise seeking to achieve a balance between personal and social (or collective) responsibility for health behaviour, emphasising the role that the social context plays in health behaviour, such as the social or peer environment, cultural norms and practices and the socio-economic context. Therefore health behaviour is arguably shaped by individual personal factors as well as the environment that the individual grows up and lives in. When the interviewees were asked about the role of personal responsibility in relation to individuals' drug taking behaviour, a range of issues emerged. Some interviewees were strongly of the view that individuals are essentially responsible for their behaviour. This was captured in the following statements:

- *"Everyone's got a responsibility to behave themselves and not to infringe upon other people's liberty … You have to take personal responsibility, otherwise you're just going to vegetate and do whatever you want. Then there's no repercussions whatsoever." (P3)*

- *"The individual has a choice and they either take it or they don't… I think ultimately it comes down to an individual's choice. I think everybody has a choice. You can go this way or you can go that way." (D1)*

- *"We're all responsible for our own actions. We have to be, like, because if we're not then nothing matters, does it? So we can't take that away. We're responsible for our actions, we've got to be." (D3)*

It was acknowledged nonetheless that personal responsibility is seriously impacted by criminogenic and societal factors that can predispose individuals to a lifetime of drug misuse and crime (as discussed earlier). This is emphasised in the following extracts from the interviews:

- *"Some people commit crime out of necessity, whether it's stealing a loaf of bread to eat." (P3)*

- *"Drugs, weapons, alcohol, things like that were part of my school life. It would have been the easy choice to go down that route of taking drugs, being a bit of a dick in school, and then that would be my life, living on Universal Credit, that would have been my life." (D1)*

- *"It's a whole combination of things. Some of it is going to come down to your personal choices, but also the experiences that you've had, what education or services were available in your area. Education in schools and colleges is completely lacking. It's a whole combination of your personal self and the things you've had to experience – the societal things." (D4)*

Personal responsibility was viewed by some as the essence of behaviour and therefore also the solution for addressing harmful behaviour, as inferred by P3, although this perspective assumes the individual possesses the agency and capability to make choices and has the support in place to change their behaviour:

- *"If you're so out of your face on drugs that you're violent, then stop taking drugs. If you're so violent when you're drunk, stop drinking. You chose to drink or to take Crack or whatever. At some point, you'll be sober enough to think, 'I should really just stop because I'm turning into a monster'. So, who's responsible? You ultimately have to say, them, because they've done it. They can't blame anyone else, whether they've had a traumatic childhood, or had posttraumatic stress from a particular incident that they don't know how to deal with, they've turned to drugs, and they've taken so much of that they've got addicted to it and ruined their life on it. Who do you blame? You can't blame society. There's enough charities and enough support out there for people with drug addiction. Now, it's everywhere. You don't have to look very far to get help with drugs. So people who've disregarded that help – I find it very difficult not to pin the blame on them, because there's a certain amount of personal responsibility. And I think as a society we're moving away from 'It's my fault.' It's always someone else's fault, you know? 'When I was young, this happened.' 'Yeah, but you're 40 now. Why are you still doing this?'" (P3)*

This view, that an individual can and should take responsibility for their negative health behaviour, was reflected in an anecdote by P3:

- *"A close friend of mine recently admitted to me that he's addicted to cocaine. He's been taking it for years. He's married with three kids and he's got a very good job on just less than six figures a year. And it came out because of a thing at work … he's been taking too much and he needs help. And now he's taken that help and he's now been sober for five months. He's taken up that help and he's admitted it's his fault and that there's no one else to blame." (P3)*

Even in the most serious cases of longstanding drug misuse associated with criminal behaviour, personal responsibility was perceived as the starting point for individual behaviour and the panacea or solution. Essentially, all the interviewees acknowledged that to resolve drug misuse and associated criminal behaviour required enabling affected individuals to take control of their circumstances and to re-engage their sense of personal responsibility and agency. The DEP was therefore seen to represent a 'trigger' on this journey to self-empowerment and self-actualisation. This theme was most evident within the accounts of those interviewees with lived experiences of drug misuse who had participated in twelve-step programmes. D2 provided deep insight into how he perceived he had changed:

- *"Before, it was all about me. I was self-centred. It was all about me inside myself. My instincts were to get what I wanted all the time. If I didn't get what I wanted, then I'd make sure I'd get it and I'd stamp on everyone who was in the way […] So when I joined the 12-step programme I had to admit I had a problem. I had to move away from where I grew up to be able to put down the drink and the drugs and to stop living how I had been. I had to take responsibility for myself, for my drug taking behaviour […] And along that road to my recovery I've had to look at how I've hurt other people, I've had to look at all the people I was resentful of, my fears, my sexual conduct and all the people I've harmed. And I've had to go out and make amends to those people. And now I keep an inventory of my behaviour. I'm no longer the sort of person that goes around harming people all the time. I've had to learn to take responsibility, to stand up and be responsible for myself, because I've caused harm even when I've been sober. So taking responsibility has been a massive step for me … 17 years as an addict and I never had any responsibility for myself. I didn't know how to read, I didn't know how to write, I didn't know how to be polite and all those things, I've had to learn along the way when I eventually put the drugs down. What I've learned is that for the rest of my life now I'm going to be continuing to look at self because that's what I'm up against every day." (D2)*

5.4.8 Blaming the Victim

Ironically, given the discussion above, it was also argued that the public – in a general relative sense – often do not understand the social context of drug misuse and will tend to 'blame the victim'. D3 suggested that others will use an individual's diagnosis or criminal behaviour to label them; he reflected:

- *"I've got a past, I've got a mental health diagnosis, and that's been used against me before in the past loads of times: 'He's a violent criminal', but your past doesn't define you, your mental health diagnosis doesn't define you."*

The notion of victim blaming was expressed particularly among the DEP providers. As D3 put it, "*As a society we like to blame … but we can't just keep chucking people in prison*." He went on to reflect upon his own experience of working as a peer mentor having previously been addicted to drugs and homeless:

- *"This council guy wanted to chuck this homeless guy's quilt away, and I said to him: "He's an addict. Why?" He said, "We've tried to help him loads of times." And I said, "But you will keep trying to help, but it will be when he's ready for the help …" I told him that I worked for MIND and that I was a drug addict once and used to sleep on the streets. But he didn't get it. It's just a lack of understanding. I guess from his point of view he goes to work every day and he finds drugs and needles and things and it's a headache for him. But if he understood it fully, if he understood that they also use because they're cold or and they're sleeping outdoors. It's horrible sleeping on the streets without anybody – that loneliness, being lonely with nothing, that's a dark loneliness. I did it for nights on end in the cold, walking around all the time because you can't stay still because you're too cold. You have to walk around and your legs are killing because you've got to keep walking, because otherwise you're going to seize up with the cold. And when you finally do lay down somewhere and go to sleep, someone comes along and pisses on you because they're drunk and starts kicking you. And then you're too weak and hurt and broken to fight back. So, you just put up with it. Then you have to go and steal some clothes because they're dry and don't smell of piss. It's a different world. So if people sort of knew that and understood that … They just see a rough sleeper, they just assume that you're a bad person or because you use drugs you're a certain type of person. But it can happen to anyone, absolutely anyone."*

D3 also explored this further, partly as a reflection of his own experiences:

- *"People just don't understand. They haven't been there themselves. They'll just see somebody in town who is off their face and they might say, 'Look at that fucking druggie, look at the state of him.' I do it, we all do it, we all judge people. We all just look and judge."*

5.4.9 Stages of Change

The *Stages of Change* or *Transtheoretical* Model, developed by Prochaska and DiClemente, was described previously as an explanatory framework for intentional health behaviour change. It proposed that individual behaviour change can occur through six stages: *precontemplation, contemplation, preparation, action, maintenance* and *termination*. As discussed previously, the model proposes that people do not change their health behaviour quickly or decisively but will move through these stages, often regressing as well as making progress. Since health behaviour change requires conscious decision-making – or free choice on the part of the individual – this process is greatly impeded when individuals exhibit longstanding habitual or addictive behaviour that is entrenched and semi-automated through repeated reward and punishment (West 2005). Nevertheless, some individuals may be at a stage where they are *contemplating* a change in their behaviour, which might be where referral to the DEP can operate as a positive 'trigger'. On the other hand, as intimated in the earlier discussion, some individuals will not necessarily be contemplating change and therefore not be ready to engage with a health behaviour change intervention.

The notion of 'readiness to change' came through in the interviews along with the view that the DEP can act as a useful trigger to behaviour change. Firstly, it was clear that an individual must be ready to engage, as D1 implied:

- *"The one thing the Prison Service taught me in all those years of trying to support and help people with drug and alcohol problems is that help will only be received and worked on if they're actually ready to receive it and want to work on it." (D1)*

D2 spoke about his own experience with drug addiction:

- *"Addiction comes with a lot of things. It comes with a tricky mind. And your mind will tell you that you're okay, that you don't need to take responsibility for yourself, that what you're doing is okay, do you know what I mean?"*

Since he had turned the corner with his addiction and had been helping others, he reflected:

- *"There've been a lot of people I've helped through the 12-step programme and on the DEP who're not quite ready to stop yet, they're not quite ready to take responsibility for themselves and say 'I've had enough of this'. That's a big part of addiction."*

Readiness to change was viewed as a very fine line that required great sensitivity. Indeed, D4 argued that when referring an individual for treatment or to an educational programme, the individual cannot be coerced:

- *"You can't force people into getting any form of help or treatment. You just want to make sure that they're aware of the options and where they can go if they do decide they want to get that support, that extra help. So it's about just kind of making people aware of where they can get that help. It's got to come from that personal motivation. So, if you tell them, "Oh, you need to go and get some help," they're not just going to go and do it just because you've told them to."*

Likewise, D3 suggested that attending the DEP might not in itself bring about a change of behaviour but "*… it might just be that little thing that makes them start to think about it*." However, as stated previously, the conditions have to be right for the individual to be able to contemplate behaviour change. D2 inferred this in suggesting that the social environment was crucial in that "*…every day now I surround myself with people who I know want the best for me, not those who want to be around me for a certain reason*." (D2) And D3 likewise said:

- *"Rather than mixing with the people who for most of my life I'd gone to get things from, I wasn't interested in doing any of that any more or being around anyone with that lifestyle. I wanted to be with people who wanted the best for me, who you could tell wanted to see me succeed … That's the difference, really."*

A police interviewee provided an example of how the social context could inhibit behaviour change and therefore be counterproductive to efforts to change behaviour:

- *"We were searching one guy's car and found some cannabis. And he'd had the DEP before so I asked him how it had been and he said it had been really good and really informational. But evidently it hadn't stopped him because we found cannabis his car and he also had a multitude of previous offences to his name. So sometimes people just don't want to listen or they just feel like that's the risk they're going to take. It's the same as smoking: you try and inform people that smoking is horrendously bad for you, but they don't want to listen, they want to carry on with it." (P2)*

All the representatives of the DEP could identify key trigger points for behaviour change, especially with individuals with histories of longstanding drug addiction. Moreover, these examples often formed the basis of discussion for DEP sessions. Usually these represented a major life event or 'shock' for the individual concerned. D1 described how he had "*known many drug users who've got to a point where they've almost died or something big has happened in their life that's made them think, 'Shit, I shouldn't be doing this, I can't do this anymore'*." This was certainly the case for D3 whose imprisonment was identified as an important trigger:

- *"The day I went to prison I was supposed to pick up my two children after school. But that morning I went to prison and I never saw them properly again. And that's a pain that you never, ever get over, it never goes away. I wake up every morning with it now, but you learn to manage it, you learn it to deal with it. I can't get to the end of my life and my kids go, 'My dad was a waste of space'. My mum is still hurt and upset because of the stuff I've done and I can't live with that. I can't swallow that pill."*

He continued:

- *"… And I hadn't been to prison before. I scraped by numerous times with suspended sentences, probation and community service. I just scraped by, by the skin of my teeth. Ultimately it was going to happen one day if I carried on the way I was. […] I think happening later in life was better because I had more to lose. It affected me more than if I'd gone to prison when I was twenty-one. I wouldn't have given a shit, to be honest. I probably would have just run around the prison selling drugs and doing all sorts of stuff inside there, and wouldn't have even thought about sorting myself out. So, I guess timing is everything." (D3)*

D2 admitted that his near-death experience had been a significant trigger:

- *"I was always in and out of hospital and I even broke my jaw one time that I was drunk. And then it nearly killed me – in February 2018, I just woke up in hospital and it was, like, I just cannot do this anymore. So I held my hands up and asked for help." (D2)*

While these kinds of major life event triggers could be important factors for some individuals, simply being referred to the DEP as an alternative to arrest and prosecution was perceived to be a trigger. Several interviewees equated with the speed awareness programme for drivers:

- *"It's like the speed awareness course … I know a couple of people who've been on that and they don't stop talking about it. They're happy to have been on it, they're embarrassed to have been caught, but a lot of them do say it was really interesting … About how going one mile an hour over the speed limit is a couple more metres and then you can kill someone. And a lot of them do come out with a quite a lot of information, and it does stick. And I've heard a lot of them – especially the older ones – who'll say they don't realise how easy it is to kill someone, you know? And I guess it's the same with the DEP. People don't realise that sort of element … There's that shocking factor of actually this is the harsh reality of it, this is what drugs are made of, this is what they do to you. We've all seen documentaries of what they mix it with, what they put in it to cut it and bulk it out." (P2)*

- *"The speed awareness course works. I've spoken to people that have been on it and they've said, "Bloody hell, I didn't know that," … and how it really put it into context, just the simple things like: 'How far are you going?', 'How far is the journey?' 'So, the journey's eight miles and you're breaking the speed limit and going 40 in a 30 and you will get there two minutes quicker. Is that two minutes worth putting everyone's life at risk?' And they break it down in a way that you understand it and it educates you and tries to change the way you think. So, I don't see how the DEP can't be a good thing: If it doesn't stop someone smoking cannabis, then it might at least stop them smoking as much or smoking a stronger brand, rather than going for this really strong stuff with loads of THC in it, and maybe they'll go for a mellower one." (P3)*

- *"She said it was basically like a driving course, the speed awareness course. Basically you get that one chance to sort of learn something about it and it scares you a little bit because you hear all the horrifying stories and you get to speak to people who have been there as well, which is brilliant, that's brilliant." (D3)*

The implication here is that shock tactics can operate as a trigger for behaviour change, but as stated previously, the individual much be in a state of readiness and have the capacity and personal resources to make the change.

Another key theme that emerged from the interviews that relates to the 'stages of change' process is the notion of 'maintenance'. For D2 And D3, who had both experienced chronic drug addition, a key part of their recovery was to actively work at maintaining the change. D3 admitted how easy it had been to relapse:

- *"When I came out of prison, I did start using again, but I was on the way up, I was always climbing up that hill. I fell down a few times which is always going to happen. You need to learn your triggers and you need to learn why that happened, what led you up to that stage. It was hard, really hard and it still is hard but I just plugged away and I got myself clean. I got myself back on medication and I got myself on a maintenance grip to ease myself down slowly. And then the last few years is really where the patience and hard work paid off because I'm clean now, clean, sober for just over three years."*

In this regard, both D2 and D3 continued to view themselves as addicts, referring to this on several occasions, and therefore asserting that 'maintenance' was a continuous struggle:

- *"Doubt does creep in, don't get me wrong. I can be thinking: 'Is this really it?' I can start thinking: 'It's supposed to be easier, I'm supposed to be happier, it's supposed to be easier now'. But it's harder at times, you know? The easy way out is to go and take some drugs, go and take some heroin. Then I could live in this fantasy world feeling warm and cosy where nothing can hurt me. But that's just causing a whole load of problems you don't realise at the time until you try and stop. And it's back to square one again. And that's the thing with being an addict, it's that chain … That's the hard part." (D3)*

D2 spoke extensively about how the 12-step programme had enabled him to find inner strength to maintain his freedom from addiction and remain focused on rebuilding his life:

- *"As part of the 12-step, I practice prayer and meditation; I get down on my hands and knees every morning and pray. And I come from a place where I never believed in anything. It's powerful. I don't believe in the old 'going to church' thing and all that, I just believe that God is in everything, He's in all of us, He's in nature, He's in the trees."* He added that a key part of this process involved *"… keeping in my mind my impact on others and helping other people … It's like I see the world different now. It's like I've flipped back the opposite way. Instead of being selfish, I try to be selfless. And it's like I've had to learn to be truthful and not to do things for people and expect something back. I have learnt to have courage and faith in myself."*

D3 similarly described how *"I've come to an inner peace, if you like, and I'm very spiritual now. I practice mindfulness and I meditate on a daily basis. I go to the gym and I do all my self-care and do things for myself. If I don't look after me, I can't look after anybody else."* (D3)

As stated previously, some individuals are at the 'pre-contemplation' stage and are therefore not necessarily ready to change their behaviour. In many instances, this was identified by the

interviewees as ambivalence and in such cases it was felt to be inappropriate to refer these individuals to the DEP. At a societal level, there was the general sense that young people are ambivalent about the seriousness of drugs; D1 suggested that societal values have shifted:

- *"Having the police turn up at my front door just never would have happened. I couldn't have done that to my parents. Now it seems to be a given."*

D4 also suggested that a culture of denial is commonplace:

- *"I think there is that kind of, 'Oh, it won't happen to me', and that, I guess, is what we've got to try and break through."*

Ambivalence was considered to be a feature of student populations in particular, which is ironic given that low level drug misuse is relatively common among this population and for whom the DEP is becoming an increasingly common outcome:

- *"Most students don't really care about the health risks. They'll weighed them up and think, 'I drink alcohol, and there are risks involved with that, and I use drugs and I use them sensibly.' … I think a lot of students therefore risk assess and then consider it a risk they're prepared to take. And a lot of them see a real distinction between cannabis and other drugs and don't really think of cannabis as being illegal; they know it's technically illegal, but they see it completely differently to other drugs. I don't want to admit that there's a sort of blasé culture of using drugs at university, but I think it's so easily available to them, and they see other people doing it, and for some of them it just becomes kind of normal, it's fine, it's not really a big deal." (P4)*

These perspectives might suggest that the DEP will have little impact on students who are not contemplating a change in their behaviour. On the other hand, the opportunity to learn about the harmful health, legal, employment and societal effects of drugs could mean the DEP operates as an early trigger, suspending what could have potentially manifested as a long term problem.

5.4.9 DEP Philosophy & Approach

The most extensive data from the interviews came largely from the DEP team who spoke at length about the philosophy, ethos and educational approach of the DEP.

[1] Supportive Approach

A key feature of the DEP that the team prefer to emphasise to participants is that their ethos and stance is supportive rather than punitive. One of the first points they announce to participants at each session is that they are not employed by the police but by the NHS. Moreover, they take a non-judgemental approach towards participants and their behaviour. These features were emphasised by D2 who said, "*I always put across that I work for the NHS and that I'm not with the police, that I'm not there to tell them to stop taking drugs and I'm not there to patronise them. I'm actually there to keep them safe … It's about supporting them on that path and it's about guidance …*" Elaborating further, she said, "*I'll tell them that even though I work alongside the police I'm there to listen to them and to give them time to reflect on their drug use and to see where it's taking them … And then they start to open up, once they realise we're not police and we're not going to judge them. I think that's the secret to DEP*."

[2] Supportive Environment

The environment and atmosphere also play an important function with respect to group dynamics. It is imperative that DEP participants are able to feel at ease when they join the DEP whether it be face-to-face or online: "*We try to put people at ease from the minute they walk in the door. We try to engage with them from the first instance they come in and we'll look for something to start a conversation to try to get that person at ease*" (D1). D2 said, "*I'll start to greet people as they come in … and I'll tell them they're not here to be told off*". D1 described a particular instance:

- *"We had a Hell's Angel come in, a fully patched member of the Hell's Angels. These are some of the hardest people you're ever going to want to meet in terms of ability to reach them and ability to have a conversation. So he walked in and I said, 'Hi, mate, come on in, there's tea and coffee there'. And then I added, 'I can see you've got all your leathers on – you must be roasting!' And then I made an inappropriate joke and said something along the lines of 'You must be sweating like Gary Glitter in Mothercare!' And he laughed, so I knew that I had an in there. I said, 'I know what it's like, I ride a bike myself.' And I added, 'You won't be interested because it's not Harley.' So he then knew I had insight into the Hell's Angels, because Angels are only allowed to ride Harleys. So that started a rapport. It wasn't the best but it was something, there was something there." (D1)*

[3] Appropriate Location

The location is also important since each site carries a particular resonance with attendees. As D1 explained, participants are more likely to attend the DEP at an NHS location because they feel more anonymous and less stigmatised. By contrast, participants were less likely or more recalcitrant towards attending the DEP at a recognised drug treatment centre or charity such as Bristol Drugs Project; with the latter it was "*for a host of reasons: one, because it's a drug hotspot in Brunswick Square and, two, because they think they're going to be labelled as an addict.*" (D1)

[4] Appropriate Duration

All the DEP team concurred that a DEP session could only run for a maximum of four hours. In most instances, the formal part of the session would run for approximately two hours and was then followed by voluntary 'one-to-one' sessions with individual attendees. The relatively short duration reflected the fact that "*… you're battling against people who don't want to be there, so as soon as you start to lose people, no matter how engaging you are, you've effectively lost the session. So when people are starting to drift off or to mess around on their phones, we have to draw it to a close. So we've condensed it down to about two and a half hours. And then we go into the one-to-ones and that's it.*" (D1)

[5] Facilitating Engagement

Engagement is an important dimension of the sessions since a key purpose of the DEP is to share experiences and build knowledge and understanding through discussion. As D1 stressed, "*It's about making sure that people feel safe to be able to say what they want to say, because it's very, very difficult just to spew out your experiences*". This is probably the most challenging stage that depends upon the interpersonal skills of the facilitators who will use humour, anecdotes and other team building tactics to try and break down initial barriers: "*I'm naturally sarcastic, but I will ensure that it's not offensive. I'll ensure I know my audience. But we'll try and get people laughing and try to get people on side.*" (D1) Ice breakers are used during the sessions for this purpose:

- *"We have a drug related quiz that gets people talking and answering questions. Then we'll look at pictures of different substances – all white powders – and we'll ask them what they can see; of course, they'll say, 'That's cocaine', and then it carries on from there." (D1)*

- *"I'll talk a little bit about a drug and then ask them a question like, 'So is it a stimulant, a depressant or a hallucinogen?' And a lot of them will turn around and say, 'Well, it's a Class A drug, isn't it?' And then I'll explain to them what it is and we'll talk about how not all drugs*

fall into one category. Like Cocaine is a stimulant, Heroin is a depressant, but Spice falls into all three categories … So then that gets them talking." (D2)

Essentially, the goal is to encourage participants to feel less inhibited and to engage in an active discussion. The DEP team perceived that they were highly successful in this respect, For example, D4 described how the face-to-face sessions would become animated and lively as participants opened up:

- *"There's a lot of engagement where people actually do contribute, which I think is really important. There's always a lot of discussion around types of drugs and around the risks. So it's definitely not us just talking at them for an hour or so. And people learn so much more that way. So if you've then got them interacting throughout the session, they're learning so much more, from each other as well as from us." (D4)*

[6] Appropriate Content

Each session is generally orientated towards the participants' backgrounds and circumstances, which essentially means that "*Every session is different depending on the make-up of the group*." (D1) Nonetheless, all sessions follow a prescribed structure, with some input, some discussion and then the one-to-ones. The presented input is used to stimulate discussion and was summarised by D1:

- *"We look at why people use certain drugs, we look at coping strategies, we look at triggers, we look at the scale of use in terms of recreational use, habitual use, dependency and addiction … and this is so people can understand and ask themselves honest questions and hopefully give themselves honest answers as to where they are with their drug use … And we look at consequences, not just for them, but the effects on family and things like that. We always finish with a picture of two roads, one going one way, one going the other. If you continue down the road of continuing to take drugs and getting caught in possession that will lead to a criminal record and will have an effect on your employment, your freedom to travel to another country, etc, etc."*

D1 expanded on how the sessions always draw upon the different experiences of participants, the goal being primarily to generate discussion:

- *"It's, 'You tell us your experiences of it, good or bad." And when they go, 'Hang on, "good"?' and you go, 'Yeah, absolutely. What good experiences have you had?' And they'll go 'Well, I had a high that lasted for forever'. Or they'll talk about cocaine and sex and they might say, 'I was able to perform for this much longer', 'I was able to do this', 'I was able to do that'. And then somebody else in the group will go, 'Well, yeah, but what about the come down?' And then the group really just facilitates itself, the discussion happens, and it's about how you steer and control it as a facilitator." (D1)*

[7] Honesty and Openness

The facilitators attach importance to being honest, sincere and open during the sessions. This means being able to talk openly about themselves and emphasising that they do not represent the police. In this respect, those DEP team facilitators with extensive experiences of drug dependency and misuse are a key asset, since the process of sharing their own experiences give participants permission and confidence to open up:

- *"I'll share my experience of each drug and I'll always say, like, "It took me this long to admit that I've had a problem … It took me thirty years to admit to myself I had a problem … And If you're feeling in that same boat, I'm here to help." It's about trying to draw them in, if you see what I mean, and as soon as I tell them about my background, they start opening up more to me." (D2)*

Similarly, D3 admitted:

- *"I'm very open. I'm not backwards in coming forwards, you know. It's my life. When I meet people now, it will probably come into the conversation within the first 10 minutes that I'm an ex addict, because it's me. It didn't for a long time because I didn't want people to judge me and I was worried that they wouldn't talk to me. But now if they don't want to be in my life then that's fair enough. That's a reflection on them not on me." (D3)*

Implicit in D3's account is the notion of being open and honest to oneself. D3 had participated in a 12-step programme that had helped him to re-adjust his self-perception and build up his self-esteem and self-efficacy. This ethos underpins the DEP in that having an honest and transparent learning process, based on shared learning and dialogue, works part way towards developing greater self-awareness. This was reflected upon by D2 in relation to some of the DEP participants he had worked with:

- *"With the behaviour thing, they're always saying stuff like: 'I'm an addict. I'm like this because I'm an addict.' And I have to stop them and say, 'No. You're full of self, you're full of instincts and every human being is driven by it. The only difference between an addict and a normal person is when it comes to taking that first drink or drug, and that is it.' You're still a human being deep down, you've still got instincts and you've still got defects of character like everybody else. I'm a human being at the end of the day. I don't like it when people blame themselves that way. Ninety-nine per cent of people in this situation don't like to look at their self." (D2)*

[8] Peer Learning

As highlighted previously, the DEP seeks to build confidence within the group and thereby generate discussion. This enables participants to learn from each other and essentially to critically examine and reflect upon their knowledge, understanding and experiences of drugs. So an important dimension here is to facilitate shared or peer learning in a co-creative way. D1 described this as "*…a two-way learning process – in that way, we as a DEP team are continuing to learn something new in each session, so it's constantly evolving*." (D1) This was echoed by D2: "*Helping them just helps me more … It helps me to grow in myself*." (D2) Poignantly, D1 added:

- *"We've all got an obligation to help each other. There's no point in saying to these people, 'You've made the wrong choices and I've made the right choices. Crack on with your life.' We should all be supporting each other." (D1)*

D2 stressed the significance of shared experiences as a way to bring people together in the learning process:

- *"If me sharing my experiences can help one person, because that one person is going through what I've gone through, it might open up their eyes to think, 'He's managed to do it. Maybe I can do it.' … It's an illness and the doctors have been at it for years and so far the only thing that's worked is one addict talking to another addict!" (D2)*

This perspective on the learning process emphasises the importance of dialogic communication in learning, what Freire in the 1970s referred to as achieving 'praxis' and what phenomenologists have termed 'fusion of horizons'. Several interviewees highlighted the key

role of dialogue in the DEP process, and D1 suggested that being able to communicate effectively is essential to effective facilitation:

- *"Twenty years in the Prison Service taught me how to communicate with people effectively. I was a hostage negotiator and I was a control and restraint instructor. All of that is about negotiation and de-escalation. So that skill set taught me to talk to people effectively, but particularly to talk to offenders, how to scale things, I guess. I can go into a board room full of chief execs and pull it off and equally I can go into Bristol Prison and talk to a landing full of prisoners. I can switch without any breakdown in communication between the two parties. And with DEP, I try and get that across to the facilitators." (D1)*

[9] Mutual Respect

The educational process is partly designed to facilitate mutual respect and a degree of empathy between participants and with the DEP facilitators, thereby reducing any perceived status barriers and awkwardness and enhancing the potential for learning. This was highlighted in the following excerpts:

- *"I hope by the end of the programme they'll go, 'Actually, he had my back. Actually, he wants me to achieve. Actually, he doesn't want me to be in a body bag because of my choices'. So, if you've done it on a personable basis and been honest in your communication and if you've not looked down on that person …" (D1)*

- *"Every one of them in there is struggling in some way and we don't know what's going on for them. So, everyone needs to be treated fairly, whoever they are. Everybody in there's equal. It doesn't matter what colour or creed you are or where you've come from, everybody in that room is equal and everyone gets the opportunity to speak." (D2)*

Mutual respect means showing that one has faith in others to be able to achieve a change in their behaviour. Therefore, while the DEP might not necessarily bring about an immediate change of behaviour for individuals, the experience may trigger the start of a process of rehabilitation. This was inferred by D1, when he said: "*I want them to leave there thinking that regardless of the choices they've made, people can still have faith in them*." (D2) He also stressed that the credibility of the facilitator is important in terms of generating successful group dynamics, effective participation and building mutual respect.

[10] Shared Lived Experiences

An important dimension of the DEP sessions is the opportunity to share lived experiences. Two of the DEP facilitators, D2 and D3, are employed for this purpose, given their extensive histories of drug misuse and addiction. The DEP team explained that personal experiences are an important ingredient for the success of the sessions, in terms of introducing a lived experience element. D2 explained how his role has developed:

- *"I started working as a peer mentor going into the courts to help people with their mental health and just being there to support them. I'd been there myself, so if they wanted to tell me their story, I could relate to it and tell them how I'd got through it […] With the DEP, I'm also sharing my experiences, and at the end of the sessions people stay behind and ask me, 'How did you do it?' And they're even congratulating me because they are able to relate to me, and because being able to tell them what I've been through helps to point them in the right direction. And being an addict myself, I've been able to tell that there are some of them there who are going down the same road that I was going down."*

D3 also shared his route into peer mentorship and involvement with the DEP:

- *"Peer support is all about trying to educate others from the viewpoint of somebody who's been through it and come out the other side. You don't want them to have to go through all that pain and hurt like I did, especially when it could have been prevented. So I guess because I have the empathy, because I have that experience, I can understand how people are. I can talk to people and I know what helped me, what you need to do to ground yourself. There's a whole load of experience there –and I've done some crazy, stupid things. So as I share my experience of being an addict, I always stress that it took me years to admit that I had a problem. And if I'd had the chance to speak to somebody like me, who'd been there and gone through that life, who'd got to that stage like I did, that might have made a difference." (D3)*

[11] One-to-One Follow-up

As mentioned previously, each DEP session is scheduled to run for approximately four hours, usually a morning or an afternoon. The taught input, which is largely discussion based runs for the first two hours and this is followed by voluntary one-to-one 'person-centred' sessions for individuals who would like to stay on at the end. D1 explained that when the DEP was first started it was anticipated that most attendees would request a one-to-one and therefore a team of staff was provided for this purpose. However, "*the reality was that you'd get maybe*

two or three people wanting this … maybe three people who want to stay on to have a chat at the end … and that's when they might want to talk about their own situation more openly and will probably ask for help." (D1) The one-to-ones can also be used to 'check in' on individuals who have been less engaged or who may have appeared anxious or withdrawn:

- *"You may get people that aren't participating because they're suffering with anxiety or perhaps because there's a language barrier. So that's when we might ask them to hang on for a one-to-one chat. Then we'll ask them what they've got from the session, as we need to be sure that they've got something from it, that they've been with us and been present." (D1)*

Alternatively, an individual may disclose in a one-to-one that they have been a victim or are at risk of harm:

- *"At one time we had a female attendee who told us at the end that she was a victim of sex trafficking. She was on the DEP because she'd been caught with cannabis. She told us that there was a person waiting outside to pick her up who was part of the trafficking group that were holding her and who'd been extremely violent towards her. She was expecting to be beaten up or worse when she left the DEP. So it was a cry for help. So we were able to help her. We'd finished the main session at three o'clock in the afternoon and we were still there at 10 o'clock at night, giving statements to the police and supporting her." (D1)*

The one-to-one sessions also provide the opportunity to link individuals with other agencies:

- *"We've got arrangements with all the local agencies and in some cases we'll literally walk them to the door and say, 'Look, this person has just done the DEP and they'd like some support please'. They'll then go in and have a full assessment … It's great to be able to respond to the needs of individuals at the time and get them that help. And that's the beauty of working with the NHS – those bolt on services are available to us to continue to offer that person support." (D1)*

5.4.10 Employing Peer Mentors

Employment of peer mentors as DEP facilitators is considered a key asset for the success of the DEP. None only do they bring lived experiences to the educational process but they bring added benefits to the peer mentors themselves. While the initial themes here are not necessarily directly related to the DEP, they provide some context to the role and function of

peer mentors as DEP facilitators. A range of themes also arose concerning the appropriateness and efficacy of using peer mentors as facilitators.

Giving Something Back (Volunteerism)

One key theme that emerged from the peer mentors who worked with the DEP was that they perceive their role as an opportunity to give something back and to rebuild their lives. D2 felt that he had turned a corner:

- *"Basically, I never thought I'd be doing what I'm doing today from where I was over three years ago … And then I just kept turning up every week, sharing my experience and gradually building up a little bit of confidence in myself. And then I started leading on little parts of the programme."*

D3 spoke about his first involvement with the DEP:

- *"They asked me if I wanted to talk about my experiences. I was like, 'Oh, God!', you know, but it's getting easier now. I can stand up in front of people and talk. The confidence is developing the more I do it. I'm just building confidence all the time. And this strength inside me … I know I'm strong now, whereas before I kind of knew I was strong but I didn't feel strong. Now you can't shut me up [laughs]. They call me the Duracell bunny because I just keep going. Now I can just stand up and flow with it, it just flows. If someone asks me a question, straight away my brain just goes back to that time … that's how it sort of goes. I don't really even think about it now, it just naturally comes out of me, which is lovely because it's so easy. It does affect me, don't get me wrong. Like, I do have to look after myself."*

Furthermore:

- *"Now, it's kind of like … this good work I'm doing, the community work I'm doing, the jobs I'm doing … it's about repairing myself. Now I work for other people's addictions. And I feel it's inspiring because not many people come through it and live a normal life. Not many people come out of it and use that to inspire and help other people. It's a special thing. And now I know it's a special thing, I can embrace it and I can hone my skills. And I guess every time I help somebody, every time I do something good, it makes it all worthwhile, it gives me hope that one day my children will maybe look at me and go, 'Well, that was my dad and I'm proud of him. I know he had a hard life and he didn't have great style and all that, but look at what he did … he turned it around and ended up helping other people'. That's all I*

want now, all I want to be is a good person, a good dad and a good son, brother and uncle. That's what's important to me now in my life." (D3)

D3 referred to a specific individual he had been helping as a peer mentor with the Courts Service:

- *"I've got a client who went to Crown Court last week and got out of a three year prison sentence basically by the skin of his teeth. He reminds me so much of myself. He wants help, he wants support but he just doesn't know how. So I've gone a little bit further with him – I've given him my work number and I'm going to take him down to a project that I think will be really good for him. He likes messing about with bikes and stuff, and there's this place called Rusty Road to Recovery where they basically do mechanics and spraying and all that stuff. It's a charity that was started up by an ex- addict I met a couple of weeks ago and we hit it off straight away because we talked the same language … And he's trying to help people. It's a brilliant project … No one judges anyone and they're learning real skills and they do real work for people, and everyone's in the same boat. Things like that are just priceless but they don't get the recognition, they don't get the advertising they need because they can't afford to advertise. It's the same old thing where these little gems are hidden away."*

A Healing Process

A second linked theme that arose from the peer mentors was the notion of undergoing healing, which continued to be an important element of their experiences as peer mentors and DEP facilitators. Both interviewees perceived that their rehabilitation from drug addiction was continuing and this therefore gave them a certain level of legitimacy and credibility as peer mentors. For both, the 12-Step programme had a significant impact on their recovery:

- *"The 12 steps has pushed all that sort of stuff out and opened my eyes to it. I won't ever forget that stuff, but for me to move forward in my life when I was living in anger before, when I wasn't living in the world that I was supposed to be living in … I mean, I still get bad days …" (D2)*

D3 expressed the same sense that he was still on a recovery journey and susceptible to relapse:

- *"When I've been with a client and I've had to give them a bit about my backstory, I'll need to reflect on that. I'll need to take a bit of time to take some breaths and think: 'Yeah, that was good. That was good what you did' and just let it settle a bit, because all that stuff is still coming out of me."*

He added:

- *"All that judgement … all that can send you back, it sends you essentially back into it, because you just can't cope with that. It's like, well, they still think I'm a druggie … It takes time for people to see a difference in you. And that's the hardest part, the transition part, that's the part where I think the most support is needed, really."*

Employing Ex-drug Users as Peer Mentors and Facilitators

There were mixed opinions about the value and effectiveness of employing ex-drug users or ex-offenders as peer mentors and DEP facilitators. The advantages were generally perceived to outweigh any disadvantages. Typically, as D1 suggested, these are individuals who may have been in the prison system with problematic drug dependency over many years: *"… And then I've seen these people again later on, and some of them are delivering drug education and going into schools and saying, 'This is what happens if you take the path that I did'."*

However, when hearing the experiences of someone with a longstanding or chaotic history of drug dependence, a recreational or low-level drug user could potentially downplay the significance of their less 'sensational' drug misuse employing cognitive dissonance. This could apply in cases where a DEP participant perceives that the experiences they are hearing do not relate to them or are very different to the experiences shared by others. This was inferred in a remark by P1: "*I'm not always a big fan of using ex-users for this because it can demonstrate that even though you've been using drugs for 10 years, you can still come off them and you can still be a success …*" The notion of cognitive dissonance was more overt in D4's comment about cannabis users:

- *"In terms of deterring them from cannabis use, I think there's that disconnect between cannabis use and then everything else. It's like, 'I always just use cannabis. I'll never move on to anything else. So that's not going to be me.' So there's quite a wall between it."*

A second challenge associated with employing individuals as facilitators who have extensive drug misuse or offending experiences is the potential for a personal conflict of interest. This is not so much an ethical or legal problem but more the discomfort a facilitator may have in the event that they meet participants they have known previously while they were using drugs or offending, which D2 expressed:

- *"There've been people on the course that I know and I wouldn't say it's a bit tricky but there was one person on there that I knew from years ago who I used to do drugs with. And at the end of the session he called out in front of the others, 'I can't believe how well you look!' and all this sort of stuff, and it made me feel a little bit embarrassed. But, obviously, you can't stop that sort of stuff. I'm from Bristol, I know a lot of people, I mixed with a lot of people when I was out there, but I don't mix with anybody today. But those people still know what I was like before and some people don't really know what I'm like today. I'm kind of on the other side now."*

On the more positive side, experience and genuine understanding were considered valuable ingredients for the DEP workshops. This was expressed in terms of being able to communicate in participants' 'language' and on their level:

- *"They just responded to me. I could talk their language. I was like them but I wasn't, you know?" (D3)*

- *"Someone that's been through all that can talk to people on their level and in their language in a way that they'll understand and accept. A cop telling someone not to take drugs – they're not interested." (P1)*

D4 described the 'emic' perspective an ex-user can bring in being able to perceive the issue of drug dependence and misuse from the perspective of participants: "*You can kind of see it from a person's perspective, not just the facts and things.*"

The other key positive aspect was the knowledge, experience and credibility an ex-user could bring to DEP sessions:

- *"I have a long criminal history and I've spent a lot of time in and out of court and prison. So, I know the system. I've got a lot of experience I can use to help other people and maybe educate them on why it's not great to be going in and out of prison and court." (D3)*

D3 also described how others had seen something in him that was perceived to be valuable:

- *"I started surrounding myself with people who you could see saw something in me, who saw that I wanted to help … It was certain staff, certain officers while I was in prison, certain people who I sort of gravitated towards who saw something in me."*

D1 also made the point that there remained a great wealth of untapped experience within communities that should be used to extend the reach of drug education:

- *"There are so many people out there who want to help and who have the knowledge and the experience. There is that wealth of knowledge out there. I could pick them out and start my own chain from that pool of experience …" (D1)*

5.4.11 Passion and Commitment

A connected theme that came from the interviews was the level of passion, commitment and faith the DEP team had for the programme, and this was perceived by police interviews as well as DEP interviewees. The DEP coordinator was viewed as a role model who was religiously committed to the long term sustainability of the DEP and had evidently made a strong personal investment in its development. This passion rubbed off on the facilitators, one of whom said:

- *"I'm really passionate about it. I look forward to going to work now. I worked in a pallet factory for eleven years and I absolutely hated that job. And then, with everything that happened, I didn't work at all for a few years. So what I'm doing today, I'm really passionate and driven about, because I know I'm talking about something that happened to me and it makes me realise where I was, it's a reminder every Friday, when I facilitate that course, of what I have to keep doing and where I've come from. I don't know where it's going, I just keep trusting the process if you know what I mean." (D2)*

5.4.12 Mixing First Time with Prolific Drug Offenders

A related issue was that of running mixed DEP groups comprising individuals with low level drug offending and those with longstanding or more established drug offending histories: "*As I understand it, it can be a student sat next to a 40 year old from the city centre, so it's sort of one size fits all*" (P4). This was a question raised by P1:

- *"We've got young students who may have dabbled in some drugs and we've got people that have maybe been using heroin for 20 years – both ends of the spectrum – and I have thought, is it really going to benefit those students being with that long term drug addict? Is it really going to benefit that heroin user being with those students? Is it going to serve the needs of both groups of people?"*

D1 argued that while the DEP is intended primarily for low level drug offenders, "*for people that haven't gone through the system, as an early intervention, if the police officer feels that the person will benefit from the intervention, he or she can be sent on that*". D2 had also questioned the rationale for mixing people up:

- "*90% of people that come on the course is for cannabis. And we've thought about this a lot: 'how can you have a student going on there for cannabis possession and then have somebody on there that's been done for heroin, and who's been to prison and all that sort of stuff?' How does that weight up?*"

D2 added:

- "*Students are educated people and they should know better … And then you've got the crack or heroin addict who isn't educated and this is why they're doing this stuff."*

Likewise, D4 argued that

- "*… from a student perspective, it is very different. They are coming from a completely different perspective. And that probably has an impact when trying to relate to people's stories. It's like, 'Well, that's completely different from me'*."

This again raises the question of cognitive dissonance whereby a low level or first time offender might not relate to the experiences of a more prolific offender. On the one hand, P1 argued that mixing participants in this way could convey the message to low level or first time offenders "*that you can take drugs and come out of it unscathed and still be successful*", which is "*probably not a good image to portray to people: There's that message there that if you take drugs your chance of dying is actually pretty minimal*". D4 proposed that it might be useful to reorient sessions towards exploring low level or first time offenders' experiences thereby enabling the DEP to be more meaningful and valid to them; for instance:

- *"Maybe it would be quite a good thing to get the student voice in there and that would be more relatable for them. I think that could actually be really beneficial. If you look at the people we get through, a lot of them are students." (D4)*

On the other hand, it was suggested that the line between low level and prolific users or offenders is not so tangible:

- *"A lot of the people that get caught with crack and heroin are younger, they're not actually older, and a lot of them are actually students as well. So you might think, 'Oh, he's forty, he must be into crack and heroin, he's probably been down the same road as I've been down', but that's not always the case." (D2)*

Mixing up people with varied drug related offending backgrounds was nevertheless strongly supported by the DEP team, since participants usually come from very different backgrounds and the diversity can be an important catalyst. For example, D1 recalled:

- *"On the very first programme that we ever ran, we had a barrister from London who was there because he was caught on a stag do taking cocaine. So he was on the DEP sat next to a ketamine addict. And you could see he was looking at him thinking, 'What the hell am I doing here? I'm nothing like this person.' But at the end they were exchanging telephone numbers. He'd clearly learned something …" (D1)*

However, the main perceived advantage – as with the use of peer mentors – was the experience a more prolific offender brings as a deterrence message for lower level offenders, combined with the opportunity for more prolific offenders to make a positive contribution through sharing their experiences. P1 argued:

"It is absolutely spot on, it works really well, because the entrenched drug users will often tell a bit of a story and, although a student using a bit of MDMA is never going to imagine in a million years that he's going to that stage of life, it does give him a bit of an insight into drug use and what can happen." He added: *"Putting people together means you're talking to someone that's done it before and then they'll tell you how it is. They come in there, don't really know anything about how it feels to take drugs, don't know what the need for those drugs does to your head, they don't know that. But if someone else who has been through that can tell them, that's good."*

He also described a session where there was one participant who had been to prison and had a long history of drug misuse:

- *"It was brilliant. It was one of the best DEP sessions we've run, because this guy was able to relate to them. When he'd started taking drugs, he told them he was the person that said, 'I'll never get caught' and that he was the person that said, 'Drugs won't ravage my body'. He was the person that said, 'I won't ever smoke Crack Cocaine, I won't ever inject Heroin'. Press fast forward twenty years, he'd done all of that. So he was able to say to the others, 'I've been where you are.' He brought that lived experience … He was able to say, 'Cannabis led me to cocaine, cocaine led me to heroin, heroin and cocaine led me to lose my job, which then led me to having to feed a habit that I didn't even acknowledge that I'd had at that time.' He said, 'I'm not saying that you're all going to go down that route, but I did and I never ever thought I would'. He brought a sense of reality to it."*

5.4.13 What Constitutes Success?

Success from the point of view of the DEP team is more about making small qualitative changes with individuals than step changes in drug-related behaviour or re-offending. It was also acknowledged that the DEP provides an appropriate diversion away from the criminal justice system:

- *"We're giving around a 1000 people a year the opportunity not to go to court, not to get a criminal record … That's 1000 people not going into our custody units, 1000 people not going through the courts system. That's millions of pounds worth of work we're actually saving, all for the relatively small cost of delivering these sessions." (P1)*

A key message emerging from these interviews is that the DEP is unlikely to change individual behaviour and as a single intervention cannot realistically prevent subsequent desistance from taking drugs or becoming involved in further drug-related offending. However, the DEP experience may operate as a small trigger for some individuals towards 'contemplating' a change of attitude or behaviour, or it may be an opportunity to seek help or support. For D1, it was important not to expect the DEP to be perceived as a 'magic wand' or panacea for drug related crime:

- *"… 'Right, so I've referred somebody to DEP, I'm never going to see this person for a drug related offence again'. That is not realistic. It's not about waving the magic wand and reducing the stats overnight."*

Similarly, P5 said:

"Success is not just stopping people taking drugs." Rather, DEP was considered to be an intervention that could trigger or nudge an individual towards a better outcome. This was implicit in several interviewees' reflections on 'success'.

For D1, it was partly about providing *"… an opportunity to make that door a one-way door as opposed to a revolving door."* He added:

- *"It's like planting an acorn … planting an oak tree. It starts from a very small seed and it doesn't become that big tree until it's grown and developed. And that's what we hope to do."*

When asked about the potential impact on reoffending behaviour, it was therefore acknowledged that

- *"… some of them do reoffend, they will reoffend, but it might be in other areas. But they won't get caught for another drug related offence – they're not going to walk down the street with a joint in their hand or carry a small amount of drugs on them" (D2).*

Likewise, D1 said:

- *"A large proportion of people who've done the DEP have not and will not ever come to the attention of the police again for a drug related offence. However, I am not naive enough to think that they haven't just become cleverer about their drug use; maybe they're not rolling a spliff in the car anymore or walking down the street smoking one, but they might be doing it at home. But if they're doing that, in a way that's still a win because they're still thinking about their behaviour, they're thinking about the consequences." (D1)*

So, a key message from the interviewees was that small steps are adequate and realistic, and success is measured as small qualitative gains, such as that described by D1:

- *"The outcome we want is for people to leave thinking, 'Actually, that wasn't too bad … These people weren't too bad'. And, 'Actually, I quite enjoyed it, I've actually learned something today'."*

D1 argued that success should not be measured quantitatively:

- *"If a politician asked me to put the effectiveness of DEP in terms of figures – you know: 'How much have you saved society per year by providing a drug education programme?' – my honest answer would be, 'I don't know … But what I can tell you is that we have more than likely stopped a family from going through the trauma of losing somebody, or of finding out that their kids are using cocaine'. Because, from my own experience, it's a world of heartache. So, for me, it's far beyond any monetary kind of savings. It's much further reaching and the impact will be felt later." (D1)*

D2 also described success in terms of who qualitatively benefits from the DEP rather than how many attend a DEP workshop:

- *"Say we've got twenty odd people signed up on the course and only ten of those people turn up, those ten people have still turned up, so that's a good thing to me, that alone is an achievement." (D2).*

Qualitative gains include engagement, enjoyment, raised self-esteem, increased self-confidence, feeling valued, being safer, which are achieved through dialogue and communication during the sessions:

- *"I see success as these people coming through the course and communicating with us. Success for me is somebody coming on that course, communicating and being present in the course and listening." (D2)*

In this sense, D1 reflected:

- *"We'll say to them, 'Your engagement is what's important today. We are all here to learn from each other. And if you learn something today that keeps you safe, that makes you think or that helps you to help somebody else keep safe and out of trouble, that's basically why we're here'. Whatever they're thinking, they will hopefully be thinking about the impact their drug use might be having, and <u>that</u> is something." (D1)*

For the police representatives, success was viewed primarily as an individual no longer coming to their attention:

- *"For the twenty or so DEPs I've handed out in the last 18 months, I would say that 80% of those people have not come to light again. I've tracked some of them down and had conversations with them afterwards, and they seem to be doing well and doing quite positively." (P5)*

In this sense, police officers are unlikely to appreciate the ethos of DEP sessions with their emphasis on involvement and small qualitative changes for participants. However, police interviewees viewed a DEP referral as a positive non-punitive tactic in terms of "*… changing people's opinions of us, how we interact with our communities and how we police by consent.*"

5.4.14 Online DEP

Several interviewees commented on the switch of the DEP to online delivery during the COVID-19 pandemic. This was generally viewed as a much less satisfactory format given the importance of group discussion, group dynamics, involvement and engagement. A range of disadvantages were perceived, including lack of dialogue, participants' reluctance to speak, audio and video connection problems, inability to read body language and inability to know whether participants relate to the content. This makes it necessary to limit the duration of the workshop to one hour and twenty minutes. From a legal or policing point of view, the only stipulation for the DEP is that the individual attends, remains for the whole workshop and participates. However, participation is much more difficult to assess online:

- *"When we're there in person and you've got 15 or 20 people sat in front of you, [1] they're attending because they're physically present, [2] they're remaining because they're still there at the end, and [3] you can tell if they're participating." (D1)*

D4 reflected that

- *"… a lot of the time, they're just sat there. You don't even know if they're listening or taking anything in, which can be quite frustrating. And that's one of the things with these online sessions, they all feel the same because you don't have that interaction. You're just going through the same content every week and people aren't giving you anything back."*

D3 stated:

- *"I don't think you can beat that personal experience. Being online, you don't get that whole feeling about someone, there's just something missing. People don't tend to speak because there's other people watching them. You've got all those faces on there and so they might not say something because they'll be wondering what the others are going to think."*

D3's comment illustrates how it is that much more difficult to build up rapport and dialogue in an online environment. Individuals are likely to be reticent to speak and may feel intimidated by others who are silent, as D4 indicated:

- *"It's like that in team meetings when people won't turn their cameras on. And then you're just talking to a screen. It doesn't feel like you're in a group of people. That's definitely one of the issues at the end of the DEP sessions where people can stay and talk to us about getting support and stuff. If you've got people that don't want to talk on camera because they're aware that they're not the only person on the call, and then they're wanting to say, 'Oh, I have a problem with whatever and I'd quite like some support …', they're probably not going to say anything if there are others listening. That's probably a massive reason why people don't want to stay behind and get some help or support. I mean, it can be really intimidating."*

Non-engagement is exacerbated by the technology. While attendees are required to keep their video switched on for the whole session, it is necessary to keep their audio on mute:

- *"Online, we've had to mute everybody because of all the background noise. People will have the telly on, and some of them will be at work with their earphones on." (D2)*

- *"You do get people making a sandwich whilst the DEP programme's running – you can see them and they're looking and listening, so at least you know they're still with you." (D1)*

Consequently, the sessions tend to be passive, didactic information giving, and therefore lose the essential participatory ethos of the face-to-face workshops, as D4 described:

- *"It's probably not a lot of them talking, it's more of us talking … That's the problem with it, really. We have people muted throughout the session because people are busy doing things or they've got children or whatever going on in the background. It can be quite distracting. So we have people muted throughout the sessions. And then at the end when we've finished we'll tell them we're going to stop presenting and that they should unmute themselves if they want to stay and have a chat or ask any questions, make any comments or get some support. So there is that opportunity at the end. Not many people do stay and talk, which is*

unfortunate. And I definitely kind of think that with the teams delivering that way that is a massive downside, because part of it is supposed to be about them engaging with the content and with the programme."

D4 also explained that individuals with "tune out" when the content does not feel relevant to them, which links with the previous argument about cognitive dissonance:

- *"Quite often I imagine that if people are just there for one specific substance they'll tune out a bit while we're talking about the other ones … So, if you just kind of listen for one substance and then disengage, it's not going to have the same impact." (D4)*

Another challenge associated with delivering the DEP online is that some of those referred do not have the skills or an appropriate platform to join online:

- *"Obviously, most young people who are 18 or 19 years old are connected online. But I had one guy recently who we referred to the DEP … but then he didn't join the session … and I knew this was going to happen. He didn't have access to the internet, so now he's ended up with a straight charge, which is a waste of everyone's time […] Quite a few people we pick up don't always have a smart phone, so it's more difficult for them to take up the DEP with it being online. I'd say I've had about 20% like this and it's not because they've not engaged with other things." (P5)*

6.0 RECOMMENDATIONS & KEY OBSERVATIONS

A number of recommendations and key observations are highlighted based on the quantitative and qualitative findings of this evaluation. These are essentially issues that could be addressed to support and improve the impact, profile and viability of the DEP as a referral route for drug-related offending.

- Given the quantity of missing data and possible data entry errors in the Niche system, there is scope to review the use of the system to enable more accurate and detailed analysis of offender profiles and histories. A key objective should be to provide seamless offender profiles that make it feasible to map offender pathways and potentially develop appropriate intervention plans for individuals with chaotic patterns of offending and drug misuse.

- Single sex DEP sessions could be considered given the 8:1 ratio of male to female referrals to the DEP. While this may impact attendance and participation, it is also important to consider that participants are potentially vulnerable and that female offenders may have experienced being subjected to violence or abuse.

- Individuals from ethnic minorities constitute a smaller proportion of DEP referrals with a 4:1 ratio of white to ethnic minority referrals. However, proportionately, ethnic minorities are over-represented which reflects recent Stop and Search data for the Force area. For the DEP, it may be prudent to explore whether attendance and participation are impacted by ethnic background.

- Half of all referrals to the DEP are from Bristol with proportionately fewer referrals from other localities across the Force area. This will partly reflect the location and history of the DEP but may also arise due to different referral behaviour across the Force. Given that other parts of the region possess pockets of multiple deprivation, it may be appropriate to extend the DEP across the region and therefore increase the DEP team to resource this.

- 75% of DEP referrals have offended prior to the offence that triggered the DEP referral. For these individuals, longer term support could be considered post-DEP, such as peer mentoring, advocacy and mental health support to maintain the intention and capacity to desist for drug-related offending and/or drug dependence.

- Options could be explored to measure intermediate and long term health and offending outcomes for DEP referrals, partly to monitor the impact of the DEP and to tailor additional support for particular groups of ex-offenders or ex-drug misusers.

- Further research could be undertaken into why up to one quarter of DEP attendees appear to re-offend and whether indeed this is a salient issue. Reoffending is likely occur among some low-level drug offenders, yet it could be that targeting and referral are reviewed and refined to screen out individuals who are at higher risk of re-offending.

- Evidently, some referrals have more than one offence category, some with a primary offence that is non drug related (e.g. theft, burglary or violence). Their offending may reflect habitual or problematic drug misuse; in such instances, there may be merit in reviewing the efficacy of DEP and the utility of alternative options or outcomes.

- The DEP provides a useful tool for the police to diffuse specific situations and to achieve a relatively low risk / low harm "quick win" outcome. In terms of community policing it

therefore provides a valuable tactic for police that is considered to be proportional and represents a compassionate and supportive approach.

- Increased dialogue between the police and the DEP team should be encouraged to facilitate shared understanding of the purpose and utility of the DEP. This would enable the police to have a clear understanding of who should be referred and to the DEP and what the outcome is likely to be for individuals. This would foster appropriate referrals as well as realistic outcomes for offenders.

- Training or guidance should be instituted to encourage police officers use DEP referral appropriate to specific situations and to the aims of the DEP programme. Inconsistency can occur across the Force area with the DEP being used for different purposes or not at all as a positive outcome. Some scrutiny of the use of the DEP as a referral pathway could be undertaken, supported with more precise Niche data management.

- Continue to develop and enhance the used of lived experiences as a core element of the DEP process to re-enforce key messages for participants, bring realism, authenticity and validity to the educational experience, and as a "trigger" for individuals who are at the contemplation stage of behaviour change.

- Consider alternative and complementary options for supporting and managing the health needs of individuals intercepted by the police and / or referred to the DEP, with consideration of a broader offer of liaison and diversion routes that prevent a legal or criminal outcome.

- Further develop and invest in a multiagency response to drug-related offending across the Force area, delivering drug education, support and treatment as alternatives to criminalisation. A multiagency approach should be supported to shift emphasis from the police towards other organisations.

- Link the DEP with other care and support pathways, strengthening links with other education, treatment, health and welfare agencies that support people both at risk of drug-related offending and with a history of prolific offending. The variety of 'offender types' warrants a multisector pathway approach that is needs-led and orientated towards harm reduction as opposed to criminalisation. Additionally, improved outcomes may be achieved by extending the support and follow-up of DEP attendees beyond the current post-DEP 1-1s, to ensure adequate post-DEP support is offered according to need.

- Consider expanding drug education as a mainstream disposal through scaling up DEP provision across the Force area as a mainstream disposal for the police and the courts, as an alternative to criminalisation. Evidently, there are circumstances where the criminal justice pathway is unavoidable, but a higher profile for non-criminal justice disposals could be more productive and appropriate as a means to interrupt or halt drug-related offending.

- Evolve the DEP for different client groups through consideration of a spectrum of DEP provision that is more closely aligned to different client needs. First time or low level offenders (e.g. university students) may have different needs and interpretations of their experiences than individuals with extended histories of offending and/or drug dependency. Further research should scope the educational and broader support needs of different groups, in collaboration with education providers and the drug treatment and support sector, with a view to expanding the DEP resource across different population groups and settings.

- Review the use of Body Worn Video in making a DEP referral, ensuring that this is consistent with PACE.

- The DEP supports several hundred referrals per year, and therefore contributes significantly to reducing the cost of drug-related offending to the criminal justice system. For this reason, investment should continue into drug education as a liaison and diversion option for criminal justice agencies within the region. Increased investment in the DEP would enable it to be further developed and extended across the Force area as a commissioned outsourced service and supported by a larger core team. Currently, the DEP is resourced by individuals on fixed term or hourly paid contracts which can create a sense of job insecurity. Volunteers and peer mentors are a valuable asset to the DEP process and there could be scope to extend their role to support higher risk individuals pre- and post-DEP, especially given that the 'trigger' effect of the DEP requires follow-up to ensure clients achieve successful outcomes.

7.0 CONCLUSION

The Drug Education Programme provides an alternative disposal for individuals involved in drug-related offending for whom an education intervention is perceived as an appropriate course of action. It essentially provides an opportunity for individuals to reflect upon their behaviour and avoid a criminal justice outcome. It is a brief educational intervention that aims to elicit a change of attitude towards drug misuse or drug related offending through a mix of information giving, discussion, reflection and the sharing of lived experiences.

Essentially, the DEP provides a 'trigger' for individuals who are likely to be contemplating a change in their behaviour and therefore its success depends upon participants being ready to contemplate a change of lifestyle. Health behaviour change interventions are rarely successful when based singularly on raising awareness or providing information. Behaviour change is a complex process that requires active learning, dialogue and reflection to enable individuals to contemplate engaging in a change of attitude or lifestyle. It should also be relevant to individuals' social work and presenting culture such that any change in behaviour is consistent with the individual's life world and social networks. An educational intervention is therefore unlikely to be effective for individuals who are either resistant to change or who are not able to contemplate change due to personal as well as social or contextual reasons. Its success in triggering behaviour change depends upon an individual's capacity, readiness and willingness to consider a change of attitude or behaviour and in some instances the degree of support they will receive following engagement in the intervention.

Moreover, a general theme from the published evidence is that behaviour change interventions are less effective with individuals from 'disadvantaged' backgrounds whose starting level of behaviour and presenting culture can undermine attempts to change or to maintain the change (Mitchie et al 2008). This is not to suggest that individuals cannot change, but the evidence does reveal that it may be much harder for disadvantaged groups to achieve success.

In terms of measuring success of drug education, it is also important to view 'success' in terms of qualitative as well as quantitative outcomes. DEP attendance is not the single most important measure of success. Small qualitative changes for individuals are arguably more important to measure than attendance rates. Furthermore, longitudinal outcomes for prolific offenders could provide useful insight into how to develop appropriate education and treatment pathways, where education is reinforced and sustained with appropriate follow-up

support, liaison, diversion and referral. In this regard, the DEP should be viewed as one element or stage of a system or education, prevention, treatment and rehabilitation.

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