Are criminal justice interventions working well enough to justify the significant investment in them? Last month's report from the UK Drug Policy Commission suggests not. Chief executive **Roger Howard** gives us an overview.

Bars to progress

A major feature of the last ten-year drug strategy, along with the expansion of community based treatment, has been the increased use of the criminal justice system (CJS) to target problem drug-using offenders with the aim of getting them 'out of crime and into treatment'. The flagship of the strategy in England and Wales has been the Drug Interventions Programme (DIP), which from its inception in 2003 has expanded quickly, costing £175 million in 2006/07. The total cost of CJS drug programmes now comes to £330 million and about one-third of referrals to community-based treatment in England and Wales are from CJS staff. Scotland too has increasingly used CJS-based interventions.

The recently published English and draft Welsh strategies indicate that drug-dependent offenders will continue to be prioritised and programme expansion will continue, albeit at a lesser pace. Importantly, this is the only area where funding is set to increase over the next three years. A new Scottish strategy is due shortly and the criminal justice system will no doubt continue to play a significant part in this too.

It is therefore timely that the first themed review by the UK Drug Policy Commission addressed this topic. We wanted to know if the evidence supports an increased criminal justice focus, and which interventions are most effective, and for whom. Over the course of eight months we commissioned the Institute for Criminal Policy Research to review the published evidence and consulted with a broad range of drug professionals, service users and policy makers.

Overall, we found that programmes within the criminal justice system can be at least as effective as those delivered on a purely voluntary basis in terms of reducing drug use and offending. The argument for using the criminal justice system as an opportunity to tackle problem drug use is strengthened by the fact that there are so many problem drug users passing through it: at least one in eight people arrested are problem heroin or crack users (compared with about one in 100 of the general population), and up to half of new prison receptions are problem drug users.

However, a headline-grabbing finding was that we know surprisingly little about the effectiveness of many of these programmes given the amount invested in them, and this is particularly the case for prison-based programmes such at CARAT (Counselling, Assessment, Referral, Advice and Throughcare) teams and drug-free wings. This is not to say that they are not doing good, but we cannot say how much, and we are a long way from knowing how to optimise the benefits of such interventions. The new drug strategy has promised a cross-government research plan to improve the overall evidence base. We hope that this is given the necessary resources and clout so that we can look forward to more informed spending decisions in future.

In our report we also came to the deeply concerning conclusion that prison drug services frequently fall short of even minimum standards and do not adhere to established best practice. A review of prison-based drug treatment funding by PricewaterhouseCoopers also said as much and concluded that a minimum standard of care in all prisons is not likely to be possible within existing funding. In fact, prison drug treatment funding has increased significantly from £7 million in 1997/8 to £80 million in 2007/08 but still lags behind the level of investment given to the more high-profile DIP programme.

The setting up of a new prison Drug Treatment Review Group under Professor Lord Patel is, therefore, to be welcomed. Of course it is not just funding which is constraining the efforts of prison staff. Harsher sentencing has resulted in overcrowding, which in turn means prisons having to deal with some of the most problematic drug users often for only brief periods of time.

The serious shortcomings in prison healthcare have been reflected in an underwhelming target announced in the new strategy, which is to achieve minimum standards of drug treatment in prisons, and then only by 2011. We absolutely must not lose sight of the principle of delivering care in prisons that is of equivalence to that found in the community, not least so that continuity of care between prison and the community can become a reality. Without proper treatment and support we put the health and well-being of prisoners at risk, and we should not be surprised if they revert to drug use and offending on release.

It is also disappointing that we still do not have commitment to the full roll-out of the Integrated Drug Treatment System (IDTS) to all prisons. It is currently only fully operational in less than a quarter of prisons. The envisaged roll-out has been subject to funding cuts and according to the new strategy it will be limited to an expansion of only the clinical elements, and to only about two-thirds of prisons, in 2008/9. Partial provision means that the quality of care received will remain variable and something of a lottery. It is perhaps no wonder that prisoners are resorting to legal action to seek the health care they need.

A lack of suitably robust independent research and evaluations makes it difficult to compare community and prison-based treatment, but on balance we concluded that we risk causing more harm than good by sending significant and growing numbers of problem drug users to prison, especially for relatively short sentences, rather than using community sentences to address their drug-related offending. For instance, a short prison sentence can disrupt community treatment programmes, cause problems with stable housing and employment and put strains on family relationships and also increases the risk of death from overdose on release from prison.

Given the overall high cost of incarceration before you even consider the additional costs of rehabilitation, it is likely that community orders will offer better value for money and have the potential to deliver similar reductions in reoffending, while improving the chances of reintegration back into mainstream society. Hence the evidence tends to support interventions such as dedicated drug courts which Jack Straw has announced will be very modestly expanded. Developments such as this and the commitment to increase the use of drug rehabilitation requirements in community sentences and conditional cautions offer some hope, but only if they are accompanied with a commitment to minimise the use of prison sentences for problem drug users not committing violent crimes.

A recent Ministry of Justice statistical review shows there is a wide regional variation in the use of custody which is only weakly related to levels of acquisitive crime and not at all linked to trends in overall crime levels, suggesting that other factors may be involved such as the preferences and prejudices of sentencers. One of the findings from the Leeds and London drug court evaluations was that training magistrates and judges in, among other things, the nature of addiction was essential for success. This shouldn't be confined to dedicated drug courts, as an understanding of addiction will help all sentencers to identify suitable candidates for DRRs and understand how to react to individual cases when there are relapses, breaches and reconvictions.

I suspect there will be many policymakers and practitioners who will argue that developing and implementing CJS interventions is not 'rocket science' and we do not need more research and evaluation to tell us what we instinctively know. I think that is short-sighted. In a knowledge-based economy, better information is going to be the key to success, for organisations and individuals. Our review has demonstrated the paucity of hard evidence to support some interventions. This is a continued source of frustration for all of us wanting improved care for offenders and others with drug problems.

Roger Howard is chief executive of the UK Drug Policy Commission.

You can download the UKDPC report, Reducing Drug Use, Reducing Reoffending, (and related reference reports) at www.ukdpc.org.uk/reports.shtml

Unlocking prison reform

When will the money follow the evidence for reforming prison drug treatment – and what are we waiting for? asks Kathy Gyngell

More than half of the 140,000 prisoners received into custody each year have a history of class A drug use. Prisons house the highest concentration and numbers of drug users in the country. Yet prisons, to date, have received little more than 5 per cent of the nearly half billion annual treatment budget that the community gets.

Last week the penny may have begun to drop. Prison treatment is to get a cash injection of £100 million over three years – staggeringly overdue, still insufficient but nevertheless welcome.

But what of the concurrent announcement for a National Prison Drug Treatment Review Group to bring a more evidence based approach to service delivery? Will evidence ever inform prison treatment decisions? It is hardly as though it is lacking. Nor is knowledge of the urgent need for post prison or second stage care and rehabilitation.

It is already known that only 50,000 of the 70,000 odd who enter custody each year with a class A drug problem get some form of detoxification, which as a 'treatment' in itself is totally insufficient. It is known that some 9,000 get short structured treatment courses, such as (P)ASRO or the Short Duration Programme (SDP) – and CBT courses, all of which need to be evaluated for 'effectiveness'. It is known that only a paltry 2,000 get to go on the only programmes which are known to work – for which there is an evidence base for successful drug free outcomes and for reduced reconviction rates. These are the 12 step and therapeutic community, intensive, longer duration programmes, mainly, but not all, run by RAPT in just a handful of prisons.

A key recommendation of the Conservatives Social Justice Policy Review was for such programmes to be set up in dedicated wings in every prison. It was made with reference to the reconviction evidence base and to an informed calculation of costs – only £30 million for a tenfold expansion of a RAPT style programme across the prison estate (a cost commensurate in fact with the government's new cash promise).

Now there is further confirmation of this 'evidence base' in the Institute for Criminal Policy Research's recent research review for the UKDPC. What's more its proven cost effectiveness has also been confirmed – earlier this year by the Ministry of Justice's publicised costs of the numbers treated, in each type of structured programme in the year 2006/7. This showed that the unit costs of the longer RAPT and therapeutic abstinence based programmes are actually significantly lower than the untested shorter duration programmes.

So what are we waiting for?

There is surely no excuse for the money not to follow the evidence right now.

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