UKDPC

UK DRUG POLICY COMMISSION

Considering the evidence in relation to "Prisons with a Purpose" (Security Agenda Policy Green Paper No.4)

A submission to the Conservative Party Justice Team

Briefing
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Summary

- The underlying ambition in the Green Paper for a '**rehabilitation revolution**' is strongly welcomed. It is clear that nothing short of a 'revolution' is required both in terms of **healthcare** services and **throughcare and aftercare** management of offenders. Reforms should be underpinned by a principle that the CJS has a duty to facilitate the **recovery** of people from addiction.
- **Addiction is a complex condition** and is "not a failure of will or of strength of character but a medical disorder" (WHO definition). Policy making will require strong leadership to bring about a new narrative and to remove the constraints of **stigma** that affects rehabilitation. Policies must be designed to be **flexible** and allow for **individual** needs and circumstances.
- The nature of addiction has implications for all policy responses but particularly those involving a level of compulsion (e.g. compulsory use of DRRs), incentives (e.g. 'Earned Release') and sanctions (e.g. reducing welfare benefit) which may not deliver the desired results. Not all problem drug-using offenders are ready or indeed able to achieve long-lasting recovery, although all can be helped towards that goal in some way. Instead, a **problem-solving, flexible approach** as exemplified by drug courts and the use of '**contingency management**' approaches in recovery services should be expanded.
- For the same reason, broad outcome goals for services linked to payment by results risk creating perverse incentives to focus on those who are easiest to fully rehabilitate. We support an accountable **outcome-focussed** system that also recognises progress with those who have a longer and more complex rehabilitation journey
- We would suggest that, alongside introducing honesty in sentencing, there should be a goal of "**appropriate, proportionate and effective sentencing**". The evidence suggests that community sentences would meet such criteria for many drug-related offenders and should be the assumed form of disposal for most, less serious, offences linked to addiction. Short prison sentences are less effective and can be disruptive to recovery.
- There should be **equivalence of care** between CJS and non-CJS drug programmes. This is particularly needed within the prison estate where service provision is below "minimum standards". This would also require **a diverse range of services** including public health interventions to reduce harm, substitute medications (e.g. methadone), psycho-social interventions, abstinence orientated programmes and reintegration services. A one-size-fits-all approach (e.g. only abstinence-based programmes) is destined to fail as it does not acknowledge there are many different types of problem drug users.
- **Prisons should be recovery focussed** even if it is unrealistic to expect them to be 'drug free'. A review of Mandatory Drug Testing and a long-term programme of research into the operations of prison drug markets should be undertaken.
- We support moves to improve throughcare and aftercare and to establish an end-to-end offender management system, but have concerns that the Prison & Rehabilitation Trust proposal with accountability resting with governors may be bedevilled by problems in its application. Instead we suggest either using existing machinery provided through **Local Criminal Justice Boards** or considering the opportunity provided by local **Crime Commissioners** or elected mayors as suggested in the Green Paper.

Introduction

Following a meeting between the Conservative Justice front bench team and the UK Drug Policy Commission (prompted by the publication of our review report, *Reducing drug use, reducing re-offending*) an invitation came to provide additional information on a number of the core proposals raised in the Conservative Party Prisons Policy Green Paper *Prisons with a purpose*. This submission examines the proposals but only insofar as they touch on the issues of drug dependency and related criminality. We seek to draw conclusions where possible as to their likely effectiveness based on available evidence. In doing so we have informally consulted also with a number of leading individuals involved with providing different types of drug intervention services within the criminal justice system.

Context: the increasing role of the CJS

Over the past 25 years there have been attempts by various governments to keep pace with the growing problem of drug use, related crime and ill-health. During the 1980s and 1990s, when there was a more consensual cross-party approach, the Conservative government built the foundations for many of today's drug policies. For example, it introduced local partnerships (Drug Action Teams) which survive to this day. It also introduced what were then controversial, but as has been effectively demonstrated, effective, public health measures to contain the real risk of infectious diseases such as HIV/AIDS (e.g. through needle exchange schemes & information campaigns). It pioneered substantial investment programmes to provide the launch pad of growth of treatment services (Department of Health central funding initiatives in 1983 & 1986) and it introduced drug education programmes in schools. Importantly it also established drug treatment initiated through the criminal justice system in the early 1990s. In terms of political leadership, the Conservative administration of the 1990s saw the drug problem as one transcending the concerns of any single government department, placing a senior Cabinet Office Minister in charge of the coordination of national drug policy.

Since 1997 there has been a plethora of legislation, initiatives, programmes and significant additional expenditure building on the earlier efforts, with leadership and coordination eventually passed to the Home Office. New resources for research to evaluate the effectiveness and value for money of interventions however have not materialised. Perhaps the most significant developments have been the greatly increased investment in drug treatment and the increased effort to identify and treat problem drug users through the criminal justice system, plus efforts to disrupt production and supply both in the UK and overseas. More recently there has been increasing recognition of the need to re-integrate a large population of dependent and recovering drug users back into mainstream society and much discussion as to how this is best achieved (e.g. welfare reform proposals of both main parties).

Many observers have noted the increasing "criminalisation" of drug policy with some concern and have called for more emphasis on responding to the problem as a major public health issue, on a par with other lifestyle challenges, or 'vices', such as alcohol use, diet and smoking. We have some sympathy with this view because there is much evidence of the unintended damage that can ensue from a CJS approach, and particularly imprisonment, such as disruption to family life and poorer accommodation and employment prospects. Some countries, especially across Europe, have longer traditions of seeing the illicit drug problem as a major public health challenge, rather than predominantly a crime and justice matter.

However, there is sufficient international evidence to conclude, as we have done, that *"while there are such high proportions of problem drug users in the CJS, we consider it appropriate to use this opportunity to encourage them to engage with treatment. There is good evidence that some*

interventions within the CJS can reduce drug use and offending". [1] That said, the UKDPC sees it as crucial that those in the justice system because of their drug dependency receive a level of health and social care equivalent to that available in the community. This is especially important as their overall health needs are greater than those of the general public. Furthermore, though there is mounting international evidence as to the effectiveness of various "clinical" interventions to reduce drug dependency, there has been little analysis of the effectiveness of organisational and systems architecture to deliver many of those interventions. Thus, even if a programme *can* work it does not mean that it *does* work in practice and still less that it will provide value for money.

A significant proportion – at least 1 in 8 - of arrestees are estimated to be problem drug users. Yet as we have concluded in our review of evidence, provision for addressing their drug problems in the CJS both in the community and, especially, in prisons is inadequate.[2]

IMPLICATIONS:

- It is appropriate to continue to use the CJS to encourage engagement with treatment and other services. The underlying ambition in the Green Paper for a 'rehabilitation revolution' is strongly welcomed. Nothing short of a revolution is required both in terms of healthcare services, throughcare and aftercare management of offenders.
- Despite the CJS setting, such interventions should adopt a largely public health approach to tackling problem drug use and should be carefully evaluated.
- In the case of drug dependent offenders (and indeed those with mental health conditions) <u>there should also be an underpinning principle and goal that the CJS has a duty to facilitate the recovery of people from addiction and dependency</u>.

Understanding the nature of substance dependence and recovery

The call for a "rehabilitation revolution" in the Green Paper is of course very welcome and of particular importance with respect to those offenders who are problem drug users and those with mental health problems. At the heart of the Policy Green Paper's proposals for responding to drug problems and associated offending through the criminal justice system there is an underlying assumption that drug dependency and addiction are largely matters of personal choice, associated with some form of character "deficit" requiring responses aimed at instilling more self–responsibility. This is a common characterisation of drug addiction which is not entirely congruent with the accumulating scientific evidence. Whilst on the one hand we wholeheartedly agree that personal responsibility is an essential part of the process of recovery, on the other hand we are only too aware of the complex nature of dependency and addictions and their causal factors. The World Health Organisation has succinctly summarised this:

[1] 'Reducing Drug Use, Reducing Reoffending', UK Drug Policy Commission, March 2008.
[2] 'Reducing Drug Use, Reducing Reoffending', UK Drug Policy Commission, 2008.

Understanding substance dependence (The World Health Organisation) [3]

Substance dependence is a complex disorder with biological mechanisms affecting the brain and its capacity to control substance use. It is not only determined by biological and genetic factors, but psychological, social, cultural and environmental factors as well. Currently, there are no means of identifying those who will become dependent - either before or after they start using drugs.

Substance dependence is not a failure of will or of strength of character but a medical disorder that could affect any human being. Dependence is a chronic and relapsing disorder, often co-occurring with other physical and mental conditions.

While addiction and dependency cannot be "excused" and personal choice is of course a factor, analysis of the histories of people with drug problems shows that the majority come from families and areas of substantial economic and social disadvantage and many have significant co-existing mental heath problems. There is also accumulating evidence about some of the complex socio-biological and psychological roots of substance misuse, addiction and dependency.[4]

Problem drug-using offenders are also a group with particularly complex and intractable problems, as has been shown in a wide range of studies. For example, the 2005/06 Arrestee Survey[5] found that among arrestees who used heroin and crack at least once a week:

- Almost a quarter had slept rough in the past month (compared with less than one tenth of other arrestees);
- Half (50%) said they had left school before they were 16, 58% said they had been temporarily excluded at some time and 36% permanently excluded (the equivalent figures for other arrestees are 32%, 39% and 21%);
- Only 1 in 10 were in employment (compared with almost half of other arrestees); and
- 29% had been in local authority care at some time (compared with 15% of other arrestees).

The Drug Treatment Outcomes Research Study (DTORS) confirms this, showing that those entering drug treatment via the Criminal Justice System are more likely than other treatment entrants to have unstable accommodation arrangements, to be unemployed and have low educational attainment[6]. It also shows that CJS referrals are more likely to be crack users and more criminally active. All these factors are likely to make treatment and re-integration more difficult. Problem drug-using offenders are also very likely to experience mental health problems – it is estimated that over 75% of drug-dependent prisoners suffer from two or more other mental health problems (which could include alcohol misuse or dependence and personality disorder) and about a third are assessed as having three or more additional mental problems.[7]

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[3] 'Neuroscience of psychoactive substance use & dependence', World Health Organisation, 2004.
[4] 'Brain Science, Addiction and Drugs' Academy of Medical Sciences, 2008.
[5] 'The Arrestee Survey 2003-2007', Boreham R., et al,. 2007 (Home Office Statistical Bulletin 12/07)
[6] 'The Drug Treatment Outcomes Research Study (DTORS): baseline report.', Jones A, et al,. 2007. (Home Office Research Report 3)
[7] 'Substance misuse among prisoners in England and Wales', Singleton N, Farrell M and Meltzer H, 1999 (ONS).

A key feature within the recovery literature is the need for a focus on the needs of the individual. The variation in the problems experienced and the resources available to each person will be different and will vary for people at different stages of their drug-using and offending careers, so different services or treatment approaches will be required to meet the varying situations of individuals. The evidence on the effectiveness of different services shows that both substitute prescribing **and** abstinence-based treatment services can be effective in reducing both drug use and offending but also points to the need for psychosocial support, employment support and stable accommodation for longer term rehabilitation[8]. To address the wide range of needs effectively will require action from a similarly wide range of agencies: employment, housing, NHS and a variety of treatment services, in addition to the criminal justice element.

Another important element of recovery, identified in a UKDPC consensus panel 'vision statement'[9] and most other models of recovery (e.g. the Betty Ford Consensus Panel[10]), is the requirement for rehabilitation and recovery to be *voluntarily-sustained* if it is to be lasting. However, this is not as simple as coercing or even incentivising offenders to "take responsibility" for their drug use as is sometimes suggested. As we have seen, addiction is now widely considered to be a chronic relapsing disorder of the brain and hence recovery will take time and relapse is likely to be common. This is reflected in the fact that many offenders have been drug-dependent for many years and will have already accessed treatment in the past. The 2005/06 Arrestee Survey shows that:

- 62% of arrestees who had ever taken heroin said they had been offered treatment;
- 57% had received treatment at some time;
- 41% had received treatment in the past year; and
- 30% were currently receiving treatment.

Among those who had ever used crack, 14% had been offered treatment for their crack use, 9% had received treatment at some time, 6% had received treatment within the past year and 4% were currently receiving treatment. Part of the reason for the discrepancy between crack and opiate users accessing treatment is that there is no widely adopted pharmacological treatment for crack or cocaine, unlike opiates where methadone and other substitutes can be prescribed.

It is therefore important to distinguish between the different groups of drug-using offenders as different interventions will be appropriate for them. Other factors which could be used to segment this group include complexity of drug use (e.g. problematic, recreational etc), stages in drug-using or offending 'careers' and motivation to change.

IMPLICATIONS:

- The constellation of often long-standing problems means that problem drug-using offenders will be more challenging to treat, rehabilitate and re-integrate into society than many other offenders or non-offending drug users.
- In order to focus on the needs of the individual, a variety of services and drug treatment approaches need to be made available, including public health interventions (e.g. needle exchange), substitute medication prescribing (e.g. methadone), psycho-social interventions, abstinence orientated programmes and reintegration services. A one-size-fits-all approach (e.g. only abstinence-based programmes) is destined to fail as it does not acknowledge there are many different types of problem drug users.

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[8] A consensus held by a number of key bodies including NICE, WHO, UNODC, etc.

[9] See http://www.ukdpc.org.uk/Recovery_Consensus_Statement.shtml

[10] Betty Ford Institute Consensus Panel (2007) "What is recovery? A working definition from the Betty Ford Institute" Journal of Substance Abuse Treatment, 33, 221-228

Stigma associated with drug addiction

The often misunderstood nature of substance dependence has been reinforced by the accompanying stigma of addiction (and vice versa). This in turn serves to frustrate the re-integration efforts of those working with problem drug users. Creating a more "receptive" climate amongst employers, housing landlords and local communities to those recovering from addictions will be a necessary adjunct to policies and programmes designed to weaken or break the links between drugs, addiction and crime. Hence there is a need for clear and innovative political leadership to break down the stigma attached to this group of people. This is no easy task, and will not be helped by some prevailing narratives which intentionally or by accident stigmatise people with addictions. We draw a comparison here with the changes in public attitudes which have emerged over the years to those with mental health problems. Although there is a long road to travel, there is no doubt that through various efforts, mental ill-health is now a more understood condition. The extent of misunderstanding about substance dependency is perhaps illustrated by the observation of one backbench parliamentarian who is reported as having said, *"Taxpayers will be outraged that so much of their money is going to junkies and winos who will use the money simply to feed their disgusting habits. Nobody forced them to get hooked on drink or drugs. It's their responsibility to get cleaned up and off benefits"*[11].

IMPLICATIONS: - A major obstacle for any policy seeking reintegration and social inclusion for recovering drug users will be stigma, and it will take a concerted effort by Government and others to change commonly-held perceptions.

A carrot and stick approach to behaviour change

Evidence shows that the CJS can sometimes initiate or incentivise the impetus for change and improve engagement with services. However, the voluntary nature of recovery raises questions about the appropriateness of sanctions linked to proposals for 'Earned Release' and drug rehabilitation requirements and the proposal for making DRRs compulsory for all problem drug-using offenders. Not all problem drug-using offenders will have the same personal rehabilitation resources available to them and they will be at a different stages in their drug-using 'careers', with relapse likely for many on the road to recovery.

While about 3 in 5 offenders (59%) report drug use of some kind less than 1 in 8 (13% of all arrestees) are estimated to be problematic heroin or crack users[12]. This means the majority of drug-using offenders have less problematic drug use patterns and evidence suggests their offending is not generally associated with their drug use. For example, only about 5% of those arrestees who did not report problematic drug use said there was a link between their drug use and offending. Therefore providing drug interventions to this group is unlikely to have a big impact on their rates of recidivism and might lead to issues associated with non-compliance if the services are not appropriate for them. One must also question whether it will be a cost-effective use of resources or whether it would suffer from a "law of diminishing returns" effect.

As the Green Paper indicates, the completion rates for community sentences such as Drug Treatment and Testing Orders are low and the evidence would suggest that there is scope for improvement. However, given the chronic, relapsing nature of substance dependency, 100 per cent compliance cannot be expected. Nor can it be assumed that a breached order has had no positive impact and has been a "waste" of funding or a failure. Drug use and offending may well have been reduced if not totally eliminated and progress made in addressing associated problems.

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[11] Quote in the *Daily Express*, 4 April 2008

[12] 'The Arrestee Survey 2003-2007', Boreham R., et al,. 2007 (Home Office Statistical Bulletin 12/07)

In our review of evidence we pointed to the need for attention to be paid to improving supervision and monitoring practice; including clarifying the role of supervision and the need for clear and rapid responses to breaches of orders to encourage compliance. An evaluation of the community sentences and benefit withdrawal pilots concluded that *"...the policy* [of sanctions] *had some potential, as a supporting factor, to influence offenders' clarity about appointments and evidence requirements and the priority placed on attending, but less potential where non-compliance relates to difficult personal issues, problematic substance use, ..."*.[13] Evidence from the USA also suggests that use of welfare benefits sanctions to enforce participation in employment schemes may be ineffective and have negative impacts on the families of problem drug users.[14] As with other intuitively appealing policies and programmes (e.g. an anti-drug public information campaign in US that unfortunately led to increased use[15]) there is always the possibility of unintended consequences. So changes need to be properly tested before being introduced too widely.

However, we also have concluded there is a need for consideration of the potential for greater use of positive incentive-based strategies to secure compliance with drug treatment programmes (i.e. contingency management) rather than simply relying on punishment-orientated responses. Both short-term, more immediate 'rewards' as well as longer term goals can help motivate behaviour change. The recent NICE review of approaches to drug treatment showed there was evidence, mainly from the USA, suggesting contingency management (e.g. through use of reward vouchers) could be effective in community treatment but this is in its infancy and very politically charged.[16]

IMPLICATIONS:

- The complex nature of problems experienced by drug-dependent offenders means that they may not respond to interventions promoting rehabilitation and behaviour change in the same way as those people, offenders or otherwise, who do no have such problems.
- 'Earned Release' may mean "Prisoners have a powerful new incentive to avoid drugs" (Green Paper p.87) but given the complex nature of problems facing drug dependent offenders it is not clear that such incentives will result in the desired behaviour changes and may have unintended consequences (e.g. increased periods of incarceration from non-compliance).
- This also applies to proposals to introduce new sanctions in an attempt to improve the success rate of community sentences with a drug rehabilitation requirement.
- Any proposal to make DRRs "compulsory" for all offenders assessed as having a problem with drugs would need to be reconciled with the voluntary nature of long-term recovery as well as consideration as to cost-effectiveness.

Sentencing policy: community vs prison sentences

The Criminal Justice Act 2003 requires courts to have regard to a number of sentencing purposes: punishment, crime reduction, reform and rehabilitation, public protection and reparation, reflecting most of those set out as the four pillars of sentencing in the Green Paper. As the Sentencing Advisory

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[13] 'Evaluation of the community sentences and withdrawal of benefits pilots', Knight et al., 2003 (DWP Research Report 198)

[14] 'Life sentences: denying welfare benefits to women convicted of drug offences', Allard P., 2002 (Sentencing Project).

[15] 'Boomerang Ads', Drug and Alcohol Findings Issue 14, 2005.

[16] 'Drug Misuse: psychosocial interventions', NICE clinical guideline (CG51), 2007

Panel (SAP) has noted recently, *"sentencers must consider, given the nature and seriousness of the offence committed and the circumstances of the offender, which of these purposes is appropriate and how it (they) might be achieved"*. [17]

We agree that community sentences need to be improved but are left with the impression that the Green Paper suggests a primary focus on the use of prison sentences. However, the paper does state: *"… There is a place for community sentences to deal with offenders whose crimes do not warrant imprisonment and where treatment in the community offers a better prospect of rehabilitation than incarceration."*

Problem drug-using offenders tend to commit less serious crimes and are mainly in prison for short sentences. The offences committed by problem drug-using offenders are mostly acquisitive. In the 2005-06 Arrestee Survey about two-thirds of arrestees (65%) who reported using heroin and/or crack at least once a week were being held for offences classed as 'theft'. The 'theft' group of offences included shoplifting (which made up over half of the cases - 37% of weekly heroin and crack using offenders), burglary, car crime and other theft. By contrast, only 13% were arrested for violent offences. Because of this profile of less serious offending, problem drug-using offenders who are imprisoned generally receive short sentences. Therefore substituting community sentences for many short-term prison sentences would not be a "watering down" of sentences but would be providing more proportionate and potentially more effective sentences. As the WHO has concluded: *"People with substance dependence are among the most marginalized in societies and are in need of treatment and care. To incarcerate offenders for drug use and dependence is not an effective prevention or treatment strategy"*. [18]

The evidence suggests that maximising the use and effectiveness of community sentences is likely to be more beneficial than imprisonment of problem drug-using offenders for comparatively less serious acquisitive crimes and drug possession offences. Community sentences have the potential to offer better value for money and deliver similar reductions in re-offending.

The lack of comparative evaluations of effectiveness and, in particular, value for money reviews, of community versus prison-based drug interventions hampers informed consideration of this issue. However, the cost of imprisonment is high and extrapolation from a small number of international studies[19] suggests that community sentences may provide better value for money. This is important in the current context of budget constraints and enormous pressures on the prison estate.

The review by Washington State Institute for Public Policy that is used within the Green Paper to estimate the impact of proposed policies also suggests that community sentences are likely to be more effective. It shows that drug treatment in the community and adult drug courts have been shown to have the biggest impact on recidivism.[20] However, it is important to recognise that these estimates of impact come from different (largely US) studies, which may have involved groups of offenders with different profiles of problems. Extrapolation is therefore difficult and it is very important that there is more rigorous evaluation of programmes within the UK.

Of course we recognise the need to improve the quality and consistency of community sentencing. Drug courts show promise and although they are relatively expensive, the integration of the principles

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[17] Consultation paper on overarching principles of sentencing', Sentencing Advisory Panel, 2008
[18] "What do people think they know about substance dependence" World Health Organisation, 2001
[19] 'The economic case for and against prison', Matrix Knowledge Group, 2007
[20] 'Evidence-Based Adult Corrections Programs: What Works and What Does Not', Washington State Institute for Public Policy, 2006

behind these into more general community sentencing practice might prove a more cost effective approach in the long term. Furthermore we suggest that more attention should be paid to developing and evaluating diversion from prosecution schemes, such as those which are in place in Scotland, and making better use of options such as conditional cautioning for certain types of offenders in the early stages of their drug use and offending careers.

IMPLICATIONS:
- We would suggest that, alongside introducing honesty in sentencing, there should be a goal of "appropriate, proportionate and effective sentencing".
- The Policy Green Paper goals should be amplified to embrace a new assumption of offering a community-based sentence with a drug rehabilitation focus for less serious offences linked to addiction (and mental health) problems.
- A flexible, problem-solving approach as implemented by drug courts might be expanded if their effectiveness is proven.

Imprisonment has a negative effect on rehabilitation

Imprisonment can have serious unintended and negative consequences for problem drug-using offenders and there are many practical issues which frustrate the delivery of successful drug treatment programmes in prisons, particularly for short-term prisoners[21]. Prison stays may create or exacerbate problems relating to housing, employment and family relationships and also expose offenders to increasing health risks such as infection from blood-borne viruses from sharing needles. Evidence supports the use of some public health measures in prison to prevent such problems and as these are adopted by the NHS in the community (through NICE guidance) they should be considered for replication in prison provision.

Enforced detoxification without adequate follow-up support also increases the risk of relapse, overdose and death, particularly on release. A recent study of cohorts of prisoners released in 1998, 1999 and 2000 showed significantly elevated mortality rates in the first 2 weeks post release among both men and women, almost entirely from drug-related causes. In the first week post release the odds of a drug-related death for women were more than 10 times greater than that at 52 weeks and about eight times greater than at 52 weeks for men.[22] It has also been estimated that one in 200 adult male injectors is likely to die in the fortnight after release from imprisonment of 14 or more days[23].

The importance of aftercare is recognised in the Green Paper and we fully support this. There is evidence that appropriate aftercare and follow-up need to be given a much higher priority both within prison and on release[24]. Those involved in the discussion groups we held as part of our study on interventions for problem drug-using offenders also stressed that, without further rehabilitation or support, relapse would be much more likely, particularly on initial release into the community. There is also a need for continuity (and therefore equivalence) of care for prisoners who were in receipt of treatment prior to imprisonment.

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[21] 'Review of Prison Drug Treatment Funding', PricewaterhouseCoopers, 2008 (Ministry of Justice).

[22] Farrel, M. & Marsden, J. (2007) "Acute risk of drug-related death among newly released prisoners in England and Wales" *Addiction* **103** 251-255.

[23] Bird, S.M. & Hutchison, S.J. (2003) "Male drug-related deaths in the fortnight after release from prison: Scotland, 1996-99" *Addiction*, 98, 185-190

[24] 'The mental health of prisoners', HM Inspectorate of Prisons, 2007 and 'HM Chief Inspector of Prisons for England and Wales 06/07 Annual Report', 2008.

Delivering effective drug interventions to inmates who are serving very short sentences is difficult as many prison stays are too short for effective treatment and may simply serve to disrupt community treatment already commenced, as well as cause dislocation with family ties. As discussed in the Green Paper, provision of effective interventions in prisons is hampered still further by the issues of overcrowding, with prisoners being moved between prisons or discharged with little notice, the time available for prisoners to take part in programmes reduced, and the capacity of programme provision inadequate for the numbers being held.

IMPLICATIONS:
- It is vital that prisons can deliver continuity of care and equivalence of care for drug users so that unintended negative consequences of imprisonment can be minimised.
- NICE guidance on public health measures should be adhered to in prisons.
- There should be a national programme designed to provide improved family support services for prisoners.

Drug treatment in prison settings

It is our view (and also that of PricewaterhouseCoopers[25]) that despite progress over recent years, current provision of drug treatment is below "minimum standards". Many of the factors contributing to this serious shortfall have been accounted for above, and Government has set a target for achieving minimum standards but only by 2011[26]. It is clear that a 'rehabilitation revolution' is required.

As in the community, a recovery-oriented focus would suggest the need for a range of different drug services within prisons to cater to different needs. The **Integrated Drug Treatment System** seeks to broaden and co-ordinate the provision of all drug treatment and support services (and the transition to and from prisons), which is essential for effective rehabilitation, and hence we believe it should be provided in all prisons. It is important that there is provision within this of the **full range** of services shown to be effective including substitute medication prescribing, detoxification and abstinence-based programmes as well as psychosocial support, and that full IDTS is available throughout the estate and not simply in a fraction of prisons.

In addition to the types of programmes described in the Green Paper, which will be effective for some prisoners there is also the need for the provision of a range of pharmacological treatments as indicated in the UNODC and WHO *"Principles of Drug Dependence Treatment"*.[27] Evidence from Australian randomised control trials of prison-based methadone maintenance therapy also indicate that retention in such treatment is associated with reduced re-imprisonment rates, hepatitis C infection and mortality.[28] By contrast, there have been very few studies undertaken to date on the use of other pharmacotherapies, such as naltrexone, specifically with criminal justice populations[29]. For short-term prisoners, who make up the bulk of the problem drug-using prisoners, their prison term will be too short for the completion of most drug rehabilitation programmes. Thus for many of them with heroin dependency, maintenance prescribing is likely to be the most effective approach and will be particularly important for those already receiving this treatment in the community prior to imprisonment.

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[25] 'Review of Prison Drug Treatment Funding', PricewaterhouseCoopers, 2008 (Ministry of Justice).
[26] 'Drugs: protecting families and communities: The 2008 drug strategy', HM Government, 2008
[27] 'Principles of Drug Dependence Treatment –Discussion Paper', World Health Organisation, 2005
[28] Dolan K., Shearer J., White B., Zhou J. & Wodak A. (2005) "Four-year follow-up of imprisoned male heroin users and methadone treatment: mortality, re-incarceration and hepatitis C infection" *Addiction*. 100, (6), 820-828.
[29] 'The Treatment and Supervision of Drug-dependent Offenders', McSweeney et al., 2008 (UKDPC).

In the UK, research has provided evidence in support of medically-assisted (e.g. with methadone or lofexidine) **opioid detoxification in a custodial setting**. Although many prisoners with heroin problems are detoxified successfully in prison, the longer-term implications of this are not clear. We do not know how many of these people subsequently become and remain abstinent within prison and in the community. The evidence from surveys, although mainly quite old, suggests that rates of drug use and offending after release are generally high. As part of the Prisoner Criminality Survey, a sub-group of drug users was followed up between four and six months after release and over three quarters of them had used drugs since release and over half had re-offended[30]. The increased risk of death this poses due to a reduced tolerance of drugs following detoxification has been confirmed by recent research[31]. Detoxification therefore needs to be part of a package of care to promote and maintain abstinence within prison and on release. Without effective follow-on care within the prison setting and post-release, it is possible that increased provision of detoxification may actually do more harm than good. Current NICE guidelines state that detoxification is inappropriate for short-term prisoners. This issue has also been discussed in the recent PWC report on prison treatment.[32]

A number of recent systematic reviews of evaluations of the effectiveness of prison-based drug treatment have also produced evidence for the effectiveness of **prison-based therapeutic communities** (TCs) in reducing illicit drug use and/or recidivism. However, there are only a handful of TCs currently operating in British prisons and there has been no evaluation of their effectiveness. It is important to note that a therapeutic community is a setting in which different drug treatment approaches may be used, so care must be taken when comparing outcomes and TCs may not provide superior benefits to other forms of residential treatment. RAPt (Rehabilitation of Addicted Prisoners Trust) delivers an abstinence-based model developed along **12-Step** lines in nine English prisons, which has been evaluated. Graduates from RAPt were shown to achieve significant and sustained reductions in drug use and offending, and lower than predicted two-year reconviction rates (actual 40%; predicted 51%), than a matched comparison group (RAPt group 40%; comparison group 50%). However, this was a small study with some methodological limitations.

IMPLICATIONS:
- Given the diverse nature of substance dependency, a range of services should be available to prisoners to address problematic drug use.
- There should be equivalence of care between CJS and non-CJS drug intervention programmes. This is particularly needed within the prison estate where service provision is below "minimum standards". This will also allow for continuity of care when prisoners go to/from the community and to other prison estates.
- Treatment interventions in prisons need to adhere to contemporary NHS clinical guidelines and best practice.

Reducing the availability of drugs in prisons

As research published by the UKDPC recently highlighted, there has been surprisingly little evidence collected about the effectiveness of many of the interventions designed to reduce the availability and

[30] Bullock (2003) "Changing levels of drug use before, during and after imprisonment" in Ramsay M (ed.) 'Prisoners' drug use and treatment: seven research studies', Home Office Research Study 267. London: Home Office
[31] Davoli M et al (2007) 'Risk of fatal overdose during and after specialist drug treatment: the VEdeTTA study, a national mult-site prospective cohort study, *Addiction* 102 (12), 1954-1959; Gibson A & Degenhardt LJ. (2007) 'Mortality related to pharmacotherapies for opiod dependence: a comparative analysis of coronial records', Drug Alcohol Rev. 26 (4):405-10.
[32] 'Review of Prison Drug Treatment Funding', PricewaterhouseCoopers, 2008 (Ministry of Justice).

supply of illegal drugs, including within prisons.[33] This is surprising given the level of public spending on enforcement and criminal justice activity in relation to drugs.

The UKDPC shares the Green Paper's concerns about the availability of illicit drugs in prisons and their ability to undermine attempts to break the link between drug use and criminal activity such as offered through detoxification and treatment programmes.

One of our Commissioners, David Blakey QPM, was asked by the Ministry of Justice to review arrangements for disrupting the supply of illicit drugs into prisons. His report, published earlier this year, provides a comprehensive range of measures which, if implemented as promised by the Government, should have a positive impact over time.[34]

We understand and have sympathy with the widely held view that prisons ought to be "drug-free". However as David Blakey observes, *"prisons are villages of often well over 1000 people and every day they need to admit goods and services and hundreds more people just to function. Disrupting the entry of drugs in those circumstances is much more complex than popular wisdom would suggest".* [35]

The PriceWaterhouseCoopers review of prison-based drug treatment funding raises the prospect of new building provision providing an "*ideal opportunity to consider building designs and operational arrangements that would facilitate the creation of environments that can be genuinely drug-free"*. [36] But, as the authors observe*, "not all prisons could be drug free but there could be voluntary facilities which had higher security and more extensive personal search requirements".* Although the brief of the consultants did not extend specifically to mandatory drug testing (MDT), they did comment on the views of various stakeholders about this matter. The general view was there was support for anonymised testing to provide an indication of the level and type of illicit drugs being taken by prisoners but not to monitor the behaviour of individuals because it was open to manipulation and other problems. Huseyin Djemil's report for the Centre for Policy Studies on drugs in prisons also recognises this fundamental point. [37] A study of the MDT programme carried out in 2001[38] suggested that it underestimated use but was a robust measure of trends in use and that it might have some limited deterrent effect but that other aspects of the prison situation were probably more important. In Scotland the system of drug testing in prisons has been reviewed but they still continue to support anonymised testing. We believe there may be merits in looking at this approach in England & Wales.

The UKDPC-commissioned review of tackling drug markets published recently looked among other things at the evidence for efforts to reduce drug availability in prisons.[39] The review concluded, "*the research evidence examining the dynamics and operation of supply routes and markets-in contrast to drug use, treatment & related policies-within custodial settings is almost non existent"*. The reports' authors observed how prison drug markets were shaped by complex interactions between *"demand, supply, security and enforcement and treatment strategies"*. They conclude that it is the interaction between enforcement measures <u>and</u> the treatment facilities that are in place which "*influenced prisoners' decisions about whether to use drugs while in prison and how to obtain them*". Quite simply, stringent enforcement measures will not significantly reduce the prisons drug market without high quality detoxification and drug treatment services operating at the same time.

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[33] 'Tackling Drug Markets and Distribution Networks in the UK', McSweeney, T. et al, 2008 (UKDPC).
[34] 'The Blakey Review: Disrupting the supply of drugs into prisons' Blakey, D., 2008 (MoJ).
[35] 'The Blakey Review: Disrupting the supply of drugs into prisons' Blakey, D., 2008 (MoJ).
[36] 'Review of Prison Drug Treatment Funding', PriceWaterhouseCoopers, 2008 (Ministry of Justice).
[37] 'Inside Out: How to Get drugs out of prisons', Centre for Policy Studies, 2008
[38] "The impact of mandatory drug testing in prisons" Singleton, N. et al Home Office Online Report 03/05 (2005)
[39] 'Tackling Drug Markets and Distribution Networks in the UK', McSweeney, T. et al, 2008 (UKDPC).

As with any drug market, prisons will have their own peculiarities and dynamics, varying between one locality and another. However, the general principle of multi-dimensional responses is one that applies here and in all drug markets. Consequently, disruption and enforcement efforts along with appropriate and proportionate disciplinary responses can provide the backdrop for other essential detoxification, treatment and recovery programmes. The Blakey review and the CPS report both highlight the need for better intelligence about drug markets and their operations. This is something we would wholeheartedly endorse.

IMPLICATIONS:
- Recommendations contained in the Blakey review to reduce supply of illegal drugs into prisons should be implemented in full as soon as possible.
- An independent review of the efficacy and cost effectiveness of the mandatory drug testing scheme and an examination of the arguments for and against the adoption of an anonymised scheme should be conducted.
- Where drug supply incidents occur there should be an automatic presumption they will be reported to the local police.
- A long-term programme of research should be carried out into the operation of prisons drug markets to help provide the basis for subsequent evidence-led interventions.

The role of prison and rehabilitation trust governors

The Green Paper's proposals to incentivise improved outcomes along with bringing together prisons and probation (via new Trusts) and decentralizing responsibility for commissioning has much in its favour. We also note the interest in alternative models of commissioning such as a local "Crime Commissioner". To enable fulfillment of the policy we also note the intention at some point to "restrain" the growth in numbers entering prison along with what would be a major logistical move reframing the prison estate by setting up more localised prisons.

The Commission welcomes these broad intentions. However, the experience of the criminal justice system over the past few decades has consistently shown such aspirations to be continually frustrated through a series of complicating factors such as inadequate resources, sentencing practices and perverse incentives or unintended consequences.

Another complicating factor in considering the potential effectiveness of the proposals is the absence of concrete evidence about the effectiveness of the organisational and systems architecture for delivery of many of the interventions. We are unaware of research evidence which could reliably demonstrate, in the criminal justice system, that governors will be more effective if they are held responsible for aftercare and reconviction rate outcomes. This is not to say such plans might not work but rather that caution is needed to consider whether such steps could work as planned and what the obstacles and unintended consequences might be.

The comparison with the health system and the various health care trusts might be a misleading one. In the health system, the myriad of decisions made about accessing health care (and hence demand on limited resources) is mediated through the PCTs and "gatekeeping" mechanisms such as NICE. In the CJS, the prison and probation services are <u>required</u> to supply the service, irrespective of whether the resources (prison places and/or programmes such as drug treatment etc) are available. Also there is no criminal justice equivalent to NICE providing an informed knowledge base and independent appraisal of interventions.

The principle of holding the proposed Prison & Rehabilitation Trust governor accountable for outcomes is, in general, a sound one, reflecting evidence about effective ways to improve the performance of service delivery. However, in looking at the specifics as applied to the criminal justice system we suspect there may well be many complicating factors which could undermine its application.

For drug dependent offenders, a simple and single outcome of reducing reconviction rates will be an inadequate measure which could create perverse incentives. For example, international evidence unequivocally demonstrates the efficacy of prescribed substitute medication (e.g. methadone and/or buprenorphine) to improve health outcomes and reduce the use of illicit street heroin and associated criminal activity. A governor might be "wise" to invest heavily in this form of treatment provision if the sole measure of performance were two year reconviction rates which are then used to trigger premium payments. However, to enhance overall recovery outcomes (as distinct from the narrower reconviction rate), substitute medication might form only an element of a more optimal package of interventions. More people might end up on maintenance programmes rather than being "moved through" the system. The reconviction outcome measure would ignore any progress in reducing severity and frequency of offending and also reductions in drug use and other improvements in ex-prisoner lifestyles. (NOMS for example has identified the seven key resettlement pathways [40] but we suspect that, in many areas, little is being spent on many of the component services)

Compounding these factors is that in the area of addictions, what is effectively payment by results (PBR) faces a major challenge insofar as addiction and dependency are acknowledged by the WHO and UN Office on Drugs & Crime (ONODC) to be complex, chronic and relapsing conditions, with multiple interacting causal factors.[41] The Green Paper acknowledges that prison governors will have "the discretion to target resources on those offenders most receptive to rehabilitation services…" (p.77) and therefore there remains the risk that governors might "cherry pick" as to whom and on what they invest resources in. The notion of premium payments for improving outcomes for the most challenging offenders appears on the surface to be a positive attempt to motivate governors to address the needs of the most vulnerable but may be fraught with risk.

The international research evidence demonstrates that sustained reductions in offending (and problem drug use) are largely influenced by such factors as offender access to employment, accommodation and other services which address underlying causal factors, including the availability of drug treatment and community-based support for mental health disorders. Given that it will be many years before the localised prison estate the Green Paper envisages will materialise, we are unsure how practically a Prison & Rehabilitation Trust governor can be held accountable for commissioning the delivery of those other services, often long distances away, and which are the statutory responsibility of other bodies (e.g. local council, Learning and Skills Council, NHS, Job Centre Plus etc). (Unless it is envisaged that those other local services will have some of their resources either ring-fenced or re-allocated in some way to the new Trust) With prisoners continuing to be held away from their own locality for the foreseeable future, often attending several prisons during the course of a sentence, it is likely to prove a managerial complexity of the highest order for the governor of a prison in one locality (especially in a rural location but serving a number of urban areas) to be commissioning services from a myriad of other services some distance away. A move away from the local PCT, LSC or housing authority having responsibility for the commissioning of appropriate services to offenders, whether in prison or the community, should be approached with considerable caution.

We are generally supportive of proposals which seek to incentivise behaviour change or broad compliance with institutional rules and regulations. So we have some sympathy with the intentions

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[40] The National Reducing Re-offending Delivery Plan, National Offender Management System, 2005

[41] 'Neuroscience of psychoactive substance use & dependence', World Health Organisation, 2004.

behind the "Earned-Release" proposals. However over many years, institutions such as prisons and schools have found that such devolved and localised discretion over punishments has led to unfair decisions and, either accidentally or wilfully, discrimination. So, apart from our earlier observations about whether those with addictions and mental health problems will behave in rational ways to incentives (negative & positive), we are unsure whether the earned-release proposal giving discretion to governors will be legally sustainable. Under Prison Rules, there exists a system, while perhaps not perfect, allows for fairness and independent scrutiny through the adjudication system and, ultimately, an appeal to a Senior District Judge. In the drug misuse field, NICE has examined international evidence for the use of positive incentives to encourage compliance with drug treatment regimes (called contingency management) and found them to have positive results, at least in other countries where they are applied, notably the USA. Trials are just beginning of the approach here in the UK. We suggest that this (positive) incentives approach might well in due course be found to have applicability here and perhaps could be examined further to see whether positive incentives, as distinct from simply negative punishment, might be worth exploring in a broader context within the prison and wider offender justice system.

Considerable progress has been made in creating and nurturing local partnerships to tackle complex problems for example through Crime & Disorder Partnerships and Drug Action Teams, both based on local authority areas (but now subject to review, see Policing Green Paper) and the Local Criminal Justice Boards based on criminal justice administrative areas. In many areas, prison governors and probation staff make a major contribution and have successfully put the rehabilitation needs of offenders and crime prevention centre stage. There is the risk that placing responsibility and accountability for prisoner aftercare with a Trust governor may result in other bodies absolving themselves of responsibility. This has been an experience across many types of partnerships and needs to be guarded against, especially when Local Area Agreements (in England) are in their formative stages.

Finally we are aware that there is a very high turnover of prison governor staff, with people frequently staying less than two years. Whilst an incentives system might well be designed to alleviate this and provide more freedom, it is likely to prove yet another complicating factor to organisational and systems architecture.

IMPLICATIONS:

- Rather than looking to a Prison and Rehabilitation Trust Governor to be responsible for aftercare, the existing machinery provided through Local Criminal Justice Boards offers an opportunity to create an enhanced commissioning system for prison and rehabilitation trusts, perhaps better connected to the locality (and hence other local bodies) from where offenders come and, importantly, where they will be returning to.
- Alternatively, the opportunity provided through powerful local Crime Commissioners or elected mayors as suggested in the document may provide even greater potential to integrate the commissioning of services for prisoners and offenders with other local public services, and to provide effective end-to-end offender management. They will be able to operate closely in the development and execution of Local Area Agreements and be receptive to the development of more "personalised" public services, including those provided through the CJS. This is likely to provide added-value in addressing crime problems and providing more sustainable community safety solutions.
- The use of 'contingency management' approaches in recovery services should be explored and potentially expanded.

Concluding Remarks

There is welcome concern in the Green Paper over the effectiveness of drug treatment both in prisons and the community and how it can reduce drug-related offending and improve wellbeing. At the heart of this issue should be the need for any justice system, in concert with the health system, to treat not only the symptoms of the problem but also address its root causes. In this respect, whatever the organisational and systems architecture, the basic premise should be that **recovery from addiction** (and by implication associated criminality) is the goal to which organisations and individuals should be aspiring.

UK Drug Policy Commission
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