UKDPC

UK DRUG POLICY COMMISSION

UK Drug Policy Commission submission to the Labour Justice Policy Working Group

Introduction

This submission will focus on two key issues relevant to the policy review. Firstly, it will focus on how we can reduce the impacts of **drug offences** on the criminal justice system. Then it will look at how the burden on the justice system of issues related to **drug dependency among offenders** can be addressed and reduced.

1. How can we reduce the impact of drug offences on the criminal justice system?

For this submission, we highlight opportunities in four areas:

(a) Reducing the numbers entering the criminal justice system for minor drugs offences (ie 'simple' possession of a controlled drug and cannabis warnings)

In 2009 there were 35,471 adults sentenced for the possession of controlled drugs in England & Wales;[1] 1,262 of these were sentenced to a period of immediate custody. The remainder received a fine (18,903) or other non-custodial disposal. The average custodial sentence length for a possession offence was 5 months. For Class A offences only, the average length was 6 months while cannabis offences invited, on average, sentence lengths of 2 months. As the Sentencing Council observes, "the most common custodial sentence length received for all classes of drugs was 28 days".

In addition to this, police are able to issue cannabis warnings or, since January 2009, Penalty Notices for Disorder (PNDs) for cannabis possession. There has been a decline in the use of Cannabis Warnings since the introduction of PNDs as well as a decline in the use of these penalties overall. There were 13,142 PNDs issued for drug offences in 2009/10 and 13,850 in 2010/11. Over the same period, Cannabis Warnings fell from 107,241 in 2008/09, to 87,333 in 2009/10 and 80,658 in 2010/11.[2]

Given that nearly 1 in 3 adults in the UK is estimated to have used a controlled drug in their lifetime,[3] and nearly 3 million adults in England and Wales used a controlled drug in the last year, mainly cannabis, it is clear that detection rates are low. Thus it may be asked what useful purpose is being served by the police, CPS, courts, prisons and probation dealing with these relatively minor possession offences, especially at a time of dwindling resources. It is questionable whether the current system delivers a fair or consistent punishment for people possessing drugs and whether it has any significant deterrent effect. Some people will cite steadily reducing prevalence of drug use as a reason for maintaining the law as it stands.

[1] Sentencing Council, *Analysis and Research Bulletin 'Drugs Offences'*, March 2011
[2] Ministry of Justice *Criminal Justice Statistic Quarterly Update to March 2011,* MoJ, August 2011
[3] British Crime Survey, 2010/11

However, we believe the evidence suggests that economic, social and cultural trends are the cause of this decline, rather than any deterrent effect of the law about possession.[4]

Over the last few years there have been various efforts by some countries to reframe their responses to drug problems. A number of countries, including in Europe, have removed or reduced their legislative sanctions, for example with the introduction of replacement civil penalties for 'minor' drug possession or consumption offences, and the setting of threshold levels below which the authorities take no action.

Some of the evidence cited in support of such changes is limited and contested, and in some cases it may be too early to draw long-term conclusions. But they clearly demonstrate that it is possible to significantly reduce or replace criminal sanctions for drug possession without leading to any significant increases in drug use or associated harms.[5] We conclude that the replacement of criminal sanctions for personal possession of controlled drugs with a system of civil sanctions is worthy of serious consideration.

(b) Ensuring proportionality in sentencing for drug offences

Proportionality should be considered both between different types of drug/drug offence, and between drug offences and other offences[6].

The rationale for the quantity thresholds used in current sentencing guidelines for different types of drug offences is not clear and the thresholds appear to have developed organically. This is a complex area, which is prone to unintended consequences, with much varying practice around the world. We suggest that there should be a consensus-forming meeting bringing together bodies like the CPS, ACPO, defence lawyers, drug specialists from a range of disciplines and other relevant groups, in order to reach agreement on appropriate threshold quantities to determine boundaries between possession, supply/intent and cultivation/production; and to determine equivalence levels between different types of drugs.

There is little analysis also for the proportionality of sentences for drug offences in relation to sentences for other types of offence. At the time of the 2010 Sentencing Advisory Panel consultation, those convicted of importation or exportation offences were sentenced more severely (average 84 months custody) than rapists (average 80 months) or those guilty of grievous bodily harm or wounding with intent (average 50 months). Over time, the average sentence length for broadly similar types of drug supply, trafficking and importation offences has steadily increased. It is also clear that Britain gives proportionately longer custodial sentences for drug supply offences than many of its European neighbours.[7]

Overall, we would welcome more explicit debate about the rationale for these sentence lengths for all drug offences. This could provide an opportunity to ease, somewhat, the pressure on the prison estate.

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[4] Reuter & Stevens (2007), *An Analysis of UK Drug Policy*, UKDPC http://www.ukdpc.org.uk/docs/UKDPC%20drug%20policy%20review.pdf

[5] For a summary of current evidence see Room and Reuter (2012) *How well do international drug conventions protect public health, Lancet.* 379, 84-91. Table on Page 87

[6] UKDPC (2010), *Response to the Sentencing Council Drug Offences Guideline consultation,* http://www.ukdpc.org.uk/resources/UKDPC_Sentencing_Council.pdf

[7] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). *Drug Offences: Sentencing and Other Outcomes*. Lisbon. 2009

(c) Distinguishing between different forms of drug offences

There are various forms of drug offences, particularly low-level supply and production offences, which we believe may warrant special treatment by the CJS given extenuating circumstances of the offender, which currently are not acknowledged.

In our response to the Sentencing Council consultation on drug offences, for the offence of the production and/or cultivation of cannabis offences (and also in cannabis-related possession cases) we supported the reference to a mitigating factor of 'serious medical condition'.[8] We also recommended including explicit reference to where the condition is for the relief of chronic pain which has been medically diagnosed. Our reason for this is that although there is now a licensed cannabis-based drug (Sativex) for prescription in certain types of pain relief, access to this is being denied on cost grounds rather than clinical need. This puts in a very difficult position people who have used or cultivated cannabis for their own use as a relief for some medical condition.

For all forms of drug offences we support the inclusion of 'addiction' as a mitigating factor, provided there can be demonstrated a determination or practical steps taken to address the addiction or associated offending behaviour. While dependency or addiction does not remove culpability, there is mounting evidence about its influence on behaviour.

In relation to supply, and possession with intent to supply offences, we consider that there should also be reference to a new and explicit aggravating factor of using vulnerable sex workers and/or trafficked people. Many sex workers may also be addicted to drugs and be coerced and used as intermediate vehicles of supply.

(d) Diverting some drug offenders from prosecution

Another step worth considering is, as happens in the US, deferment of prosecution and a 'slate wiped clean' if a perpetrator successfully goes through a treatment programme. Diverting away from prosecution people who have entrenched drug problems and commit acquisitive crime, with an incentive to participate in treatment such as via a deferred prosecution, could offer another route out of reoffending and towards a more sustainable recovery.

In (a) above we have raised the prospect of considering the removal of criminal penalties associated with the possession of small amounts of drugs for personal use. We conclude also from our research and other evidence that there are new opportunities to examine lessons from elsewhere about ways to deal with some of those people committing other non-violent drug offences. We think this could be especially appropriate where someone is committing low-level drug dealing.

At first sight, looking to divert low-level drug dealers from prosecution may appear to be undermining community confidence in the justice system. However, counter-intuitively, the US Department of Justice's Drug Market Initiative (DMI) across over 20 cities has demonstrated the success of diverting such people, who often have an accompanying drug dependency problem, into a structured programme.

According to the analysis, "The DMI seeks to focus on geographically-defined drug market locations and eliminate the overt drug market and the associated violence. The model includes a highly focused deterrence strategy coupled with police-community partnerships that seek to offer sources of social support to the subjects of the deterrence strategy while at the same time re-establishing informal social controls within the neighborhood in order to prevent the re-

[8] UKDPC, *Response to the Sentencing Council Drug Offences Guideline consultation*, op cit

emergence of the drug market". [9] It is, in essence, a strategic and sustainable problem solving intervention. The underpinning principles are not dissimilar to those of the Boston Gun Project, which is often cited as an innovative diversion and crime reduction programme. In the UK, in Brighton and elsewhere, local police have been inching towards such interventions, with signs of positive impacts. [10]

2. How best can we address the challenge of drug dependency among offenders both in and outside our prisons?

While the above approaches might reduce the burden on the CJS of those committing some current drug offences, there is also scope for addressing the impact of those with drug addictions and dependency, who commit other associated 'low-level' acquisitive crimes.

The government's Drug Strategy places considerable emphasis on improving recovery prospects for those entering and exiting drug treatment programmes. As the Home Secretary says in her introduction to the document, "Individuals do not take drugs in isolation from what is happening in the rest of their lives. The causes and drivers of drug and alcohol dependence are complex and personal."

These causes and drivers include: social and environmental factors, such as poverty, disadvantage and social networks; and personal factors, such as experiences of abuse, and genetic make-up. The importance of fostering better understanding and knowledge about the causes and drivers of substance addiction cannot be underestimated because it will help inform what is feasible and achievable through the CJS.

In a major review of the evidence base for interventions through the CJS, we concluded that in terms of effectiveness at reducing drug use and offending:

- *There is reasonable evidence to support:* drug courts; community sentences such as DTTOs and DRRs; prison-based therapeutic communities; opioid detoxification and methadone maintenance within prisons and the community; and the RAPt 12-step abstinence-based programme.

- *There are no evaluations of the effectiveness of:* CARAT interventions; drug-free wings; programmes based on cognitive behavioural therapy, such as short-duration programmes and ASRO (Addressing Substance Related Offending) programmes; conditional cautions; diversion from prosecution schemes; and Intervention Orders.

- *There is mixed evidence for:* Criminal Justice Integrated Teams; Restrictions on Bail; and the added value of drug testing as part of a community order.[11]

As we concluded, it is widely acknowledged that there is no 'magic bullet' for the problem of drug dependency, which is recognised as a long-term, relapsing condition. Rates of reoffending and breaches remain high and expectations must be realistic as to what interventions can achieve.

The subsequent experience and limited evidence from the Drug Interventions Programme, Community Justice Centre, and Drug Courts, and emerging lessons from the Integrated

[9] See: http://drugmarketinitiative.msu.edu/HighPointMSUEvaluationPSN12.pdf
[10] UKDPC (2008), *Reducing Drug Use, Reducing Reoffending,* http://www.ukdpc.org.uk/resources/RDURR_Full_Report.pdf
[11] UKDPC (2008), *Reducing Drug Use, Reducing Reoffending,* op. cit.

Offender Management system, hold out the prospect of potentially being able to divert more people away from imprisonment. But at heart, the success of these criminal justice interventions will rest on wider social and economic policies. Without these, recovery, and hence reductions in offending rates, will be undermined. It is naïve to think that, without new ways to secure training, jobs and accommodation for those drug-dependent people committing crimes to sustain their habits, the CJS will be in a position to make major inroads to change drug and offending behaviours. That is not to set our sights low but rather to be realistic as to what is likely to be achieved.

In our 2008 review we reached a number of key conclusions, which remain relevant:

> *1. The principle of using CJS-based interventions to encourage engagement with treatment is supported by the evidence.*
>
> *2. Following a period of expansion and a focus on quantity, attention should now focus on quality.*
>
> *3. Net-widening to include additional groups of drug-using offenders in CJS-based interventions may have negative consequences.*
>
> *4. Community punishments are likely to be more appropriate than imprisonment for most problem drug-using offenders.*
>
> *5. Prison drug services frequently fall short of even minimum standards.*
>
> *6. Given the sizeable investment in CJS interventions for drug-dependent offenders, we know remarkably little about what works and for whom.*[12]

In considering what other measures might prove worth examining we highlight five:

(a) Addressing drug dependency in prison

While abstinence may be successfully achieved in a relatively short space of time in a prison environment there may not be time for the treatment necessary to achieve sustainable recovery upon release. Thus for those on short sentences with entrenched dependence, alternative treatment approaches, such as substitute prescribing combined with psychosocial interventions, that are continued on release might be more appropriate and less risky. However, there may be others for whom shorter interventions with a drug-free focus will be helpful.

It is for this reason that provision of medication-assisted treatments (MATs) should be made available, at the same time as drug-free recovery wings are currently piloted, as the latter will only meet the needs of a small proportion of prisoners. The evidence base for methadone and buprenorphine medications, both inside and outside prison, is very strong. It is the failure of complementary actions to address the practical barriers of jobs, accommodation, social stigma, child rearing and family relationships that have undermined the gains that MATs have initially produced.

In the case of drug-free wings for short sentence prisoners, it is important that these are introduced with care and with adequate monitoring of outcomes. The risk of overdose death on release from prison following detoxification is well documented.[13]

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[12] UKDPC, *Reducing Drug Use, Reducing Reoffending,* op cit

[13] Farrell M and Marsden J (2008), *Acute risk of death among newly released prisoners in England and Wales*, *Addiction* 103(2):251-5; Davoli M, Bargagli AM, Perucci CA, Schifano P, Belleudi V, Hickman M,

There are many other practical measures the prison system could take to address the drug problems of prisoners, which would also provide a more stable platform upon which to build longer-term recovery efforts. These include:

- Improving the process for identifying problem drug users on reception.
- The consolidation of the Integrated Drug Treatment System in all prisons.
- Ensuring all prison healthcare adheres to NICE and other clinical guidelines.
- Enhancing performance management and clinical governance of prison healthcare.
- Continuity of care within the prison system and with community services before prison and after release.
- The provision of appropriate follow-on care packages within prison and after release for those being detoxified.
- The provision of harm reduction measures to reduce the risks of blood-borne viruses and of drug-related deaths on release.

For more details, see our report, Reducing Drug Use, Reducing Reoffending.

(b) Widening the range of services and targeting these effectively

There is a need for a wider range of services to meet the differing needs of individual drug-using offenders, for example more services that address the needs of stimulant users.

The UKDPC review[14] found that effective treatments for crack and cocaine users are needed, more residential treatment may also be appropriate, and there is a need to pay attention to the quality of all treatment services being provided. This has important implications for the local commissioning process as well as the awareness and competence of commissioners.

Greater provision of services to promote reintegration (such as housing, education and employment) is required in order to improve long-term outcomes. Many drug-using offenders have complex needs, with low rates of employment and high rates of homelessness, even when compared with other offenders. They are also likely to have mental health problems.

The importance of regular reassessment to meet changing circumstances and promote recovery should also be noted. This is the basis of effective care planning and there is extensive guidance for practitioners, but implementation remains variable. Attention now needs to be given to ensuring the delivery of good care planning and what is required in terms of staff training and motivation, management and service commissioning to maximise the benefits from current programmes. However, for this to be really effective we need a better understanding of which programmes work best for which types of drug user.

The previous and the current coalition governments have been keen to promote a Payment by Results system across public services. Steps to improve long-term recovery outcomes from drug dependency and addiction has been the driving force behind the setting up of eight pilot schemes in England for drug treatment and recovery programmes. In principle we are very

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Salamina G, Diecidue R, Vigna-Taglianti F, Faggiano F, for the VEdeTTE Study Group (2007) *Risk of fatal overdose during and after specialist drug treatment: the VEdeTTE study, a national multi-site prospective cohort study,* Addiction 102 (12) , 1954–1959

[14] UKDPC, *Reducing Drug Use, Reducing Reoffending,* Op Cit

supportive of steps to enhance outcomes and get better VFM for taxpayers. However, we have expressed considerable caution about the practicalities and real costs involved in a policy and service delivery area where outcomes are transferred across so many governmental departments and funding streams.[15]

(c) Expanding the use of heroin assisted treatment for those with profound opiate addictions

There is much unwarranted political and media controversy over the use of replacement or substitute medications, such as methadone and/or buprenorphine, to treat those with heroin dependency problems, whether they are caught up in the criminal justice system or not. This is surprising because there is substantial international and UK evidence (for example by NICE) to support their use. The controversy and sidelining of the scientific evidence is either because of ideological reasons or because of a misinterpretation of data (or both). In the latter case for example, the fact that some people may stay on a prescribed alternative drug regime for some length of time is cited as an illustration of a failure of methadone. In fact, the task of rebuilding a shattered life caused by drug dependency is as much and perhaps more to do with someone getting a job and stable accommodation. What we do know from a wide range of scientific studies about drug treatment is that crime goes down and health and wellbeing improves. But, such benefits can deteriorate over time.

So, using clinically prescribed substitute drugs is and should be a part of a balanced treatment and recovery system. This also includes adopting the promising lessons from the use of diamorphine (ie clinical heroin) as a substitute for street heroin. Clinical trials across the world are beginning to show the benefits of this for, at least initially, a small group of street heroin dependent users for whom other treatments (including residential and/or methadone) has not worked.[16] More recently though, a clinical trial in Spain provides further evidence that more so than methadone, the heroin treatment can stabilise and improve the physical and mental health of some long-term heroin users with severe co-morbidities and high mortality who would otherwise impose a substantial burden on the health care system.[17] They will also undoubtedly be people with chronic low-level offending backgrounds.

In England, the government has prevaricated over the wider roll-out of similar programmes. We think two things should be done with programmes for prescribing heroin to those dependent on opiates: the first is to expand the current limited clinical trial to many more towns and cities. The second is to initiate a properly evaluated clinical trial to see whether the use of clinically prescribed heroin in different forms, accompanied by appropriate levels of social care, could be applied to a slightly wider group of opiate dependent users who do not have such histories of treatment failures as the current trials are restricted to.

(d) Using suspended sentences and expanding use of non-custodial sentences

The use of suspended sentences, perhaps for up to two years, might help to some degree in non-serious cases to relieve pressures on the prison estate and may be applicable even in cases of repeat property-related crimes: the ones most usually associated with drug-related offending.

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[15] UKDPC, *By their fruits… Applying payment by results to drugs recovery*, http://www.ukdpc.org.uk/resources/UKDPC_PbR.pdf

[16] *Heroin maintenance for chronic heroin-dependent individuals.* Ferri M., Davoli M., Perucci C.A., Cochrane Database of Systematic Reviews: 2010, Issue 8.

[17] *The Andalusian trial on heroin-assisted treatment: a 2 year follow-up*, Oviedo-Joekes E., March J.C., Romero M. et al. ☐Drug and Alcohol Review: 2010, 29(1), p. 75–80.

It is important to note, however, that not all drug use among offenders is directly associated with offending. For a considerable proportion of offenders it is part of a way of life which includes both drug use and offending. Reducing their drug use is unlikely to lead to reductions in their offending. There is a danger that less problematic drug users, whose offending is not related to drug use, might face additional sanctions as a result of failing to complete drug treatment as part of a non-custodial sentence, leading to the further criminalisation of these, mainly younger, drug users.[18]

The greatest challenge to the system and to longer-term recovery prospects lies in the churn of non-violent offenders whose incarceration presents great practical problems to the long-term recovery process. We have noted with significant interest the Scottish development of removing the option of imposing prison sentences of less than six months. We are not aware of any findings as to what the impact this might have been on drug-related offending rates. However, given that many of those sentenced for drug-related offences get a short period of incarceration, such a power in England & Wales could provide the opportunity for more and enhanced community orders with treatment as part of the sentence.

There is also an opportunity to improve compliance with community sentences in order to improve treatment outcomes. There is some evidence that swift but very modest sanctions applied to breaches of the terms of a community sentence can be an effective way of enhancing compliance, for example if applied to those on DRRs. Some evidence from Project Hope in Hawaii supports this.[19]

Equally, the use of small incentives to help induce compliance in drug treatments (contingency management) might also have potential for those on community sentences. We appreciate the sensitivity of this but, unless radical measures are taken to improve outcomes, the value achieved from public money for justice and health care will continue to be limited.[20]

(e) Requiring better evidence

Despite the considerable focus and investment in CJS interventions within UK drug strategies, the weakness of the evidence base severely hampers the development of policy and practice. Answers to even basic questions regarding throughput and output are not freely available and we simply do not know enough about which programmes work best for whom. However, there are opportunities within current programmes and data systems to answer these questions through a coordinated research and analysis programme, the findings of which should be widely disseminated.

We have read with interest calls for a body similar to NICE to work within the CJS to provide robust evidence about the efficacy different types of interventions. We support these calls but with the proviso that resources have to be identified to carry out the necessary independent research.

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[18] Wunderlitz J (2007) *Criminal justice responses to drug and drug-related offending: are they working?* Australian Institute of Criminology Technical and Background Paper No. 25 Canberra: Australian Institute of Criminology

[19] http://www.pewcenteronthestates.org/uploadedFiles/PSPP_HOPE_Brief_web.pdf?n=8765

[20] *Contingency Management for Treatment of Substance Abuse* in *Annual Review of Clinical Psychology*, Vol. 2: 411-434 (April 2006)