UKDPC

UK DRUG POLICY COMMISSION

A response to the Ministry of Justice Breaking the Cycle consultation

Briefing

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The UK Drug Policy Commission (UKDPC) is an independent body providing objective analysis of evidence related to UK drug policy. It aims to improve political, media and public understanding of drug policy issues and the options for achieving an effective, evidence-led response to the problems caused by illegal drugs.

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The UKDPC brings together senior figures from policing, public policy and the media along with leading experts from the drug treatment and medical research fields:

This response from the UK Drug Policy Commission (UKDPC) to the consultation *Breaking the Cycle* concentrates on those aspects relating to drug-related offenders. The UKDPC welcomes and broadly supports the general thrust of the proposals set out in the Green Paper and the conclusions reached relating to the importance of engaging drug-related offenders in treatment in order to improve longer term recovery and rehabilitation prospects.

As is noted, there is extensive evidence that many of the offenders processed through the criminal justice system have drug (and/or alcohol) dependency or addiction problems. Many have multiple underlying health problems, especially mental ill-health. Over the years, various attempts have been made, with varying degrees of impact, to channel such people into programmes which address the health and social problems and behaviours that underlie their offending.

Given the high prevalence of people with drug problems throughout the justice system, many of the wider proposals in the Green Paper will directly impact on them. However, since many other organisations such as the Prison Reform Trust, Rethinking Crime & Punishment, and the Howard League, will be submitting evidence on those, the UKDPC has limited this response to the proposals directly relating to tackling the 'drug-related' aspects of offending and rehabilitation.

DRUG-RELATED OFFENDING IN CONTEXT

The government's recently published drug strategy places considerable emphasis on improving recovery prospects for those entering and exiting drug treatment programmes.[1] 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. The solutions need to be holistic and centred around each individual, with the expectation that full recovery is possible and desirable."*

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 abuse addiction cannot be underestimated because it will help inform what is feasible and achievable through the criminal justice system.

In a recently published paper,[2] the Director of the US National Institute of Drug Abuse summarises the relevance of new knowledge emerging from the neurosciences:

"Addiction has a strong genetic component and both developmental stages (adolescents and young adults being at the highest risk for substance use

[1] *Drug Strategy 2010, Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*, HM Government
[2] Nora D. Volkow et al. *Addiction: Pulling at the Neural Threads of Social Behaviors* in Neuron, 69, February 24, 2011

dependency (SUD)) and environmental factors (e.g., exposure to stressful environments) play crucial roles in modulating the vulnerability for SUD in part through their influence on how the human brain works and responds and adapts to various types of stimuli (including drugs). Scientific insights into drug-induced impairments of specific brain circuits are beginning to answer many of the questions that had baffled us for so long, such as (1) why drugs can be so disruptive to social relationships, (2) why the social system used to deter behavior (e.g., the threats of incarceration or of loss of custody) does not work well in addicted subjects, (3) why social stressors (such as those that may be triggered by poverty) increase vulnerability for addictions….Ultimately, this leads to a cycle of drug abuse that is difficult to break free of, even when an addict may truly want to become drug-free, resulting in the typical pattern of drug relapse so often seen in addicted individuals…..Because the functions of these (brain) regions are also impaired in addicted individuals, this could explain an addict's inability to accurately steer their behaviors in appropriate directions despite having access to the required knowledge."

In looking at the implications for policy she concludes:

"Addiction involves persistent drug-induced adaptations in the brain systems responsible for controlling behaviors that are necessary for proper integration into complex social systems. Hence, therapeutic interventions should take this into consideration and create incentives for the substance abusers to engage and stay in treatment including strategies that help strengthen social ties with family and community. Social interactions are powerful re-inforcers that can provide the addicted individual with alternatives to help counteract the perceived high-reward value of drugs. An important consequence of the long-term brain adaptations is that most addicted patients will require a long period of treatment, during which relapse is likely to occur, which should be considered a predictable setback and not a failure of the treatment. This also explains why the best treatment outcomes are reported by programs that offer continuity of care for a 5-year period."

Clearly, this analysis and the drivers of social disadvantage, plus clear evidence of stigma towards recovering addicts[3] will have profound implications for the likely outcomes of sentencing policy; drug treatment programmes both in prison and the community; and rehabilitation efforts; as well as for payment by results initiatives.

We now turn to addressing the key Green Paper consultation questions of direct relevance to these issues.

[3] *Working Towards Recovery: Getting problem drug users into jobs*, UK Drug Policy Commission 2008; *Getting Serious About Stigma: the problem with stigmatising drug users*, UK Drug Policy Commission 2010

Q11. How can we use the pilot drug recovery wings to develop a better continuity of care between custody and the community?

The Green Paper states, *"We are committed to creating drug free environments in prison and we will therefore increase the number of drug free wings, where increased security measures prevent access to drugs."*[4]

The UKDPC is of the view that looking to achieve drug-free prisons remains a major challenge and probably an unachievable aim. As David Blakey pointed out in his 2008 review of disrupting the supply of drugs into prisons,[5] *"Prisons are villages of often well over 1,000 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".* The then government accepted the recommendations and they offer a practical set of actions which can disrupt the supply and reduce the pervasive impact of illicit drugs. More and better sharing of intelligence between prison and police is welcomed, as is the use of technology such as BOSS chairs and the ability to disrupt mobile phones.

The idea of drug-free wings is not new and has been tried before in Britain. Some of the prison-based Therapeutic Community (TC's) drug treatment programmes take place in what are effectively deemed to be 'drug-free' environments. There is some evidence to support TC's both in prisons and in the community (but not that they are necessarily 'better' or more cost-effective than other drug treatments). The evidence base for so called 'drug-free wings' is very limited. In our 2008 review of the evidence base for addressing drug-related offending, we found no evidence for the effectiveness of drug-free wings, or for other interventions such as CARATS[6]. That is not to say they do not 'work', rather that there has been no attempt at systematic evaluation of their impact. We support in principle the plan to pilot drug-recovery wings but stress these must be robustly and independently evaluated if any lessons are to be drawn about their impacts.

We must express strong concern, however, that the focus of the proposals regarding addressing drug problems in prisons appears to be limited to the introduction of drug-free/recovery wings. It is a basic tenet of prison health care policy that prisoners are entitled, broadly speaking, to the same standard of health care as those in the community. This means enabling those prisoners with opiate addiction problems to have access to (i) the full range of medically assisted treatments (MATs) including methadone and buprenorphine, and not just for detoxification purposes and (ii) a full range of public health measures designed to address the very real problem of blood-borne viruses amongst this vulnerable group of people.

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[4] *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders,* Ministry of Justice, Green Paper, Para 91

[5] D Blakey, *Disrupting the supply of illicit drugs into prisons*, Ministry of Justice http://www.justice.gov.uk/publications/docs/blakey-report-disrupting.pdf

[6] *Reducing Drug Use, Reducing Re-offending*. UK Drug Policy Commission, 2008

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, including recovery wings. These were set out in our 2008 review and include:

- Improving the process for identifying problem drug users on reception.
- The rolling out of the Integrated Drug Treatment System to all prisons.
- Ensuring all prison healthcare adheres to NICE and other clinical guidelines.
- Enhancing performance management and clinical governance of prison healthcare.
- The evaluation of the many programmes that have not yet been evaluated, with the results widely communicated.
- 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.

Many of these issues were also addressed by the Patel Review Group Report into prison drug treatment.[7]

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.

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. [8] While abstinence may be successfully achieved in a relatively short space of time in a constrained prison environment there may not be time for the treatment necessary to achieve sustainable recovery upon release. Thus for those with entrenched dependence on short sentences, 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. Therefore, it is essential that the pilots are targeted and properly evaluated.

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 piloted as the latter will only meet the needs of a small proportion of prisoners. The evidence base for methadone and buprenorhine medications, both inside and outside prison, is very strong. The criticism levelled at such proven interventions is misdirected. It is the

[7] *The Patel Review*, Prison Drug Treatment Strategy Review Group, Department of Health, 2010
[8] Farrell, M. and Marsden, J. (2007) 'Acute risk of drug-related death among newly released prisoners in England and Wales' *Addiction*, 103, 251–255

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.

Q12. What potential opportunities would a payment by results approach bring to supporting drug recovery for offenders?

In the light of the government's plans to introduce PbR to drug treatment and recovery services, the UKDPC recently held an expert seminar to look at the lessons of such systems as applied in health care, employment services and justice services, both domestically and internationally. This seminar involved the then US Deputy Drug Czar.

No one, internationally, has sought to or applied anything so radical as proposed for a drug recovery PbR system. Most models, including the widely reported one for drug treatment in the state of Delaware,[9] in fact involve payments for evidence-based activity with an additional payment for achieving quality standards. The current proposals for PbR for recovery envisage four outcome domains (criminality, employment, drug use and well-being) whereas most PbR systems have focused on one outcome domain and usually with one 'principal' funder or customer. The potential benefits are of course significant. But this must be tempered with the high risk of failure which has consequences not only for the organisations involved but also for the drug-dependent offenders involved. We do not think the potential risks have been adequately acknowledged.

The findings from the seminar conclude that there is wide support for a more outcome-based system of funding and purchasing services, and for a greater focus on recovery and social reintegration. The direction of travel is welcomed, but the devil is in the details. A cautious approach combined with thorough and robust independent evaluation is of particular importance given that the approach being taken to payment by results in recovery is going into uncharted territories and is effectively a social experiment with a particularly vulnerable group.[10]

In the report, UKDPC expresses several concerns about the introduction of PbR for drug treatment services, including:

- The planned timetable for PbR may result in changes being introduced before their consequences have been fully understood and the system can be properly developed. In other services, like other parts of healthcare, PbR has been introduced over a period of several years.
- The challenge of moving to a new system will be compounded by the fact that the introduction overlaps with radical wider health service reforms, a new system

[9] Mclellan, A.T. et al (2008) *Improving public addiction treatment through performance contracting: the Delaware experiment*, *Health Policy*. 87(3): 296–308
[10] *By their fruits: Applying payment by results to drug recovery,* UK Drug Policy Commission, 2011

of prison commissioning, the introduction of elected police commissioners, and restricted budgets for local councils.

- In basing PbR for drug recovery on outcomes across four very different areas – crime, employment, drug use, and wellbeing – there will be enormous practical challenges for those delivering services and for the management of the system. Many people using substance misuse services have complex and varying needs that are met by a wide range of providers; the new system will need to account for this in determining which providers are paid for a successful outcome.
- A key challenge will be to decide how the payments are triggered: there are no clear answers about what results are measured, what timescales are used, and how service users' own wishes are taken into account.
- A significant bureaucracy may be needed to manage the new system, prevent providers from neglecting those who have the most complex problems, and ensure that people are able to access the types of care that meet their particular needs. This has the potential to create additional costs that outweigh any savings made by introducing PbR.

One other major concern about the introduction of PbR systems across Whitehall is that the multiplicity of initiatives does not appear to be interlinked in any systematic way. We have PbR for alcohol treatments, general health and mental health care in the Department of Health; the Work Programme in DWP; PbR for reductions in re-offending in the Ministry of Justice and also, across Whitehall, for drug recovery. It is clear that many of the people such initiatives are designed to help will be found across all these silos. While these are only pilots at the moment, their longer term integration must be given priority to avoid duplication and overlap and hence potential confusion, otherwise the risk of gaming and duplication of incentive payments will increase.

Q13. How best can we support those in the community with a drug treatment need, using a graduated approach to the level of residential support, including a specific approach for women?

The Green Paper states "*that a range of treatment interventions will be required, varying in intensity depending on the assessed problems*". A range of high, medium and low level interventions is proposed.

As we stated earlier, the evidence suggests that most drug-related offending is non-violent, usually property theft and hence one would not expect custody to be the natural option. The only factor which increases this probability is that, because of the underlying addiction, those imprisoned especially for short sentences will be repeat offenders.

Unfortunately, there is no robust domestic or international evidence which points to residential treatment being more effective than other treatments, nor for which people it will be effective. We know that some types of drug residential treatment

can be successful in reducing drug use and offending. We also know that MAT programmes (methadone and buprenorphine) and psycho-social interventions also have proven effectiveness and cost benefits.[11] What remains unproven is the comparative effectiveness and value for money of the different interventions. What has been demonstrated is that when MATs are also accompanied by substantive support efforts to address work, accommodation and other social needs, outcomes improve.

We therefore conclude from this that it is not the modality of treatment that is the critical factor (i.e. whether the treatment is residential, MAT, or psycho-social) but rather the adequacy and depth of these other crucial recovery building-blocks. The value of many community-based residential treatment centres is that they combine psycho-social interventions with help finding work or training, a roof over one's head and improving family relationships. These are invaluable to long-term recovery. What we have not seen is a controlled trial looking at the relative cost-effectiveness of residential and non-residential provision where similar levels of support are available.

From this we conclude that whilst the principle of using residential provision as an alternative to prison might have some value, the efficacy of developing other enhanced community provisions must be explored. This will determine whether there is a need for substantive investment in building or opening new residential provision or whether scarce resources might be better spent enhancing the medium-level services envisaged, with some degree of control such as electronic monitoring. But later we also question whether some of those who might be involved in such provision should be there at all.

One further issue, which our scrutiny of evidence has explored, is the opportunity to improve compliance with community sentences in order to improve treatment outcomes. There is a small but emerging body of evidence which suggests 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.[12] We think this warrants the setting up of pilots which can be evaluated. Equally, the use of small incentives to help induce compliance in drug treatments (so called 'contingency management') which has been piloted here and elsewhere 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 sub-optimal.

There is one school of thought that argues for commissioning residential rehabilitation services at a national or regional level. We would caution against going down this road. As the PWC report into prison drug treatment concluded, the commissioning system, even as it existed then in 2008 was in need of integration,

[11] McSweeney T et al., *The treatment and supervision of drug-dependent offenders: A review of the literature*, UK Drug Policy Commission, 2008
[12] Hawken, A. and Kleiman, M., *Managing Drug Involved Probationers with Swift and Certain Sanctions: Evaluating Hawaii's HOPE.* Dec 2009. Submitted to the National Institute of Justice.

not more fragmentation.[13] Divorcing the commissioning of residential rehabilitation services from other local substance misuse treatment and recovery services is likely to lead to further fragmentation.

With regard to specific approaches to helping women drug-related offenders, we are concerned about the lack of appropriate provision for women with young children, some of whom will be caught up in sex-work and have been victims of current or earlier abuse. In such circumstances we consider the use of some form of graduated approach, with enhanced access to a genuine 'place of safety' such as offered by a residential treatment provider, could well prove valuable. In Scotland, the specialist 218 Centre was set up to help women offenders with substance misuse problems. This has been evaluated by the Scottish Government.[14]

Q17. What changes to the Rehabilitation of Offenders Act 1974 would best deliver the balance of rehabilitation and public protection?

The rehabilitation periods in the Act that are likely to apply to people with drug-related offending histories (usually non-violent) are over-long and do not serve the needs of society in encouraging offenders with drug problems to achieve recovery, lead law-abiding lives and become financially active citizens. They should be shortened. Research by the UKDPC complements that of other bodies, insofar as employers report considerable reluctance to employ people with a history of heroin or crack use.[15] We have also found considerable stigma directed towards people with drug problems which the ROA serves to reinforce.[16]

Q32. What are the best ways to simplify the sentencing framework? And,

Q36. Should we provide the courts with more flexibility in how they use suspended sentences, including by extending them to periods of longer than 12 months, and providing a choice about whether to use requirements?

The Green Paper is right to seek to simplify sentencing along with reducing inappropriate uses of custody. We would add to this the inappropriate use of community sentences in many of the cases where offences have been committed by those with drug dependency problems. In general we think some of the measures

[13] Price Waterhouse Coopers (2008) *Review of Prison-Based Drug Treatment Funding, Final , December 2007* Report to Department of Health and Ministry of Justice.
[14] Evaluation of the 218 Centre, *Scottish Government, 2006,* http://www.scotland.gov.uk/Publications/2006/04/24161157/2
[15] *Working Towards Recovery: Getting problem drug users into jobs*, UK Drug Policy Commission 2008
[16] *Getting Serious About Stigma: the problem with stigmatising drug users*, UK Drug Policy Commission 2010

proposed could reduce the use of custody and steer more people into treatment and longer term recovery.

However, we think the opportunity should not be overlooked to make a more fundamental examination of whether it is still appropriate to process large numbers of people with drug dependency and addiction problems through the criminal justice system and to apply the penalty of either imprisonment or a community sentence.

We are aware the Sentencing Advisory Panel looked at this issue shortly before its demise and that the Sentencing Council is currently reviewing sentences for drug offences. But this will only consider guidance in the light of the existing sentencing provisions as largely set out in the Misuse of Drugs Act. However it is not within the Sentencing Council's remit to examine the underpinning range of penalties as set out in the legislation. Clearly that is a parliamentary matter.

At the start of this submission we explored the issue of drug-related offending in the context of advancing knowledge about some of the causes and drivers of substance use addiction. We think it is now time for the government to consider substantially removing, reducing or replacing the criminal penalties both for (a) simple drug possession offences under the Misuse of Drugs Act and (b) for those drug-dependent offenders who commit non-violent offences. In practice, most simple possession cases do not end with a term of imprisonment and many of the short-term sentences are given to people who are prolific non-violent but drug-dependent offenders.

The United Nations Office for Drugs & Crime has recently published a discussion paper based on a scientific workshop looking at the issue of the use of the criminal justice system to address addiction problems.[17] It states, *"Following the provisions of the international drug control conventions, treatment, rehabilitation, social reintegration and aftercare should be considered as an alternative to criminal justice sanctions"*.

Over the last few years there have been various efforts by other countries, often with profound drug problems, to reframe their responses to drug problems, and especially drug-related crime committed by those with substance use dependency. A number of South American countries and some European countries have sought to remove, reduce or replace their traditional legislative provisions and range of penalties.[18] It should be noted, none of these amount to 'legalisation'. Rather, as our government and parliament has done, they have sought to introduce a more flexible range of responses. For example, in the UK since the Misuse of Drugs Act was passed, we have seen the introduction of cannabis warnings and fixed-penalty notices, the absence of the usual possession offences in regard to anabolic steroids, and the planned provision not to arrest or prosecute people for simple possession offences with new 'legal highs' under a temporary ban.[19]

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[17] *From coercion to cohesion: Treating drug dependence through health care, not punishment*. UNODC, 2010 http://www.unodc.org/docs/treatment/Coercion/Final_eBook_Sept_2010.pdf

[18] Hughes, C. E. and Stevens, A., *What can we learn from the Portuguese decriminilization of illicit drugs?*, British Journal of Criminology, 50, 999-1022

[19] *Police Reform & Social Responsibility Bill*, Home Office, 2010

Other countries have applied civil penalties for simple possession offences for a range of drugs, including heroin and cocaine. Others have chosen to use administrative discretion in the application of the criminal law, of which the Netherlands is the most widely known.

We acknowledge that 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 one thing is clear and that is, as various observers have argued, 'the roof hasn't fallen in on them yet'.

Such an approach has been suggested by the Government's own official drugs advisory body: "*there is an opportunity to be more creative in dealing with those who have committed an offence by possession of drugs. For people found to be in possession of drugs (any) for personal use (and involved in no other criminal offences), they should not be processed through the criminal justice system but instead be diverted into drug education/awareness courses (as can happen now with speeding motor car offenders) or possibly other, more creative civil punishments (e.g. loss of driving licence or passport).*"[20] This is, in effect, a call for depenalisation and/or decriminalisation for simple drug possession only.

At the heart of our concern is the need not simply to deliver sustainable justice for victims of crime, even if such victims are businesses rather than individuals. We also wish to see more concerted effort to prevent crime by addressing the underlying substance use dependency that drives some non-violent crime.

Sentencing fewer people to imprisonment is a necessary first step and one supported by evidence. But simply putting in place a community sentence, even if it is more constructive, misses the point about the emerging evidence of neuroscience about how the socio-biological nature of addiction will simply frustrate even the best efforts of the criminal justice system to help someone recover over the long term.

While we have sympathy with the aim to have more constructive community sentences, the reality is that treatment and especially sustainable recovery is a long-term process and ill-suited to the relatively shorter time spans of the CJS. We have to rethink our approach even to those people with drug use dependency problems who commit non-violent crimes. The evidence from the Drug Interventions Programme, Community Justice Centre, and Drug Courts, and more recently emerging lessons from the Integrated Offender Management system, hold out the prospect of potentially being able to divert more people away from imprisonment. The use of suspended sentences, perhaps for up to two years might help to some degree and we would wish to see their application even in cases of repeat property-related crimes, the ones most usually associated with drug-related offending.

[20] *ACMD Response to the drug strategy consultation*. Home Office, 2010 http://www.homeoffice.gov.uk/publications/drugs/acmd1/acmd-response-drug-strategy-2010?view=Binary

But a more radical step would be to consider, as happens in the US, deferment of prosecution and a 'slate wiped clean' if a perpetrator successfully goes through a treatment programme. Diverting people who have entrenched drug problems and commit offences, away from prosecution, 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, built upon a foundation of public health.