UKDPC

UK DRUG POLICY COMMISSION

Reducing Drug Use, Reducing Reoffending

Consultations with key stakeholders to inform the UK Drug Policy Commission report

Evidence Review
March 2008

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Published by:
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This publication is available online at www.ukdpc.org.uk/reports.shtml

ISBN: 978-1-906246-02-0

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.

UKDPC is a company limited by guarantee registered in England and Wales No. 5823583 and is a charity registered in England No. 1118203. The UKDPC is grateful to the Esmée Fairbairn Foundation for its support.

The findings in this paper reflect the many views of the wide range of people who participated in the consultation process and are not necessarily the views of the UK Drug Policy Commission.

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About the consultative process

As part of our assembly and analysis of the evidence, the UK Drug Policy Commission (UKDPC) conducted semi-structured group discussions with policy makers, practitioners and service users between October and November 2007. The aims were to get a 'reality check' on the Institute for Criminal Policy Research (ICPR) evidence review, improve our understanding of current practice and consider the implications for future policy and practice.

It is recognised that practice can vary significantly by region and this qualitative research was not designed to produce a representative picture of the UK. However, we believe that listening to policy makers, practitioners and service users has been an important and valuable part of our analysis of the evidence and the wider UKDPC engagement process.

The UKDPC would like to thank all of the people who participated in the group discussions, and in particular the following organisations for assisting in the set-up of the groups:

- Addaction
- RAPt
- Glasgow Addiction Services
- Nottinghamshire County DAAT
- Littledale Hall Therapeutic Community
- Adfam
- Clinks
- various UK government departments.

Methodology

In total, 12 policy makers, 29 practitioners and 18 service users participated in a total of six group discussions. Participants came from Glasgow, Edinburgh, Nottinghamshire, London, Bristol, Middlesbrough, Lancaster, Belfast and Hull.

The scope of the discussion was around the treatment and supervision of drug-dependent offenders in the UK. This included testing on arrest, required assessments, community orders with a Drug Rehabilitation Requirement (DRR), prolific and other priority offender (PPO) programmes, assessment and treatment in prison, and services addressing wider needs (often termed 'throughcare' and 'aftercare') – and their equivalents.

Recruitment was carried out via stakeholder networks, primarily at Drug Action Team level. To aid discussion through shared experiences, groups consisted of either colleagues at professional level or associates at service user level – and although everyone knew someone else in their group, most people did not know everyone. The maximum group size was 15 people (practitioners), and the minimum was 3 people (service users).

Policy makers from Scotland, Northern Ireland and England came together for one large group discussion, where a summary of our findings (evidence review and service user and practitioner feedback) formed the structure of the meeting.

Two practitioners groups involved professionals in the treatment and supervision of drug dependent offenders. This included police, arrest referral, courts, probation, prison, criminal justice integrated team (CJIT)/DRR and CARAT (counselling, assessment, referral, advice and throughcare) workers as well as treatment providers. They were given a short presentation which summarised the evidence review to initiate discussion.

There were three service user groups. The participants were all over 18 years old and included both males and females. They had a wide range of backgrounds and experiences in terms of both drug problems and contact with the criminal justice service and had recent (within past three years) experience of community orders with a DRR, custodial sentences or both. Some were currently engaging with DRRs and others were no longer in contact with the criminal justice system (CJS).

Overall findings

Identifying and assessing the needs of drug users within the criminal justice system

- **Overall, using the CJS to refer offenders to treatment was considered to be beneficial.**
- **There was no clear consensus about which groups of offenders should be prioritised for identification and assessment – but most felt some prioritising is necessary.**
- **'Net widening' was usually not rejected in principle, if resources allowed – although quality was seen as more important than quantity.**
- **Many felt the process of giving assessments could be more objective, and should actively involve the offender when considering care plan options.**
- **Although it should be standard practice, some service users felt they need more regular assessments to allow for responsive changes to care plans.**
- **If drug problems are identified in a pre-sentence report, they are not always addressed at the start of a prison sentence.**

Practitioners were generally positive about the enhanced role of the CJS to identify drug users and direct them into treatment. One practitioner said it proved that "if you do take the horse to water, sometimes it does drink". However, some policy makers felt that although treatment can impact on drug use and offending, it was less clear what added value the CJS element has delivered: would numbers in treatment have increased anyway as treatment provision expanded, and could alternatives such as outreach offer better value for money? An alternative view was that the money for treatment would just not have been available without the CJS focus. There was a wider debate about whether we have the right balance between the CJS and the health sector, and some practitioners questioned whether the CJS has a role at all if the primary aim is rehabilitation – court diversion schemes might be more appropriate. Scottish practitioners were also doubtful that England's greater CJS focus has resulted in better outcomes. However, the dominant view was that increased treatment provision through the CJS has been a positive step. Policy makers discussed whether the balance of community and custodial sentences is right, but highlighted that most Drug Interventions Programme (DIP) clients avoid prison and those serving short custodial sentences have often already breached community sentences.

Policy makers recognised that 'net widening' and targeting are key issues for the development of CJS interventions. With finite resources it is important to prioritise who should be screened for treatment referrals to achieve the best value for money, but it was not clear how to achieve this – for instance, is it better to intervene early or to target the most problematic users? Practitioners were generally supportive of 'widening the net' to include lower-level offenders and drugs other than heroin, crack and cocaine (e.g. methamphetamine), even if this means those being presented to treatment are likely to be less problematic users. The view widely held by practitioners was that anyone using drugs can benefit from treatment (which, for example, could take the form of a brief intervention). While this could put additional strain on already stretched resources (which raised the issue of capacity within local services to absorb additional demand), many practitioners felt uncomfortable about prioritising resources based on offending behaviour – creating a more or less 'deserving' population of problem drug users. If the assessment process could filter through those most likely to benefit from treatment and if treatment provision were available, then increasing the use of testing itself to encourage more problem drug users into treatment was not opposed in principle.

It was felt that people who could benefit from treatment are sometimes overlooked in the police custody suite due to the emphasis on 'trigger offences' and PPOs. Furthermore, it was said that there could be perverse incentives for pre-sentence report writers to screen out the more problematic drug users and not recommend them for community orders with a DRR to simplify their workloads. Practitioners also highlighted that not all drug problems identified in pre-trial assessment are routinely picked-up and dealt with if an offender received a prison sentence. Some service users had not had their drug problems identified across multiple prison sentences, or were not given access to services because they had initially given a negative drug test (although there may be many reasons for this, including time spent in remand custody).

Some practitioners felt that mandatory drug testing (MDT – currently operating in England and Wales) is largely for control and punishment purposes rather than for identifying and treating individual drug users, although we did have cases where a positive MDT had resulted in a needs assessment. Scottish practitioners did not feel they had lost anything when MDTs were abandoned: "I do not need MDTs to tell me that we've got a problem with drug use in our prisons".

Occasionally there is a problem of resources, with examples of waiting times of several weeks between assessment in police custody and treatment (although this was rare). However, even a short delay was felt to be a significant problem, as it was felt that you needed to seize the opportunity whilst the motivation was there, and even 24 hours' delay could be too late.

There was general acceptance that the assessment process could be better. Service users frequently reported that they did not feel properly involved in the assessment process. Some felt they are given treatment programmes without any serious consideration of their goals or any element of choice of available options: "It's someone else's decision about whether or not you are suitable for rehab". Practitioners felt that individual preference on behalf of the assessor can still affect the likely treatment given to offenders, and this is more evident in some regions than others. It is also still the case that restrictions on the availability of a range of treatment services could significantly constrain what is offered to clients – especially with residential rehabilitation. There are some cases where agencies duplicated effort by each assessing clients separately, and so better arrangements and protocols are needed for sharing information. However, service users called for frequent reassessments along the treatment path so that progress can be recognised and care plans adjusted accordingly. There was concern among service users that currently you could be maintained on a script and then forgotten unless you actively sought to change the situation yourself.

Treatment and supervision in the community

- **Most practitioners felt the use of testing should be limited to validating claims of abstinence and to check whether a client is using their substitute prescriptions and/or 'topping up'.**
- **Repeated failed drug tests should have clear consequences. The perception among both workers and users is that continuous positive tests do not constitute a breach.**
- **Consideration should also be made to focusing resources on those who are motivated to change and to 'rewarding' engagement by incentivising positive behaviour.**
- **Magistrates with knowledge of addictions and treatment availability are valued.**

Service users were generally positive about the use of Drug Treatment and Testing Orders and DRRs. Almost all service users felt that they gave their lives some structure, and for some the threat of breach and sanctions made a big difference to their motivation: "Truthfully, I wouldn't be here now if I didn't have to", admitted one offender on a DRR. Some even wanted more contact time imposed, and one participant claimed to have committed further crimes to get it (as they were not allowed to voluntarily increase their number of contact hours).

The level of 'coercion' is felt to be subtle – for instance, you must consent to a DRR to be on one – and that 'negative incentive' might be a more appropriate description. Practitioners and service users both said there were no real sanctions for testing positive to illegal drugs, only for missing appointments (failed drug tests do not automatically breach the terms of an order – this will be at the discretion of the offender manager). Service users called for boundaries to be set and a clearer threat

of jail for consistent positive tests, whilst recognising that some flexibility is needed for relapse. However, positive incentives or rewards were also considered to be effective. Some practitioners did not see such initiatives as a 'reward' as such, but rather a way of building relationships, reinforcing positive behaviour change and helping to integrate drug users into society. Policy makers referenced evidence, particularly from the USA, for contingency management and restorative justice.

One solution that was recommended which could provide more flexibility for a DRR was a 'tiered' approach to treatment provision. Minimum levels of engagement would be required to avoid breach, and enhanced provision would then be given to those who were fully engaging in treatment and who were motivated to change their behaviour (with every effort made to encourage this). This would help to focus resources on those people most likely to benefit from treatment and incentivise positive behaviour, and would also filter out the destabilising influence of those who were not fully engaged.

It was acknowledged that some offenders on a DRR do not make any effort to engage in services – they simply turn up when required, and go 'round and round' the system accruing multiple breaches. For practitioners, one of the main perceived benefits of drug courts is that magistrates become experienced at understanding when offenders are genuinely engaging in treatment, albeit with relapses. Multiple relapses should not necessarily result in revoking an order or preventing a new order from being given, but will require a flexible approach. This already happens in many cases.

There was also some criticism, both from practitioners and service users, about the 12-week target – where an intervention is considered 'successful' if the client is retained in treatment for a minimum of 12 weeks. It was felt that this target encourages some services and service users to 'play the system', and that it is wrong that "you can walk out after 12 weeks exactly the same as you walked in but it will be classed as a success". Furthermore, someone who fails to complete the 12 weeks might still get something out of it that could improve their chances of completion next time. It was also pointed out that the 12-week target applies to both intensive and non-intensive programmes and so the actual amount of contact time involved can vary dramatically.

Both practitioners and service users were not convinced of the benefit of the supervision element to a community order – and service users were frequently critical of probation officers. Offender managers were usually cited as the principal contact but it was felt they often fall short in this role, and there are clear examples where the relationship between the offender and the probation officer was not conducive to recovery (although there were also occasional examples to the contrary).

Practitioners agreed that testing does not improve clinical or therapeutic outcomes. Testing is expensive (in one case, testing kits are already being rationed) and in many cases it has no real purpose – it is not being used to monitor treatment progression and a positive result does not result in the breach of an order. It was felt that testing should be limited to validating claims of abstinence and to check whether substitute prescriptions are being taken and whether a client is 'topping up' (suggesting the prescription level may be too low). Although instances were highlighted where clients 'begged' for more testing so that they could remain motivated, it was also acknowledged that testing could be demotivating for those who had reduced but not stopped their drug use.

There was some concern surrounding the expanded role of methadone (and substitute prescribing generally) – that it is being used as a form of control or to meet government targets rather than to improve people's health. Some accepted that it has its place and is right for some people, but overall there is a need for the focus to shift towards 'moving people on'. This is related to the need for frequent reassessments and accompanying maintenance prescribing with other forms of help and support. It is also related to ensuring a tailored response to individual needs rather than adopting a one-size-fits-all approach.

Prison drug treatment

- **For many respondents their perception was that prison drug treatment provision is, at best, inadequate. Some practitioners felt the Integrated Drug Treatment System (IDTS) initiative may be addressing this where it is in operation.**
- **Many felt rehabilitation should be more of an integral part of the prison sentence (as with a DRR), and treatment requirements should influence the choice of prison (some prisons could become specialised in certain drug treatments).**
- **It was felt that drug-free wings may help to achieve abstinence if managed properly.**

The overall impression from the discussions was that prison treatment frequently falls well-short of the mark and does not compare to treatment provision in the community, although there are indications of improvements in recent years and notable exceptions. The problem is one of both quantity and quality. It was reported that prisoners had resorted to bringing their own drugs into prison to self-manage their detoxification rather than have to rely on prison services. Service users had some clear examples where they felt CARAT workers had helped them, although generally the view was that "they talk to you and that's it" and they are under considerable pressure to cope with demand.

Some practitioners in England had experience of IDTS, which aims to expand the quantity and quality of drug treatment within prisons. One practitioner said the programme has been very successful at reducing the number of positive MDTs and

improving behaviour of prisoners on one estate. They felt it was important that IDTS is provided in all prisons, and there was a general consensus that if prison treatment services were improved there would be a dramatic reduction in drug use.

Both practitioners and service users felt that treatment is not always considered a 'core function' of prison. It was suggested that treatment requirements could be addressed as part of the prison sentence, as happens with community orders with a DRR. In this way, the sentencer would have to ensure the prison is able to address the offender's drug rehabilitation requirements, and the prison service would have an explicit responsibility for rehabilitation. There was also a suggestion that the amount spent on reducing the supply of illegal drugs in prisons is small in comparison to other spends and that more could be done here.

Drug-free wings were not considered to be drug-free, although there is usually (but not necessarily) less drug use. There are various examples of how drug-using prisoners are able to cheat MDTs and provide negative tests to remain on the drug-free wing (with its associated privileges). However, both practitioners and service users felt that drug-free wings could work if they were properly 'policed', and that prisoners who wanted to get 'clean' would benefit from being separated from people who are still in the addiction cycle. Examples were given of genuinely drug-free wings (as far as this is ever possible) which are separated from the rest of the prison and are largely self-regulating.

Many service users saw prison as an opportunity to reduce their drug use or become drug-free, and some reported that they looked forward to that aspect of it. But for many, without appropriate treatment to change their behaviour, "the only thing that's changed is you don't have the substance in your system". Therefore, it was felt that detoxification in prison should be accompanied by rehabilitation to address the underlying behaviour – as happens with programmes such as RAPt (Rehabilitation of Addicted Prisoners Trust).

The problem of addressing the substance misuse needs of short-duration prisoners was raised frequently. A common view was that, in terms of rehabilitation, it is a waste of time sending people to prison for short periods, and that a community order would be more constructive instead. However, it was pointed out that short-duration programmes (SDPs) have been developed and are running in 42 local prisons. One service user said that they benefited from the information on treatment services which they were given during an SDP, which helped them later when they had the opportunity to engage in treatment. Another service user felt there is a real lack of information about the processes and options available, both within prison and on release, and that SDPs may have a role to play here.

Continuity of care and wider needs

- **Addressing the wider needs of drug users in treatment and recovery was seen as essential and an area that required more focus.**
- **Services could be commissioned to work on both sides of the prison wall, and/or modular care packages which can be part delivered in prison introduced for short-duration prisoners.**
- **Some service users and practitioners suggested greater use of licence for a DRR and to provide structure and access to services on release.**
- **In some cases there is a need to develop and follow protocols to deal with Friday, early and unanticipated releases.**
- **More should be done on release to support those who have achieved a reduction of, or abstinence from, drugs whilst in prison.**

Continuity of care, particularly from prison into the community, was still seen by all groups as a major problem that needs to be addressed. There were examples of DIP workers being notified of the release of a prisoner too late to make all of the necessary arrangements, or even after the prisoner has been released. As one service user said: "what goes on in jail, stays in jail". It was noted by all groups that the issue of drug-related deaths post-release is a serious one that needs to be addressed.

Often it is the small but important practical issues that undermine the process. It was accepted that the first few hours after release are crucial, and yet prisoners are still not being routinely met at the prison gate to ensure they are in contact with services. The problem of releasing prisoners on a Friday, when services are closing down for the weekend, was well known. Appointments are not always lined up in advance as some services will not accept appointments until after clients are released from prison.

One potential solution is to allow more treatment agencies to provide the same services, both in prisons and in the community, which would help facilitate continuity of both treatment programmes and providers. A modular approach to treatment was also suggested, where progress could be made both inside and outside of jail, and that the care plan should allow for transfer from prison into the community and vice versa.

It was felt that release from prison following a period of reduced drug use or abstinence is a real opportunity to assist recovery through a structured support programme aimed at developing coping strategies and addressing aftercare needs. Suggestions included more use of residential 'halfway houses' and supported housing and more constructive use of a licence on release to provide DRR-like access to services.

The wider needs of those in treatment or in recovery was frequently cited as an important area for improving return on investment in treatment by maximising recovery outcomes: "Having spent all this money on getting me clean you'd think they'd want to keep me that way". Wider needs include housing, employment, training and education, mental health needs, relationship problems and debt. Some service users felt that CJS workers are only interested in their drug use: "not the help I *really* needed". It was felt that community orders with a DRR could routinely include more requirements for training and employment as in most cases it is not (just) the drug use that is the problem ("for us, drug use is the solution!").

Addressing accommodation needs in particular was seen as crucial by all groups – in one example, housing support is integrated into the care plan as a 'tier 4' service. However, there are also examples of drug users in treatment and recovery being housed in temporary accommodation where drug use was rife, or having to sleep rough (particularly on release from prison).

Training and employment is seen as a problem area in that it is very difficult for ex-offenders to find work, which means it is more likely they will revert to illegitimate means of finding income. There are some examples of progress in this area – for example, employers were invited to a prison open day to foster links to employment – and the Offender Learning and Skills programme was seen as a step in the right direction.

A key issue for policy makers was that while it may be true that drug-using offenders are in particular need of such help and support, any suggestion of prioritising this group would be problematic: "you can't reward bad behaviour".

Structures and partnership working

- **Despite protocols, multi-agency partnerships frequently break down.**
- **There is a need for simpler structures and incentives for partnership working, particularly at the local level.**
- **It is often unclear who is the single lead agency or contact, and the National Offender Management Service (NOMS)/probation offender managers often do not provide this role.**
- **Some practitioners felt that drug courts could provide a unique focus for a 'one-stop shop' for service users to access a range of services.**
- **Policy makers were more cautious about 'one-stop shop' solutions, but recognised that better local partnership working was key.**

All groups recognised there are failures in structures and partnership working, which lead to problems with continuity of care and aftercare provision. It was generally agreed that multi-agency working is essential as no single agency has the 'answer', but it is not always clear who is responsible for what, and who has the lead/coordinating role. There is clearly an issue about who takes overall leadership responsibility, and who acts as the main day-to-day contact for service users. The system as a whole is generally recognised to be extremely complex, and service users felt they need more information about how it all works and what is available (this currently happens to some extent through informal peer networks).

There are numerous examples of breakdown in communication between agencies which caused problems for continuity of care or led to breaches (e.g. a service user was down for two appointments at the same time). There are also examples of duplication of effort. One practitioner gave the example of how DRR and CJIT caseloads are managed separately and felt this was not necessary. Competition for funding was cited as one reason why multi-agency communication is not always as good as it should be, as this could develop into a culture of secrecy.

When asking practitioners why some regions seem to work better than others, there was no simple answer. Some suggested that co-location is a practical step towards better multi-agency working – and that drug courts might provide a focus for a 'one-stop shop' for service users. Others pointed to individuals who value the importance of partnerships, and observed that things can quickly change when key personnel move on. There were also suggestions of joint targets, simplifying the number of initiatives and developing a simpler structure for funding – for example, a specific budget for aftercare, or a system where 'the money follows the person'. Between prison and probation, the issue was often that probation operates at a local level whereas prisons run at a national level. There were similar issues raised concerning the lack of jurisdiction for the National Treatment Agency and Healthcare Commission in prisons.

There was some debate among policy makers about whether 'new localism' (the devolution of power to Local Strategic Partnerships, Local Area Agreements, etc.) would exacerbate or help solve some of the problems of multi-agency working. Either way, it was felt that national institutions could only do so much to promote best practice, and that the solutions are likely to be local. Policy makers were more cautious about advocating 'one-stop shop' solutions but were clear that effective partnerships are needed.