UKDPC

UK DRUG POLICY COMMISSION

Reducing Drug Use, Reducing Reoffending

Are programmes for problem drug-using offenders in the UK supported by the evidence?

Policy Report
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Kings Place
90 York Way
London
N1 9AG

020 7812 3790
info@ukdpc.org.uk
www.ukdpc.org.uk

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The UK Drug Policy Commission (UKDPC)
11 Park Place
London
SW1A 1LP
Tel: +44 (0)20 7297 4750
Email: info@ukdpc.org.uk
Web: www.ukdpc.org.uk

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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:

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- RAPt
- Glasgow Addiction Services
- Nottinghamshire County DAAT
- Littledale Hall Therapeutic Community
- Adfam
- Clinks

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Summary

Over the past ten years, UK drug strategies have increasingly focused on providing treatment and support services for drug-dependent offenders – who commit a disproportionate number of acquisitive crimes (e.g. shoplifting and burglary) – as a way of reducing overall crime levels. This criminal justice focus has been reinforced in the recent 2008 UK drug strategy (new Welsh and Scottish drug strategies are also being developed). The UK Drug Policy Commission (UKDPC) has analysed the evidence for the effectiveness of these initiatives for reducing drug use and reoffending and of the wider impact of this more prominent criminal justice approach.

To inform our analysis we commissioned an independent review of the published evidence from leading researchers at the Institute for Criminal Policy Research (ICPR), King's College London. We also listened to policy experts, local commissioners, drug workers and current and ex-drug users. The papers from both of these pieces of work along with a copy of this report are available online at www.ukdpc.org.uk/reports.shtml.

What is the extent and nature of drug misuse among offenders and to what extent is this linked to crime?

- At least 1 in 8 arrestees (equivalent to about 125,000 people in England and Wales) are estimated to be problem heroin and/or crack users, compared with about 1 in 100 of the general population.
- 81% of arrestees who used heroin and/or crack at least once a week said they committed an acquisitive crime in the previous 12 months, compared with 30% of other arrestees.
  - 31% reported an average of at least one crime a day, compared with 3% of other arrestees.
- Between a third and a half of new receptions to prison are estimated to be problem drug users (equivalent to between 45,000 and 65,000 prisoners in England and Wales).
- Drug-related crime costs an estimated £13.5 billion in England and Wales alone.

Problem drug users are much more likely to be found within the criminal justice system (CJS) than within the wider population. There is also strong evidence that problematic use of some drugs, notably heroin and crack, can amplify offending behaviour, and there is a particularly strong association with acquisitive crime, such

as shoplifting and burglary. However, for most offenders who use drugs, whose drug use is less extensive, there is no direct causal link between drugs and crime. For example, most are not committing crimes to pay for their drugs.

Problem drug-using offenders have particularly high rates of offending, but they also have high rates of a range of other problems, such as homelessness, unemployment, low educational attainment and disrupted family background, which make the relationship between drugs and crime more complex and the task of rehabilitation more challenging.

What interventions are in place within the UK for problem drug-using offenders?

- The budget for adult drug interventions within the CJS was over £330 million in England and Wales in 2006/07.
- The Drug Interventions Programme (DIP) was established in April 2003, and by January 2008 over 3,750 offenders a month were entering treatment through the programme.
- The number of community sentences with a drug treatment element commenced in 2006/07 in England and Wales was 15,799; in Scotland there were 696 Drug Treatment and Testing Orders (DTTO) and 477 probation orders with a drug treatment element.
- Numbers on maintenance-prescribing or detoxification programmes in prison in England and Wales are up from under 14,000 in 1996/97 to over 51,500 in 2006/07.
- Investment in prison treatment in England and Wales has increased from £7 million in 1997/98 to £80 million in 2007/08.

There is now a wide and extremely complex range of interventions operating in different areas of the UK. Some of these interventions identify drug-misusing offenders and encourage them to engage with general community drug treatment and other support services, while others provide such services within a criminal justice setting. Some of the main types of provision are shown in the tables below, but the list is not exhaustive.

Main types of community-based provision

Type of provision	Numbers
England and Wales	
Testing to identify heroin, crack and cocaine users following arrest for particular, mainly acquisitive, crimes. **Mandatory assessments** following a positive test which may lead to a referral to drug treatment services. It is an offence to refuse the assessment but not the treatment. **Restrictions on Bail (RoB)** following a positive test allows for drug treatment to be a condition of court bail.	37% positive drug tests in 2006/07 39,903 entering treatment in 2006/07 via DIP
Conditional cautioning allows for a condition conducive to rehabilitation, which can include drug treatment, to be a condition of a police caution, with prosecution for the original offence possible if the offender does not comply.	Around 800 drug-related conditions between 2004 and 2007
Drug Treatment and Testing Orders (DTTOs) and now **Drug Rehabilitation Requirements (DRRs)** are community sentences which result in sanctions if the requirements are not met. The **Offender Substance Abuse Programme (OSAP)** and **Addressing Substance Related Offending (ASRO**) are accredited behaviour-change programmes, sometimes attached to community orders. **Drug courts** and similar community justice courts have been piloted. They build on DTTOs and DRRs by providing continuity of sentencer for the review process and use a problem-solving and inter-agency approach to help address the causes of offending.	15,799 DTTO/ DRR starts and 5,939 completions in 2006/07 2,943 ASRO and 928 OSAP in 2005
Scotland	
Diversion from prosecution with drug referral.	63 in 2006/07
Probation orders with drug-related condition.	477 in 2006/07
Drug Treatment and Testing Orders.	696 in 2006/07

Main types of prison-based provision

Type of provision	Numbers
England and Wales	
Detoxification for drug-dependent prisoners on reception. **Maintenance prescribing** is becoming increasingly used for short-term prisoners who were receiving this prior to imprisonment.	51,520 detoxification or maintenance prescribing in 2006/07
The **Integrated Drug Treatment System (IDTS)** aims to expand and improve drug treatment in prison through enhanced clinical services, psychosocial support and improved coordination and continuity of care.	In 2008, 29 prisons have a full IDTS and 24 have enhanced clinical services
CARAT (Counselling, Assessment, Referral, Advice and Throughcare) teams undertake assessments of need for drug services and provide one-to-one motivational support and group work for problem drug users. They also undertake a case management role facilitating access to a wider range of services, both in custody and upon initial release.	77,860 initial CARAT assessments in 2006/07
Drug-free wings and **voluntary testing programmes** aim to help prisoners remain abstinent from drugs while in prison.	
12-step treatment models such as those provided by RAPt (Rehabilitation of Addicted Prisoners Trust).	930 in 2006/07
Cognitive behavioural therapy (CBT) high intensity programmes (FOCUS or STOP).	360 in 2006/07
Short Duration Programmes (SDPs) are 4-week programmes based on CBT and a harm minimisation approach for short-term prisoners.	5,760 in 2006/07
P-ASRO (Prison – Addressing Substance Related Offending) is an offending behaviour programme of low to medium intensity.	3,780 in 2006/07
Therapeutic communities provide treatment based on a social-learning approach and peer support.	300 in 2006/07

Type of provision *(continued)*	Numbers *(continued)*
Scotland	
The **Enhanced Addictions Casework Service (EACS)** provides a similar role to CARAT teams, including addictions assessments and motivational support sessions.	4,051 assessments and 12,298 support sessions in 2006/07
Methadone prescribing.	1,228 (census on 08/12/2006)

What is the evidence for the effectiveness of these approaches?

- CJS staff were involved in referring over a third (35%) of those starting a new episode of drug treatment in England.
- 6 months after being in contact with the DIP, around half (47%) of offenders reduced their offending; 28% showed increased offending.
- The proportion of offenders in England and Wales who successfully complete a DRR/DTTO has risen from 28% of those who started in 2003 to 44% in 2006/07. In Scotland the completion rate is between 38% and 40%.
- Those who complete an order have lower reconviction rates (53%) than those who do not (91%).
- It is estimated that 1 in every 200 injecting heroin users may die within 2 weeks of leaving prison due to overdose.

There is strong evidence that drug treatment can reduce drug use and reoffending for some individuals, and several studies have demonstrated that CJS referrals to treatment can be at least as effective as non-CJS 'voluntary' referrals.

However, we cannot say what the overall impact of CJS interventions has been as we do not know the extent to which drug-using offenders would have accessed treatment in other ways. There is also no evidence that allows reliable comparisons of the effectiveness or value for money of different interventions or identifies those offenders that would benefit most from different programmes. Nevertheless, this review indicates 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 published 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.

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.

It should also be noted that much of the evidence on the effectiveness of recent British initiatives was gathered during the piloting process or the early stages of implementation. Clearly, their long-term viability will need to be judged on the outcomes that are achieved once they have become more established and have had the opportunity to learn from experience.

Key conclusions arising from the thematic review

It is clear from this review that in many areas the evidence about the effectiveness of different interventions is seriously weak or absent. However, by considering the evidence that is available, we believe it points to the following as key issues for policy and practice development.

1. The principle of using CJS-based interventions to encourage engagement with treatment is supported by the evidence.

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 and CJS treatment referrals in the UK do not, as yet, appear to have had a negative impact on 'voluntary' treatment capacity. However, if priority access is given to offenders (as is suggested under the 2008 UK drug strategy) and overall treatment capacity is not sufficient to meet demand or need, there is some concern that a two-tier system might develop, in which those seeking help voluntarily find it difficult to access treatment.

2. Following a period of expansion and a focus on quantity, attention should now focus on quality.

Following a period of expansion of both the range of interventions available and the numbers being engaged in them there are now many options available for addressing the needs of problem drug-using offenders. However, there appears to be considerable variation in provision between areas and there is now a need for consolidation to focus on improving the quality of provision and outcomes:

- There is a need for a wider range of services to meet the differing needs of individual drug-using offenders, for example more services specifically for stimulant users.
- There is a need to improve the assessments of problem drug users in order to match them to appropriate treatments, with regular reviews and reassessments.
- Greater provision of services to promote reintegration (e.g. housing, education and employment) is required, in order to improve long-term outcomes.
- A focus on the impact on outcomes of delivery issues, such as staff skills, morale and management, is necessary to improve consistency of service quality.
- The multiplicity of programmes, funding streams and commissioning processes hampers the delivery of care packages that address the wide range of needs of problem drug-using offenders. Attention now should focus on developing simplified and integrated commissioning, funding and management systems.
- Attention should be paid to improving supervision and monitoring practice; including clarifying the role of supervision and considering the potential for greater use of positive incentive-based strategies to secure compliance (contingency management) rather than the current punishment-orientated focus.
- Interventions that adopt a holistic, problem-solving approach are likely to be most successful. Drug courts, for instance, are supported by a good international evidence base. However, their effectiveness in the UK context needs to be proven and ways found to apply the underlying principles more widely and in a cost-effective manner.

3. Net-widening to include additional groups of drug-using offenders in CJS-based interventions may have negative consequences.

While a focus within the CJS on offenders whose crimes are linked to drug use is appropriate, current evidence suggests that net-widening to include less problematic drug users is likely to be inefficient and could be harmful.

Current Home Office guidance states that the principle should be: “drug-related crime should be dealt with by drug-related punishment”. 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 associated with, for example, a DTTO/DRR, leading to the further criminalisation of these, mainly younger, drug users.

Furthermore, extending the use of drug testing in police custody suites by expanding the range of trigger offences or testing for a wider range of drugs is likely to suffer from diminishing returns (greater costs for every additional drug user identified) and the identification of more recreational drug users, which might have a negative impact on the quality of subsequent assessments and interventions.

Instead of including less problematic drug users within the community sentence or prison interventions, schemes that divert drug-using offenders in the early stages of their offending and problem drug-using careers from prosecution on condition that they address their substance use and other problems may merit expansion.

4. Community punishments are likely to be more appropriate than imprisonment for most problem drug-using offenders.

Imprisonment can have unintended 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.

An environment which is struggling to cope with record numbers of prisoners is unlikely to be conducive to recovery, and custodial sentences may frequently do more harm than good. By creating or exacerbating problems such as housing, employment and family relationships and increasing health risks such as infection from blood-borne viruses, the chances of successful long-term outcomes are further reduced. Enforced detoxification without adequate follow-up support also increases the risk of relapse, overdose and death, particularly on release.

Maximising the use and effectiveness of community sentences is likely to be more beneficial than imprisonment of problem drug-using offenders for less serious acquisitive crimes and drug possession offences. Community sentences have the potential to offer better value for money and deliver similar reductions in reoffending.

5. Prison drug services frequently fall short of even minimum standards.

With so many drug-dependent offenders within the prison system it is essential that the extent and effectiveness of drug treatment and other interventions is improved so that prison care is equivalent to that found in the community. Despite difficult conditions caused by overcrowding and short-term sentences, the efforts of governors, prison and healthcare staff have delivered some notable improvements and the numbers being detoxified in custody are significant. However, this is often not matched by sufficient support and aftercare and many prisoners are not getting the help they need. This will lead to an increased risk of relapse and overdose, particularly on release into the community. Key areas to address are:

- 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.

6. Given the sizeable investment in CJS interventions for drug-dependent offenders, we know remarkably little about what works and for whom.

Despite the considerable focus and investment on CJS interventions within UK drug strategies, the weakness of the evidence base severely hampers the development of policy and practice in this area. 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.

In particular, we consider the following specific areas should be given priority in any such programme:

- Research into the assessment and matching of interventions to individuals, and the development of a typology of drug-using offenders to assist this.
- Independent evaluation of the Drug Interventions Programme and interventions not yet evaluated, particularly conditional cautions, diversion from prosecution schemes and prison interventions.
- Production and publication of data, including outcome measures, for drug interventions.
- Comparative evaluation of DTTOs/DRRs and drug courts.
- Consideration of the impact of interventions on women and Black and minority ethnic groups.
- An assessment of the process and outcomes for drug-dependent offenders discharged from prison and the identification of good practice.
- Comparative study of the costs and benefits of community and prison sentences for drug-dependent offenders.

1. About this review

Background: A criminal justice approach within UK drug strategies

The ten-year UK drug strategy that ran from 1998 to 2008 had an increasingly strong focus on directing problem drug-using offenders into treatment via the criminal justice system (CJS) as a means of reducing community harms arising from drug-related crime and disorder. The Drug Interventions Programme (DIP), which uses a wide range of community- and prison-based measures to identify problem drug-using offenders and provide them with treatment and support services, has expanded greatly since 2002. The UK government has recently launched a new drug strategy, *Drugs: protecting families and communities*, to run for ten years from April 2008 (Wales and Scotland are also developing new strategies), in which the focus on reducing drug-related crime through the CJS has been reinforced.

In Scotland the current strategy, *Tackling Drugs in Scotland: Action in Partnership*, has less of a criminal justice focus, but a number of similar provisions are available. In Northern Ireland the prevalence of problem drug use is lower, and this is reflected by fewer programmes running within their CJS. However, there are some indications that drug problems may be increasing, and their strategy, *New Strategic Direction for Alcohol and Drugs 2006–2011*, contains a commitment to consider the impact of arrest referral schemes and to assess the need for extending the number of schemes and the use of Drug Treatment and Testing Orders.

Since 1998, there has been a significant increase of the resources available for drug treatment throughout the UK, a major growth in the number of people getting assistance for their drug problem and expansion of treatment intervention services both in the community and throughout the CJS. However, the new UK strategy and associated three-year action plan contains a number of new initiatives and priorities, such as interventions to support families of drug users. Therefore, there will be many competing demands for the resources available and it is vital that the programmes adopted are effective and deliver value for money. In addition, although the area has been the subject of a number of systematic reviews, there is still considerable debate about the appropriateness of using the CJS to encourage drug users into treatment. Some commentators argue that 'skewing' the drug treatment system to help offenders distorts priorities and needs. Others argue it further criminalises a group of people already experiencing significant problems. However, we also recognise that problem drug use and related offending causes

many individual and community harms. Therefore, the UK Drug Policy Commission identified the interventions for adult problem drug-using offenders as a key area for early review in its three-year work programme.

Aim and scope of this review

The aim of this review is to consider the evidence underpinning the interventions that make up this important plank of the UK strategies and to identify the key issues and policy implications arising from this, to inform development of both policy and practice and to encourage informed debate about the issues. The review addresses the following key questions:

- What is the extent and nature of problem drug use among offenders and to what extent is this associated with crime and disorder? (Section 2)
- What interventions are in place within the UK for problem drug-using offenders? (Section 3)
- What is the evidence for the effectiveness of these approaches and what are the key factors that impact on effectiveness? (Section 4)
- What are the implications of this evidence for policy and practice? (Section 5)

The review has involved three stages:

1. A review of the published (English language) literature was commissioned from the Institute for Criminal Policy Research at King's College London.[1] This addressed the questions outlined above and looked at the evidence of effectiveness of programmes in terms of either reductions in crime or reductions in drug use.
2. Consultative group discussions were held across the UK. The groups included users, practitioners and policy makers, who were asked to reflect on the evidence and the issues associated with these programmes from their differing perspectives. More details are available in the accompanying report of the key issues they raised.[2]
3. The key points from the first two stages were pulled together along with information from other published sources to produce this overall review.

The scope of this report is interventions aimed at adult problem drug-using offenders in the UK (principally Scotland, Wales and England due to the lower levels of problem drug use in Northern Ireland, which means that interventions are more limited in both number and scope). The term 'problem drug use' is imprecise, but in the context of this report we are using it to mean drug use whose features include dependence, regular excessive use and serious health and social consequences. It will typically involve the use of opiates, particularly heroin, and stimulants, particularly crack cocaine, often as part of a pattern of polydrug use. A high proportion of problem drug users will be dependent on drugs, but the group will also include some frequent

drug users who may not meet all the criteria for a diagnosis of dependence. While interventions for this group of problem drug-using offenders are the main focus of this report, in practice it is not always possible to separate these from early interventions aimed at preventing the development of more severe use. Reflecting current policy, the focus is on those illegal drugs most strongly linked to drug-related crime (principally heroin, crack and cocaine), although we recognise the overlaps and compounding factor of alcohol misuse and of mental health problems.

The two background papers that support this report are available on our website (www.ukdpc.org.uk). This report draws heavily on those papers and, unless otherwise indicated, the evidence referred to in this report can be found within them, together with references to the original data sources (in the case of the review paper).

2. What is the extent and nature of drug use among offenders and to what extent is this linked to crime?

Drug use is widespread among offenders in the criminal justice system

We know that offenders tend to have much higher rates of drug use than the general population. Table 1 compares drug use prevalence in the household population in England and Wales with offenders at different stages in the CJS. A similar picture can be seen in Scotland where, in the household population aged 16 to 59, 13% had used any illicit drug and 0.5% had used heroin in the past year, according to the 2006 Scottish Crime and Victimisation Survey.[3] By comparison, the 2006 Scottish Prisoner Survey found that 67% of prisoners reported having used illicit drugs in the year before coming to prison and about half of these (52%, which is about one-third of all prisoners) said they had used heroin in that period.[4]

*Table 1: Comparison of drug use prevalence in the general household and offending populations in England and Wales***

Survey	Population covered	Percentage reporting use in the past year			
		Any drug	Heroin	Crack	Cocaine
British Crime Survey 2005/06	Household population aged 16 to 59	10	0*	0*	2
Arrestee Survey 2005/06	Arrestees aged 17+	59	15	15	23
Community Penalties Criminality Survey 2002	Community sentence starters aged 16+	61	22	19	18
Prisoner Criminality Survey 2000	New male prison entrants aged 16+	73	31	31	32

*0 = less than 0.5%

** It should be noted that drug use has declined in recent years in both the household and the arrestee populations so care needs to be taken in comparing these surveys with the older surveys of offenders within the CJS.

In addition, drug users in the offender population have far more extensive drug problems than in the population as a whole:

- In England, it was estimated that, in 2005/06, 1% of people aged 15 to 64 years were problem opiate and/or crack users; in Scotland, 1.8% of people aged 15 to 54 were estimated to be problem opiate or benzodiazepine users in 2003; while in Northern Ireland it was estimated that 0.3% of the population aged 15 to 64 were problem opiate or cocaine users (including powder cocaine) in 2004.[5]
- In comparison, the Arrestee Survey 2005/06 indicated that about 13% of arrestees in England and Wales were dependent on heroin (85% of the 15% of all arrestees who had used heroin in the past year), about 8% were dependent on crack and 5% on cocaine powder, while 13% reported they had injected drugs at some time.[6]
- Thus at least 1 in 8 arrestees (equivalent to about 125,000 people in England) are estimated to be problem heroin and/or crack users compared with about 1 in 100 of the general population.
- In the Criminality Surveys (conducted in England and Wales in 2000 and 2002), 39% of male prisoners said they had experienced a problem staying off drugs in the year prior to interview and 23% said they had injected drugs in that time; men serving sentences in the community were slightly less likely to report problems, 27% reported experiencing a problem staying off drugs and 17% that they had injected in the previous 12 months.[7]
- The Scottish Prison Survey for 2006 found that almost half of prisoners (44%) reported that their drug use was a problem for them on the outside.[8]
- Therefore, between one-third and a half of new receptions to prison are estimated to be problem drug users (equivalent to between 45,000 and 65,000 prisoners in England and Wales).
- There are also very high rates of polydrug use within the offending population – for example, the Prisoner Criminality Survey found that 58% of new male entrants to prison had used two or more different drug types in the previous year, while the Community Penalties Criminality Survey found that 40% of people starting community sentences had done so.

Problem drug-using offenders have particularly complex and wide-ranging problems

Problem drug-using offenders are a group with particularly complex and intractable problems, which means they will be more challenging to treat, rehabilitate and reintegrate into society. For example, the 2005/06 Arrestee Survey 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 recent report from the Drug Treatment Outcomes Research Study (DTORS) confirms this, showing that those entering drug treatment via the CJS are more likely than other treatment entrants to have unstable accommodation arrangements, to be unemployed and have low educational attainment.[9] For example, it showed that 6% of referrals from the CJS were in education, employment or training compared with 14% of those with other sources of referral. Also almost half of CJS referrals had been in unstable accommodation for some of the four weeks prior to treatment entry compared with just over a third of those with other referral sources. 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 reintegration more difficult.

Problem drug-using offenders are also very likely to experience other mental health problems – 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 were assessed as having three or more additional mental problems.[10]

Women have different patterns of drug use to men

Although women make up a comparatively small proportion of the population within the CJS, the rate of increase in the female prison population in recent years has been greater than for men. In the general population, the prevalence of drug use is considerably lower among women than among men, but the picture is different among those within the CJS (Table 2). The Arrestee Survey shows that female arrestees are less likely to have used cannabis, powder cocaine and ecstasy in the past month than their male counterparts but more likely to have taken crack and are more likely to have used heroin.[11] Similar patterns are evident when use in the past year is considered among offenders at different stages in the CJS. The evidence also shows that the prevalence of problem drug use among women, particularly younger women, within the CJS is greater than among men, with female arrestees being more likely than male arrestees to report using heroin and crack at least five times a week.

Table 2: Comparison of drug use prevalence among men and women in the general household and offending populations in England and Wales

Survey	Population covered		Percentage reporting use in the past year			
			Any drug	Heroin	Crack	Cocaine
British Crime Survey 2005/06	Household population aged 16 to 59	Men	13	0	0	4
		Women	7	0	0	2
Arrestee Survey 2005/06	Arrestees aged 17+	Men	60	15	15	25
		Women	51	18	19	16
Community Penalties Criminality Survey 2002	Community sentence starters aged 16+	Men	63	22	19	19
		Women	50	22	16	16
Psychiatric morbidity among prisoners survey 1997	Sentenced prisoners aged 16 to 64	Men	66	21	18	20
		Women	55	26	20	11

Drug use and Black and minority ethnic groups

The disproportionate representation of Black and minority ethnic (BME) groups throughout the CJS is well documented. According to Home Office data on race and the CJS, Black people were six times more likely to be stopped and searched under PACE (Police and Criminal Evidence Act) provisions than White people and Asians were twice as likely. The most frequent reason for conducting a stop and search under these powers across all ethnic groups was drugs. Additionally, in mid-2005, BME groups accounted for about 24% of the male prison population, a figure disproportionate to their numbers in the general population. In fact, for those sentenced at the Crown Court, both for drug offences and some other probable drug-related offences (e.g. fraud and forgery), Black offenders are more likely to be given an immediate custodial sentence.[12]

However, a range of studies have found that, among those within the CJS, patterns of drug use vary between different ethnic groups and drug use is less prevalent among some BME groups than among their White counterparts. For example, the Arrestee Survey showed that arrestees who had taken heroin, crack or cocaine (the drugs tested for in the DIP) within the previous 12 months are more likely to be White and less likely to be Black or Asian than other arrestees.[13] Similarly, surveys of prisoners show that the prevalence of drug dependence prior to imprisonment is higher among White prisoners than BME groups[14] and that the pattern of drug use

varies, with Black prisoners showing similar levels of use and dependence on cannabis and crack to White prisoners but lower use of other drugs, particularly heroin. Also, prisoners of South Asian origin tend to report lower rates of drug use than either White or Black prisoners.[15] However, it should be noted that BME groups are not homogeneous, and the sample size in most studies is too small to allow separate identification of many groups who might have quite distinct drug use patterns.

All this points to a need to know much more about how BME, and indeed newly arrived communities', offending and drug misuse behaviour may be linked, how it is dealt with through the CJS and the implications of different patterns of use for drug interventions.

Problem drug users often 'cycle' through treatment

As drug dependency and addiction has been acknowledged to be a chronic relapsing condition and many offenders have been drug-dependent for many years, some of those entering the CJS will have already been referred to treatment or have accessed treatment voluntarily 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.

The relationship between drug use and crime – a reality check

There is debate about exactly how much crime is drug-related[16] and, more particularly, drug-driven – most problem drug-using offenders have a raft of problems, including social deprivation, and many will have committed crimes before they became drug-dependent. There are also problem drug-using individuals who do *not* commit crime to fund their habits. However, there is strong evidence that there is some relationship between drugs and crime, with dependence on some types of drugs amplifying offending behaviour in some people.[17]

In the UK, acquisitive offending is currently mainly linked to problematic heroin and crack use. For example, in the Arrestee Survey 2005/06:

- 81% of arrestees who reported taking heroin and crack at least once a week reported committing an acquisitive crime in the previous 12 months (compared with 30% of other arrestees);
- 31% reported committing an average of at least one acquisitive crime a day (for other arrestees the equivalent figure was 3%);

- about two-thirds (64%) of arrestees who used heroin and crack at least once a week said they had committed a crime to get drugs in the previous 12 months and over half (58%) that they had offended while high on drugs (for other arrestees the equivalent figures were only 5% and 8% respectively).

Nevertheless, as can be seen from the diagram below, while about 3 in 5 offenders (59%) report drug use of some kind, fewer than a quarter of these report heroin and crack use (about 22% of drug-using arrestees, 13% of all arrestees). Therefore, the majority of drug-using offenders have less problematic drug use patterns and, since only about 5% of arrestees who did not report problematic drug use reported a link between their drug use and offending, it would appear that their offending is not generally associated with their drug use.

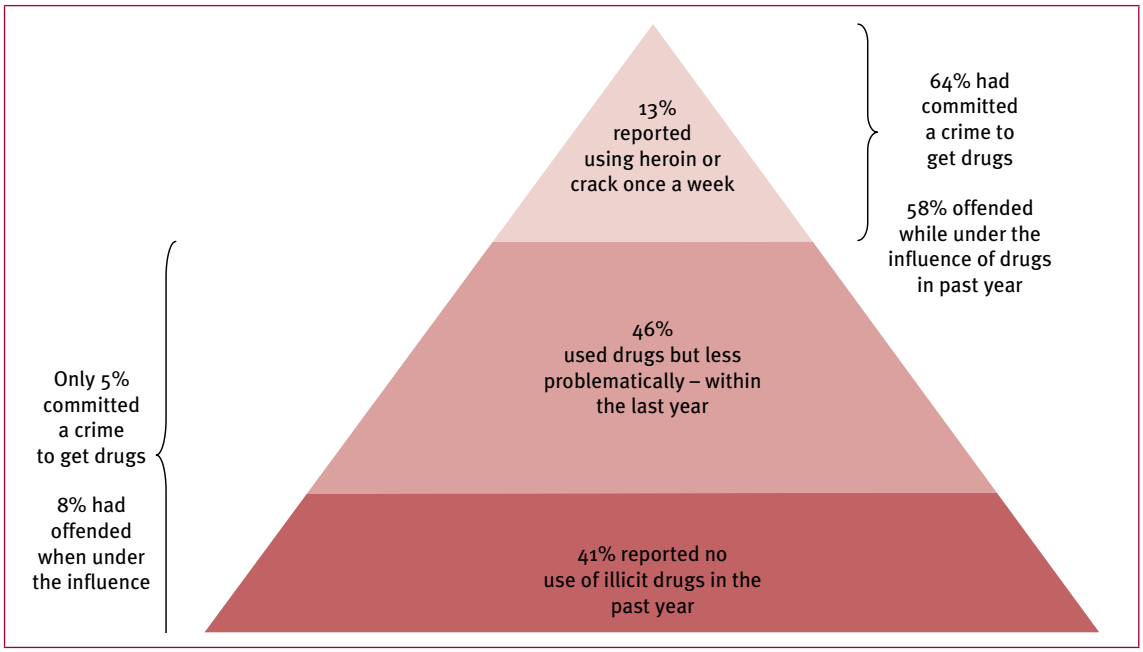


Figure 1: Drug use and its relationship to offending among arrestees

Source: Arrestee Survey 2005/06

We have focused here on drug-related acquisitive crime, as this is also the focus of the interventions we discuss in subsequent sections. However, in addition to this acquisitive offending, violent crime and disorder may occur when people are under the influence of drugs, and violence can also be associated with the operation of drug markets. With respect to lower level violent crime and disorder, the Arrestee Survey shows that problem drug users are less likely to be arrested for these offences than other arrestees. For example, while frequent heroin and crack users made up 13% of all arrestees in the 2005/06 survey, they made up only 4%

of those arrested for assault and only 1% of those arrested for criminal damage.[18] Such offending is strongly linked to alcohol use, but may also be exacerbated by recreational use of drugs such as cocaine. Problem drug-using offenders may often act as street-level dealers in order to fund their drug habit and in this role may be involved in some of the violence associated with markets, as victims as well as perpetrators. Treatment has been shown to reduce their involvement in drug dealing along with other acquisitive offending. However, organised crime gangs are responsible for most of the violence associated with drug markets and they will not usually be problem drug users, so the main aim of the interventions to get problem drug users into treatment is the reduction of drug-related acquisitive crime.

Drug use, and in particular problematic drug use, causes extensive harm to individuals and communities. It has been estimated that in 2003/04 the economic and social costs associated with Class A drug use in England and Wales were about £15 billion, with drug-related crime responsible for 90% (£13.5 billion) of this.[19] Overall, problem heroin and crack use accounted for 99% of the total costs.

Segmentation of drug-using offenders

It is important to distinguish between the different groups of drug-using offenders as different interventions will be appropriate for them. There is no agreed typology of drug-using offenders, although a distinction is often made between recreational and problem users. However, there may also be important distinctions to be made within those broad categories. The guidance on conditional cautioning identifies four target groups of adults: recreational drug users (drug possession their only offending); those whose drug use is becoming problematic (their drug use is beginning to cause them problems and may contribute to disorder and some minor offending); offenders who also use drugs (low-level offenders who also use drugs); those who have begun offending to fund their drug habit (early problem users). In addition to these groups there are those offenders with the most severe drug use problems (mainly frequent heroin and crack users) described earlier. Other research has suggested a simple distinction between drug-using offenders who are primarily drug users who offend, mainly to obtain drugs, and those who are primarily offenders who happen to also use drugs.[20] Other factors that might also have an impact on the type of intervention likely to be effective are the individual's stage in their drug-using or offending career, their level of motivation to change and the complexity of their drug use and other social problems.

For the purposes of this report we will refer to four broad groups of drug-using offenders (although it should be noted that this is not based on empirical evidence and research is needed to produce an evidence-based typology to assist in assessment of offenders and the targeting of interventions):

1. Recreational drug users (this covers the first and third of the groups identified as appropriate for conditional cautioning) who use cannabis and drugs such as ecstasy and cocaine but are not dependent on them and their use is not related to their offending (other than drug possession).
2. Problem recreational users (the second group identified in the conditional cautioning guidance) whose use of drugs may be getting out of control and, particularly in association with alcohol, may contribute to disorder and minor offending.
3. Early-stage dependent drug users (the fourth group described above) who are in the early stages of dependency, mainly on crack and/or heroin but also other drugs, and who are beginning to commit acquisitive crimes to fund their drug use.
4. Severely problematic drug users (mainly heroin and crack users) who have an established drug dependency and a history of extensive acquisitive offending to fund their habit as well as a raft of social problems as described earlier in this section.

In summary, three things become clear from the evidence presented in this section:

- A significant proportion of known offenders are problem drug users whose continued drug use, coupled with their many other social problems, causes extensive harm both to the wider community and to themselves.
- The CJS may provide an important opportunity and vehicle through which to address their drug misuse and other factors which underpin their offending behaviour through access to treatment and other interventions.
- However, not all drug use among offenders is necessarily directly associated with offending. For a considerable proportion of offenders it is just part of a way of life which includes both drug use and offending and reducing their drug use is unlikely to lead to reductions in their offending.

3. What interventions are in place within the UK for problem drug-using offenders?

Under the previous drug strategies there has been considerable growth in the range of interventions targeting problem drug-using offenders, and this is likely to continue. The recently published UK Government drug strategy indicates an intention to build on "successes and our knowledge of what works" through proactively targeting and managing drug-misusing offenders and maximising the effectiveness of prison and community sentences.[21]

The overall investment in drug interventions for offenders whose drug use is problematic is now significant. For example, the budget for specific drug interventions within the adult CJS in England and Wales in 2006/07 was over £330 million,[22] with the DIP receiving over half of this (Figure 2). These figures do not include funding for drug treatment services provided through the pooled treatment budget (which for all treatment was £385 million in 2006/07) or local arrangements (about £200 million annually).[23] Problem drug-using offenders may also access generic services, for example offender resettlement programmes, which are not included in the above.

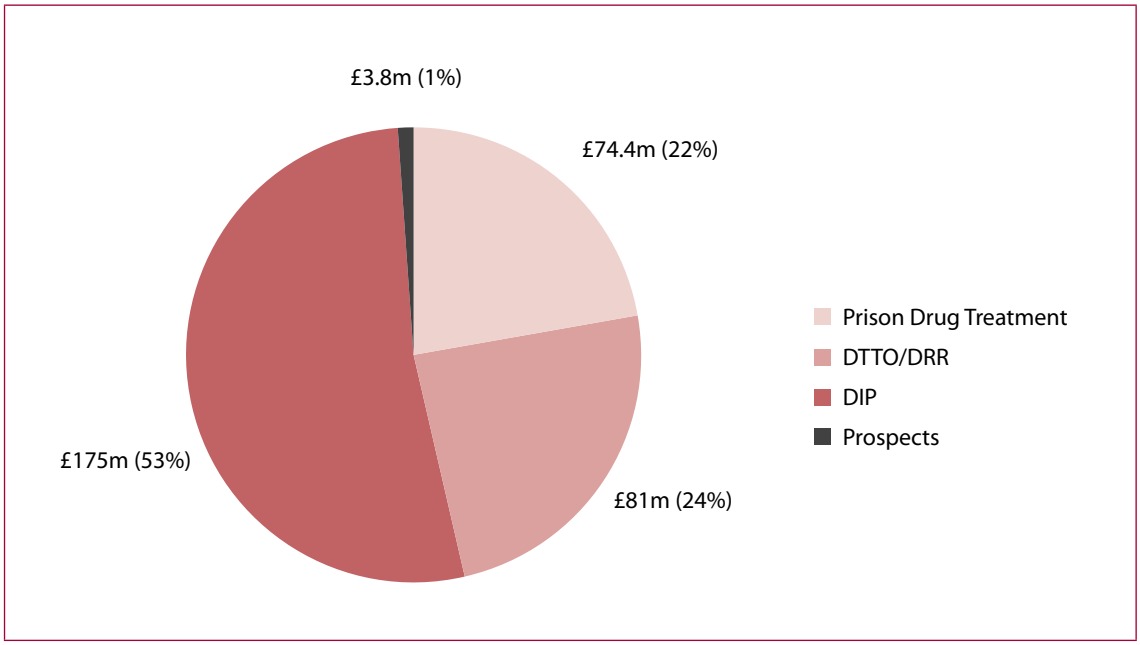


Figure 2: 2006/07 budget on drug intervention in the CJS (E&W) (£million)

There is considerable variation in approaches to tackling problem drug use among offenders in the UK within countries, regions and localities, and the landscape is complex to say the least. It has proved impossible within our timeframe to get a clear picture of exactly what provision is available where. However, a wide range of interventions targeting problem drug-using offenders are now available and we have attempted to summarise these in Table 3.

Community-based interventions

Many of the community-based interventions for problem drug-using offenders are concerned with encouraging them to engage with the general treatment system, rather than providing specific treatment options for offenders alone. In England and Wales, the **Drug Interventions Programme** (DIP), which was introduced in April 2003 with new elements having been phased in each year since, provides a range of interventions aimed at getting problem drug-using offenders into treatment and other support. The opportunities for intervention in the community start in the custody suite on arrest and then go through the court process, to the sentence agreed, and may also sometimes include the period following release from prison.

The programme of **testing on arrest, mandatory assessment** and **Restrictions on Bail** (RoB), known as Tough Choices, operating in 165 custody suites in mostly higher crime areas in England and Wales aims to identify problem drug-using offenders and encourage them to engage with treatment services. Drug testing (using an oral fluid test) is carried out on those people who are arrested on suspicion of committing an offence shown to have a high degree of association with problem drug use (e.g. burglary, robbery, theft), known as a 'trigger offence'. The tests show if they have used heroin or cocaine (crack or powder forms) recently. The new UK strategy outlines plans to expand DIP interventions, such as the Tough Choices regime, on a self-funded basis. **Criminal Justice Integrated Teams** (CJITs) undertake the assessments of offenders who test positive. They undertake a case management role, referring offenders to treatment and organising the provision of other support, such as employment and housing services, as appropriate. In other 'non-intensive' areas and in Scotland and some parts of Northern Ireland, CJITs or **Arrest Referral** workers operating in police stations aim to provide a similar service by interviewing arrestees (rather than drug testing them) to identify those with a drug problem and referring them to a helping agency. In 11 custody suites in Wales and England, testing on charge (rather than arrest) is being continued, and drug testing is also being piloted in some areas of Scotland.

RoB reverses the presumption of court bail for those defendants who have tested positive for heroin, cocaine of crack cocaine. RoB makes the requirement to undergo an assessment of the defendant's drug misuse and any proposed follow-up treatment a condition of court bail. The **Prolific and other Priority Offender (PPO) programme**, which provides intensive monitoring of certain types of offenders

identified as a priority in a local area, also often includes many drug-dependent offenders. In the future, there will be greater integration of DIP and PPO programmes.

In addition, in England and Wales the Criminal Justice Act 2003 introduced **conditional cautioning**, which allows for a condition conducive to rehabilitation (such as engaging in drug treatment) to be attached to a police caution, with the sanction of prosecution for the original offence if the offender does not comply with the condition. This is aimed at drug-using offenders with less entrenched drug problems, not necessarily related to their offending. There are no robust figures available for the number of conditional cautions with different conditions attached that have been given. To date, however, it appears that they have not been often used in practice, although the new UK drug strategy action plan aims to increase the numbers issued to 2,000 by the end of March 2009.[24] An early evaluation[25] suggested that about a fifth of conditional cautions will have a drug referral condition attached and it has been estimated that a total of about 4,000 conditional cautions have been issued since they were introduced in late 2004.[26] On this basis, the total number given with drug-related conditions would be only about 800.

Within the courts in Scotland there is a **diversion from prosecution scheme** which includes substance misusing offenders (148 cases were referred to drug treatment/education in 2004/05). This scheme aims to refer accused individuals to appropriate services that will address the underlying causes of their offending where it is believed that formal criminal justice proceedings are not necessary (i.e. where there is no overriding public interest for a prosecution). Diversion is designed to stop the offending/punishment cycle before it starts.

Once convicted by the courts, problem drug-using offenders may be given **community sentences** with associated drug-related requirements. **Drug Treatment and Testing Orders (DTTOs)** have been in use in England, Wales and Scotland since 1999. However, in England and Wales, DTTOs have now been replaced with community sentences with **Drug Rehabilitation Requirements (DRRs)**. The new UK drug strategy promises an extra 1,000 DRRs in 2008/09. Offenders may also be made subject to a community sentence with a requirement to attend an accredited offending behaviour programme provided by the offender management services (probation), such as **Addressing Substance Related Offending (ASRO)**, which involves group work addressing the offender's motivation to change, understanding the elements that led to substance abuse and offending, preventing relapses and building a positive future, or the **Offender Substance Abuse Programme (OSAP)**. In 2005, 2,943 offenders started on the ASRO and 928 on the OSAP programmes. It is possible for offenders to be given a community sentence with more than one requirement attached, for example having a DRR and a requirement to attend an accredited programme. In Scotland, **probation orders with a condition of treatment**

are also available – 477 such orders were made in 2006/07. A further development of DTTOs to target offenders with less severe drug problems has recently been announced in Scotland.

Recently, in both Scotland and England special drug courts have been piloted. In these **Dedicated Drug Courts**, the same District Judge or panel of Magistrates who sentenced the offender provides continuity in reviewing the offender's progress on DRRs or DTTOs, building on the existing judicial review element of the DRR or DTTO. Following encouraging results from the Scottish pilot study, the two courts are being continued for a further three years, after which they will be reviewed. In England, two pilot drug courts are being evaluated to explore the effect of continuity on an offender's motivation to stay in treatment and so reduce drug use and related offending. The government has indicated that, if the results of the pilot are positive, a further four dedicated drug courts may be established. There are other similar initiatives, such as the Community Justice Centres/Courts developed in Liverpool and Salford and now being extended to other areas, which also seek to bring together services to address offending behaviour. A pilot Family Drug and Alcohol Court covering three London boroughs commenced in January 2008. This will work with substance-misusing parents whose children are the subject of care proceedings, with the aim of achieving their rehabilitation in order to allow their children to return to their family.

Section 25 of the 2005 Drugs Act provides for an **Intervention Order** (IO) which can be made alongside an Anti-Social Behaviour Order (ASBO), which could require participation in an activity such as drug treatment where drug use is identified as a cause of the behaviour.

In England and Wales there is also provision for **drug testing conditions** or a **condition to address substance misuse** to be attached when prisoners (sentenced to 12 months or more in custody) are **released on licence**.

Table 3: Interventions for problem drug-using offenders within the CJS

Processes to identify drug users for interventions	**Interventions to promote engagement with treatment and other services (or maintain drug-free status)**	**Interventions addressing substance use and/or offending**
Community-based provision		
Drug testing and mandatory assessment Arrest Referral Court-based assessments	CJIT case-management Prolific and other Priority Offender (PPO) programme Restrictions on Bail (RoB) Conditional cautioning Diversion from prosecution Probation orders with drug treatment conditions Drug Treatment and Testing Orders (DTTOs) Drug Rehabilitation Requirements (DRRs) Drug Courts and Community Justice Courts Intervention Orders Drug testing and other drug-related conditions on release on licence	Addressing Substance Related Offending (ASRO) Offender Substance Abuse Programme (OSAP)
Prison-based provision		
Initial health screen Counselling, Assessment, Throughcare, Advice & Referral (CARAT) or Enhanced Addictions Casework Service (EACS) assessments Mandatory Drug Testing	CARAT or EACS throughcare Voluntary testing programmes Drug-free wings	Detoxification Maintenance prescribing 12-Step drug programmes Prison – Addressing Substance Related Offending (P-ASRO) Short Duration Programmes FOCUS STOP (Substance Treatment and Offending Programme) Therapeutic communities Motivational support or group work from EACS or CARAT

Prison-based interventions

There have been a number of important changes and enhancements to the provision of prison-based drug interventions in recent years. Commissioning responsibility for the delivery of healthcare services for prisoners in England passed to the NHS through local Primary Care Trusts in April 2006. More recently, the **Integrated Drug Treatment System (IDTS)** has been rolled out across 53 prisons in England and Wales (29 having full IDTS and a further 24 having enhanced clinical services), representing about 40% of prisons. IDTS aims to boost the quality and availability of treatment for imprisoned problem drug users – with an emphasis on offenders' first 28 days in custody – through enhanced clinical services and psychosocial (CARAT support. The approach aims to expand and improve the provision of drug treatment within prisons by:

- improving clinical treatment practices, based closely on assessed need;
- boosting CARAT support during the early phase of intense clinical management;
- enhancing the links between CARAT staff, clinical services and community treatment teams; and
- improving overall continuity of care for problem drug users.

In addition to the changes to the way clinical services have been commissioned and organised, there has been an expansion in drug treatment options available in prisons in recent years, with greater provision of detoxification and methadone prescribing now being made available for short-term prisoners who were receiving this prior to imprisonment.

The **CARAT (Counselling, Assessment, Referral, Advice and Throughcare)** service was established in 1999 and has expanded its services considerably since then. CARAT is best described as a low-threshold, National Treatment Agency Tier 2/3 drug service that, following assessment, delivers treatment and support, providing problem drug users with access to a range of wider drug and non-drug services both in custody and upon initial release. CARAT teams also take the lead role in prison under the DIP to help ensure timely continuity of treatment in the community on release. In Scotland the **Enhanced Addictions Casework Service (EACS)**, which was introduced in 2005, provides a similar role to CARATs. It provides addiction assessments (including alcohol) to prisoners with a sentence of 31 days or longer, one-to-one motivational support and group work. Prisoners with sentences of less than 31 days are referred to either voluntary throughcare or national addictions throughcare services.

Within prison, identification of drug dependency and problem drug use may occur through the **reception health screening process** and through CARATs assessments. Engagement with the CARAT service is voluntary. In addition, in England and Wales the random Mandatory Drug Testing regime (see below) may reveal someone as a drug user within the prison. In Scotland, the Addictions Testing Measure (see below) uses

anonymised testing so cannot be used to identify drug users. However, an addictions assessment should be offered to prisoners with a sentence of 31 days or longer by the EACS, while those with a shorter sentence are referred to either voluntary throughcare or national throughcare addictions services, depending on criteria.

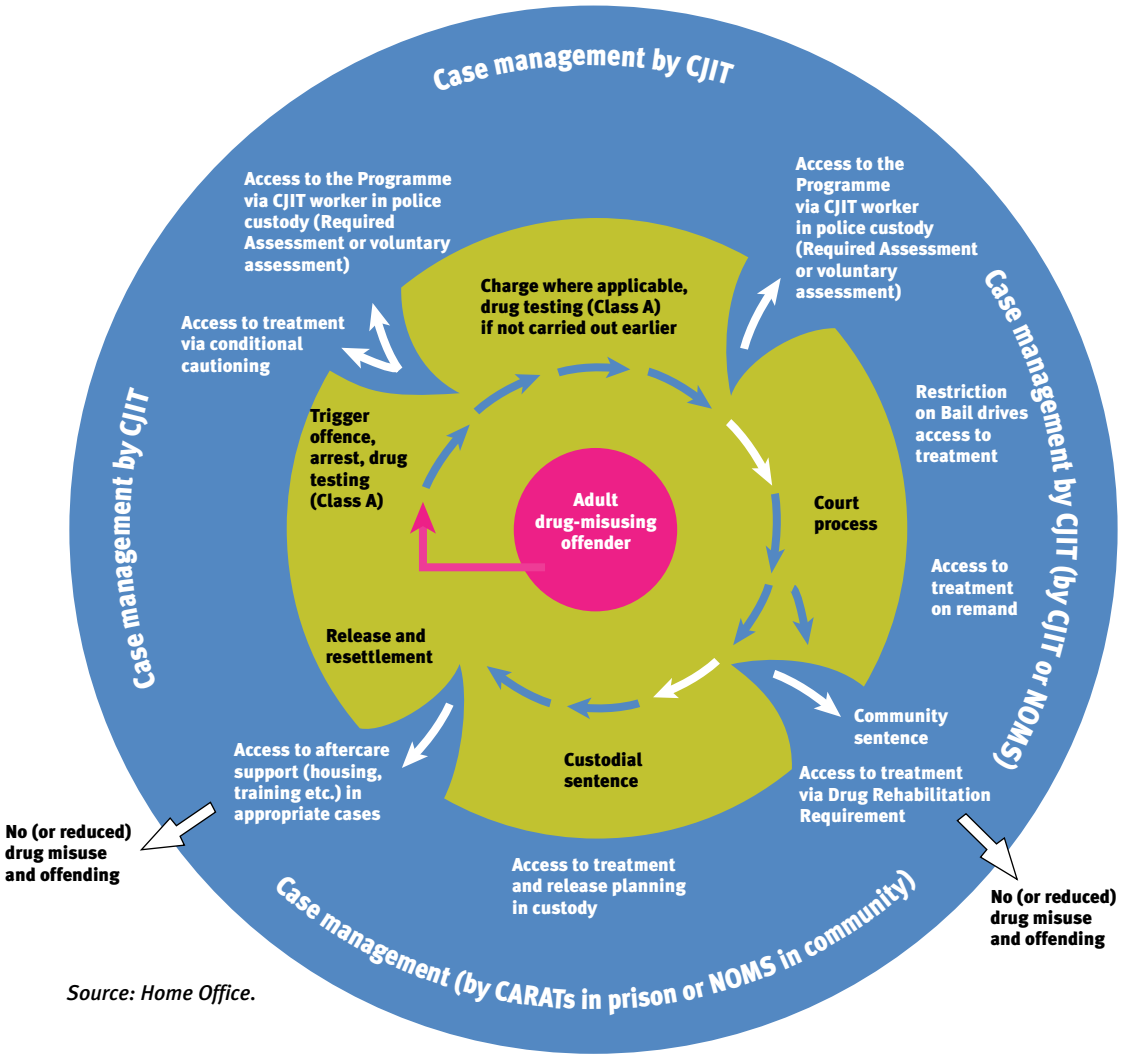
Other interventions provided in some establishments are:

- **Short Duration Programmes (SDPs)** which are four-week programmes based on cognitive behavioural therapy and a harm minimisation approach designed to help prisoners on short sentences look at their drug use patterns and behaviour;
- **P-ASRO (Prison – Addressing Substance Related Offending)**, a low to medium intensity cognitive behavioural programme similar to that provided to people on community sentences;
- longer cognitive behavioural therapy programmes – **FOCUS** and/or **STOP (Substance Treatment and Offending Programme)**;
- **12-Step programmes**, delivered by prison staff and by RAPt (Rehabilitation of Addicted Prisoners Trust), and
- **therapeutic communities**, which are generally based on a social learning approach, teaching new behaviours, attitudes and values, reinforced through peer and therapeutic community support.

There are also **drug-free wings** and **voluntary testing programmes** in some prisons which aim to help prisoners remain abstinent from drugs while in prison. In England and Wales, a programme of **Mandatory Drug Testing (MDT)** is carried out within prisons to detect and deter drug use within prisons. In some cases this may be used to identify prisoners who might benefit from drug interventions. In 2006/07, 8.6% of mandatory drug tests in prisons were positive compared with 10.3% in 2005/06.[27] In Scotland, the MDT regime was replaced by the **Addictions Testing Measure** (ATM) in 2005. This involves voluntary anonymised testing, to encourage compliance and avoid the necessity for cheating, which might affect the accuracy of the results. In 2006/07, 28% of tests on the ATM were positive for where the drug misuse occurred in prison. A further 13% were positive but the drug use detected might have occurred prior to imprisonment.[28]

In England, a pilot programme providing post-release accommodation, called **Prospects**, was commenced in five pilot areas, but it has since been terminated after initial evaluation findings showed it offered poor value for money. The pilots aimed to provide accommodation for the reintegration of offenders with drug problems from prison into the community and included a drug treatment element within their programmes.

As described above, there is now a wide range of different programmes available operating at different points within the CJS. Figure 3 provides an overview of how the DIP in England and Wales aims to operate, taking advantage of this range of opportunities within the CJS, both in the community and in prisons, to encourage drug-misusing offenders to engage with treatment and support services.



Source: Home Office.

Figure 3: How the DIP programme works at all stages of the CJS

Extent of provision

Table 4 provides a snapshot of the numbers engaged in different programmes. To place these numbers in context it should be noted that the number of arrests of people aged 18 and over for recorded crimes in England and Wales in 2005/06 was just over 1 million (and the Arrestee Survey suggests that more than 1 in 8, or over 125,000, would be problem heroin and/or crack users). In 2006/07, about 40,000 offenders engaged with treatment within the DIP (which identifies heroin, crack and powder cocaine users) and just under 16,000 started DRRs in England and Wales.

In England and Wales, greater use appears to be made of community sentences with a drug treatment provision than in Scotland. In England and Wales the use of these community sentences has increased from 4,842 in 2001/02 to 15,799 in 2006/07. In Scotland, the orders were introduced later and use has increased more slowly, rising from 412 in 2003/04 to 696 in 2006/07. Based on mid-2006 population estimates for the UK, the incidence of DTTO/DRRs per 10,000 of the adult population (aged 16 and over) during 2006/07 was 1.7 in Scotland (although this does not include the additional option of probation order with a drug treatment or education condition) and 3.6 in England and Wales.

The number of new receptions to prisons in England and Wales in 2006 was just under 129,000, with about 78,000 people in custody at any one time. As shown in Section 2, between about a third and a half of prisoners reported a problem with drugs prior to prison, suggesting that between 45,000 and 65,000 problem drug users currently enter prison each year (it should be noted that there will be many more who use drugs but do not consider these a problem and/or who have alcohol problems). The proportion of entrants now receiving CARAT assessments and detoxification/maintenance prescribing (around 60% and 40% of new entrants, respectively in 2006/07 in England and Wales) suggests these have achieved good coverage. However, the provision of other interventions, such as SDPs or P-ASRO, seems inadequate.

In Scotland, where a little under a half (44%) of prisoners reported their drug use was a problem in the 2006 prison survey, 4,546 prisoners were offered an addiction assessment in 2006/07 (representing only 17% of the 26,195 recorded entries into prisons in that year). As shown in Table 5, the majority of those offered an assessment (89%) completed one and over 12,000 one-to-one motivational support sessions were delivered. The numbers being prescribed methadone on 8 December 2006 made up 17% of the prison population on that day.

Table 4: Numbers engaged in different programmes for problem drug-using offenders within the CJS

Coverage	Type of provision	Time period covered	Numbers engaged
England and Wales			
Community	DIP[29] – % positive drug tests – number entering treatment	2006/07	37% 39,903
	Conditional caution[30]	2004 to 2007	~ 800
	DTTOs or DRRs[31] – starts – completions	2006/07	15,799 5,939
	ASRO OSAP[32]	2005	2,943 928
Prisons[33]	Detoxification or maintenance prescribing†	2006/07	51,520
	CARAT initial assessment*	2006/07	77,860
	12-Step programme	2006/07	930
	Cognitive behavioural therapy (CBT)	2006/07	360
	Short Duration Programme	2006/07	5,760
	P-ASRO	2006/07	3,780
	Therapeutic community treatment programmes	2006/07	300
Scotland[34]			
Community	Diversion from prosecution with drug referral**	2006/07	63
	Probation orders with drug-related condition***	2006/07	477
	Drug Treatment and Testing Orders***	2006/07	696
Prisons	Addictions assessment undertaken	2006/07	4,051
	Motivational support sessions	2006/07	12,298
	Methadone prescribing (one-day census)	08/12/2006	1,228

† Data not currently available for these interventions separately for a full year. However, since the start of 2007/08, figures have been collected separately and show that in the first few months of 2007/08 detoxification made up 79% of the healthcare interventions and methadone maintenance 21%.

* Includes juveniles.

** Excludes figures for Highland as these cases were not recorded.

*** Includes some estimated data for Argyll and Bute, East Dunbartonshire and West Dunbartonshire.

4. What is the evidence for the effectiveness of these approaches?

Considerations of programme effectiveness should take account of the fact that problem drug use is a chronic and relapsing condition. Recovery from dependent drug use and desistance from offending need to be viewed as processes or journeys, rather than single events that can be orchestrated easily. Therefore, it is likely that most drug-dependent offenders will go through multiple treatment and other interventions before they end their offending and drug-using careers. It is to be expected that a proportion of problem drug-using offenders will breach their DTTOs/DRRs and drop out of treatment programmes. Reconviction rates are likely to remain quite high, despite the best efforts of the many drug workers and prison and probation staff involved in these programmes. However, this does not mean that the quality or outcomes of programmes cannot be improved.

In this report we are focusing on interventions within the CJS. However, as pointed out previously, many of these interventions rely on getting offenders to engage with drug treatment and rehabilitation services within the community. There is very good evidence to show that such interventions can successfully reduce both drug use and offending within the wider problem drug-using population. However, we have not covered this evidence within this report because it has already been reviewed to provide the basis of a range of guidelines produced by NICE (the National Institute for Health and Clinical Excellence)[35] and other agencies[36]. Most of the available evidence relates to treatment for problem opiate use; interventions for users of crack and other drugs are less well developed and evidenced. Treatment and rehabilitation services provided within the prison system are expected to adhere to these same guidelines. However, it can not be assumed that they will necessarily be as effective, since problem drug-using offenders often have a wide range of entrenched problems in addition to severe drug problems. Also, as discussed below, there are particular problems and issues associated with providing services within the CJS, such as difficulty providing follow-up care after detoxification and continuity of care within the prison system and on release because of unplanned moves to other prisons, which may affect outcomes from these services.

In general, there is good international evidence that a range of approaches can be effective in reducing offending and drug use among drug-dependent offenders through engaging them in treatment and providing other forms of support – in short, these programmes *can* work. However, the evaluations of programmes in

the UK, which would show that these programmes *do* work in this country, have been limited. UK evaluations have shown it is possible to engage drug-dependent offenders, many of whom have very complex problems, in treatment via the CJS – the Drug Treatment Outcome Research Study (DTORS) found that CJS workers were involved in the referral of over a third (35%) of those entering treatment. However, while in some cases offending is reduced following treatment, the evaluations undertaken to date are limited in the extent to which they show that offending changes are specifically due to the particular programme or intervention being evaluated. This is not to say that these programmes are not effective, just that there is very little research evidence to show if this is the case. This is in part due to the very rapid development and roll-out of programmes, which has made evaluation difficult as the programme under consideration has changed during the course of the studies and inevitable teething problems have decreased programme effectiveness. It is also not possible to say whether other types of programme or interventions could bring similar results.

There is also very little published research that shows *who* the programmes work best for and *what features* of individual programmes and their delivery are key to successful outcomes. This relative absence of robust evidence, which applies to all programmes, makes it difficult to make judgements on where to direct investment or how to improve current programmes.

It is also important to recognise that even if an intervention is shown to be effective (i.e. it is able to reduce drug use and offending), it does not necessarily follow that it is cost-effective and provides *value for money*. Unfortunately, there is very little evidence available relating to the cost-effectiveness of the programmes currently implemented in the UK. Based on findings from the National Treatment Outcomes Research Study (NTORS), it has been estimated that for every £1 spent on treatment, between £9.50 and £18 is saved on economic and social costs associated with drug misuse.[37] However, NTORS was based on a cohort of drug users entering treatment in 1995, only about half of whom were offenders, and all participants entered treatment voluntarily. Therefore, the estimates do not include the additional costs associated with referring them and maintaining their engagement with treatment through the CJS incurred in the programmes described below. The profile of drug users included in the study is also likely to be different from that of current problem drug-using offenders, so it cannot be assumed that this cost–benefit ratio will apply to current interventions.

This leads us to reiterate the important point, made in Section 2, that drug-using and drug-dependent offenders (and indeed problem drug users generally) are a heterogeneous group. There is no single intervention, or magic bullet, that will solve their dependency and change their behaviours or overcome the problems underpinning their drug use. A one-size intervention will not fit all.

Community-based interventions

Contemporary research is equivocal about the impact of **drug testing** itself, which is undertaken at different points in the CJS, on illicit drug use and offending behaviours, and engagement with treatment services. For example, within the criteria set by a recent systematic review there was no research evidence to be found for the effectiveness of testing either as a stand-alone form of routine monitoring or in providing added value when used in combination with treatment interventions.[38] Within the DIP, drug testing is used to identify drug-using offenders within custody suites. In the early stages of DIP implementation, when testing was done at charge and assessments were voluntary, there were concerns that some drug users were being missed or were not being engaged in the programme. In 2007/08, some 175 custody suites in England and Wales were testing either on arrest or on charge, with about half the police forces in England and Wales having some custody suites undertaking testing. An early evaluation of drug testing on charge[39] found no significant direct effects on drug consumption or offending behaviour. However, there was some evidence of increased access to treatment services among those testing positive compared with those drug users testing negative (even after differences in levels of drug consumption were taken into account), although the research design and high attrition rate mean the results must be viewed with caution. More recent evidence from the DIP shows that the introduction of Tough Choices, which brought testing on arrest (as opposed to on charge) and mandatory (as opposed to voluntary) assessments, has successfully increased the numbers being tested and engaging in treatment.[40] However, moving from testing on charge to testing on arrest led to a decrease in the proportion of those who tested positive and a decrease in the proportion of identified drug users who were high-rate offenders. There is as yet no evidence as to whether the programme is able to deal with these less problematic users effectively.

There is some evidence to suggest that the effectiveness of drug testing on arrest as a mechanism for identifying problem drug-using offenders who are not in contact with services may be eroded over time. The 2005/06 Arrestee Survey showed that, of those arrestees who used heroin and/or crack (HC) at least weekly:

- 79% had been arrested at least once before in the past year;
- 57% of these had been drug tested before at a police station (by comparison, in the 2003/04 survey, 27% of frequent HC-using arrestees who had been arrested before reported having been tested at charge before);
- the proportion of heroin using arrestees who were in treatment had increased between 2003/04 and 2005/06.

The Arrestee Survey also showed that the proportion of those arrested for trigger offences who reported taking heroin and crack at least weekly decreased from 35% in the 2003/04 survey to 24% in the 2005/06 survey. The reason for this is not clear,

for instance it might be a result of the efforts made to reduce drug-related crime or of changes in policing practice, but this also suggests that efficiency of the drug testing programme may reduce over time since the number of tests that will be required for each problem drug user identified will increase.

In non-intensive areas (as in Scotland, where piloting of testing on arrest is just starting in a limited area), other mechanisms are used to identify drug-misusing offenders. There is evidence that these more traditional **arrest referral** approaches may also be successful in identifying and engaging drug users in treatment,[41] but there have as yet been no evaluations that would allow comparison of outcomes and the value for money of different approaches to identifying problem drug-using offenders for treatment in custody suites.

The evaluation of **Restriction on Bail** (RoB) pilots in three English sites, despite some positive findings in terms of compliance and treatment engagement, concluded that their success in retaining defendants in treatment and their impact on illicit drug use and offending was unclear and there were concerns about the effectiveness of the selection of individuals for the intervention.

The national evaluation of **Criminal Justice Integrated Teams (CJITs)** [42] (undertaken before the introduction of mandatory assessment) across 20 sites has reported significant reductions in drug use and offending behaviours among a sample of those taken onto CJIT caseloads (n = 703). CJITs were successful at ensuring that a very high proportion of those assessed and taken on to the CJIT caseload accessed treatment (although this was at a rate commensurate with previous arrest referral arrangements) and those engaging with treatment reported reductions in illicit drug use and offending. However, the investment and start-up costs in developing and implementing the DIP were heavy and the evaluation concluded that the cash savings achieved in the 20 CJITs that it examined were offset by the costs of providing the service – although this might not apply to a more established programme. The introduction of **mandatory assessments** following a positive drug test on arrest has improved participation in the assessment process compared with the period prior to this.[43] However, the proportion of those assessed as requiring further intervention who then agreed to the intervention declined slightly (although differences in the characteristics of the cohorts may explain this). Following the introduction of Tough Choices there was also a slight increase in the proportion of individuals being referred to less structured and intensive Tier 2 treatment only (such as brief interventions, advice and information, often delivered by the CJIT). Discussions with users and practitioners suggested that the assessment process was not always working to maximum effectiveness. It was suggested that assessments might need to be more objective and frequent, more effectively identifying options appropriate to the individual and their stage in their drug-using career, and involving the offender more in the development of their care plan.

The recent report of data from the DIP showed that almost half (47%) of a cohort of offenders entering the DIP under testing on charge reduced their offending (as measured by offences recorded in the Police National Computer) in the six months after engagement compared with the six months before, while 28% showed increased offending. However, from the published data and the evaluations undertaken to date[44] it is difficult to identify which elements of the programme are most effective or which groups of offenders are currently best served. Concerns have been expressed within our consultation groups that there is limited provision for crack cocaine and other stimulant users, and this is also acknowledged in the new UK drug strategy with respect to treatment services in England. Evidence from the Arrestee Survey suggests they will be making up an increasing proportion of those testing positive on arrest.[45]

Prolific and other priority offender (PPO) schemes aim to identify and select prolific offenders and engage this group using proactive police disruption, targeting activities and, where appropriate, brokering rapid access to drug treatment and other support services (61% of PPOs initially allocated to the scheme in September to October 2004 were assessed as having a drug misuse problem). Historically, evaluations of these schemes have produced mixed results and been hampered by the use of weak methodologies. One of the most comprehensive assessments of the impact of English and Welsh PPO schemes on offending recently described a 43% reduction in offending (comparing the total number of convictions in the 17 months before and the 17 months after programme implementation) among a sample of 7,800 PPOs identified during the two months following implementation in September 2004. Although the change cannot be attributed with certainty to the programme, the results are promising and consistent with qualitative data from interviews with PPOs, which indicate that many reported having reduced their offending or desisted from crime following engagement with these schemes Most attributed changes to the enhanced support and interventions they had received, including access to drug treatment.

A recently published report examined the use of **conditional cautions** in the early stages of the implementation of the scheme.[46] This showed that the extent of use of conditional cautions varied markedly between areas. The number of cases reviewed was small; 305 cases that were considered for a conditional caution of which 221 were given. Of those given a conditional caution, almost a fifth (39 cases) received some sort of drug referral condition. About a quarter of those given a conditional caution failed to comply with some aspects of the caution, and in the majority of those cases (48 out of 54) the Crown Prosecution Service decided to prosecute the offender. In general, the study found support for the scheme but identified some issues that needed to be addressed in the national roll-out. One area of concern identified was that a proportion of the cases put forward by the police for

consideration for a conditional caution were not, in fact, suitable for a charge, which suggests that there is a potential for 'up-tariffing' (i.e. where a new disposal is used for offenders who would have otherwise received an existing, less serious disposal) as a result of the introduction of this scheme.

A small-scale evaluation of the Scottish **diversion from prosecution** pilot schemes, although not focused specifically on cases diverted in order to address drug problems, showed that they were viewed positively by professionals and the accused. Procurators fiscal and diversion staff felt that diversion was more likely than prosecution to address underlying problems, although the costs were quite high. The outcome data collected were extremely limited and do not distinguish those with drug problems, so the effectiveness of the programme cannot be assessed. However, the proportion of social work diversion cases that were terminated for non-compliance was low (13 out of 196).[47]

There is a growing body of UK evidence concerning **community-based treatment orders**, such as **DTTOs** and **DRRs**,[48] which indicates that, although many drug-dependent offenders fail to complete DTTOs, those who are successfully retained on the programmes report reducing both their illicit drug use and their offending and show improvements in other domains. Recent UK evidence shows that offenders who enter treatment when subject to such orders have similar retention and completion rates as drug users entering treatment through other routes, and that they also show greater reductions in offending.[49] Although low completion rates are a common feature of the evaluations conducted, the evaluations of the pilots in England and Scotland showed that those who completed orders were significantly less likely than those who did not to be reconvicted. It should also be noted that experience with use of the orders has developed and those who breach their orders are now often allowed by the courts to continue, reflecting a recognition of the entrenched and relapsing nature of many offenders' drug problems, and the National Probation Service's latest annual report has indicated that completion rates are increasing (from 28% in 2003 to 44% in 2006/07).[50] In Scotland, the proportion of DTTOs successfully completed increased from 29% in 2003/04 to between 38% and 40% in 2004/05 to 2006/07. [51]

There is some information from research concerning the factors that are associated with variations in outcomes including: differences in the profile of those being sentenced to the orders in terms of offending or drug use; treatment quality and setting (whether community or residential); responsiveness of the intervention (e.g. whether appropriate for crack users); and enforcement practices. However, there is still a knowledge gap with respect to which individuals will do best in which programmes and therefore how to allocate individuals effectively to the most appropriate treatment and support services.

Our discussions with practitioners and offenders raised issues around the drug testing that can be associated with these orders. While for some there may be positive motivation obtained from providing a clean test, for others, such as those who have cut back but not stopped, it might have a reverse effect. Where people have acknowledged illicit use it perhaps might seem pointless, and Probation National Standards allow for offenders on DRRs/DTTOs to sign to say they have used drugs and not be tested – although not on two consecutive occasions. The general view was that the use of testing should be limited to validating claims of abstinence and to check whether a client is using their substitute prescription and/or 'topping up', in line with best practice guidelines. It was also suggested by service users that clearer negative consequences for repeated positive tests would improve motivation for some people, although the importance of positive incentives to reward compliance were also considered important to reinforce behaviour change.

The role and impact of the supervision element within these orders was also raised in our consultations, and international studies have failed to show that supervision provides additional value over and above that gained from treatment. However, the models of supervision tested may well be different to those in place in the UK, and in this case it may provide the incentive to engage with treatment that might otherwise be lacking. The new community sentences may also present opportunities for adding additional elements, such as unpaid work requirements, or provide other opportunities or services that might be of benefit in the integration of drug users into society (e.g. some restorative justice elements). Although no robust evaluation of substance-related offending behaviour programmes has been published, a recent report of a reconviction analysis of offenders engaged in accredited offending behaviour programmes [52] showed slightly (7%) lower than predicted offending rates for those referred to the substance misuse programmes, **ASRO** and **OSAP**. The group of offenders who completed the programmes showed the biggest reduction in reoffending compared with predicted rates (20%), but they made up only about a fifth of those referred and may be different from those who did not complete the programme. Furthermore, those who did not even start the programme also showed a reduction in reoffending. It is therefore not possible to draw any robust conclusions about effectiveness of these programmes from these data.

A European study into 'coercive' approaches to getting drug users into treatment (QCT Europe) showed that the best outcomes were obtained among those who received in-patient treatment (i.e. treatment within a hospital, clinic or residential rehabilitation centre). However, it is not clear to what extent this finding would apply to the UK (the sample in this country was entirely drawn from out-patient services). In-patient care will not be appropriate for all offenders and is costly, and for many offenders out-patient treatment such as methadone maintenance may be more appropriate.

In our consultative work, the negative impact that unmotivated individuals could have when attending some services, such as group work, simply to meet the requirement of their order was described. These difficulties are echoed in European research about the impact of integrating problem drug-using offenders with those going through treatment on a voluntary basis. "Workers believed that successful treatment was obtained only by using extensive motivational therapy to transform external motivation into self-motivation. In this study,[53] as in many others, workers reported on the negative effect of unmotivated clients on the rest of the group. Behavioural patterns acquired while in prison were transferred to the therapy group, thereby considerably aggravating the atmosphere in the centre as well as impairing the motivation of other patients".[54] However, it should be noted that many offenders entering treatment through the CJS have high levels of motivation, in fact DTORS found no difference in levels of motivation between those entering treatment from the CJS and those entering by other routes, a finding supported by the QCT Europe study.[55]

There is some limited evidence that suggests community sentences with treatment orders are likely to cost less than prison sentences on a cost per day basis, but no robust value for money assessment of alternative sentencing disposals has been published. [56]

Several reviews of the evaluative evidence in support of **drug courts** in the USA have reported positive results, with drug court participation and completion being linked to reduced drug use, rates of re-arrest and recidivism. Some of the schemes have also been shown to be cost-effective and drug courts are now in widespread use in the USA. Most evaluations in other jurisdictions, and in Scotland, have also reported encouraging findings. However, differences in how drug courts have been implemented and delivered have been shown to impact on their effectiveness as have the offender groups targeted and the treatment approaches used. Attempts to introduce drug courts in Britain have, to date, largely been built on pre-existing DTTO or DRR arrangements and direct a high proportion of offenders into methadone maintenance treatment, in contrast to the abstinence-based approaches more commonly used in the USA. Therefore, it is unclear how transferable these findings are to the UK context.

The US National Association of Drug Court Professionals identified four key components of the drug court model:

- review hearings before a judge in court to assess progress;
- mandatory completion of drug treatment;
- random and frequent drug testing; and
- the use of progressive negative sanctions for non-compliance and positive rewards for achievements.

The speed of access to treatment has also been recognised as a significant factor in the success of drug courts in the USA.

The Dedicated Drug Court model differs from DTTOs and DRRs in the emphasis placed on consistency of sentencer, in particular, and the greater frequency of oversight within the judicial review process. However, it could be argued that there are some fundamental differences between the DTTO/DRR and the Dedicated Drug Court model in the USA; a key one being the scope for greater discretion that judges in the latter have for rewarding good behaviour and progressive negative sanctioning of non-compliance. In the USA, the judge may have the discretion not to proceed with hearing charges if a defendant is successfully engaged with a treatment programme. In contrast, in the UK the case is usually heard and sentence is either passed or deferred in order to monitor progress, but court administrations are reluctant to have too many deferments. Feedback from practitioners indicated that they felt that the main benefit of the drug court model was that magistrates/judges develop a better understanding of which offenders are making an effort to engage with services and which are just 'playing the system'. However, it is also possible that the greater involvement of the judge in the supervision process, at least in the US context, may also help to leverage in additional services, such as housing, that support the integration of the offender into society. It is important that the current pilots in the UK are used to ascertain the effectiveness of this approach in the UK context and the value for money of the courts compared with other approaches. If the results are positive, it is important that any roll-out also includes evaluation to identify which offenders will benefit from this approach and the key factors for success.

Community Justice Centres may also deal with problem drug-using offenders as part of their workload. A qualitative evaluation of the North Liverpool Community Justice Centre[57] suggested that there were a number of benefits to the approach. As well as supporting an efficient and speedy court operation, case studies suggested that the problem-solving approach used enhanced offenders' engagement with the court and their compliance with their sentence and helped with underlying problems such as drug addiction, housing and debt. Drug- or alcohol-related services were found to be the services most likely to be accessed. However, as yet no outcome evaluation has been undertaken to confirm the impact of the interventions on drug use and offending.

There appears to be no published evidence relating to the effectiveness of **Intervention Orders** that can be attached to ASBOs.

Prison-based interventions

In the UK, research has provided evidence in support of methadone and lofexidine for the effective management of **opioid detoxification in a custodial setting**. Although many prisoners 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 reoffended.[58] There is evidence that appropriate aftercare and follow-up needs to be given a higher priority, both within prison and on release.[59] Those involved in our discussion groups also felt that without further rehabilitation or support, relapse would be much more likely, particularly on initial release into the community. The increased risk of death following detoxification in a community setting has been confirmed by recent research.[60] It is therefore not surprising that there is also clear evidence that the period following release from prison is one of much higher risk of drug-related death, and it has been estimated that 1 in 200 adult male injectors is likely to die in the fortnight after release from imprisonment of 14 or more days.[61] 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 will do more harm than good.

Evidence from Australian randomised control trials of **prison-based methadone maintenance** therapy also indicate that retention in such treatment is associated with reduced reimprisonment rates, hepatitis C infection and mortality. 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.[62]

These treatment options are now available within the UK prison system, but a recent report by HM Inspectorate of Prisons[63] indicated that although drug misuse is assessed at reception, this is not always done fully and prisoners were not always referred to services, and that prisoners reported that "detoxification was too little, too fast and too late". The report also noted that little psychosocial or mental health support was provided to those withdrawing from drugs. Other issues raised were a lack of communication between healthcare staff and CARAT workers and the issue of continuity of care when prisoners are transferred between prisons, both of which

may be addressed in those places in which the **Integrated Drug Treatment System** is operational. Prison healthcare services are now provided through the NHS with the aim of ensuring that prisoners have similar access to treatment to people in the community, but we were unable to locate routinely published statistics on the levels of provision or the outcomes of these clinical services, which would be necessary to monitor the adequacy and outcomes of this provision. While noting improvements in provision for substance use, the recent annual report of HM Chief Inspector of Prisons also commented on the considerable variability in provision across the prison estate and pointed out that "population pressure meant that substance-dependent prisoners could be transferred having barely completed detoxification. Few category C training prisons had adequate arrangements for their support, particularly for those being maintained on methadone, or could provide secondary detoxification for those who relapsed in custody".[64]

A number of recent systematic reviews of evaluations of the effectiveness of prison-based drug treatment have produced strong evidence for the effectiveness of **prison-based therapeutic communities** in reducing illicit drug use and/or recidivism. However, there are only a handful of therapeutic communities 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 therapeutic communities 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%), and lower than predicted than a matched comparison group (RAPt group 40%; comparison group 50%). However, this was a small study with some methodological limitations.

The **Mandatory Drug Testing** (MDT) programme operated in prisons in England and Wales primarily aims to deter use of drugs within prisons, but it may also be used to identify users and refer them for treatment. The evaluation of the programme conducted in 2001 showed that at that time it may have had some limited deterrent effect but that it underestimated use, may in a very few cases have encouraged initiation of heroin use (because heroin use is detectable for a much shorter time than cannabis use) and rarely resulted in referral to treatment as most commonly positive tests were dealt with by the imposition of added days of imprisonment. Overall, as mentioned earlier, English and Welsh prisons have made considerable progress in reducing drug misuse and overall random MDT levels have fallen from

24.4% in 1996/97 to 8.6% in 2006/07. As mentioned in Section 3, in Scottish prisons mandatory drug testing has been abandoned in favour of the anonymous **Addictions Testing Measure**.

Despite the increased investment in drug interventions in prisons – £77 million in England and Wales in 2006/07[65] – there is little published data on the impact of most interventions delivered in prisons. With the exception of the RAPt programme and the use of mandatory drug testing, there has been very little evaluative work done to assess the effectiveness of most prison-based interventions in the UK (e.g. **CARATs, drug-free wings, detoxification and opioid maintenance provisions**).

The **prison-based programmes based on CBT**, such as **Short Duration Programmes (SDPs)** and **ASRO**, have also not been evaluated. However, while the provision of meaningful rehabilitation programmes to short-sentence prisoners (a high proportion of whom will be problem drug users) may not be possible because of their very short stays, anecdotal evidence suggests that SDPs may be effective if they motivate prisoners and link them into treatment programmes on release.

It is well established that prisons are high-risk environments for the transmission of blood-borne viruses,[66] and that there is an increased risk of drug-related death on release, as already mentioned. There is good international evidence that it is possible to provide a range of **harm reduction measures**, including needle and syringe exchange programmes, within a custodial setting.[67] However, a survey in 2005 by the Prison Reform Trust and the National AIDS Trust[68] showed that prisoners received inadequate healthcare in relation to both HIV and hepatitis C, with potentially grave consequences for their own health and for others' as a result of onward transmission. They found evidence of significant levels of undiagnosed infection of both HIV and hepatitis C in prisons and also dissatisfaction among both staff and prisoners with the information and training available in this area. At present, in UK prisons the policy is not to introduce needle exchange where security remains of paramount importance – instead, prisons make disinfectant tablets freely available to prisoners as part of their harm reduction strategy. However, this provision has not been properly evaluated in the UK and there is some international evidence to suggest that it may not be particularly effective.[69] There has been a notable improvement in provision of hepatitis B vaccination over recent years. In England the majority of prisons offer hepatitis B vaccination, and since the Scottish Prison Service introduced a vaccination programme to all inmates in 1999 there have been no outbreaks of acute hepatitis B infection among injecting drug users in Scotland.[70]

Factors that influence outcomes

A range of factors besides intervention design will have an impact on effectiveness. The evaluations referred to above identified a number of these:

- **Variability in levels and nature of provision**. Despite considerable investment and improvements in the UK during recent years, the quality, availability and approach to interventions and treatment for drug-dependent offenders in both community and prison-based settings remains variable and inconsistent. In one study in the treatment field, the agency providing care was the variable that explained more of the observed variability in treatment outcomes than any other.[71] The QCT Europe study found a similar situation among interventions in the CJS.[72] As mentioned earlier, QCT Europe also found in-patient treatment to yield particularly good outcomes, and more general British treatment outcome studies such as NTORS and Drug Outcomes Research In Scotland (DORIS) have also demonstrated the effectiveness of residential treatment. However, the availability and use of residential treatment is limited. At the same time, concerns have been raised in parts of the UK about some fundamental aspects of methadone treatment, such as inconsistencies in practice and the variable quality of service being provided. In the context of prison drug treatment, provision is often patchy, poorly coordinated and subject to the many vagaries of prison administration.
- **The characteristics of those receiving interventions** will have a profound impact on the outcomes of the treatment approach adopted. As indicated earlier, there is some evidence to suggest that those referred into treatment via the CJS are a more intractable group, who are likely to be harder to engage and retain in treatment. Better matching of offenders to treatment options might improve outcomes. There is also a high proportion of crack users in the offending population who may require different treatment approaches. This underlines the critical importance of initial and subsequent assessments and care-planning procedures and pathways.
- **The competences and quality of individuals and organisations delivering interventions** will also play an important part in shaping outcomes. Evidence from the USA and elsewhere highlight the critical importance such factors have in explaining the differences in performance between similar services.
- **The wider context in which interventions are delivered** will also be as important in shaping outcomes as the particular treatment approach adopted. Scotland, for example, has greater flexibility in its approach to the treatment and supervision of drug-dependent offenders. There is less emphasis on performance management, greater flexibility in guidelines regulating the nature and extent of contact with offenders subject to probation supervision, and the courts have more scope for discretion in responding constructively to non-compliance. These

factors may have contributed to improved outcomes for some criminal justice interventions north of the border. The challenge associated with providing treatment within a prison system under enormous pressure from increasing numbers also needs to be recognised along with the limitations on what can be provided to short-term prisoners.

- **The inadequacy of aftercare and social re-integration provision in the UK** may reduce the effectiveness of the treatment and supervision of drug-dependent offenders. Both the CJS and drug treatment services are limited in their capacity to tackle the wider social and environmental factors that can facilitate and perpetuate problematic patterns of drug use and offending (e.g. housing and employment needs). However, a recent study involving service providers indicated that "the introduction of throughcare and aftercare (in April 2004) as part of DIP had made a difference to service delivery" and that it had "lead to better integration and coordination of services".[73]
- The current **strategies for encouraging compliance** with orders or retention in treatment (e.g. drug testing) and the limited use of innovative strategies (e.g. contingency management) to promote engagement and incentivise behaviour change may also be reducing the potential effectiveness of some programmes. Our CJS has little opportunity or flexibility to utilise innovative incentivising approaches, unlike some other jurisdictions.

Much of the evidence on the effectiveness of recent British initiatives was gathered during the piloting process or the early stages of implementation and is largely descriptive in nature. Clearly, the long-term viability of these initiatives will need to be judged on the outcomes that are achieved once they have become more established and they have had the opportunity to learn from experience. The very rapid roll-out of interventions and the constant changes of available provision have also impacted on the effectiveness of the programmes by restricting the time for developing the partnerships necessary for delivery and for raising awareness of the available options.

In summary, this review indicates that:

- there is reasonable evidence (although some is from other countries, and cost-effectiveness has generally not been considered) in support of: 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 published evaluations of the effectiveness of: CARAT interventions; drug-free wings; Short Duration Programmes; ASRO (Addressing Substance Related Offending) programmes; conditional cautions; diversion from prosecution schemes; and Intervention Orders;

- the evidence concerning the effectiveness of other programmes is more mixed: there were some positive findings with respect to CJITs (Criminal Justice Intervention Teams) and RoB (Restrictions on Bail), both elements of the DIP, but overall their impact was limited and the evaluation of drug testing within the CJS found little evidence of added value. However, the evaluations encountered problems and the DIP is a complex programme that has evolved over time; engagement rates have increased over time and there is evidence that some of those who engage with treatment do have lower reconviction rates.

5. Key conclusions arising from the thematic review

The evidence pertaining to interventions for drug-dependent offenders needs to be considered in context:

- recorded crime, especially acquisitive crime, has been and still is falling;
- the prison population is rising continuously and, in response to the problems of overcrowding, more prisons are planned, and the time available for prisoners to receive interventions is being reduced;
- it appears that overall drug use prevalence has now stabilised, although, within this, patterns of use have changed and cocaine is now the second most commonly used illicit drug after cannabis;
- there remains a cohort of some 400,000 problem drug users with extreme problems, many of whom are involved in offending and have frequent contact with the CJS, and among whom crack use alongside opiate use has become more common;
- a host of initiatives have been launched and provisions made to encourage these offenders to engage with treatment and other services to stabilise their lives, but the pace of change has been such that these have had little opportunity to bed down or be comprehensively evaluated;
- following this rapid expansion, no further increases in overall budgets in this area are likely in the foreseeable future;
- 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. Therefore expectations must be framed in this context.

It is clear from this review that in many areas the evidence about the effectiveness of different interventions is weak or absent. However, it is important not to allow the knowledge gaps to inhibit action in an area of considerable need. Having reviewed the evidence, we believe it points to the following as key issues for policy and practice development.

5.1: The principle of using CJS-based interventions to encourage engagement with treatment is supported by the evidence.

- **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, and that CJS referrals to treatment in the UK do not appear to have had a negative impact on 'voluntary' treatment capacity.**

The evidence described in Section 2 of this report shows that a significant proportion of offenders in the CJS have highly problematic heroin and/or crack use which is associated with high rates of offending. People entering treatment through the CJS have also been shown to have more complex needs, for example less stable accommodation, lower educational levels and higher unemployment, than people entering treatment through other routes.

Several international studies have demonstrated that so-called 'coercive' CJS referrals to treatment can be at least as effective as non-CJS 'voluntary' referrals in reducing drug use and reoffending, and it should be noted that treatment is never mandatory and offenders must agree to participate. In the UK, CJS interventions have been shown to have successfully channelled some problem drug-using offenders into treatment for the first time. However, it is not clear to what extent the expansion of general drug treatment provision that has occurred would have led, or will lead, to some of this group entering treatment without the need for CJS interventions. There is also strong international evidence that using the CJS to get drug-dependent offenders to enter treatment can reduce both their offending and drug use, although success depends on a range of factors, not least the quality and appropriateness of the treatment provided.

A number of data sources show that the majority of problem drug users in treatment still come from other sources of referral than the CJS and that waiting times have reduced for all clients. This suggests that the expansion of the treatment system has been sufficient to limit the potentially negative impacts of an increase in CJS referrals on the capacity of the wider treatment sector. Therefore, the current principle of using the CJS to identify problem drug-using offenders and encourage them to engage in drug treatment programmes, sometimes through quasi-coercive measures that make the alternatives unattractive, is supported by the evidence.

The recent UK drug strategy proposes that problem drug-using offenders be given priority for treatment alongside those with children. If there is sufficient capacity within the system this may be appropriate. However, it is important to ensure that this does not lead to a two-tier system, in which those seeking help voluntarily find it difficult to access treatment.

5.2: Following a period of expansion and a focus on quantity, attention should now focus on quality.

Following a period of expansion of both the range of interventions available and the numbers being engaged in them there are now many options available for addressing the needs of problem drug-using offenders. However, there appears to be considerable variation in provision between services and areas and there is now a need for consolidation to focus on improving the quality of provision and outcomes. A focus on quantity – that is, getting increasing numbers into programmes – may have a negative impact on the quality of those programmes, resulting in reduced benefit, and so greater consideration needs to be given to which offenders are likely to benefit from the different programmes.

A number of factors have been identified that will impact on outcomes and apply across the range of programmes operating in both prison and community settings.

- **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 interventions currently being provided are largely geared towards getting offenders to engage with treatment and other services and hence their success is linked to the quality and availability of these services. There is a concern that an emphasis on reducing offending may cloud the focus on the individual and their recovery, leading to simply the 'management of addiction' with a view to containing offending behaviour. Certainly, we have heard from individuals, particularly service users, who felt that this was the case. What is undoubtedly true is that there should now be a greater focus on improving the quality of treatment and sustaining recovery across the board.

There is a need to have a range of treatment options available to meet differing needs – this review suggests 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. Given the high proportion of problem drug-using offenders with complex needs and entrenched drug problems, consideration should be given to expanding the use of heroin-assisted treatment for this group if the current pilot programmes are successful.

As the extent of in-patient treatment currently available in the UK is relatively limited, an expansion of the availability and use of residential programmes might provide an opportunity to improve outcomes from community orders, although this should not be to the detriment of existing levels of provision of other treatment

modalities. However, as residential programmes are expensive and not suitable for all drug users, more guidance would be required on the criteria for selecting community versus residential forms of treatment to ensure that treatment matches needs.

- **There is a need to improve the assessment of problem drug-using offenders in order to match them to appropriate interventions, with regular reviews and reassessments.**

The importance of matching the intervention provided to the needs of the individual is mentioned above. The assessments carried out by CJITs and CARAT workers and their equivalents are obviously key to this. Anecdotal evidence provided by users and practitioners suggests that this is not always effective, with little choice of intervention available. There is a perceived dominance of out-patient maintenance therapies over other options, which may not always be appropriate. The need for regular reassessment to meet changing circumstances and promote recovery was also raised. This is, of course, the basics of effective care planning and there is extensive guidance for practitioners on this topic, 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.

A number of those engaged in our consultative programme suggested that the value for money and effectiveness of treatment and recovery interventions is being undermined or compromised through a focus on throughput numbers. The 'law of diminishing returns' may become an important factor, as the system processes more and more drug-using offenders, many of whom may have low levels of use or who may not yet be at the point in their drug dependency histories at which they will be able to take full advantage of treatment. They may not be sufficiently motivated to embrace the opportunity to tackle their addiction, or the interventions provided may not be appropriate at that stage. We recognise that the links between initial motivation and outcomes are not straightforward, but if compliance and outcomes deteriorate this will have a negative impact on the overall effectiveness of the system.

- **Greater provision of services to promote reintegration (such as housing, education and employment) is required in order to improve long-term outcomes.**

Evidence described earlier shows that 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 co-existing mental health problems. The provision of employment, training or housing has been

shown to be key to better longer term outcomes in both the treatment of drug use and general programmes to reduce reoffending. Therefore, increased provision of a range of support services, such as housing, education and employment opportunities, and family support services, is needed if outcomes are to be improved. There are a number of programmes underway or being piloted which address these issues, but further improvements in provision are necessary to meet existing levels of need.

- **A focus on the impact on outcomes of delivery issues, such as staff skills, morale and management, is necessary to improve consistency of service quality.**

While at the moment it is not possible to compare the effectiveness of the different programmes aimed at treating and managing drug-dependent offenders, it is likely that the differences between different types of programme are smaller than the variability in outcomes within a particular type of programme, as discussed in Section 4. More attention is needed on the impact of different aspects of programme delivery on outcomes.

- **The multiplicity of programmes, funding streams and commissioning processes hampers the delivery of care packages that address the wide range of needs of problem drug-using offenders. Attention now should focus on developing simplified commissioning, funding and management systems.**

We have found when conducting this review that the level of resources being made available for drug-related interventions and the funding routes they follow are complicated and not transparent. This is something others have commented on.[74] These resources are also divorced from much local or regional commissioning in the healthcare, social care and offender management sectors. We appreciate that steps are being taken to address this, such as the transfer of responsibility for prison healthcare to local Primary Care Trusts. However, with such a fragmented system, costs and benefits deriving from successful interventions to address substance misuse problems are not easily identifiable or transferable. This situation is further complicated by the fact that costs and benefits are frequently experienced at different levels. So for example, the expenditure on imprisoning a problem drug user is met from national Ministry of Justice budgets (in England), but any cost benefits (as such) are accrued at local community level. Therefore, improving provision by redirecting resources is made extremely difficult, or nigh on impossible.

Initiatives such as the Justice Reinvestment approach, developed in the USA and piloted in this country in Gateshead,[75] are beginning to look at alternative ways to address this problem. This initiative is aimed at transferring the budget allocation on crime control (and imprisonment) to more positive social expenditure within local communities. Although this is still at an early stage, we think there is merit in

exploring further how expenditure on those going through the CJS, and especially prison, because of drug-related offending could be redirected towards addressing their drug dependency. A link to programmes considering individualised budgets for people with chronic health conditions might also be made, something proposed in the recently published drug strategy for England.

We conclude that much of current national expenditure is directed at dealing with the consequences of criminal behaviour when it could be channelled to addressing the underlying causes at an earlier stage. One of the reasons this has perhaps not happened is that spending and resource allocations are split between national and local agencies. With new arrangements such as Local Area Agreements and Local Strategic Partnerships, the potential is there to identify more optimal and sustainable problem-solving solutions. This also might encourage some simplification of programmes, initiatives and management.

However, to date, only limited budgets and expenditure have been devolved or localised, and this notably excludes much criminal justice and drug treatment resources.

These programmes require extensive working in partnerships across organisational boundaries involving health, criminal justice and ancillary services, such as housing and employment, which will all have different priorities and perspectives. The links between prisons and the community are an area where there are frequent problems. Simplification of management, commissioning and funding systems should aim to promote partnership working.

Given the limited information available, it is not possible to assess whether the overall investment in drug-related interventions is adequate. However, the evidence in Section 2 reveals the enormous levels of problematic drug use among offenders in the CJS and the particular concentration of this group within prisons, which suggests that more resources might be necessary to meet this need.

- **Attention should be paid to improving supervision and monitoring practice; including clarifying the role of supervision and considering the potential for greater use of positive incentive-based strategies to secure compliance (contingency management) rather than the current punishment-orientated focus.**

International research has struggled to show the added value of supervision and monitoring of offenders over and above the gains from specialist treatment. While the criminal justice framework itself may provide motivation for engagement in services, either through the threat of sanctions in the community or by creating a ‘captive audience’ in custody, the impact of supervision and the use of testing should be carefully scrutinised.

Anecdotal evidence provided to us suggests that in practice the input from the probation service and offender managers is limited. This is perhaps understandable in the current context of major organisational changes and growing caseloads relative to resources. When considering the often deep-seated underlying problems that characterise the lives of many problem drug users, for example childhood abuse, it is hardly surprising that a few hours of supervision each month are unlikely to make much impact. Guidance has recently been issued which clarifies the role of offender managers in their work alongside CJITs in dealing with offenders on community sentences with drug rehabilitation requirements. However, there is variability in offender management across areas. Some offender managers are implementing the accredited offender management scheme (ASRO), and there are also opportunities for attaching requirements such as unpaid work alongside DRRs which might provide additional benefits in terms of increasing readiness for employment for some offenders. However, a balance needs to be struck around the need for appropriate sequencing of interventions and avoiding overburdening offenders with a disproportionate number of requirements. We would suggest that variability between areas should be investigated to identify practice that enhances drug-using offenders' engagement with drug interventions so that good practice can be shared. This may include strategies that promote positive behaviour, sometimes referred to as 'contingency management'.

Drug testing is also used extensively to monitor compliance with DTTOs and DRRs but, as described in Section 4 above, users and practitioners felt that in many cases little use was made of the results of the tests. It is important that failed drug tests do not necessarily result in a negative sanction, since the relapsing nature of drug dependence and the severe drug problems of some offenders may make abstinence extremely difficult. Furthermore, a failed test might simply indicate a need to review the level of substitute medication or the need for alternative or additional interventions. However, there was a strong feeling from both users and practitioners that testing should only be done if it has a specific purpose and that, if and when repeated failed drug tests do occur, they should have clear consequences. While this is simply good practice, it appears that at present this is not always being followed, and that resources and opportunities for reinforcement are wasted as a result.

- **Interventions that adopt holistic, problem-solving approaches to addressing drug use and offending are likely to be most successful. Drug courts, for example, are supported by a good international evidence base. However, their effectiveness in the UK context needs to be proven and ways found to apply the underlying principles more widely and in a cost-effective manner.**

A problem-solving approach underpins drug courts and similar initiatives and there is comparatively strong international evidence in support of this basic approach. There are a number of interventions within the UK that adopt this approach to addressing offending behaviour, such as drug courts and Community Justice Centres/courts. Although in some interventions therte is a primary focus on problem drug use, this is not necessarily the case, and in all cases other problem areas, such as housing and employment problems, are likely to be addressed as well. These principles could also be applied to diversion from prosecution schemes (including conditional cautions) and community sentencing.

Drug courts have a good international evidence base and a number of characteristics for success have been identified and are described in Section 4 above. The evaluations of the drug courts currently in operation in England and Scotland should indicate if the approach provides value for money and should be rolled out more widely. However, the throughput of such courts is likely to be comparatively small and it is important that any expansion is accompanied by collection of data to allow the identification of the key features of successful operation and the types of offender who will benefit from this approach. We appreciate the costs of unique or adapted courts administration systems that focus on drug misuse are significant. At a time of finite resources, an alternative to specialist drug courts may be to adopt their principles more widely throughout the existing courts system. This will require adequate treatment services to be made available, so as not to 'hijack' current local provision, and a considerable programme of development and training for court officials, Crown Prosecution Service, magistrates and judges.

5.3: Net-widening to include additional groups of drug-using offenders may have negative consequences.

- **Current evidence suggests that net-widening to include less problematic drug users in community-based interventions within the CJS is likely to reduce the efficiency of these programmes and may have unintended negative consequences for some offenders.**

While the CJS provides the opportunity to identify problem drug users, and net-widening to include less problematic users (perhaps earlier in their offending and drug careers) in CJS-based interventions is intuitively appealing, the evidence suggests this is not appropriate and may have a range of negative consequences.

In Scotland, it is proposed to extend the use of DTTOs to lower tariff cases and there have been calls to expand the range of drugs tested for in the DIP, both of which will probably lead to the inclusion of a high proportion of offenders whose drug use is less problematic (recreational or occasional drug users whose offending is not related to their drug use or whose drug use may be associated with some minor

crime and disorder, such as vandalism – groups 1 and 2 described in Section 2 of this report). However, the basis for current coercive interventions is the evidence that treating opiate-dependent offenders can lead to reductions in their offending and that contact with the CJS may be a trigger point that can increase their motivation to change. This does not necessarily apply to other drug-using offenders.

Current Home Office guidance[76] states that the principle should be "drug-related crime should be dealt with by drug-related punishment". 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 associated with, for example, a DTTO or DRR, leading to the further criminalisation of these, mainly younger, drug users.[77] The recently announced pilot of DTTOs for lower level offenders in Scotland appears to recognise these dangers and it is important that this issue is addressed in the evaluation.[78] Interventions to prevent the escalation of drug problems among recreational drug users require a completely different approach to that for drug-dependent offenders, and the need for such interventions should be considered alongside those for alcohol misuse and other criminogenic factors which may underlie both the drug use and the offending.

This is not to suggest that intervening with 'recreational' and less problematic drug users is not valuable, rather that for the CJS the priority for drug-specific interventions should be with those whose drug problems are most severe and whose offending is more likely to be directly drug-related.

- **Extending the use of drug testing in police custody suites by expanding the range of trigger offences or testing for a wider range of drugs is likely to prove poor value for money and may have a negative impact on the quality of subsequent assessments and interventions.**

As described earlier, the DIP in England uses drug testing on arrest (for opiates and cocaine/crack) in 'intensive' areas to identify drug-using offenders for mandatory assessment of their treatment needs. Current evidence suggests that expanding drug testing is likely to result in decreased efficiency (and value for money) and quality being sacrificed to increased quantity. It should therefore not be considered without further analysis of the potential impact and the consideration of alternative approaches.

Extending drug testing to additional drugs, amphetamines for example, will tend to identify more people who have less severe drug problems, whose offending is unlikely to be linked to drug use and for whom most current treatment options are inappropriate (groups 1 and 2 referred to in Section 2 of this report). As described in Section 2 of this report, the Arrestee Survey shows that users of other drugs have much lower rates of offending than those who use heroin and crack and are less

likely to have committed a crime to get drugs or when under the influence of drugs. They also use drugs less frequently. The identification of powder cocaine users within the current testing regime already pulls a substantial number of 'recreational' drug users into the DIP – the Arrestee Survey suggests that over three-quarters of 'last year' powder cocaine users were not dependent. As users of these drugs use them relatively infrequently, a considerable proportion of users will test negative, hence testing will not be a very efficient way of identifying problem drug users. We therefore think that extending drug testing to include additional drugs is currently inappropriate.

The evidence cited in section 4 shows that this change in the profile of users is already reflected in an increase in the proportion being assessed as not requiring an intervention following the introduction of Tough Choices and an increase in the proportion being referred to receive non-specialist (Tier 2) treatment interventions. Thus the costs of identifying offenders for treatment in this way have gone up, as more tests and assessments are 'wasted' for every offender actually referred for treatment. Expanding the range of trigger offences will have a similar effect, as the offences most likely to be committed by heroin and crack users (groups 3 and 4 referred to in Section 2) were included in the original list.

On top of the additional costs associated with testing (Home Office guidance for areas considering testing suggests that these are currently about £10-£14 per test) and assessment, there may be an impact on quality from any extension of testing. Even if those who do not need treatment are filtered out at the assessment stage, there is a danger that the sheer volume of assessments and subsequent interventions will impact on their quality and might have wider implications for mainstream provision (e.g. capacity to cope, or diversion from dealing with more severely affected clients). There has also been no comparative study of the impact of the work of CJITs in non-intensive areas, where more traditional arrest referral approaches rather than drug testing are used to identify problem drug-using offenders, which anecdotal evidence suggests can also be effective. These non-intensive areas could provide valuable comparisons for intensive areas (despite inevitable differences between the populations). The piloting of drug testing at charge in Scotland could provide a similar opportunity for comparative research.

- **Schemes that divert drug-using offenders in the early stages of their offending and problem drug-using careers from prosecution on condition that they address their substance use and other problems may merit expansion.**

As an alternative to widening the net to include less problematic drug users within the community sentence or prison interventions, schemes that divert them away from prosecution might be more beneficial. Conditional cautions in England and Wales and the diversion from prosecution schemes in Scotland have not been widely

used to date, nor have robust outcome assessments been published. However, these schemes may be appropriate for less problematic drug-using offenders whose drug use and offending is not entrenched (groups 1 and 2 as described in Section 2) and we suggest their use be expanded and properly evaluated. However, it is important that up-tariffing (placing further requirements or sanctions on the offender than would normally be expected) is avoided, and also that the offender's other problems, which may be underlying both their drug use and offending, are addressed. The new UK drug strategy action plan calls for the number of conditional cautions to increase to 2,000 by March 2009. While we welcome this in principle, it will be important to ensure that the setting of a numeric target does not lead to inappropriate referrals and that the right sort of treatment is available to meet the needs of those referred under this programme.

5.4: Community punishments are likely to be more appropriate than imprisonment for most problem drug-using offenders.

A key policy issue, within finite resources, is the balance between provision in the community and prisons to address offenders' drug use. Proven reoffending rates are high for both prison and community sentences, and the types of offences that are most often drug-related are those with the highest reoffending rates. However, the latest available figures show that the two-year reoffending rates for those on DTTOs are improving: rates have declined from 89% in 2002 to 82% in 2004. In 2004, the reoffending rates for those on DTTOs were still higher than for custodial sentences, but the report authors[79] suggest that the data should be treated with caution.

- **Imprisonment can have unintended 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.**

An environment which is struggling to cope with record numbers of prisoners is unlikely to be conducive to recovery, and custodial sentences may frequently do more harm than good. By creating or exacerbating problems such as housing, employment and family relationships and increasing health risks such as infection from blood-borne viruses, the chances of successful long-term outcomes are further reduced.

Delivering effective drug interventions to inmates who are serving very short sentences is difficult as prison stays are too short for effective treatment and may simply serve to disrupt community treatment already commenced.

Provision of effective interventions 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. Also, as described earlier, imprisonment can have profound negative consequences which may exacerbate drug use and offending in the future, such as loss of housing and employment, damage to families and increased health risks such as infection from blood-borne viruses. Enforced detoxification without adequate follow-up support also increases the risk of relapse, overdose and death, particularly on release.

- **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 reoffending.**

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[80] suggests that community sentences may provide better value for money. While it is not clear how applicable this would be to the UK situation, we think it reasonable to conclude that community sentences which also address drug dependency offer greater potential benefit than imprisonment. This is important in the current context of budget constraints and enormous pressures on the prison estate. It is particularly relevant as the majority of problem drug users are not within the CJS for violent offences but for less serious acquisitive crimes, such as theft and fraud. As mentioned above, we would also suggest that more attention should be paid to developing and evaluating diversion from prosecution schemes, such as are in place in Scotland, and making better use of options such as conditional cautioning for certain types of offenders (groups 1 and 2 as described in Section 2).

The analysis of existing datasets suggested in Chapter 5.6 and in Annex A would help to identify those groups who are most appropriate for different sentences, which would assist the courts.

5.5: Prison drug services frequently fall short of even minimum standards.

- **With so many drug-dependent offenders within the prison system, it is essential that the extent and effectiveness of drug treatment and other interventions is improved so that prison care is equivalent to that found in the community.**

The current trend towards imprisoning more people has created a system in which it is difficult to provide an adequate response to the needs of drug-dependent offenders. Even if more use is made of community sentences and diversion schemes there will still be a large number of drug-dependent offenders within prisons, who are often extremely damaged individuals with considerable health problems. Despite the difficult conditions caused by overcrowding and short-term sentences, the efforts of governors and prison and healthcare staff have delivered some notable improvements in care and the numbers being detoxified in custody are significant. However, this is often not matched by sufficient support and aftercare and many prisoners are not getting the help they need. This will lead to an increased risk of relapse and overdose, particularly on release into the community. There are many areas where further improvement is required:

- **The process for identifying problem drug users on reception** to prison needs to be improved so that those with drug problems are identified as soon as they are imprisoned, including when on remand, and assessments including pre-sentence reports identifying drug problems accompany the individual to ensure prompt treatment. It is important that drug use is identified early as withdrawal from drugs may induce or compound other mental health problems and needs to be managed appropriately and then followed up with appropriate aftercare.
- **Rolling out the Integrated Drug Treatment System (IDTS) to all prisons** would help to improve both the quality and quantity of care across the prison estate in England and Wales and improve communication and coordination between healthcare and CARAT staff. Currently, only 29 prisons have benefited from the full IDTS programme, with a further 24 having enhanced clinical services only. Plans to roll-out the full IDTS programme to all prisons have been subject to delay and will be limited to an expansion of the clinical elements to around 35 prisons in the next year. While it is important that minimum standards of clinical care are met, a far greater level of support is required to successfully meet the needs of prisoners.
- It is important that prisoners have the same access to and quality of care as people in the community, particularly as drug-dependent offenders are likely to have exceptionally poor healthcare histories. Consequently, it is essential that **all prison healthcare must adhere to NICE and other clinical guidance**.
- There must be **enhanced performance management and clinical governance** of all healthcare delivery so that the adequacy of provision can be properly assessed. For example, in England we suggest stronger collaboration between the HM Inspectorate of Prisons, the Healthcare Commission and the National Treatment Agency in the review of provision across the prison estate. There is an array of different interventions for drug-dependent offenders within the prison system but there are no **published figures for the numbers receiving different types of provision**.
- **Programmes that have not yet been evaluated**, such as drug-free wings and

the voluntary testing compacts, **must be evaluated** to ensure they are effective. This information is essential for planning appropriate and cost-effective service provision. We are aware that a number of cohort studies are underway that may provide some of this information, but the need for more formal evaluations should be reviewed. It is also important that the findings of these evaluations are published in appropriate academic journals to facilitate the wide dissemination of the findings.

- **Continuity of care**, both within the prison system and with community services before prison and after release, is key to the provision of high-quality care and sustaining positive outcomes, particularly for short-term prisoners. Although this is recognised in official guidance, more must be done in practice.
- There has been an increase in the provision of detoxification for drug-dependent offenders within the prison system, but this must be matched by provision of follow-up interventions as the evidence indicates that without the provision of **follow-on support**, any gains are likely to be quickly lost.
- A period of imprisonment can expose drug-dependent prisoners to additional harms, such as risk of infection with blood-borne viruses (e.g. HIV and hepatitis) from sharing needles and an increased risk of drug-related death on release. The recent reintroduction of disinfecting tablets is welcome, and the possible experimental introduction of providing other **harm reduction measures**, including needle and syringe exchange programmes, should be explored following evidence on their introduction within custodial settings in other countries.

5.6: Given the sizeable investment in CJS interventions for drug-dependent offenders, we know remarkably little about what works and for whom.

- **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 in this area. 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.**

As described in Section 3, there is now a wide range of interventions, both in prisons and the community, which seek to reduce offending by helping problem drug-using offenders to deal with their drug use and stabilise their lives. The evidence base in support of these (sometimes very complex) interventions is generally weak, and in some cases non-existent. There is no evidence that is robust enough to allow comparisons of the effectiveness or value for money of different interventions or to clearly identify those offenders who will benefit most from different programmes.

The weakness of the evidence base for many interventions and programmes

severely hampers the development of policy and practice in this area and there is a need for much greater investment in information collection, research and analysis. Over £300 million per year is spent on drug programmes for which there is no robust evidence of cost-effectiveness, leaving aside the additional general costs of policing, probation, imprisonment etc. Historically, research and evaluation has accounted for only a tiny amount of the budget – considerably less than 1%. A substantial increase in funding to support a coordinated research programme and a range of independent evaluations is required to remedy this.

The priority given to providing interventions to problem drug-using offenders is laudable, but in many cases the speed of implementation has hampered proper delivery and evaluation of the programmes. In addition, we could not find any published information on the numbers receiving many interventions and no up-to-date information on the characteristics of those in receipt of the interventions or their outcomes. The lack of this basic information makes it hard to draw any robust conclusions about the adequacy or balance of current provision. We feel that it is appropriate now for governments within the UK to focus primarily on the current range of interventions and seek to improve their operation and assess their effectiveness.

Although the operation of many of these programmes is complex, and we do not underestimate the challenges in evaluating these programmes, there is a need to address the following to provide information to improve the value for money obtained from resources and the better matching of programmes to individuals' needs:

- more consistent collection and publication of data on throughputs and costs of different programmes;
- publication of information about the characteristics of those exposed to different programmes and drug use and offending outcomes assessed in a standardised way;
- evaluation of those interventions that have had no evaluation, e.g. drug-free wings (see above), and further evaluation of those interventions only evaluated in their development phase; and
- assessment of the variability in outcomes from interventions between areas and an investigation of the delivery issues associated with these to ensure that programme benefits can be maximised.

There is a range of new datasets that have the potential to provide valuable information on the characteristics of individuals entering different programmes, including information on drug use and offending, and which in some cases have the potential for linkage, such as the Drug Interventions Record (DIR), the National Drug Treatment Monitoring System (NDTMS), the Offender Assessment System (OASYS), and the Police National Computer research extract. The recent report on the DIP[81] shows how these might be used to shed valuable light on the operation of current interventions.

A coordinated programme of research and analysis is required and we suggest key areas for study in Annex A to this report. To maximise the impact of such a programme it is also important that the findings are widely disseminated in a range of formats and in a timely fashion, including publication in appropriate peer-reviewed academic journals. This will enhance both the use and credibility of the findings.

References

[1] McSweeney T, Turnbull PJ and Hough M (2008) *The Treatment and Supervision of Drug-dependent Offenders*. London: UKDPC.

[2] UK Drug Policy Commission (2008) *Reducing Drug Use, Reducing Reoffending: Consultations with key stakeholders to inform the UK Drug Policy Commission report*. London: UKDPC.

[3] ISD Scotland (2007) *Drug Misuse Statistics Scotland 2007*. Edinburgh: Information Services.

[4] Scottish Prison Service (2006) *9th Prisoner Survey 2006*. Available from: http://www.sps.gov.uk//MultimediaGallery/ba7098ab-94b3-4783-aaaf-e85673c21a68.doc [Accessed 08/01/2008]

[5] Hay G, Gannon M, MacDougall J, Millar T, Eastwood C & McKeganey N. (2007) *National and regional estimates of the prevalence of opiate use and/or crack cocaine use 2005/06: a summary of key findings*. Home Office Online Report 21/07. London: Home Office;
Hay G, Gannon M, McKeganey N, Hutchinson S & Goldberg D (2005) *Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland Executive Report* Edinburgh: Scottish Executive. Available at: http://www.drugmisuse.isdscotland.org/publications/local/prevreport2004.pdf [Accessed: 11/03/08];
Hay. G., Higgins, K., Gannon, M. and Carroll, C. (2006) Estimating the Prevalence of Problem Opiate and Problem Cocaine Use in Northern Ireland. Belfast: Drug & Alcohol Information and Research Unit, Department of Health, Social Services and Public Safety

[6] Boreham R, Cronberg A, Dollin L and Pudney S. (2007) *The Arrestee Survey 2003-2006*. Home Office Statistical Bulletin 12/07. London: Home Office.

[7] Budd T, Collier P, Mhlanga B, Sharp C & Weir G (2005) *Levels of self-report offending and drug use among offenders: findings from the Criminality Surveys*. Home Office Online Report 18/05. London: Home Office

[8] Scottish Prison Service (2006) *op*. cit.

[9] Jones A, Weston S, Moody A, Millar T, Dollin L, Anderson T & Donmall M (2007) *The drug treatment outcomes research study (DTORS): baseline report*. Home Office Research Report 3. London: Home Office

[10] Singleton N, Farrell M and Meltzer H (1999) *Substance Misuse Among Prisoners in England and Wales* London: ONS.

[11] Boreham R, et al. (2007) *op. cit.*

[12] Home Office (2006) *Statistics on Race and the Criminal Justice System 2005*. London: Home Office

[13] Boreham R, Fuller E, Hills A & Pudney S (2006) *The Arrestee Survey Annual Report Oct 2003 – Sept 2004*. Home Office Statistical Bulletin 04/06 London: Home Office.

[14] Singleton N, Meltzer H, Gatward R with Coid J & Deasy D (1998) *Psychiatric Morbidity Among Prisoners in England and Wales*. London: TSO.

[15] *Ibid.*; Liriano S and Ramsay M (2003) 'Prisoners' drug use before prison and the links with crime' in Ramsay M (ed.) *Prisoners' Drug Use and Treatment: Seven research studies*. Home Office Research Study 267 London: Home Office.

[16] E.g. Stevens A. (2007) *Weighing up crime: The estimation of criminal drug-related harm*. Paper presented at the First Annual Conference of the International Society for the Study of Drug Policy, March 22-23, 2007, Oslo, Norway. Available at: http://www.issdp.org/conferences/oslo2007/issdp%20stevens%20paper.pdf [Accessed: 08/03/08]

[17] Bennett T & Holloway K (2005) "The association between multiple drug misuse and crime" *International Journal of Offender Therapy and Comparative Criminology* 49(1), 63-81;
Boreham *et al.* (2007) *op.cit.*;
Urbis Keys Young (2004) *The Relationship between Drugs and Crime*. Canberra: Australian Government Attorney-General's Department

[18] Boreham *et al.* (2007) *op.cit.* p33

[19] Gordon L, Tinsley L, Godfrey C and Parrott S (2006) 'The economic and social costs of Class A drug use in England and Wales, 2003/04' in Singleton N, Murray R and Tinsley L (eds) *Measuring Different Aspects of Problem Drug Use: Methodological developments*. Home Office OLR 16/06. London: Home Office.

[20] Best D, Day E, Homayoun S, Lenton H, Moverley R and Openshaw M (in press) 'Treatment retention in the Drug Interventions Programme: Do primary drug users fare better than primary offenders?' *Drugs: Education, Prevention and Policy*.

[21] HM Government (2008) *Drugs: Protecting families and communities* London: HM Government, pp. 16-17.

[22] House of Commons Hansard Written answers for 15 October 2007 (Col 754W). Available at: http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm071015/text/71015w0002.htm#07101530000037. [Accessed 11/03/08].

[23] Available at: http://drugs.homeoffice.gov.uk/treatment/strategy/pooled-treatment-budget. [Accessed 08/11/08].

[24] HM Government (2008) *Drugs: Protecting families and communities Action Plan 2008-2011*. London: HM Government.

[25] Blakeborough L & Pierpoint H (2007) *Conditional cautions: An examination of the early implementation of the scheme*. Ministry of Justice Research Summary 7. London: Ministry of Justice.

[26] HM Government (2007) *Working Together to Cut Crime and Deliver Justice: A strategic plan for 2008-2011*. London: TSO.

[27] HM Prison Service (2007) *Annual Report and Accounts April 2006-March 2007*. London: HM Prison Service.

[28] ISD Scotland (2007) *Drug Misuse Statistics Scotland 2007*. Edinburgh: Information Services.

[29] House of Commons Hansard Written answers for 21 January 2008 (pt 0058). Available at: http://www.publications.parliament.uk/pa/cm200708/cmhansrd/cm080121/text/80121w0058.htm#0801235002421 [Accessed: 7/2/08]

[30] Estimates calculated as described on page 29 of this report.

[31] National Probation Service (2007) *Performance Report 24 and Weighted Scorecard Q4 2006/07*. Available at: http://www.probation.homeoffice.gov.uk/files/pdf/NPS%20Performance%20Report%2024.pdf [Accessed: 29/11/07].

[32] House of Commons (2006) House of Commons Written Answers 22 May 2006 (pt 0050) c1505W. Available at: http://www.publications.parliament.uk/pa/cm200506/cmhansrd/vo060522/text/60522w0050.htm#06052439000054 [Accessed: 11/03/08]

[33] House of Commons Hansard written answers for 14 Jan 2008 (pt 0033). Available at: http://www.publications.parliament.uk/pa/cm200708/cmhansrd/cm080114/text/80114w0033.htm [Accessed: 7/2/08]

[34] Scottish Government (2007) *Criminal Justice Social Work Statistics, 2006-07*. Statistical Bulletin, CrJ/2007/12. Edinburgh: Scottish Government.

[35] NICE (2007a). *Methadone and buprenorphine for the management of opioid dependence*. NICE technology appraisal 114. London: National Institute for Health and Clinical Excellence;
NICE (2007b). *Naltrexone for the management of opioid dependence*. NICE technology appraisal 115. London: National Institute for Health and Clinical Excellence;
NICE (2007c). *Opiate detoxification for drug misuse*. Clinical Guideline 52. London: National Institute for Health and Clinical Excellence
NICE (2007d). *Psychosocial management of drug misuse*. Clinical Guideline 51. London: National Institute for Health and Clinical Excellence .

[36] Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Dependence: UK guidelines on clinical management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

[37] Godfrey C., Stewart D & Gossop M (2004) "Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS)" *Addiction* 99 (6) , 697–707.

[38] Holloway K, Bennett T & Farrington D (2005). *The effectiveness of criminal justice and treatment programmes in reducing drug-related crime: a systematic review*, Home Office Online report 26/05. London: Home Office.

[39] Matrix research & consultancy & NACRO (2004) *Evaluation of drug testing in the criminal justice system*. Home Office Research Study 286. London: Home Office.

[40] Skodbo S, Brown G, Deacon S, Cooper A, Hall A, Millar T, Smith J & Whitham K. (2007) *The Drug Interventions Programme (DIP): addressing drug use and offending through 'Tough Choices'* . Home Office Research Report 2. London: Home Office

[41] Sondhi A, O'Shea J and Williams T (2002) *Arrest Referral: Emerging findings from the national monitoring and evaluation programme*. DPAS paper 18. London: Home Office; Birch A, Dobbie F, Chalmers T, Barnsdale L, Mcivor G and Yates R (2006) *Evaluation of the Arrest Referral Pilot Schemes*. Crime and Criminal Justice Research Programme Research Findings No. 87/2006. Edinburgh: Scottish Executive.

[42] King's College, London; University of Bristol; Imperial College, London; and the London School of Economics and Political Science (2007) *National Evaluation of Criminal Justice Integrated Teams: Summary*. London: The Institute for Criminal Policy Research School of Law, King's College, London.

[43] Skodbo S *et al.* (2007) *op. cit.*

[44] Matrix research & consultancy & NACRO (2004) *op. cit.*;
King's College, London; University of Bristol; Imperial College, London; and the London School of Economics and Political Science (2007) *op. cit.*;
Hucklesby A, Eastwood C, Seddon T, Spriggs A (2007) *The Evaluation of the Restriction on Bail Pilot Final Report*. Home Office Online Report 06/07. London: Home Office

[45] Boreham *et al.* (2007) *op.cit.*

[46] Blakeborough L & Pierpoint H (2007) *op.cit.*

[47] Barry M and McIvor G (2000) *Diversion from Prosecution and Other Service Agencies: Evaluation of the 100% funding pilot programmes: 1999*. The Scottish Government. Available at: http://www.scotland.gov.uk/Publications/2000/03/851ca140-55f5-4a7e-bc7a-f6efe6c88ceb [Accessed: 03/12/2007]

[48] Turnbull, P.J., McSweeney, T., Hough, M., Webster, R. and Edmunds, M. (2000) *Drug Treatment and Testing Orders: Final Evaluation Report*. Home Office Research Study 212. London: Home Office;
Eley, S., Gallop, K., McIvor, G., Morgan, K. and Yates, R. (2002) *Drug Treatment and Testing Orders: Evaluation of the Scottish Pilots*. Edinburgh: Scottish Executive Central Research Unit;
Barker, V., Horrocks, C., Kelly, N. and Robinson, D. (2002) *Experiencing Drug Treatment and Testing Orders in Wakefield: Taking a Narrative Approach*. Huddersfield: University of Huddersfield;
Ricketts, T., Bliss, P., Murphy, K. and Brooker, C. (2005) 'Engagement with drug treatment and testing orders: A qualitative study', *Addiction Research & Theory*, 13 (1): 65–78,
Best, D., Man, L., Rees, S., Witton, J. and Strang, J. (2003) *Evaluating the Effectiveness of Drug Treatment and Testing Orders in London*. A Report to the London Probation Area. London: National Addiction Centre.

[49] Naeem, F., Bhatti, F., Pickering, R. and Kingdon, D. (2007) 'A controlled trial of the effectiveness of drug treatment and testing orders (DTTO) with shared care', *Journal of Substance Use*, 12 (4): 253–265.

[50] National Probation Service for England & Wales (2007) *Annual Report 2006-2007*.

[51] ISD Scotland (2007) *Drug Misuse Statistics Scotland 2007*. Edinburgh: Information Services; Scottish Government (2007) *Criminal Justice Social Work Statistics, 2006-07*. Statistical Bulletin, CrJ/2007/12. Edinburgh: Scottish Government.

[52] Hollis V (2007) *Reconviction Analysis of Programme Data using Interim Accredited Programmes Software (IAPS)*. London: NOMS.

[53] Kurze M and Egg R (1989) Berichte, Materialien, Arbeitspapiere (BMA) Heft 3. Eigenverlag Kriminologische Zentralstelle, Wiesbaden

[54] Heckmann W, Kerschl V and Steffan E (2003). *QCT Europe Literature Review – Germany*. Available at: http://www.kent.ac.uk/eiss/documents/pdf_docs/German%20review%20in%20English.pdf [Accessed: 11/02/08].

[55] Jones A *et al.* (2007) *op. cit.*;
Stevens A, Berto D, Frick U, Hunt N, Kerschl V, McSweeney T, Oeuvray K, Puppo I, Santa Maria A, Schaaf S, Trinkl B, Uchtenhagen A, Werdenich W. (2006) "The relationship between legal status, perceived pressure and motivation in treatment for drug dependence: Results from a European study of quasi-compulsory treatment". *European Addiction Research*, 12 (4): 197-209.

[56] Matrix Knowledge Group (2007) *The economic case for and against prison*. London: Matrix Knowledge 'group;
Moore TJ, Ritter A, Caulkins JP. (2007) "The costs and consequences of three policy options for reducing heroin dependency" *Drug and Alcohol Review*. 26, 369-378

[57] McKenna K (2007) *Evaluation of the North Liverpool Community Justice Centre*. Ministry of Justice Research Series 12/07. London: Ministry of Justice.

[58] 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.

[59] HM Inspectorate of Prisons (2007) *The Mental Health of Prisoners*. London: HMIP;

HM Chief Inspector of Prisons for England and Wales (2008) *06/07 Annual Report*. London: TSO.

[60] Davoli M, Bargagli AM, Perucci CA, Schifano P, Belleudi V, Hickman M, 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;

Gibson AE & Degenhardt LJ. (2007) "Mortality related to pharmacotherapies for opioid dependence: a comparative analysis of coronial records" Drug Alcohol Rev. 26(4):405-10.

Strang,J.; McCambridge,J.; Best,D.; Beswick,T.; Bearn,J.; Rees,S.; Gossop,M. (2003) "Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study" *BMJ* 2003;326:959-960

[61] Bird SM and Hutchison SJ (2003) 'Male drug-related deaths in the fortnight after release from prison: Scotland, 1996-99'. *Addiction*, 98: 185-190.

Farrell M & Marsden J (2005) *Drug-related mortality among newly released offenders 1998 to 2000*. Home Office Online Report 40/05. London: Home Office.

[62] McSweeney T *et al*. (2008) *op. cit*.

[63] HM Inspectorate of Prisons (2007). *op.cit*..

[64] HM Chief Inspector of Prisons for England and Wales (2008) *06/07 Annual Report*. London: TSO.

[65] Prison Reform Trust (2007). *Bromley Briefings Prison Factfile December 2007*. London: Prison Reform Trust.

[66] Strang J, Heuston J, Gossop M, Green J, Maden T. (1998) *HIV/AIDS Risk Behaviour Among Adult Male Prisoners* Home Office Research findings No. 82. Londong: Home Office;

Prison Reform Trust/National AIDS Trust (2005) *HIV and Hepatitis in UK Prisons: Addressing prisoners' healthcare needs*. London: PRT/NAT.

[67] Canadian HIV/AIDS Legal Network (2008) *Needle and Syringe Programs and Bleach in Prisons: Reviewing the Evidence* Available at: http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1291 [Accessed:12/03/08]

[68] Prison Reform Trust/National AIDS Trust (2005) *HIV and Hepatitis in UK Prisons: Addressing prisoners' healthcare needs*. London: PRT/NAT.

[69] The Canadian HIV/Aids Legal Network (2008) *op. cit*.

[70] Health Protection Agency (2007) *Shooting Up: Infections among injecting drug users in the United Kingdom 2006*. London: Health Protection Agency.

[71] Meier P (2005) *A national survey of retention in rehabilitation services* NTA Research briefing: 10 London: NTA
National Drug Evidence Centre (2004) *Treatment effectiveness:demonstration analysis of treatment surveillance data about treatment completion and retention* London: NTA

[72] McSweeney T, Stevens A & Hunt N (2006) *The quasi-compulsory treatment of drug dependent offenders in Europe Final National Report – England*. King's College London & University of Kent. Available at: http://www.kent.ac.uk/eiss/UK%20Final%20Report.pdf [Accessed 11/03/08].

[73] Stephenson M (2006) *National Aftercare Research Project Report Year 3*. London: Addaction.

[74] RSA (2007) *Drugs – facing facts: The report of the RSA Commission on Illegal Drugs, Communities and Public Policy London*: RSA

[75] Allen R and Stern V (eds). (2007) *Justice Reinvestment- a new approach to Crime and Justice*; London: International Centre for Prison Studies

[76] National Probation Service (2005) *Effective Management Of The Drug Rehabilitation Requirement (DRR) And Alcohol Treatment Requirement (ATR)* PC57/2005 London: National Probation Service

[77] 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.

[78] Scottish Government (2008) *Drug treatment pilot announced* Available at: http://www.scotland.gov.uk/News/Releases/2007/12/31112929 [Accessed: 11/03/08]

[79] Cunliffe J & Shepherd A (2007) *Re-offending of adults: results from the 2004 cohort*. Home Office Statistical Bulletin 06/07

[80] Matrix Knowledge Group (2007) *op.cit*.

[81] Skodbo S et al (2007) *op.cit*.

Annex A: Key areas for research

We consider the following specific areas should be given priority in a coordinated drug research programme:

1. Research into the assessment and matching of interventions to individuals and the development of a typology of drug-using offenders to assist this and other research.

As mentioned above, not all drug-using offenders are drug-dependent and their offending is not always drug-related. Individuals will also be at different stages of their drug use and offending careers and have different treatment histories. Different groups will respond differently to the interventions available, and if programmes are to operate efficiently and achieve the desired outcomes of reductions in drug use and offending then it is important to identify the groups that are most likely to benefit from each type of intervention.

A common finding of the evaluations in this review is that outcomes vary according to the characteristics of individuals, such as extent of drug use, age, offending histories etc. Comparisons of the effectiveness of different interventions have been hampered by the variation in the characteristics of those in the different programmes, and there is also variation in the information provided on these characteristics which adds to the problems. It is also the case that the few published statistics on drug interventions in the CJS provide hardly any information on the characteristics of those engaged with the programmes.

At present there is no agreed typology to describe the different groups of drug-using and dependent offenders. The development of such a typology would assist in the identification of which interventions worked best for which groups. It would also help with the planning of services through allowing assessments of the sizes of the different groups, and with the matching of appropriate interventions to individuals within programmes.

Building on the work to develop a typology of offenders, there is a need to look at the way in which individuals are assessed for and matched to interventions and how these are reassessed and adjusted through the course of an order or prison term. This is not just important for offenders but also for the treatment system generally,

where there is a need to consider how care packages and treatment journeys are put together.

2. Evaluation of the DIP and of interventions not yet evaluated, particularly conditional cautions and diversion from prosecution schemes and prison interventions.

A coordinated programme of robust evaluations of outcomes is needed, recognising in the design of the different evaluations the need for clear identification of the groups for which the intervention is effective and hence the appropriate comparison interventions. Cost-effectiveness and value for money should be key components of these evaluations. Without this it is not possible to build a picture of the current provision for different groups of offenders nor assess its adequacy.

The DIP receives a large share of the funding devoted to interventions for drug-dependent offenders within the CJS. The evaluations to date have been limited and beset by methodological problems. The programme has also been amended and enhanced constantly, so the findings of the evaluations may be of limited relevance. A lot of information is being collected and some very encouraging case studies produced and it is important that proper outcome assessments are now made. This should consider wider outcomes beyond reoffending and analysis of value for money. Some of the areas that should be addressed are:

- a comparison of processes and outcomes in intensive and non-intensive areas;
- a more detailed assessment of the process of assessing and matching offenders to interventions;
- a consideration of the characteristics of those benefiting from the programme and the combination of inputs that yield the best outcomes.

The complexity of the programme makes this very challenging and the evaluation will require considerable resources. Nevertheless, given the size of the investment it is imperative that this is carried out. For public trust in the findings, the evaluation also needs to be independent and peer-reviewed.

3. Production and publication of data, including outcome measures, for drug interventions within the CJS.

At present the level of information being published on the performance of drug interventions within the CJS is woefully inadequate. Even the simplest figures, such as the number of prisoners receiving each different type of intervention, do not seem to be routinely published. It is possible that such data are being collected but are not being published. The improvements made to NDTMS provide an example of what might be achieved. As many of the providers of components of the interventions will be contributing data to NDTMS there should be an opportunity to

build on this through data linkage. The cohort studies underway may provide some of this information and adequate resources should be provided to these to ensure that they are published in a timely fashion and the data is placed in the public domain so that further analysis is possible to maximise the benefits accrued from these expensive studies.

4. Comparative evaluation of DTTOs/DRRs and drug courts and specifically any added value of court supervision.

DTTOs/DRRs and drug courts are related and aimed at similar groups of offenders (drug courts often building on DTTOs/DRRs) and their use is increasing. Both have or are being evaluated in the UK and have some positive support from these evaluations. However, the evaluations were done in the early stages of implementation and may not reflect the current situation. As drug courts are more resource intensive than DTTOs/DRRs, it is important to identify any added value that they can bring if they are to be rolled out more widely and cost-effectively.

We consider that the use of community sentences should be maximised so it is important that research is conducted to investigate:

– which individuals these interventions are effective for;
– whether and in what ways drug courts perform better than DTTOs/DRRs;
– what are the elements of effective practice for these sentences.

5. Consideration of the impact of interventions on women and Black and minority ethnic groups.

There seems to be very limited information on the extent to which the different interventions are meeting the needs of female or BME groups or may have a differential impact on them. Given that the patterns of drug use and offending vary, there may be some unintended consequences. For example, the Arrestee Survey suggests that Black offenders are more likely to use crack cocaine only than White offenders, while a number of the studies in this review have suggested that crack users do worse within the interventions. If failure within an intervention results in the imposition of a harsher penalty, for example a prison sentence for breaching a DTTO, then there may be a differential negative impact from DTTOs for Black offenders. This is not necessarily the case, but there is a need for more consideration of this whole area.

6. An assessment of the process and outcomes for drug-dependent offenders discharged from prison and the identification of good practice.

Previous research has highlighted some of the particular dangers for drug-using offenders on discharge from prison, such as risk of drug-related deaths. There is also anecdotal evidence of both good practice (accompanying discharged prisoners to an appointment with a drug service immediately on release) and bad practice (releasing people late on Friday when drug services are already closed). In addition, there are particular challenges to providing services on release: for example, short sentences so that there is no supervision on release; unplanned releases; and the high rates of homelessness among this group. A study that considers the process and outcomes, identifies the services and types of provision required and highlights good practice would help improve provision in this area.

7. Comparative study of the costs and benefits of community and prison sentences for drug-dependent offenders.

If more evidence becomes available, collected on a more consistent basis, it may become possible to undertake a study comparing the value for money of community and prison sentences for drug-dependent offenders. Such a study would need to consider the full costs and benefits of these different sentences, including the wider harms (e.g. increased deaths on leaving prison), the impacts on families and the disruption to treatment programmes as well as the more obvious crime and drug use outcomes.