

# Reducing Drug Use, Reducing Reoffending

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

### Summary

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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 the full version of this report are available online at [www.ukdpc.org.uk/reports.shtml](http://www.ukdpc.org.uk/reports.shtml).

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#### **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  |
|--|--|
| <b>England and Wales</b>   |  |
| <b>Testing</b> to identify heroin, crack and cocaine users following arrest for particular, mainly acquisitive, crimes.  | 37% positive drug tests in 2006/07                       |
| <b>Mandatory assessments</b> 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.   | 39,903 entering treatment in 2006/07 via DIP             |
| <b>Restrictions on Bail (RoB)</b> following a positive test allows for drug treatment to be a condition of court bail.   |  |
| <b>Conditional cautioning</b> 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 |

| Type of provision ( <i>continued</i> )   | Numbers ( <i>continued</i> )  |
|--|---|
| <p><b>Drug Treatment and Testing Orders (DTTOs)</b> and now <b>Drug Rehabilitation Requirements (DRRs)</b> are community sentences which result in sanctions if the requirements are not met.</p> <p>The <b>Offender Substance Abuse Programme (OSAP)</b> and <b>Addressing Substance Related Offending (ASRO)</b> are accredited behaviour-change programmes, sometimes attached to community orders.</p> <p><b>Drug courts</b> 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.</p> | <p>15,799 DTTO/DRR starts and 5,939 completions in 2006/07</p> <p>2,943 ASRO and 928 OSAP in 2005</p> |
| <b>Scotland</b>  |   |
| <b>Diversion from prosecution</b> with drug referral.  | 63 in 2006/07   |
| <b>Probation orders with drug-related condition.</b>   | 477 in 2006/07  |
| Drug Treatment and Testing Orders.   | 696 in 2006/07  |

**Main types of prison-based provision**

| Type of provision   | Numbers  |
|---|--|
| <b>England and Wales</b>  |  |
| <p><b>Detoxification</b> for drug-dependent prisoners on reception.</p> <p><b>Maintenance prescribing</b> is becoming increasingly used for short-term prisoners who were receiving this prior to imprisonment.</p>   | <p>51,520 detoxification or maintenance prescribing in 2006/07</p>                 |
| <p>The <b>Integrated Drug Treatment System (IDTS)</b> aims to expand and improve drug treatment in prison through enhanced clinical services, psychosocial support and improved coordination and continuity of care.</p>  | <p>In 2008, 29 prisons have a full IDTS and 24 have enhanced clinical services</p> |
| <p><b>CARAT (Counselling, Assessment, Referral, Advice and Throughcare)</b> 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.</p> | <p>77,860 initial CARAT assessments in 2006/07</p>                                 |
| <p><b>Drug-free wings</b> and <b>voluntary testing programmes</b> aim to help prisoners remain abstinent from drugs while in prison.</p>  |  |

| Type of provision ( <i>continued</i> )   | Numbers ( <i>continued</i> )                             |
|--|--|
| <b>12-step treatment models</b> such as those provided by RAPt (Rehabilitation of Addicted Prisoners Trust).   | 930 in 2006/07   |
| <b>Cognitive behavioural therapy (CBT)</b> high intensity programmes (FOCUS or STOP).  | 360 in 2006/07   |
| <b>Short Duration Programmes (SDPs)</b> are 4-week programmes based on CBT and a harm minimisation approach for short-term prisoners.                              | 5,760 in 2006/07   |
| <b>P-ASRO (Prison – Addressing Substance Related Offending)</b> is an offending behaviour programme of low to medium intensity.                                    | 3,780 in 2006/07   |
| <b>Therapeutic communities</b> provide treatment based on a social-learning approach and peer support.   | 300 in 2006/07   |
| <b>Scotland</b>  |  |
| The <b>Enhanced Addictions Casework Service (EACS)</b> 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 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.