

Searching for a fix

Drug misuse, crime and the criminal justice system

This paper examines the case for increasing the provision of drug treatment in residential and community settings, and making less use of imprisonment to deal with drug-related offences. It finds that tackling drug-related crime should not only be the job of the criminal justice system, and concludes that while ongoing attempts to provide drug treatment to offenders are welcome and have achieved a lot, what is now needed is an emphasis on early interventions and drug treatment on demand in the community.

Key lessons

- According to the British Crime Survey, each year around four million people use an illegal drug. One million people use Class A drugs such as heroin, crack and cocaine.
- There are up to half a million problem drug users in England and Wales – people whose drug use causes significant health or social harm to themselves or society.
- There is strong evidence of a link between drugs and crime, with problem drug users often spending large amounts of money financing their drug use. In parts of the country, two-thirds of people arrested for offences such as burglary test positive for heroin or cocaine.
- More than six out of ten people think that drugs are a problem in their local community.
- The misuse of illegal drugs contributes to crime and social exclusion. The total economic and social costs of problem drug use are between £10.1 billion and £17.4 billion a year – around £35,000 per user.
- The majority of prisoners have a history of substance use, and almost half of recently-sentenced male prisoners used heroin, crack or cocaine in the year before prison.
- Only a small proportion of problem drug users are currently receiving any sort of drug treatment. There are just 1,715 residential drug treatment places available in England. While waiting lists are coming down, there is still much more to be done to ensure that residential drug treatment is readily available and can be used as a viable alternative to custody for less serious offenders.

debat@policy
rethink
justice

“There has been increasing recognition by Government of the links between the misuse of Class A drugs and crime.”

Introduction

There is strong evidence of a link between the misuse of drugs and crime. Although the relationship is complex and not all crime committed by drug users is caused by their drug use, problem drug users are disproportionately likely to commit acquisitive crimes and to be prosecuted, convicted and sentenced.

Most illicit drug use is on a recreational basis with few negative implications for society and no link to other offending. However, research for the Home Office has found that there are up to half a million problem drug users in England and Wales (Godfrey et al, 2000).

There has been increasing recognition by Government of the links between the misuse of Class A drugs and crime. A whole raft of reforms, including the establishment of the National Treatment Agency in 2001, the introduction of sentences such as Drug Treatment and Testing Orders and measures in the Criminal Justice Act 2003 to extend drug testing further – including a presumption against bail for those who test positive for drugs and refuse treatment - have been intended to lead to more effective solutions to problem drug use.

The Government's Updated Drug Strategy, published in December 2002, set out action to tackle the harm caused by drugs, including increasing the annual spending on treatment services. Government funding for drug treatment has more than doubled since 2000 to over £500 million in 2003-04 and will rise further to £573 million by 2005-06.

Using the criminal justice system as a gateway into drug treatment is a key component of the Government's drug strategy. In April 2004 the Government's Criminal Justice Interventions Programme (CJIP), which targets offenders believed to be committing crimes to fund their drug habit, was introduced in high crime areas. CJIP aims to identify problem drug users through drug testing when charged by the police, refer offenders to drug referral workers while in police custody and then guide offenders into treatment. The Prime Minister Tony Blair has said: “The Criminal Justice Interventions Programme aims to cut the destructive cycle of drugs

and crime and stop the 'revolving door' between offending and prison. Everybody wins. Drug users get help through treatment and support, and communities suffer less from the scourge of drug-related crime.”

A survey of sentencers carried out for Rethinking Crime and Punishment found that many judges and magistrates thought that increased seriousness of offending – in particular linked to drug use – was a contributory factor behind the rise in the prison population (Hough, Jacobson and Millie, 2003).

Against this background, this briefing argues that while attempts to tackle the links between drugs and crime are welcome, there are limits to the extent to which it is appropriate to use the criminal justice system in general, and prisons in particular, as a gateway to drug treatment, and that investing in early interventions and residential and community drug treatment could prevent some problem drug users from entering the criminal justice system at all.

Drug use, crime and prisoners

Many problem drug users currently end up not only in the criminal justice system but inside prisons. In many cases the previous offending of prisoners was directly or indirectly related to drugs. One-half of drug misusers' annual £1 billion expenditure on drugs is raised through crime (Audit Commission, 2002). Over half of prisoners (55 per cent) report committing offences connected to their drug taking, with the need for money to buy drugs the most commonly cited factor (Ramsay, 2003).

One in six of all prisoners are inside for drug offences. Only a small minority of these (600 in 2002) are in prison for drug possession. The vast majority of people locked up for drug offences are in prison for supply or importation offences and so are not necessarily drug users themselves.

A study for the Home Office found that almost half of recently-sentenced male prisoners (47 per cent) had used heroin, crack or cocaine in the 12 months when last at liberty. Heroin was the drug most likely to have been used on a daily basis. Altogether, 73 per cent

“...it is impossible to know whether prisoners who enter prison drug dependent are actually receiving the continued drug services that they require.”

of respondents had taken an illegal drug in the 12 months before entering prison (Ramsay, 2003).

In the twelve months before prison, 44 per cent of women used heroin and 43 per cent crack/cocaine, with a third reporting tranquilliser use. At Styal (a women's prison) an estimated 75 per cent of the total number of receptions have drug problems (House of Commons written answers, 8 April 2003, Col. 218W).

Prison Service figures show that 11.7 per cent of prisoners failed random drug tests in 2002-2003. This is likely to underestimate the true extent of drug misuse in prisons. A survey of women prisoners found that over a quarter were still using heroin while in prison, albeit mainly on an occasional basis compared with daily use outside (Home Office, 2003).

Over half (53 per cent) of prisoners who used drugs in the last year and 38 per cent of all prisoners considered themselves to have a drug problem (Ramsay, 2003).

Prisons are increasingly being used as a location for drug treatment. In 2002-03, a total of 50,701 prisoners received drug detoxification, 51,970 received the CARAT (Counselling, assessment, referral, advice, throughcare) service, and 4,386 received drug rehabilitation (House of Commons written answers, 10 February 2004, Col. 1426W).

Just over a third of women dependent on drugs reported receiving advice or education from CARAT workers (compared with 23 per cent of drug-using men) although in many cases this was simply an initial assessment. Altogether 71 per cent of dependent women reported receiving some kind of help, although for many this referred only to medication for detoxification. A quarter of drug-dependent women reported receiving counselling, while fewer than 10 per cent reported attending drug courses or rehabilitation programmes (Home Office, 2003).

According to the Home Office, just 10 per cent of prisoners who had used drugs in the last year were receiving drug treatment. More than four out of ten prisoners who had used drugs in the previous year

wanted drug treatment but were not yet receiving any (Ramsay, 2003).

Addaction have found that just 24 per cent of their drug service users who had been in prison reported that being locked up had helped them to stay drug free. Fewer than one in four were offered aftercare on release (Addaction, 2004).

Less than one in four (22 per cent) drug dependent men in prison were on a drug free wing, compared with 35 per cent of drug dependent women. Thirty seven per cent of women and 38 per cent of men who had used drugs in the 12 months before prison were on a voluntary testing unit or drug free wing (Home Office, 2003).

Concerns have been raised about drug detoxification in prisons. Research has found that '...arrangements for detoxification appeared to vary considerably between different prisons', with prisoners reporting that detoxification programmes were not long enough (Home Office, 2003).

Although the Prison Service carries out a substantial number of drug detoxifications, there is no routine recording of what proportion of prisoners who were given detoxification entered one of the Prison Service's drug rehabilitation programmes (House of Commons written answers, 17 June 2003, Col. 150W). It is therefore impossible to know whether prisoners who enter prison drug dependent are actually receiving the continued drug services that they require.

Short-term prisoners are especially unlikely to receive drug treatment. Research into short-term prisoners on release has found that 'levels of drug use were higher than in prison, though not as extensive as pre-prison' and that levels of reoffending post-prison were significantly higher for drug users (62 per cent) than for abstainers (36 per cent). The highest rates of reoffending were for those prisoners using Class A drugs on a daily or near-daily basis' (Ramsay, 2003).

While growing numbers of prisoners can take advantage of drug treatment in prison, this may be negated by negative impacts of imprisonment

“The Government has said that its updated drug strategy is on track to double drug treatment capacity by 2008...”

such as homelessness, the loss of family contact and the deterioration of physical or mental health. This means that even those prisoners who do receive comprehensive drug treatment may use drugs again on release unless they are provided with an integrated social care package.

Drug Treatment and Testing Orders (DTTO) can be a successful community sentence for some drug misusing offenders who would otherwise have been considered for prison, according to the National Audit Office (NAO). The NAO found that DTTOs can help offenders reduce the level and frequency of their drug use. However, in 2003 just 28 per cent of people on DTTOs successfully completed the order – a finding which has led the NAO to call for more to be done to support those who are on DTTOs (National Audit Office, 2004).

What is drug treatment?

The National Treatment Agency defines drug treatment in the following ways:

- Specialist community prescribing – Prescribing of substitute medication such as methadone by a specialist (e.g. consultant psychiatrist) to clients in a non-residential setting. Prescribing must also be complemented by counselling or other forms of structured support.
- GP community prescribing – Prescribing of substitute medication by a general practitioner who will normally be supported by a drug specialist for more complex cases. Again, prescribing must be complemented by other forms of structured support.
- Care planned counselling – Formal structured counselling, which must be provided by accredited counsellors.
- Structured day care programme – Intensive community-based support, treatment and rehabilitation. This form of treatment may include counselling, groupwork, advice and information, complementary therapies and support with education, employment and accommodation.

- Residential rehabilitation – Treatment provided in a residential setting, normally following detoxification. The objectives are to provide clients with a supportive, controlled and structured programme to engender and maintain abstinence from drugs. All residential rehabilitation services are managed by voluntary organisations.
- Inpatient treatment – This refers to treatment within hospitals which require the client to stay in the hospital. It is provided by NHS hospitals, either in specialist addiction units or psychiatric beds.

The adequacy of drug treatment

In 1997, just after Labour came to power, 75 per cent of the £1.4bn drug control programme went on enforcement and just 13 per cent on treatment. These proportions are now being steadily rebalanced (Guardian, 19 November 2003).

The number of people in drug treatment is increasing. Around 140,000 accessed drug treatment in 2002/2003, a 41 per cent increase on 2001 (www.nta.nhs.uk/news/DrugTreatSumBrief.htm). There has been a four-fold increase in the time clients stay in treatment from 57 days in September 2001, to 203 days in June 2003.

In 2002/03 around 80,600 problem drug misusers successfully completed treatment (including being referred on to other drug treatment agencies) or were retained in treatment at the end of year compared to around 75,500 in 2001/02 (an increase of 7 per cent). However as a percentage of the total number in treatment during the year, the numbers successfully completing or retained in treatment fell from 59 per cent in 2001/02 to 57 per cent in 2002/03.

The Government has said that its updated drug strategy is on track to double drug treatment capacity by 2008, with 200,000 problem drug users to be treated each year' (House of Commons written answers, 17 July 2003, Col. 639W).

According to the National Treatment Agency, average waiting times have been cut from nine weeks in December 2001 to just 2.7 weeks in March 2004.

“ In much of the country it appears that drug treatment is more readily available in prisons than outside. ”

Longest waits are for specialist community prescribing and residential rehabilitation, where average waiting lists are 3.9 weeks and 3.7 weeks respectively.

Despite the fact that there has been increased investment in community drug services and that every £1 invested in drug treatment saves £3 in reduced criminal justice costs (Gossop et al, 1998), many problem drug users are still unable to access appropriate treatment without delay.

Although there have been significant improvements in waiting times, current delays still deter problem drug users from accessing treatment. Presenting for drug treatment is often a major step to take and if treatment is not immediately available, motivation may be lost. While national average waiting times have improved, in some places people still face very lengthy waits. In Peterborough, waiting times for specialist prescribing are 16 weeks, compared to the national average of 3.9 weeks, and in Somerset waits for residential rehabilitation stood at 36 weeks in March 2004.

In much of the country it appears that drug treatment is more readily available in prisons than outside. According to 'Streets Ahead, A Joint Thematic Inspection into the Street Crime Initiative', 'In HMP Liverpool, where community residential detoxification waiting times were reported as lengthy, the local authority had requested permission to send community patients to the local prison for faster treatment provision' (HM Inspectorate of Constabulary et al, 2003).

People leaving prison can find it especially difficult to access appropriate drug treatment in the community. The Social Exclusion Unit found that the chances of 'continuing drugs programmes and support on release are very slim' (Social Exclusion Unit, 2002). The need for effective post sentence work, particularly for drug users, was also highlighted in the review of the street crime initiative. Although examples of good practice were found, this good practice tended to be in isolated pockets (HM Inspectorate of Constabulary et al, 2003).

Problem drug users can find it difficult to be signposted to effective treatment. Two-thirds of GPs do not have easy access to specialist support and one-half are reluctant to prescribe substitute drugs (Audit Commission, 2002).

The Audit Commission's 'Changing Habits' report found that although drug treatment services can help people overcome drug problems, many drug misusers still struggle to get the help that they need. It was found that long waiting lists and limited treatment options drive drug misusers away from treatment (Audit Commission, 2002). It was found drug misusers with complex needs struggled the most to get the help they needed.

Drug users with mental health needs face particular problems. Drug treatment providers often refuse to treat people with mental health problems, and mental health providers often refuse to treat people with substance misuse problems. There is a need for greater joint commissioning of services, with an emphasis on an integrated social care approach.

Marginalised groups can face additional problems in drug services. A study of drug treatment amongst young homeless people found inadequate provision of drug treatment in the community (Wincup et al, 2003).

Three-fifths of prisoners report that their drug use caused problems in areas such as employment, finances and relationships (Home Office, unpublished). These are all issues that may have to be addressed when someone is released from prison.

The need to increase the availability of residential drug treatment

Temporarily removing problem drug users from their home community as part of their drug treatment can prove beneficial. Residential drug treatment, when preceded if necessary by in-patient detoxification and followed up by ongoing support, can provide some of the benefits of prison-based treatment by temporarily enabling people to leave behind the environment in which they were problem drug users, without the negative impacts that imprisonment can present.

“ Residential rehabilitation clearly can be effective in reducing problem drug use... ”

The National Treatment Agency has reported that: 'Residential rehabilitation units can have among the best outcome of any treatment modality – particularly for clients with complex needs' (National Treatment Agency, 2003).

The National Treatment Outcome Research Study (NTORS) reported on one-year follow-up outcomes from patients admitted to four short-term and 12 long-term programmes. Some 38 per cent of the patients treated in residential programmes were abstinent from illegal drugs at 4-5 year follow-up and 47 per cent were abstinent from heroin. Reductions in rates of illegal drug use during the 90 days before intake compared to follow-up were as follows:

- Heroin (from 75 to 50 per cent)
- Crack cocaine (from 37 to 18 per cent)
- Other stimulants (from 71 to 32 per cent)
- Benzodiazepines (from 57 to 28 per cent) (EATA, 2003).

Residential rehabilitation clearly can be effective in reducing problem drug use but the number of residential places has fallen and there appear to be significant infrastructure issues which are preventing many problem drug users from being able to access residential places.

The Department of Health does not collect figures centrally on the number of places available in residential drug treatment. According to the National Treatment Agency there are currently 1,715 beds in residential drug treatment services – run by both the voluntary and private sectors.

From Drug Action Team figures, it is estimated that there were approximately 3,700 people accessing drug residential rehabilitation services nationally in 2002/03 – just ten new people a day (National Treatment Agency, 2003).

Local authorities fund residential drug rehabilitation places out of their community care budgets. As there is no ring-fencing of money for the purchase of residential services, local authorities are free to make their own decisions about the extent to

which they want to fund such treatment. Although the Government does not collect information on numbers of individuals funded by local authorities to undertake residential rehabilitation or details of how much each local authority spends on it (House of Commons written answers, 27 February 2004, Col. 603W), evidence from service providers suggests that problem drug users face a postcode lottery, with little national consistency around the availability of publicly funded drug treatment.

Although there have been significant reductions in waiting times for residential drug treatment, there are considerable regional variations in the length of time problem drug users have to wait for treatment. The Drug Action Team areas with the longest average waiting times for residential rehabilitation in March 2004 were Somerset (36 weeks), Islington (21 weeks), Dorset (12 weeks), Kingston upon Hull (11 weeks) and Leicestershire (10.6 weeks).

The National Treatment Agency has estimated that as many as 58 new residential rehabilitation services will be needed by 2008 to meet the drug strategy target of doubling the number of people in drug treatment (National Treatment Agency, 2003).

Figures from the National Treatment Agency show that the mean cost per week of residential treatment is £810. However, as this includes some very expensive private treatment, the median figure of £430 per week is more useful. For the median stay of three months, this works out at a charge of just over £5,000 – although this figure is still slightly distorted as some services also provide detoxification while others do not (National Treatment Agency, 2003).

The Government does not have information available on the value for money given by residential drug rehabilitation. However, Health Minister Melanie Johnson has said: 'Residential rehabilitation has been shown to be one of a number of effective forms of drug treatment' (House of Commons written answers, 8 July 2003, Col. 769W).

“ ...there is a very real danger that the best way to receive treatment will increasingly be through being arrested. ”

Public support for drug treatment

There is growing evidence of public support for the provision of drug treatment in the community, rather than an increased use of imprisonment.

A recent Mori poll for Rethinking Crime and Punishment found that rather than build more prisons, most people thought that prison overcrowding would best be dealt with by building residential drug treatment centres (52 per cent) or by developing tough community punishments (52 per cent).

Research into public opinion about non-custodial penalties by the University of Strathclyde on behalf of Rethinking Crime and Punishment found that 'almost all respondents, including tabloid readers, adopted 'liberal' positions on the issue of drug crime, and felt strongly that drug users should be treated rather than punished' (Rethinking Crime and Punishment, 2002).

A survey of 1001 people in England, reported in 'Treatment Works: Fact or Fiction' (EATA, 2003) found that:

- 95 per cent thought that letting drug users know where they can get hold of information to come off drugs was an appropriate way to tackle drugs. It also found that 91 per cent thought that providing drug treatment was an appropriate way to tackle the drug issue.
- There were high levels of support for the principles of treatment and rehabilitation, with 95 per cent of respondents saying that treatment centres were a good idea for their area.
- However, the research found that 'when questioned in depth, many people were negative about the prospect of actually living near a treatment centre.' This suggests that there is a need to reassure communities of the benefits of drug treatment, and of the low risks of having a treatment centre nearby.

A third of people were not sure what drug treatment actually was. This indicates that there is still a need for the government and treatment providers to make the public more aware of what drug treatment involves and of the benefits, both to problem drug users and to society as a whole.

As the 'Treatment Works' report found, 'there is a long way to go before the public understands what treatment actually involves and is comfortable living next door to it' (EATA, 2003).

The way ahead

It is clear that considerable progress has been made in responding to the treatment needs of problem drug users – especially those who are in prison. More people than ever before are accessing drug treatment services. This is a welcome development.

However, with the Government placing an increasing emphasis on using the criminal justice system as a gateway and fast-track into treatment, there is a very real danger that the best way to receive treatment will increasingly be through being arrested. This will create a perverse incentive for problem drug users to commit crimes. It is also an approach that does not do enough to intervene in someone's drug-taking before they have started committing serious crimes.

The Government should therefore consider the following policy proposals:

- Guidance should be issued to sentencers that no one should be sent to prison solely because it is thought that this is the best place for them to receive drug treatment.
- The same level of drug treatment should be available to people both inside and outside the criminal justice system.
- There should be a major expansion of residential rehabilitation services, along with ring-fenced funding for the purchase of residential drug treatment services. The National Treatment Agency should collect information on expenditure by local authorities on residential drug rehabilitation.
- Current waiting times, while much-improved, are still too long and need to be further reduced with a timescale put in place for effectively introducing drug treatment on demand.
- Prisons should be instructed to monitor the proportion of prisoners who complete treatment following detoxification.

- With the establishment of the National Offender Management Service, a key objective should be to ensure that people are able to continue to receive drug treatment and support on release from prison.
- Harm reduction approaches based on gradual withdrawal as well as abstinence should be widely available.
- There is a need for an increased emphasis on treating people, not individual problems. This means that relevant agencies should monitor the progress made across all key areas of someone's life during and after drug treatment. There should be better monitoring of the housing and employment outcomes of people who enter drug treatment in the community.
- More joint commissioning should be encouraged as many problem drug users also have other social care needs that are not currently being met.
- Local authorities should be actively encouraged to grant planning permission for drug services where these meet local treatment needs.
- There is a need to raise the profile of drug treatment and to ensure that both drug users and the wider public understand what it involves and its potential benefits.

Written by Joe Levenson

References

- Addaction (2004), *Collecting the evidence: clients' views on drug services*, London: Addaction.
- Audit Commission (2002), *Changing Habits: The Commissioning and management of drug services for adults*, London: Audit Commission.
- European Association for the Treatment of Addiction (EATA), (2003), *Treatment Works: Fact or Fiction? A report into the awareness of drug treatment and its effectiveness*, London: EATA.
- Godfrey, C., Eaton, G., McDougall, C. and Culyer, A. (2000), *The economic and social costs of Class A drug use in England and Wales, 2000*, Home Office Research Study 249, London: Home Office.
- Gossop, M., Marsden, J. and Stewart, D. (1998), *National Treatment Outcome Research Study – At One Year*, London: Department of Health.
- HM Inspectorate of Constabulary et al (2003), *Streets Ahead, A Joint Inspection of the Street Crime Initiative*, London: Home Office.
- Home Office (2003), *Differential substance misuse, treatment needs of women, ethnic minorities and young offenders in prison: prevalence of substance misuse and treatment needs*, Home Office Online Report 33/03.
- Home Office, *Criminality Survey: drugs follow-up, 2001*.
- Hough, M., Jacobson, J. and Millie, A. (2003), *The Decision to Imprison*, London: Prison Reform Trust
- National Audit Office (2004), *The Drug Treatment and Testing order: Early Lessons*, London: National Audit Office.
- National Treatment Agency (2003), *Briefing on Tier 4 Services*, London: National Treatment Agency.
- Ramsay, M. (ed) (2003), *Prisoners' drug use and treatment: seven studies*, Home Office Research Findings 186, London: Home Office.
- Rethinking Crime and Punishment, 2002, What do the public really feel about non-custodial penalties*, London: Rethinking Crime and Punishment.
- Social Exclusion Unit (2002), *Reducing Reoffending by ex-prisoners*, London: Social Exclusion Unit.
- Wincup, E., Buckland, G. and Bayliss, R. (2003), *Youth homeless and substance use: report to the drugs and alcohol research unit*, Home Office Research Findings 191, London: Home Office.

Rethinking Crime & Punishment is a strategic grantmaking initiative funded by the Esmée Fairbairn Foundation which aims to raise the level of public debate about the use of prison and alternative forms of punishment.

Esmée Fairbairn Foundation
11 Park Place
London
SW1A 1LP

Tel 020 7297 4738
Fax 020 7297 4701

info@rethinking.org.uk
www.rethinking.org.uk

