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# Rehabilitating Drug Policy

## What can we do better to reduce offending by drug addicts?

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**Contents**

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# Introduction

## *A 12-step experience*

A weekday evening, on a quiet street in a small church hall, a Cocaine Anonymous meeting is about to begin. Greeters at the front door draw in newcomers from the light rain, while others take on refreshment duties, offering teas, coffee and biscuits to anyone approaching the table. Old friends chat and new connections are made. On one side of the hall is a table covered with sets of carefully arranged leaflets, and a few larger texts from CA and other 12-step programmes, including the original: Alcoholics Anonymous. At the front is a large sign-board propped up against a chair with the 12 steps emblazoned on it, along with the legend 'we are here and we are free' running along the bottom.

Before long, this local *fellowship* is called to order and everyone takes their seats in the hall, facing a desk where the secretary of the meeting and a guest speaker are sat. The group is diverse. It is divided evenly by sex, and has individuals from a number of ethnic and social backgrounds. There is a rhythm and ritual to much of the meeting. At the start, everyone takes a turn in introducing themselves to the group with their name and the refrain, 'I am an addict'. The group returns the greeting with a friendly but solemn 'hello' followed by their name.

Some passages from the 12-step canon are read aloud. Members from the group take it in turns and are then thanked by the whole group for their contribution. Then the core of the event is underway. The guest speaker is introduced, an addict in recovery who is visiting from another group in the Fellowship. She explains her struggle with step two, where addicts must seek a 'higher power' (possibly, but not necessarily, a Christian god) to restore them to sanity, the theme of this session. Her description lasts for a few minutes; much of it revolving around the love she felt for her family, and the shame that she was struggling to provide for her daughter, that inspired her desire to recover.

Then those at that same stage of recovery are invited to speak from the floor, always introduced with the same ritual greeting. Sometimes responses come in quick succession. Other times silence descends (apart from the birds chirping outside in the church garden) waiting for that moment of reflection to inspire another speech. After those on step two have

had a chance to speak, everyone in the group, regardless of their current step, is invited to contribute their own stories and thoughts to the group.

Some common themes emerge from the discussion; the fellowship members immediately recognise similar experiences as they are described, and, whether visitor or member, it is impossible not to react emotionally to some of the pain, and joy, that is being shared. They discuss the loneliness of a life on drugs, the way it cuts individuals off from the joys of ordinary community, of gratitude and acts of kindness. They talk about the way that their characters became hardened to others – some members have spent time living on the streets where a default to aggression is the only available replacement to genuine personal security.

For some, the complete absence of feeling (either good or bad) was their experience: living in an almost zombie-like state where the natural world and the human environment becomes devoid of any interest or wonder. Then there are the incessant cravings that block out all other goals or desires in life. But they also discuss the strength that they found to enter recovery and stop taking drugs. This strength was not found within themselves (many felt too demoralised to break free alone), but by looking beyond themselves to that 'higher power'.

As the meeting draws to a close, a collection to pay for the upkeep of the fellowship is passed around the members. Visitors are pointedly not permitted to contribute – the group is established to be self-sufficient rather than reliant on acts of charity. Several individuals have CA related community events to announce and the secretary for the evening explains that a number of posts need to be filled, including helpers and secretaries. Each position must be held for a year each – a key aspect of the fellowship is about taking responsibility and performing a service to the community. The duties are not to be taken lightly. The formal proceedings end with everyone standing up and joining their hands in a circle for a collective prayer. Then, in an instant, the tension of the ritual is broken and the atmosphere is filled once again with friendly conversation, while those on duty tidy up the hall.

The 12 steps describe the stages an individual must follow to become sober and drug free. 12 traditions set out how fellowship groups are to be organised and 12 concepts bind each group to the whole international Fellowship, making 36 principles. These are the pared down instructions that function as a basic genetic code of the organisation, easy to interpret and follow in a variety of local contexts. This allows the Fellowship to spread and reproduce

across communities and nations. The principles are clear but, at the same time, non-didactic. The disposition of the meetings emerges through practices that are passed on organically from long-time members to newcomers.

The group exerts a sort of gravitational pull on its members and their behaviour. If members fail to turn up, calls are made to find out what is happening and whether they are struggling with anything or, worse, heading for a relapse. Due to their shared experiences, basic decencies like honesty about oneself and one's past can be cultivated. But this is not just about self-help and group reciprocation. The Fellowship is oriented to bring its message of sobriety and sanity to others, creating a regular and frequent space for addicts in the neighbourhood to enter. Anyone struggling with addiction, and a desire to break free, can turn up – an unmatched community resource, though one that is avowedly and constitutionally apolitical.

12-step is not the only path to recovery, although it is perhaps the most well-established. Some addicts do not respond well to the spiritual emphasis and benefit from other approaches. Nevertheless, this is a paradigm example of civil society healing itself. It is the spontaneous, altruistic and voluntary acts of individuals combining to form associations that bind them and thereby make them stronger than those that strive alone. No government mandate could hope to create such a fellowship by *fiat*, although it is certainly possible for policy to help or hinder their creation and accessibility.

Some of those in the group will have been involved in crime. Many will have not, and their drug problem will have been unknown to the majority of the community around them. For them, the tragedy of addiction and the struggle to become drug free was deeply personal and familial, but not necessarily the subject of public policy. It is important to remember that drug abuse is always a personal tragedy, and that recovery is one of the greatest struggles an individual can bear, and a triumph when it is achieved.

Public policy can never be the director or prime-mover of a recovery process. No one in the drug rehabilitation field can suggest a way to *make* individuals recover before they are personally committed to becoming so. It is a personal decision and responsibility. But what public policy can do is open up more opportunities for recovery for those who are willing to try. It can give individuals the space to heal, and allow the spontaneous powers of civil

society to help them along the way.

Even this supporting role can be difficult to provide in the context of criminal justice. Addiction cannot be an excuse for committing crime, and addicts must accept the same severity of sanctions as anyone else caught and convicted of a criminal offence. Anything else would be less than fair. However, while penalties must be handed out evenly, it is also right that those who have offended be allowed the opportunity to address what is wrong in their lives, in whatever circumstances they have arrived.

## The Challenge

Drug misuse and dependence is one of the most serious problems for offenders in Britain's criminal justice system, and for society as a whole. A 2008 UK Drug Policy Commission report, *Reducing drug use, reducing reoffending*, found that in 2000, 73 per cent of male prison entrants had used a drug in the year before, and 31 per cent had used heroin. In 2002, 61 per cent of those given a community sentence had used a drug in the last year, and 22 per cent had used heroin. In 2005, 15 per cent of arrestees had used heroin. The UK DPC compared this to the 2005/06 British Crime Survey of households that found that less than 0.5 per cent of individuals had used heroin in the previous year.[1]

An academic study commissioned by the National Treatment Agency for Substance Misuse (NTA), a special health authority tasked with increasing the accessibility and effectiveness of drug treatments in communities and prisons, estimates that in 2009/10 there were 306,150 opiate and/or crack users.[2] This includes 264,072 opiate users and 184,247 crack cocaine users, implying a large degree of overlap. Home Office surveys have shown how this translates into stark social costs. Overall costs have been estimated to be £15.4 billion a year.[3] This is mostly attributed to the costs of acquisitive crime, especially burglary and theft. In fact, it is estimated that between a third and a half of all acquisitive crime is committed by

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1 'Reducing Drug Use, Reducing Reoffending', *UK Drug Policy Commission,* March 2008, p. 19: http://www.ukdpc.org.uk/resources/RDURR_Full_Report.pdf

2 Hay, G., et al, 'Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2009/10: Sweep 6 report', *Centre for Drug Misuse Research*, University of Glasgow, 2011: http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/virtuallibrary/OpiateCocaineprevalencestats2009-10.pdf

3 'DRUG STRATEGY 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Lives', *HM Government*, 2010, p. 4: http://www.homeoffice.gov.uk/publications/drugs/drug-strategy/drug-strategy-2010?view=Binary

offenders who are addicted to heroin, crack or both.[4] Around 400,000 welfare claimants (8 per cent of all recipients) are believed to be dependent on drugs or alcohol at a cost of around £1.5 billion.[5] The challenge is to encourage and support these individuals into leading better, healthier lives and to reduce their many negative impacts on the welfare of the rest of society.

## The Opportunity

Drug addiction traverses several spheres of policy, including the judicial, the clinical, and wider therapeutic and social concerns. Desired outcomes in each of these spheres can differ. For example, the criminal justice system, when encountering drug addicts may prioritise the prevention of further crimes against the public and punishing offenders in an appropriate way. When clinicians are engaged, major priorities will be public health as well as the addict's immediate healthcare needs. Therapeutic engagement might go further, emphasising improving the personal wellbeing and the emotional welfare of an addicted individual, particularly by tackling underlying mental health problems. Related social interventions might widen the scope of desired outcomes to include an addict's integration or re-integration into society, allowing them to live successful flourishing lives, and to fulfil their obligations towards family and work.

There are several ways in which these different desired outcomes can interact. They might present themselves as trade-offs. For example, punishing a drug addicted offender might be at the cost of their mental health or make them less likely to comply with treatment that is useful for preventing the spread of disease. In such cases, these outcomes might be seen as competing for priority in policy. However, in other circumstances, and perhaps more often than not, these different outcomes can function as complements rather than competitors. For example, dealing with risks to public health might be made much easier by tackling an addicts' underlying mental health problems; and paying a debt to society through an appropriately delivered sanction might be a good first step towards re-integration.

Good policy, therefore, will combine these potentially competing demands in a way that supports rather than undermines their respective outcomes. With drug addiction manifest in

[4] 2010 Drug Strategy, p. 7.
[5] 2010 Drug Strategy, p. 5.

such a variety of settings and dimensions, it is neither surprising that this goal is much more easily articulated than achieved, nor that the policy debate surrounding drug addiction often seems remarkably fraught as a result.

From a criminal justice perspective, the policy challenge is reinforced by the psychological effects of drug dependency. There is sound evidence that effective policing and consistent sanctions can deter many potential offenders from committing crime.[6] However, for many drug addicts the prospect, even likelihood, of such sanctions can pale into insignificance compared to their immediate desire to avoid the effects of withdrawal, and the impulsive disposition that drug dependency generates.[7] Their time and life horizons are reduced so that the long-term consequences of their actions, even if fearful on reflection, are discounted at the moment of decision to commit crime. As a result, increasing criminal sanctions alone is unlikely to be the most effective way of tackling drug addicted offenders. For these reasons, clinical and psychosocial interventions, as we outline in this report, that aim at recovery for drug addicts are widely considered more promising.

The further challenge, even with generally sound clinical and psychosocial interventions, is establishing what interventions are the most effective in individual cases. There is an on-going controversy over the benefits of harm-reduction treatments, which can involve substituting illegal drug use with safer more controlled prescribed drug use, and what might be considered drug-free recovery (treatments that aim to achieve continued abstinence from all addictive substances). Underlying these debates is the fact that addiction is complex and deeply personal. It is an issue that is quite resistant to quantifying and comparing clinical outcomes.

As a consequence, enduring and successful solutions are going to be found by tailoring treatment interventions to individuals, and showing a willingness to combine approaches from different disciplines and perspectives. Such an approach is difficult to achieve in any field, and especially in public policy. The key barriers to achieving this could be summarised as follows:

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6 Robinson, P. and Darley, J., 'Does Criminal Law Deter?', *Oxford Journal of Legal Studies*, Vol 24, No.2, 2004, p. 173: http://webscript.princeton.edu/~psych/psychology/research/darley/pdfs/Does%20Criminal%20Law%20Deter.pdf

7 Robinson and Darley, p. 179

- No single individual or institution can be relied upon to possess all the knowledge of an individual case necessary to deliver an appropriate intervention. This means that the single biggest challenge is informational; co-ordination between different agents, rather than of one agent delivering the solution alone.
- The individual that most stands to benefit from a successful intervention (the drug user) will frequently, because of their circumstances and disposition, be in a poor position to choose the correct course of action without support and additional motivation.
- The rest of the gains made from successful specific interventions are dispersed over many areas of communal life and several spheres of government. This means that concentrated costs have diffuse benefits that are hard to discern, making it difficult to reward the agent that truly made a difference. As a result, targets and other methods of performance management are unlikely to track the people and decisions that can really make that difference.

Despite these obstacles, the benefits of successful recovery are significant. For example, one longitudinal study of drug addicts entering treatment in England and Wales, NTORS, underlined the gains that have been associated with successful treatment interventions:

> *[D]rug misusers who had stopped regular heroin use were more than 10 times less likely to be involved in crime than those who continued to use heroin regularly.*[8]

The advent of the Coalition Government has seen a renewed interest in rehabilitation in the criminal justice system and an institutional shake-up. The NTA has replaced the Ministry of Justice as central commissioning body of drug interventions in prisons. In 2012, the National Treatment Agency will be incorporated into Public Health England, a new agency tasked with tackling premature death, illness and health inequalities. This presents a useful opportunity to take stock of what is working, and what is worth trying or extending within the criminal justice system.

[8] Gossop, M., Marsden, J. and Duncan Stewart, D., 'NTORS After Five Years', *National Addiction Centre*, London, 2001: http://www.addictiontoday.org/addictiontoday/files/ntors_5.pdf

## Methods and Approach

This report examines what is currently working in drug rehabilitation, and what could be done better, with specific reference to the criminal justice system and criminal justice outcomes in England and Wales. The following sections attempt to answer two key questions:

1. What drug interventions are effective?
2. How should effective drug interventions be delivered?

The primary evidence is a series of open-ended interviews with practitioners and advocates in the field of drug addiction. In addition, this report attempts to distil some of the implications of current empirical evidence on treatment. Greater weight is given to systematic reviews of the evidence where they have been carried out.

Weighing up different studies with very different methodologies is one of the most significant challenges in this area. In medicine, and increasingly in criminology, the best method for detecting the efficacy of an intervention is widely held to be randomised controlled trials (RCTs). These studies randomly assign a set of individuals from a group for a particular treatment, while placing the remaining individuals into a control group that receives no treatment or another treatment to which the intervention is being compared. In fact, RCTs are sometimes referred to as the 'gold standard' for testing the efficacy of treatments; more realistically, they can be considered the most scientifically sound method yet developed of identifying the impact of a specific treatment given particular circumstances. Evidence on the applicability of a particular treatment can be improved through the use of multi-site RCTs, which can control for the extent that treatment relies on local context and implementation. The potential self-selection effects of those able or willing to undergo a particular treatment can be controlled for by using intention-to-treat analysis (ITT), where the outcome measures reflect anyone dropped from the study from the moment they are selected for one treatment group.

Unfortunately, RCTs are still comparatively rare in criminology worldwide, and practically non-existent in the UK. This means that most RCTs that examine drug treatment focus on clinical interventions and measure primarily clinical outcomes. Inevitably supplementing

these studies, therefore, are other approaches that might indicate efficacy without quite the same evidential strength as an RCT. These include studies that have imperfect controls (comparison groups that are not assigned randomly) and those that compare the same set of individuals before and after treatment. For such studies, large improvements in observed health and behavioural outcomes might plausibly be, at least partially, attributed to the associated intervention.

Another important facet of drug rehabilitation research is the use of longitudinal studies. Rather than comparing the effects of one-off interventions, these studies attempt to track the characteristics and history of drug users, and their various interactions with drug treatment services. This can help to establish the overall effectiveness of drug treatment services in general, and also what sort of drug user characteristics are associated with the best outcomes for specific treatments. This is useful for matching individuals to the right interventions. However, because continuing willingness to interact with treatment services is one of the most important indicators of improved future outcomes, it is impossible to determine with certainty what the effect of an actual treatment is by looking at a longitudinal study alone. The impact of treatment, as opposed to user characteristics and history, cannot easily be disaggregated.

Professor D. Dwayne Simpson, commenting on the results of DATOS, a major US-based longitudinal study into drug addiction outcomes, described how both longitudinal and experimental approaches are necessary:

> *... [W]ithout experimental assignments to test the impact of selected interventions on appropriate clients, there is no scientific guidance for therapeutic protocols; without freedom for clients to 'come and go' in a naturalistic fashion, the path of recovery and its interactions with important treatment and environmental influences cannot be explored.*[9]

So an understanding of what works in drug treatment cannot be gained from either RCTs or longitudinal studies alone, rather RCTs (and other trials that compare specific outcomes) are required to demonstrate the efficacy of an intervention, while longitudinal studies are

[9] Franey, C. and Ashton, M., 'The Grand design lessons from DATOS', *Drug and Alcohol Findings*, Issue 7, 2002, p. 17.

necessary to indicate the applicability of those interventions to different people and circumstances.

It should be noted that many who reviewed this report were able to point towards additional evidence that we were unable to cover on this occasion. As a result, the evidence-base for this report must be admitted as inevitably partial and defeasible. The second section of this report, in particular, relies on the experiential accounts and concerns of a few practitioners in the drug treatment field. It does not provide a systematic analysis of what is already implemented in the field. It is not a summation of all that is known in the drug field and so its conclusions should be considered to be thematic, that is introducing the sort of issues that policymakers must consider when implementing support for drug addicts, rather than substantive recommendations. With these caveats in mind, it is hoped that this report can play a small role in updating the publicly available evidence of what works in the drug addiction field and introduce some ideas and concerns regarding how policymakers can encourage their implementation.

# 1. What interventions are effective?

In this section we discuss and briefly review the evidence for the following interventions which represent the key approaches to drug treatment and recovery:

- Detoxification
- Opioid Substitution Therapy
- Heroin Substitution
- Opioid Antagonist Therapy
- 12-Step
- Therapeutic Communities
- Cognitive Behavioural Therapy

Although there are a number of ways of categorising these different interventions, and they are often used in combination, in this case we look at pharmacological approaches first, followed by psychotherapeutic approaches.

## Pharmacological interventions

Pharmacological interventions include the prescription and provision of drugs designed to ease the effects of withdrawal from drug use, replace illegal drug use or block the effects of illegal drug use. Effective pharmacological substitutes and interventions tend to be concentrated around opiate use. Despite trials of different interventions, there is very little evidence of effective pharmacological treatments of stimulant dependency.[10] This means that treatments for cocaine addiction are essentially restricted to the psychosocial. In addition, it is rare that a pharmacological treatment alone is effective without significant psychosocial support.

### Detoxification

Detoxification is the managed process of withdrawal of addictive substances (especially heroin and other opiates) from a dependent user's body. Dependent users of opiates have

[10] See the Cochrane Library: http://www.thecochranelibrary.com/details/browseReviews/579489/Cocaine.html

developed a physical tolerance for a certain level of substance use. Withdrawal has physical side-effects while the various systems that regulate the body re-establish the stable equilibrium known as homeostasis. How best to detoxify a patient is primarily a clinical decision, but patients may also be able to choose between shorter-lasting but more intense approaches, or longer, gentler approaches. Detoxification can be hastened with antagonistic medication, eased through the use of painkillers or sedation, or prolonged through tapered doses of substitutes such as methadone. The full process of withdrawal can also be avoided by replacing illegal opiate use with a prescribed opiate substitute. Depending on the severity of the patient's drug dependency and their general health, detoxification can take place at home, with medication prescribed by a GP, in hospital or in a residential unit established for the purpose.

More radical approaches have included putting individuals under heavy sedation or general anaesthetic for the duration of detoxification. This allows them to avoid much of the experience of withdrawal. Recent evidence has suggested that the risk of complications (including death) substantially outweigh the observed benefits of these approaches.[11] For this reason, NICE guidelines now state that neither should be offered to patients as a detoxification strategy.[12]

Although the painful symptoms of withdrawal figure widely in the public's imagination, it is usually far from the most dangerous or difficult stage of drug rehabilitation. The symptoms, though subjectively experienced as intense, are physically similar to a bout of flu. In cases of particularly dependent addicts, symptoms can involve muscle aches, profuse sweating, nausea and diarrhoea. As Dr James Bell explains:

> *Opiate withdrawal doesn't look like much.* [Patients] *don't look too different from an agitated person. But precipitated* [drug induced] *withdrawal looks much more intense.*

It is important to note that suffering from withdrawal is not the same as having an addiction (although it can represent one symptom of drug dependency) and cessation of even highly

[11] Gowing, L., Ali, R., White, J.M., 'Opioid antagonists under heavy sedation or anaesthesia for opioid withdrawal', Cochrane Database of Systematic Reviews 2010, Issue 1, Art. No CD002022: http://www2.cochrane.org/reviews/en/ab002022.html

[12] Department of Health (England) and the devolved administrations, 'Drug Misuse and Dependence: UK Guidelines on Clinical Management', Department of Health (England), 2007, p. 59: http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

addictive substances like cocaine have no observable physical withdrawal symptoms. In fact, the psychological effects of ceasing drug use are usually more significant than physical symptoms. The most common challenge is a continued 'craving' for the addictive substance.

***Relapse***

As a result of these psychological dimensions, detoxification on its own hardly ever constitutes a successful treatment because addicts tend to relapse and return to drug use, often at the earliest opportunity, unless they are offered further intervention. Rather than necessarily being the first stage of recovery, detoxification on its own increases risks of overdose and other complications. Bell explains the problem in stark terms:

> *The critical issue in opiate dependence is relapse. That explains why, after detox, most people relapse. The risk is when people relapse, they die. The month after detox has an increased risk of death from overdose.*

In fact, detoxification can even be part of an addict's regular misuse of drugs. Deirdre Boyd, CEO of the Addiction Recovery Foundation, considers detoxification on its own to be nothing more promising than *'[g]etting toxic substances out of the body, such as the ancient romans vomiting so they could continue orgies of food and drink.'*[13] Bell explains that heroin users do not have a straightforward trajectory of misuse. They can go through periods of heavy remorseless use followed by periods of abstinence, then a period of 'dabbling' before a return to dependency. The result is that a user may go through multiple episodes of withdrawal and relapse. Although the chances of relapse reduce the longer an individual can remain abstinent, there are still individuals who will relapse decades after, even having stringently avoided opiates. Robson confirms:

> *Detoxification on its own has no influence on longer-term outcome. It is only useful if it forms part of some more general treatment plan.*[14]

[13] Boyd, D., 'A Glossary for our times', *Addiction Today*, 2010: http://www.addictiontoday.org/addictiontoday/2010/08/when-is-recovery-not-recovery-rewrite-dictionary.html

[14] Robson, P., *Forbidden Drugs* (3rd edition), OUP, Oxford, 2009, p. 212.

However, relapse, while not a sign of success, is not a sign of failure or 'back-to-square-one' either. One survey of people who had become successfully drug free found that they had an 'average of 4.9 previous attempts at achieving abstinence'.[15] Consequently, while detoxification is an important step in a drug intervention, it is rarely a successful treatment on its own, or a secure path to recovery.

***Detoxification in prison***

Without continued access to illegal drugs, a dependent heroin user will begin to experience withdrawal spontaneously. This means that many drug users entering prison, whether on remand or starting a sentence, present immediate clinical needs. This point of entry is one area where the prison service has been significantly overhauled in recent years through the introduction of the Integrated Drug Treatment System (IDTS) in 2006. It is currently managed by the National Treatment Agency and provided by local Strategic Health Authorities.

Nino Maddalena describes a dramatic shift in approach, quality and coverage of clinical care for drug addicts, at least with respect to his own experience of one prison in the early 1990s:

> *[Before IDTS] if you came in as a drug user, you would be given some pain killers and sent back to your cell for a couple of nights. Every now and then, you had a more forward thinking doctor prepared to prescribe what you might have in the community.*

Now, drug users are assessed on similar terms to those presenting in the community with the same array of detoxification procedures as recommended by NICE. Maddalena suggests that this reform has been associated with lower rates of self-harm and suicide. Statistical trends are equivocal on this point, however, showing a small reduction in self-inflicted deaths in custody alongside an increase in self-harm incidents in prison in recent years.[16]

Mike Trace is supportive of the new system, which he describes as now having sound

[15] Best, D., et al., 'Lots of Happy Endings', *Addiction Today*, August 2007, p. 27: http://www.addictiontoday.org/files/addiction-today-107---happy-endings---david-best.pdf

[16] 'Reporting of deaths in custody', *Ministry of Justice*, July 2011: http://www.justice.gov.uk/downloads/publications/statistics-and-data/mojstats/reporting-deaths-custody.pdf ; Safety in Custody 2010 England and Wales, *Ministry of Justice*, July 2011: http://www.justice.gov.uk/downloads/publications/statistics-and-data/mojstats/safety-custody-2010.pdf

medical protocols, and good triage methods for assessing the short-term prescribing needs of prisoners: 'Detox has improved massively in the last 5 years'. But he has concerns about the way that the Integrated Drug Treatment System connects with the rest of prison drug services:

> *Ironically, IDTS is the most unintegrated part of the system. The front end is pretty good but it is purchased by the Department of Health. Everything else is provided by the Ministry of Justice. The systems are not joined up very well.*

This division will be changed again in 2012, with health commissioners taking responsibility for planning all drug treatment provision in prisons, not just the initial and clinical elements. There are both risks and opportunities associated with this change. Continuity is certainly a benefit since even the most appropriate detoxification procedure does not boost the chances of recovery without an immediate move to further steps in treatment. On the other hand, Trace has some concerns that DoH commissioning might focus on clinical interventions and, thus, marginalise successful psychosocial treatments to which criminal justice commissioners might be more receptive.

## Opioid substitution

A widespread approach to tackling heroin dependency, and one with particular support among healthcare practitioners, is Opioid Replacement or Substitution Therapy. This involves replacing an addict's use of heroin with a less dangerous substance. The most common approach is Methadone Maintenance Therapy (buprenorphine is another common alternative with comparable outcomes), and is usually taken orally. Methadone is a long lasting opioid agonist. If applied correctly to replace heroin, methadone abolishes withdrawal within 24 hours, although for some addicts there remains some minor chronic symptoms of withdrawal. Moreover, methadone blunts the effect of subsequent heroin use and offers some protection against overdose. This simultaneously reduces an addict's incentive to carry on taking illegal drugs, while making bad outcomes slightly less likely should they lapse. Bell sums up the principle of the intervention as follows: *'The aim of maintenance is to make heroin use boring. You can lapse but you can't relapse.'*

Supporters for Opioid Substitution Therapy tend to emphasise how, for many users, heroin

addiction is *'a chronic relapsing condition'*,[17] even a lifelong disorder; a condition where management can relieve many related problems, if not necessarily the fundamental problem of dependency. One 2004 United Nations report summarised the benefits of substitution as follows:

- Reduced transmission of HIV (for intravenous users)
- Keeping more drug addicts in treatment and consistently reducing their use of illegal street drugs
- Reductions in death rates for addicts who are using a substitute rather than heroin itself
- Pregnant women are less likely to suffer complications at birth and the harm to unborn children is reduced
- More involvement in legitimate employment and higher incomes
- Lower levels of criminal involvement, especially in drug-related criminal behaviour[18]

However, there are also weaknesses to this approach. Full recovery advocates suggest that the 'chronic relapsing condition' model too often becomes a self-fulfilling prophecy, with a lack of confidence in more robust approaches to recovery leading directly to a lack of focus on treatments that could lead to genuine lasting recovery. Methadone and other heroin substitutes still carry a significant risk of fatal overdose, particularly when starting the treatment. Withdrawal effects from methadone last significantly longer than heroin, making it a potential barrier to drug free recovery. Moreover, it is possible for treatments intended for specific individuals to be diverted into an illicit trade. This can represent a particular challenge in a prison context.

There is disagreement over the side-effects and psychological implications of long-term maintenance. Some healthcare practitioners tend to emphasise how continued methadone use is consistent with living normal and successful lives, especially if the individual's other mental health needs are being addressed. It is possible for methadone users, on their account, to participate in family life and work. They argue that, with the correct prescription and

[17] Reducing Drug Use, Reducing Reoffending, p. 23.
[18] 'Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention', *WHO/UNODC/UNAIDS position paper*, p. 18-19: http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf

proper supervision, methadone merely avoids the effects of withdrawal without impacting on other aspects of behaviour. It is not necessarily intoxicating.

Boyd contests this characterisation of methadone and other maintenance programmes. She sees these prescription drugs, which are also extraordinarily powerful painkillers, as representing a 'chemical cosh' – especially in the cavalier quantities that they are often prescribed. They blunt emotional reactions and reduce a user's ability to relate and sympathise with those around them. This renders them unable to deal with their emotional history and face up to how they have hurt others (especially family members) through their selfish and harmful actions. This is a key and early stage in 12-step recovery programmes, making continued prescribing incompatible with this sort of approach. To some extent, this debate will always involve some subjective disagreement about what constitutes an unencumbered psyche and an ordinary, or indeed flourishing, human life. But it is increasingly clear that, for many individuals, dependence on methadone is a barrier, rather than a path, to sustained recovery.

Both the strengths and weaknesses of methadone maintenance are illustrated by systematic reviews conducted by the Cochrane and Campbell Collaborations. Crucially, most trials involved methadone prescriptions combined with additional psychotherapeutic support (a more consistently applied approach in the US than in the UK), rather than methadone as a substitute treatment alone. Surveying 11 randomised controlled clinical trials, the Cochrane authors found that methadone maintenance was more successful at keeping addicts in treatment than non-pharmacological approaches or a placebo.[19] Methadone also significantly reduced the use of street heroin. However, they did not find significant differences in important outcomes such as reduced criminal activity and risk of death. The Campbell review compared methadone maintenance against control groups that included waiting lists, detoxification, a number of psychosocial alternatives and placebo. Its results were consistent with the Cochrane review although it suggested some weak but positive support for methadone when compared against all alternatives:

> *Methadone maintenance has no significantly better effect on criminality than any of these control treatments. Also, a non-significant but positive effect of Methadone*

[19] Mattick R.P., Breen C., Kimber J., Davoli M., 'Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence', *Cochrane Collaboration*, 2009.

*maintenance over all other control conditions is detected.*[20]

In the UK, Professor Michael Gossop documents an association between methadone prescription and lower crime rates in one major longitudinal study, NTORS.[21] More recently, the NTA attempted to quantify some of the effects of methadone prescribing on convictions (a more reliable measure of criminality) on a group of offenders. They compared data from the Police National Computer and their own database of opiate and crack addicts. They extracted 1,476 individuals who had been convicted of 4,381 offences in the year before (2004/05) they had been prescribed methadone, and who had not been subsequently imprisoned. This allowed for a before-and-after comparison (since in neither years were any of the individuals incapacitated). In the following year, they committed 2,248 offences; two-thirds of individuals receiving a methadone prescription for 10 months or more were convicted of no further offences. This provides circumstantial, though defeasible, support for the contention that methadone plays a role in reducing crime. Commenting on the methodological robustness of the results, the authors explain:

> *... [I]n the absence of a control group it is not possible to ascribe the reduction in recorded offending to the effect of prescribing per se. Indeed, an initial examination of criminal records data for a wider population of problem drug users suggested that there were natural peaks and troughs in arrest patterns, irrespective of whether or not an intervention was provided. However, the reduction in recorded offending was greatest for those with the longest duration of prescribing. This suggests an association with treatment, although the direction of the association cannot be determined.*[22]

**Methadone and drug free recovery**

The evidence for the value of methadone as a way of easing people into drug free recovery, by lowering doses slowly over a period of time (tapering), is limited. A Cochrane Review found that, while methadone eased the symptoms of withdrawal, 'the majority of patients

[20] Mattick et al., p. 21.
[21] Gossop, M., 'Drug misuse treatment and reductions in crime: findings from the National Treatment Outcome Research Study (NTORS)', June 2005: http://www.addictionservicesguide.com/articles/NTORS.PDF
[22] Millar et al., 'Changes in offending following prescribing treatment for drug misuse', *National Treatment Agency*, November 2008: http://www.nta.nhs.uk/uploads/nta_changes_in_offending_rb35.pdf

relapsed to heroin use'.[23] Methadone performed only moderately better than placebo with slightly fewer programme drop-outs. With these mediocre results for methadone alone, there is a broad consensus that methadone is usually insufficient to foster recovery, whether that is defined as living a drug free life or, at least, a life that is not defined by drug misuse. At the same time, methadone is defended as a way of bringing individuals into treatment who would otherwise refuse to engage with treatment services at all and continue regularly taking street drugs

David Biddle and Mark Moody at the Crime Reduction Initiative (CRI) acknowledge the problem with relying on methadone alone as way to recover:

> *If you medicate someone, all you replace* [drug use] *with is time. You reduce volume of offending, but you don't eliminate it. It is very important to make sure* [addicts] *don't have time on their hands and replace deviant thinking with something else.'*

However, they challenge the conclusion that methadone cannot contribute to full recovery from their own experience of providing community drug rehabilitation services. CRI make significant use of methadone and is responsible for around 7,500 methadone prescriptions each day throughout the UK. However, the majority of their service users are on 'reduction scripts' (continually lowering doses), with many eventually becoming drug free. They attribute this to the use of intensive psychotherapeutic support that helps to develop a new way of life and more opportunities for recovering users.

Biddle and Moody point especially to Warrington, where CRI are commissioned to provide an integrated service for addicts which includes clinical, therapeutic, housing and employment support.[24] Their internal figures suggest that more than a third of their service users in this district are discharged drug free. A more thorough independent evaluation of these outcomes is essential before drawing firm policy conclusions. However, this experience suggests that methadone prescriptions might aid drug free recovery for many individuals so long as it is not used as an alternative to intensive therapeutic interventions but as a complement.

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[23] Amato, L., Davoli, M., Minozzi, S., Ali, R., Ferri, M., 'Methadone at tapered doses for the management of opioid withdrawal', *Cochrane Database of Systematic Reviews*, 2005, Issue 3. Art. No CD00340: http://www2.cochrane.org/reviews/en/ab003409.html

[24] See 'SMS Warrington': http://cri.org.uk/sms_warrington.php

Direct comparisons between treatments that include methadone and non-pharmacological treatments are difficult to make. Systematic reviews find a significant tendency for drug addicts to drop out of trials when they are made aware that they are selected for a psychosocial intervention that does not include a methadone prescription. This suggests that many addicts who are prepared to receive a methadone prescription are often different (or at a different stage in their addiction history) to those willing to undergo, for example, a drug free recovery focused psychosocial treatment that requires immediate abstinence.

**Methadone substitution in prison**

Methadone maintenance has become, perhaps, the default clinical response to heroin-addicted prisoners.[25] Trace suggests that there is 'an institutional assumption that everyone gets put on methadone'. However, evidence that methadone maintenance alone is a path to long-term social reintegration or reduction in re-offending for prisoners is remarkably weak. A Campbell Collaboration review of the evidence found that '[n]arcotic maintenance programs did not exhibit reductions in re-offending or drug use.'[26] In fact, although the small number of studies available means the conclusions should be interpreted carefully, it is possible that maintenance was associated with higher re-offending: 'program participants had somewhat higher re-offending rates than non-participants in four out of the five available evaluations'.[27]

A recent US-based RCT illustrates this general result with particular clarity. It compared three groups of prisoners in Baltimore prisons: one set were randomly assigned to counselling only while in prison followed by an open-ended referral to community drug services on release. Another group was assigned to counselling with a transfer to a methadone prescription on release, and the final group to counselling with a methadone prescription that also began in prison. Those given a methadone prescription were significantly more likely to remain in treatment than controls and less likely to test positive for illegal drugs after 12 months. But there were no significant differences when it came to self-reported criminal activity and the

[25] See Chambers, M., 'Coming Clean', *Policy Exchange*, June 2010, p. 40: http://www.policyexchange.org.uk/images/publications/pdfs/Coming_Clean_-_Jun__10.pdf; see also Reducing Drug Use, Reducing Reoffending, p.37.

[26] Mitchell, O., Wilson, D., MacKenzie D., 'The Effectiveness of Incarceration-Based Drug Treatment on Criminal Behavior', Campbell Systematic Reviews (11) 58, 2006: www.campbellcollaboration.org/lib/download/98/

[27] Mitchell et al., p.17.

likelihood of being arrested in the 12 month follow-up period.[28] A reasonable conclusion, from a purely crime and disorder perspective, is that methadone prescriptions *might* be better than not offering any intervention at all, but not by very much.

Reflecting this experience, there is an increasing acceptance from many on the harm-reduction side of the treatment debate that methadone maintenance is not achieving all that can be done in prison. In defence of the strategy, Bradbury and Maddalena suggest that rolling out methadone programmes across the prison system has had substantial benefits. They argue that it has reduced cases of suicide, self-harm and the market for illegal drugs inside prison. They explain that for some prisoners, especially those on remand or in sentences that can be as short as two weeks, there are simply no other viable options but stabilisation. Indeed, Trace, whose organisation focuses on providing drug-free recovery programmes in prison is more than willing to grant methadone a role in treating prisoners:

> *There is no problem with methadone as a method of service provision. It is an essential part of what we have built up in this country.*

But when it comes to longer term prisoners, Bradbury and Maddalena acknowledge that part of the emphasis on methadone represents a lack of ambition rather than long term clinical need:

> *We did get concerned that there was risk-averseness creeping in, particularly amongst clinicians… People on longer sentences seemed to be maintained longer and longer. Perhaps from 6 months to a year, some of them appeared to be continued to be maintained longer than seemed to be sensible.*

Latest NTA guidance now emphasises, in Bradbury's words, an expectation that methadone users should be '*reducing their medication, getting detoxed and moving towards a psychosocial approach'* during the course of their sentence.[29] As a new policy direction, the extent to which this is or will be achieved across the prison system is uncertain at the moment, but the pronounced intention is a positive step.

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[28] Kinlock, T., 'A Randomized Clinical Trial of Methadone Maintenance for Prisoners: Results at Twelve-Months Post-Release', Journal of Substance Abuse Treatment, October 2009, 37(3): http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2803487/

[29] See: http://www.nta.nhs.uk/uploads/updated_guidance_for_prisons_march10.pdf

## Heroin prescription

Some clinicians have gone further than substituting heroin with another substance, arguing that methadone is insufficient to attract some chronic heroin users into treatment and consistently keep them away from street drugs. Instead, making prescribed heroin injections available might improve outcomes for this particularly difficult group. In dealing with these individuals, there have been some trials of regular supervised heroin provision and injection in a clinical setting. This can be a single pharmacological intervention in itself or provided alongside methadone that might be permitted as a take-away prescription. Supervised injection has associated higher costs of provision but significantly reduces overdose risk.

Bell, who manages an injecting clinic in Camberwell, describes his experience as follows:

> *I was very sceptical about this treatment. These were demoralised and hard-bitten addicts, people with 20-30 experience years of drug use; they have swollen legs from infections and ulcers. They were homeless and very damaged souls, almost exclusively.* [With treatment] *they improve dramatically; they stop injecting street drugs and their health recovers.*

A Campbell review analysed criminal justice outcomes for a number of drug substitution interventions and found:

> *Heroin maintenance has been found to significantly reduce criminal involvement among treated subjects, and it is more effective in crime reduction than methadone maintenance.*[30]

This suggests that for some users who have not responded to other treatment approaches, providing prescribed and supervised heroin is an effective way to reduce crime. It also reduces the risk of the spread of communicable diseases. A prospective cohort study conducted in Germany suggested that these benefits could be maintained over at least a two-year period.[31]

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[30] Killias, M. et al, 'Effects of Drug Substitution Programs on Offending among Drug-Addicts', Campbell Systematic Reviews, 2009:3: www.campbellcollaboration.org/lib/download/739/

[31] Verthein, U., et al, 'Long-term effects of heroin-assisted treatment in Germany', *Addiction*, Volume 103, Issue 6, June 2008, p. 960–966: http://onlinelibrary.wiley.com/doi/10.1111/j.1360-

Concurring results were recently found in Britain. A multi-site RCT compared heroin substitution with oral and injectable methadone for chronic users who were already enrolled on a methadone maintenance programme but were continuing to use street drugs. It found that heroin substitution was significantly better at retaining users in treatment, and was associated with significantly lower street heroin use. After 26 weeks, 72 per cent of those enrolled on heroin substitution had tested negatively in more than 50 per cent of tests for street drugs, compared with 27 per cent on oral methadone. By the end of the study, significantly more individuals given heroin substitution were reporting consistent abstinence from street drugs: 51 per cent compared with 17 per cent on oral methadone and 29 per cent on injectable methadone.[32] However, these results should not be considered typical of either methadone or heroin substitution treatment generally since the trial also involved a more intense level of therapeutic engagement than normal as well.

An additional benefit to this approach was observed in Switzerland. Many of the chronic users targeted for substitute heroin turned out also to be low-level street dealers in heroin ('user-dealers'). Their enrolment onto substitute heroin was associated with significant reductions in their number of arrests for possession. Martin Killias contends that this effectively deprived heroin traffickers of a 'workforce' that was willing to distribute drugs on the street. As a result, drug suppliers moved away from the streets and into private residences. This suggests that the illegal market in heroin became substantially less viable and visible as a result of regularising drug use amongst chronic and dependent addicts: 'drugs like heroin might become less easily available to casual or novice users or to those who otherwise might wish to experiment out of curiosity'.[33]

The clear disadvantage of this approach is that it represents no immediate attempt to become drug free. Killias has gone as far as to suggest that there is a trade-off present in supporting this intervention: it may effectively reduce crime and disorder but, by offering addicts a way

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0443.2008.02185.x/full

[32] Strang, J. et al, 'Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial', *Lancet* 2010; 375: 1885–95: http://donaldmacpherson.ca/wp-content/uploads/2010/05/British-Heroin-Trial-Results.pdf

[33] Killias, M. and Aebi, M., 'The Impact of heroin prescription on heroin markets in Switzerland', in Hough, M. and Natarajan, M. (eds), *Crime Prevention Studies*, volume 11, 2000, p. 95: http://www.popcenter.org/library/crimeprevention/volume_11/04-Killias.pdf

to keep using heroin, also reduces opportunities for them to go on to become drug free. This underlines the importance of targeting this treatment only at those individuals for whom no other intervention is effective. In addition, without close supervision, there is a significant risk of prescribed heroin being diverted into the street economy. Despite these problems, this intervention remains a viable approach in some contexts, with demonstrable efficacy, for individuals who are otherwise unable or unwilling to co-operate with other approaches. This applies especially if the policy priority is to reduce offending immediately. No studies could be found regarding heroin substitution in prisons.

## Opioid antagonists

While most pharmacological interventions fit more easily into the harm reduction approach, an exception is the use of opioid antagonists, which block the effects of illegal drug use. The goal in this case is to cultivate and maintain abstinence. As a result, unlike opioid maintenance, opioid antagonists can be used in conjunction with abstinence-focused therapies. Rather than substitute heroin with a more controlled, but frequently as addictive, substance, opioid antagonists actively counter the effects of heroin. If compliance with the treatment is maintained following a successful detoxification, it can help willing addicts remain completely free of opiates.

The most commonly used antagonist is naltrexone. It blocks the euphoric effects of heroin, acting as a significant deterrent to injecting while on the treatment. As a way of keeping heroin out of an addict's system, it is acknowledged to be effective. Bell explains that the only experience of injecting heroin while taking naltrexone is one of 'buyer's remorse'; they have simply wasted their money. More controversial is how to apply this treatment in a public health setting. The main issues are ensuring continued compliance with treatment, and, ideally, inducing long term abstinence from heroin. As Minozzi et al. explain:

> *[N]altrexone has good pharmacodynamics and pharmacokinetic properties. However, from an applied perspective, the medication has little application since the medication compliance rates are very poor.* [34]

[34] Minozzi, S., Amato, L., Vecchi, S., Davoli, M., Kirchmayer, U., Verster, A., 'Oral naltrexone maintenance treatment for opioid dependence', *Cochrane Database of Systematic Reviews*, 2011, Issue 4. Art. No. CD001333 2011: http://www2.cochrane.org/reviews/en/ab001333.html

The standard preparation has to be swallowed daily as a tablet. If treatment ceases, its effectiveness at blocking the effects of opiates ends after about 48 hours. In this form, the National Institute for Clinical Excellence's guidance recommends the use of naltrexone 'as a treatment option in detoxified formerly opioid-dependent people who are highly motivated to remain in an abstinence programme'.[35] However, it emphasises the need for conditions that permit supervision and review of the course of treatment.

Other formulations have been developed to give addicts more opportunity to stay committed to abstinence once detoxification has been completed:

- An implant can be inserted into the abdomen using a minor surgical procedure, allowing Naltrexone to be absorbed slowly into the body. A single implant can last from a few weeks to more than 6 months.
- Naltrexone can also be injected into deep muscle tissue, allowing it to be absorbed into the body over the course of a month (at which point another injection is required to maintain treatment).

The idea of these approaches is to allow addicts to stay on course without having actively to take naltrexone themselves on a daily basis. These methods still require significant medical supervision to ensure continued compliance and to observe for signs of dangerous side-effects. Implants, for example, sometimes have to be removed if the site of the surgery becomes infected. Implants are not currently licensed for general medical use, although they are permitted for some medical trials. Bell explains that current implants are not guaranteed to be safe, nor necessarily produced to a sufficient standard to be sure that they produce stable and effective doses of naltrexone. This, he feels, is a major barrier to properly evaluating their effectiveness.

These challenges of application and compliance render the evidence in favour of naltrexone mixed and incomplete. A Campbell review suggests that the addition of naltrexone *'reduces*

[35] See: 'Drug misuse – naltrexone', http://www.nice.org.uk/TA115

*criminality significantly more than behaviour therapy or counselling'*,[36] but it is important to note that the trial treatments combined naltrexone with counselling rather than testing naltrexone alone. A Cochrane review concurred, noting a statistically significant reduction in incarceration rates amongst offenders using naltrexone, but emphasised high overall drop-out rates (72 per cent of 1152 participants across 13 trials)[37] and concluded '*studies conducted to date have not allowed an adequate evaluation of oral naltrexone treatment in the field of opioid dependence*'.[38] However, a sub-group analysis of trials that included 'forced adherence' which included individuals on parole, or supervised by members of their family, found a statistically significant improvement in abstinence compared with controls.[39] This indicates that naltrexone could work well in some criminal justice settings.

The addition of psychosocial treatment alongside naltrexone plays an important role in allowing the addict to stay committed to abstinence. Private providers of naltrexone as a detoxification and maintenance treatment often emphasise the need for a close friend or family member to be present to support the addict during the on-going process of recovery, as well as to supervise compliance. Other schemes combine naltrexone maintenance with a variety of other therapies in order to encourage patients to stay committed. The potential for these combined treatments is perhaps illustrated best by one recent study conducted in the Netherlands.[40] This 'comprehensive' treatment combined oral naltrexone maintenance with a Community Reinforcement Approach (CRA) for a group of addicts who were recruited from a methadone maintenance programme. It is described as follows by its practitioners:

> *CRA uses positive reinforcement for each treatment step, no matter how small (successive approximation). Consequently, a CRA therapist looks continually for opportunities to reinforce the substance using individual… it utilizes social, recreational, familial, and vocational reinforcers to assist consumers in the recovery process. As a behavioral program, CRA makes extensive use of modeling, role-*

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36 Egli, N., Pina, M., Skovbo Christensen, P., Aebi, M.F., Killias, M., 'Effects of drug substitution programs on offending among drug-addicts', *Campbell Systematic Reviews*, 2009:3, p. 6: http://www.campbellcollaboration.org/lib/download/675/

37 Minozzi et al, p. 12.

38 Minozzi et al, p. 12.

39 Minozzi et al, p. 11.

40 Cor, A. J. et al, 'High abstinence rates in heroin addicts by a New Comprehensive Treatment approach'. The American Journal on Addictions, 16: 123-130, 2007: http://www.communityreinforcement.nl/images/310707_AJoA_High%20abstinence%20ratespdf.pdf

*playing, and shaping. Its goal is to make a sober lifestyle more rewarding than the use of substances.*[41]

Rates of abstinence after 10 and 16 months of treatment were 28% and 32% respectively. 24% of participants had been persistently abstinent over the 16 month follow up period. The authors noted: '*the degree of success is much higher than that which could be expected from regular treatment approaches, such as methadone tapering'*. Although patients in the study were not selected randomly, the authors were able to make the tentative conclusion that *'abstinence as a goal of treatment is attainable for a larger proportion of opioid-dependent patients than has been assumed to date'*.[42] However, it should also be noted that the therapists used to provide the CRA elements of the treatment appeared to be particularly well-qualified, suggesting that naltrexone is no substitute for intensive, well-designed, psychosocial treatment.

**Naltrexone in prison**

Naltrexone can be prescribed to prisoners either to aid with detoxification or to support abstinence from opioids, but information on its use in the prison system is very limited. Trials of the use of naltrexone in prison are rare and have not been evaluated in a systematic review. One Australian study suggested that compliance with naltrexone maintenance is particularly difficult to achieve in a prison setting, with a mere 7 per cent retention rate after 6 months, significantly less than the methadone-prescribed control group.[43]

Bell queries whether naltrexone maintenance is ever worthwhile in a prison context. He argues that the supply of illegal heroin in prison is insufficient for anyone to cultivate a serious habit or become physically dependent but that if prisoners can get hold of illegal substances, they will simply stop taking naltrexone in order to take them. Trace, by contrast, does see a limited use for it as a 'nudge' to improve compliance amongst prisoners who are already motivated to remain abstinent. He believes it could be valuable where prison privileges are associated with consistently passing drugs tests. Naltrexone, in such cases,

[41] See: http://www.communityreinforcement.nl/en/?Werkpage1:CRA
[42] Cor, et al, p. 129
[43] Shearer, S., Wodak, A. and Dolan, K., 'Evaluation of a prison-based naltrexone program', *International Journal of Prisoner Health*, Volume 3, Issue 3, 2007: http://www.informaworld.com/smpp/content~db=all~content=a780730057

could help in the battle to stop an abstinent prisoner from lapsing and, for example, losing their place on a drug recovery wing.

## Psychosocial interventions

While clinical treatments can usually be delineated by the form and function of the prescribed drug, psychosocial interventions can be harder to pin down and define. In fact, some of the most effective practitioners utilise a number of different therapies and vary their approach according to what an individual addict responds to best. As a result, they depend more on specific implementation, the competency of practitioners, and local context. They can be broadly divided into those that aim for abstinence or full recovery, and those that aim at tackling problematic thoughts and behaviour associated with drug use as part of a harm reduction intervention. Other distinguishing features include the length of interventions and their intensity, especially frequency of attendance and the focus applied to individuals. These sometimes seem to be more significant features in predicting outcomes than the content or therapeutic dynamic of the treatment, with more intense programmes producing consistently better outcomes.

Systematic evidence suggests that psychosocial interventions can be particularly effective in a prison setting at reducing re-offending on release, more so than methadone substitution treatments alone.[44]

### 12-Step Programmes

Perhaps the most prominent full recovery focused psychosocial approach is the 12-step model, as used by, among others, Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous. 12-step conceptualises addiction as a disease that can be controlled *only* through refraining from drug use and maintaining sobriety. The disease can never be cured. The approach can take the form of a structured programme, provided in the community, within a prison, or in a residential rehabilitation clinic. Residential programmes usually take 6 to 12

[44] Mitchell O., Wilson D., MacKenzie D, 'The effectiveness of Incarceration-Based Drug Treatment on Criminal Behaviour', *Campbell Collaboration*, 2006.

weeks but can last as long as 18 months. Within this structure, a very wide variety of treatment approaches might be used. Boyd explains that key therapies used in 12-step rehabilitation programmes include:

> *Psychodynamic therapy, Reality therapy, group therapy, motivational interviewing, motivational enhancement therapy, cognitive behavioural therapy, Gestalt, Family systems, Images & poetry, Creative therapies (art, music, dance, drama), Humanistic, Yalom's Group Treatment, Transactional analysis, Rogerian, Psychosynthesis, Complementary therapies, Genesis relapse prevention.*

There are also less structured self-help fellowships, which can provide a 'sense of purpose and belonging'[45] and mentors who can provide a constant example of living a drug free life. Individuals who pass through a structured programme are expected to continue their recovery by participating in a local fellowship.

The programme has an avowed spiritual, though non-denominational, component: participants must admit the unmanageability of their lifestyle and seek a higher power for help and guidance in staying away from all drug use and maintaining sobriety.[46] The core of the programme is about shifting self-centred and destructive behaviours towards helping others and having regard for their feelings. In this sense, apologising to people you have wronged and supporting other addicts are important personal developments in the programme. Perhaps the most significant feature of 12-step fellowships is that they continually present up-front and accessible individuals who were dependent addicts but have gone on to live entirely drug free lives. This might be contrasted with clinical settings where the general experience will be one of chronic and relapsing drug abuse, which, when presented to drug users, might become a self-fulfilling and self-reproducing problem. Judge Philips, who has attended 12-step meetings as an observer, describes the attitude of participants towards newcomers as 'unconditional, altruistic love'.

Generally, 12-step approaches are considered incompatible with harm reduction interventions, which are often seen as an attempt at controlled drug use. Many 12-step residential clinics, for example, only accept people who are drug free or are willing to

[45] Robson, p. 204
[46] For a list of the steps that recovering addicts must take, see: http://www.ca.org/12and12.html

undergo an immediate detoxification procedure. However, some 12-step practitioners are willing to combine their efforts with some substitute treatments, such as methadone prescriptions.[47]

12-step programmes are approved by many clinicians. Robson, for example, comments:

> *... AA and NA are very effective at breaking an unhealthy self-focus through their emphasis on helping others, and provide an inspiring model of attainable abstinence to those who have begun to abandon hope'.*[48]

However, when it comes to strictly clinical criteria, evidence for the efficacy of 12-step programmes is limited:

> *Objective evidence that the 12-step approach significantly enhances likelihood of abstinence in comparison with natural remission or other interventions is lacking.*[49]

A key reason for this lack of clinical evidence is the difficulty associated with testing 12-step in an RCT or similarly robust trial. Attendance of a fellowship group, for example, is not a prescribed treatment, controlled by available resources and a medical assessment. 12-step participants are, in most circumstances, self-selecting. Individuals have to be motivated to become drug free in order to enter a 12-step programme, and, for attendance of a fellowship meeting, that is the only requirement. In addition, 12-step fellowships are not going to turn away willing individuals who are motivated to join them, even if, for example, they had been selected to be in a control group for a trial. So there is rarely a way, practically or ethically, to test efficacy. As a consequence, quantitative evidence put forward in support of 12-step programmes, almost inevitably, infers a causal relationship from a correlation. But when circumstantial evidence of this kind is permitted, a likely link emerges between 12-step and many individual recoveries. David Best's *end of career* survey concluded:

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[47] Hayes, S. T., et al, 'A Preliminary Trial of Twelve-Step Facilitation and Acceptance and Commitment Therapy With Polysubstance-Abusing Methadone-Maintained Opiate Addicts', *BEHAVIOR THERAPY* 35, 2004, p. 684: http://actmadesimple.com/upimages/Kelly_Wilson_ACT_substance_abuse.pdf
[48] Robson, p. 27.
[49] Robson, p. 205.

> *[A] crucial finding was the prominence of 12-step support in the recovery journeys reported by participants in the study… lack of awareness of 12-step support often cited as a reason for previous failures.*[50]

Intensity of attendance, especially of fellowships after residential rehabilitation, seems to be a key predictor of successful drug recovery.[51] Judge Philips recalls an example of an NA representative, that he came to know, who first became free of cocaine by attending three fellowship meetings daily for thirty days. There are also important differences between simple attendance and active participation in 12-step fellowships, with participation being much more associated with future abstinence.[52]

**12-step in prison**

Intriguingly, despite the current small scale of provision, evidence for the efficacy of 12-step is relatively strong within a prison setting. Around 900 prisoners were able to access a 12-step programme in the prison system in years 2007/08 and 2008/09.[53] The intensive 12-step programme run by the Rehabilitation of Addicted Prisoners Trust, in particular, has had widely acknowledged success in allowing prisoners to go on to live drug free and crime free lives. It is described as a '20 week, abstinence-based, intensive, psychosocial intervention, designed around a 12-Step framework, augmented and adapted with Motivational Enhancement Therapy, Cognitive Behavioural Therapy, and other evidence-based approaches'.[54]

In one recent report, RAPt examined 663 prisoners from the Police National Computer which included one group that was able to access RAPt's treatment and a control group that was only able to access a lower intensity treatment of four weeks duration. While the control group had a re-offending rate of 73 per cent, for the treatment group it was 44 per cent, a

[50] Best, et al, p. 27.
[51] See, for example, Fiorentine, R., 'After Drug Treatment: Are 12-Step Programs Effective in Maintaining Abstinence?', *The American Journal of Drug and Alcohol Abuse*: http://informahealthcare.com/doi/abs/10.1081/ADA-100101848
[52] Weiss, D., et al, 'The effect of 12-step self-help group attendance and participation on drug use outcomes among cocaine-dependent patients', *Drug and Alcohol Dependence*, Volume 77, Issue 2, 14 February 2005, pp. 177-184: http://www.ncbi.nlm.nih.gov/pubmed/15664719
[53] Chambers, p. 40
[54] See 'RAPt publishes findings of new study into the impact on reoffending of intensive drug treatment in prisons', RAPt, April 2011: http://www.rapt.org.uk/news.asp?section=36&sectionTitle=News+%26+Views&itemid=260

substantial improvement.[55] The control group was not randomised. However, since accessing 12-step is mediated heavily by availability inside prison (rather than willingness of the participant, as in the community), it is plausible to suggest that at least some of this effect is due to the programme's efficacy.

There are a number of reasons why access to 12-step programmes in prisons specifically might be beneficial. 12-step requires an addict's commitment to become drug free, and this sometimes comes only after it has become obvious that their drug use is a serious problem with serious consequences for the user. An offender being imprisoned, especially for a longer than average sentence, might, at that point, realise that their criminal lifestyle is unsustainable. Indeed, it is sometimes the most heavily addicted users who respond only to an intensive abstinence-focused psychosocial programme precisely because there is no safe or controlled level of drug with which they are able to cope.

### Therapeutic Communities

Therapeutic Communities (TCs) resemble drug free residential rehabilitation clinics and 12-step fellowships in so far as they attempt to bring drug users and former users together to help each other recover. The difference, as Danny Clarke explains, is that while 12-step, at its core, is about confronting drug using beliefs and behaviours in a very direct manner, TCs place a greater emphasis on building up alternative modes of behaviour, as well as social structures, to replace the aberrant ones that accompany drug addiction. For those who lack the sort of relationships present in workplaces and families, these environments can provide a productive routine and lifestyle guidance. Since they usually involve developing a whole community and alternative peer group at a particular location, these are typically intensive and long-term programmes. They are able to transform some people's lives, especially those who are able to stay the full course, but can be counter-productive for those ill-suited to the community, leading to early drop-outs or expulsion if an addict relapses into drug use.

Concrete evidence proving efficacy of TCs compared with other treatments is not strong at this stage.[56] One Cochrane review explained, '[t]here is little evidence to show that TCs offer significant benefits in comparison with other residential treatments', although residential TCs

[55] RAPt, 2011.
[56] Robson, p. 204.

were associated with better outcomes than a community (non-residential) TC alternative. However, the evidence for the use of TCs for treating prisoners, both to reduce drug use and re-offending, is much stronger. For example, another Cochrane review found promising results for 'the use of therapeutic communities with aftercare facilities'.[57]

A recent Campbell review examining interventions in prisons concluded that TCs 'exhibited strong and consistent reductions in drug relapse and recidivism.'[58] This might be because prisoners, more than other groups of problematic drug users, are less likely to have many of the basic social structures that many others take for granted. It is possible that TCs can provide an opportunity to develop those structures and cultivate new ways of behaving and interacting with others. Importantly, TCs involve separating those attempting to become drug free from other prisoners which might indicate the importance of offering alternative peer groups in prison.

All studies emphasise that we are still at a comparatively early stage of concluding the precise effects of TCs in a criminal justice setting. Nevertheless, TCs seem to be one of the most promising responses to drug abuse. Places on TCs are available in prisons in England and Wales although infrequently compared with other programmes (280 placements in 2007/8, 260 in 2008/9).[59] The UK Drug Policy Commission have noted that, despite the promising systematic evidence 'there are only a handful of therapeutic communities currently operating in British prisons and there has been no evaluation of their effectiveness'.[60] As a result, we might tentatively conclude that TCs are one approach that could be usefully expanded in British prisons and also evaluated in more detail to ensure they are being successfully implemented.

### Cognitive Behavioural Therapy

Cognitive Behavioural Therapy is a 'talking therapy' designed, as Robson explains, to 'uncover self-defeating patterns of thinking which, it is argued, lie at the heart of depression,

[57] Perry, A., 'Interventions for drug-using offenders in the courts, secure establishments and the community', *Cochrane Database of Systematic Reviews*, 2006, Issue 3. Art. No.: CD005193: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005193.pub2/full
[58] Mitchell et al.
[59] Chambers, p. 40.
[60] Reducing Drug Use, Reducing Reoffending, p. 48.

anxiety and guilt'.[61] Of all talking therapies in general, it has perhaps the most robust evidence of efficacy.[62] It can be used to tackle problematic drug using behaviour specifically, or deal with other patterns of behaviour that may underlie problematic drug use.

Unlike 12-step, CBT does not identify addiction as an incurable disease, but as problematic behaviour that can be modified, leaving open the possibility that some individuals may be able to control their drug use. As a result, CBT can be provided alongside drug maintenance treatments such as methadone prescribing. Programmes tend to be of shorter duration and less intensity than 12-step programmes and TC approaches, making it flexible and easier to fit around other routines and interventions. This makes CBT attractive, perhaps superficially, when it comes to resourcing and planning treatments, but it is often insufficient to foster a transformative change of behaviour amongst seriously addicted individuals.

Although there is evidence that CBT is more effective at tackling drug abuse than no treatment at all, there is less evidence to show that it improves on other treatment alternatives.[63] In addition, there is not all that much evidence of effectiveness for offenders and prisoners, especially as currently provided in the British prison system.[64] Acknowledging this lack of evidence, the Ministry of Justice commissioned a feasibility study for an RCT of one prison-based CBT programme, P-ASRO.[65] This is at a remarkably early stage of research, considering that CBT is one of the most commonly used psychotherapeutic interventions in prisons in England and Wales.[66] At this stage, while it is plausibly doing more good than harm, we do not know enough about how effective these programmes are and especially whether they provide anything like the intensive intervention that many drug addicts in the criminal justice system seem to require to turn their lives around.

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[61] Robson, p. 2.
[62] See for example, Butler, A. et al, 'The empirical status of cognitive-behavioral therapy: A review of meta-analyses', *Clinical Psychology Review*, Volume 26, Issue 1, January 2006, p. 17-31: http://www.sciencedirect.com/science/article/pii/S0272735805001005
[63] See http://archives.drugabuse.gov/TXManuals/CBT/CBT19.html
[64] Reducing Drug Use, Reducing Reoffending, p. 49.
[65] Kerr, J. et al., 'Assessing the feasibility of conducting a randomised controlled trial or other outcome study of P-ASRO', *National Centre for Social Research*, January 2011: http://www.natcen.ac.uk/media/665137/06%20pasro%20feasibility%20study%20report_final_jan%2011.pdf
[66] Chambers, p.40

# 2. How should effective drug interventions be delivered?

In the previous section, we reviewed some of the current thinking and research on specific treatments for drug addiction. We concluded that, while the current default treatments of focusing on substitution (especially methadone for heroin addicts) was not the most effective approach available, no treatment alone represents a single answer to addiction. Rather, a variety of alternative approaches each have the potential to make marginal gains on current outcomes. Rather than having one default treatment, a variety of appropriate treatments should be available.

So in this section, we take a step back from the treatments themselves and ask how they can be delivered in such a way that these additional gains can be realised. Given the complexity and expertise required to evaluate the interventions themselves, it is on this more general level that policy-makers can hope to make a positive impact. This section begins by outlining some key features of what such a delivery mechanism would look like under the headings:

- Diversity
- Continuity
- Intensity

It continues by arguing that available evidence seems to suggest that increased integration of services could allow for significant improvements. It then examines how service providers can be incentivised to deliver appropriate and effective treatments in the context of the Government's interest in using payment-by-results to reward successful providers.

## Features of effective drug interventions

### Diversity

Delivering effective interventions is complicated by the varied and multiple characteristics that individual drug users have. There are casual users, and some heavy users, who are not

addicts as such, but whose impulsive, sometimes criminal, behaviour might be associated with their recreational drug use. Others suffer from addiction but may only use small amounts of drugs at a time. Others are heavy using physically dependent addicts. Interestingly, volume of drug use has little association with long-term prognosis. Philip Robson explains: 'the severity of the addiction in terms of frequency of use or quantity consumed has little or no bearing on the likelihood of successful rehabilitation'. It is possible for someone to be a chronic but infrequent addict who never fully recovers, while a heavy user might 'hit rock-bottom' in one episode and then go on to become drug free.

Mental illness is frequently associated with drug use. Drug users suffering simultaneously from mental health problems are identified as having a 'dual diagnosis'. For some users, the addiction might be the primary mental health disorder. For others, it might be a sign of another serious underlying mental illness. The nature and the intensity of related mental health disorders is a key factor in determining the most appropriate treatment. For example, Deirdre Boyd suggests that sufferers of schizophrenia and other psychotic disorders will require pharmacological treatment. Clinical psychiatry will be the primary provider of care in such cases. However, she also believes that drug users suffering from clinical depression are much more likely to respond to 'talking therapies' and that should be the preferred intervention in those cases.

Boyd explains the breadth of recovery required in order to become truly free of addictive behaviour. It is not just about addressing drug taking alone but all associated aberrant and selfish behaviours and beliefs:

> *... abstinence is sustainable only when behaviours and relationships are healthy (e.g., with family), when relapse triggers are addressed, when childhood traumas are faced and no longer influence actions, when life is lived with honesty to self and others (no crime), when amends are made for past actions and a determination made not to create future problems, and a promise is made to help others suffering from addiction.*[67]

Making a parallel point, Bell describes a number of common antecedent factors to drug

[67] Boyd D., 'Rehabilitation Works: the evidence', *Addiction Today*, December 2010: http://www.addictiontoday.org/files/addiction-today-127---rehabilitation-evidence.pdf

addiction itself that include ‘a low tolerance for frustration’, a ‘prevailing dysphoria’ and ‘a general lack of rewards in life’. He goes so far as to suggest that for some drug addicts, a greater barrier to recovery than drug use itself is the welfare trap, whereby individuals are afraid to enter work in case they lose entitlement to benefits. For this reason, he approves of some of the recent attempts to reform welfare to make work more attractive for those currently in receipt of benefits.

Bradbury explains that it is common for delinquency to precede drug addiction. It is comparatively rare for addicted offenders to have been ‘model citizens’ before they were introduced to drugs. He suggests that drug use, rather than introducing offending behaviour for the first time, tends to multiply it, usually due to the urge to feed the habit that has been cultivated as an adjunct to a delinquent lifestyle. For these individuals, drug treatment itself is insufficient to put a complete stop to offending:

> *Through treatment,* [addicts] *may recover but that doesn’t make them reformed model citizens. It just means they aren’t stealing to buy* [for example] *heroin. They may still steal. They just aren’t getting up every morning in order to steal. Drug addiction magnifies offending behaviour.*

For a small number of offenders, drug addiction is the primary motivator for crime and resolving that addiction is sufficient to allow them to integrate into a normal productive lifestyle. But these are exceptions to the rule amongst offending drug users. As a result, successful interventions must address the many different needs of addicts, including those relating to mental health, housing or access to employment or training, in order to shift them into living consistently crime free lives. We need service providers that are able to use a variety of intelligent approaches to tackle the needs of individual drug addicts. In fact, the last thing needed is services that pursue either a singularly pharmacological, therapeutic, or spiritual approach to recovery. We need services that are willing to use all available options in any reasonable combination according to what is working in a particular context.

### Continuity

If diversity is the availability and willingness to use a variety of interventions appropriate to each offender, then continuity is the combination these different interventions, ensuring that

they make the difference in outcomes. It includes co-ordinating information and expertise regarding all the different aspects of an addict's condition. Without this, gains achieved through even the best individual interventions will be lost as services and supporters lose contact with addicts, allowing many to drift back towards drug taking and crime. This is particularly important given one of the key conclusions from the previous section: that the best interventions are those that take place over a long period and are followed by continued support and aftercare.

Continuity also includes simple hand-over points where addicts may be lost between services. Boyd points out that having a companion meet a discharged prisoner to take them to their next recovery meeting can be crucial to preventing relapses. Judge Philips, who runs a dedicated drug court, keeps a mobile phone on constantly so that offenders he knows can call him when they are feeling particularly vulnerable or likely to relapse. He wishes that probation officers and other key workers could do the same.

Co-ordinating information and expertise is an acknowledged weakness in the criminal justice system and this has implications for how appropriate and effective a sentence, or disposal, will be at encouraging offenders to address their drug problems. The Government's Bradley Review, focusing on mental health provision for offenders, identified several relevant points of failure. A core problem is a lack of co-ordination between mental health services and the criminal justice system with the result that important information is not available for sentencing and that relatively under-qualified staff are sometimes required to assess individual offenders. It is common for individuals to 'arrive at court without any information regarding their mental health problems or learning disabilities'.[68]

This means that 'it can fall to probation staff working in courts, untrained in mental health or learning disability, to recognise the potential signs of a mental health problem or learning disability.'[69] Full psychiatric reports might not be requested when appropriate, but even when reports are requested, 'there are many problems with the timeliness, quality and appropriateness of the reports received by the courts.'[70]

[68] Bradley, K., *The Bradley Report*, Department of Health, April 2009, p. 69: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf
[69] Bradley, p. 69.
[70] Bradley, p. 71.

Bell's own experience echoes Bradley's findings. He suggests that this lack of co-ordination amounts to a 'gulf between services for offenders' and the rest of mental health, resulting in the criminal justice system 'acting in isolation from other clinical interventions'. As a result, he claims, probation and courts often implement treatments that are not recommended by mental health workers who have previously assessed and prescribed a treatment in a different setting. He gives the example of one panel of magistrates which encouraged and funded a detoxification procedure as a drug rehabilitation requirement for one offender who was a patient of his and, at that time, on a maintenance programme. Shortly afterwards, she relapsed, an approach that Bell describes as 'setting people up to fail'.

### *Dedicated Drug Courts*

The use of dedicated drug courts, rather than ordinary magistrate court proceedings, points to one promising solution to this present lack of continuity. The core of this model, imported from the US, is to allow offenders with drug problems to be reviewed by the same judge, or panel of magistrates, continuously from the beginning to the end of a sentence. In this way, sentencing disposals can be refined to support, as well as sanction, individual offenders. It also means that the results of mandatory drug tests or failures to fulfil certain requirements of a community order can be judged on a more individual basis, examining them in the light of progress achieved by an offender and their disposition to improve. Judge Philips, who initiated and is one of the presiding judges in the drug court in Hammersmith and Fulham, describes the unique innovation from ordinary court procedure:

> *The big difference is we promise continuity. Everyone who is sentenced to a* [community] *drug order in this court is sentenced to be reviewed by this court. And the judge or bench that sentences is the one that reviews, and if it goes wrong, the judge or bench that resentences.*

Drug courts have now been piloted in six areas in England and Wales, since 2001 in Leeds, 2005 in Hammersmith and Fulham, and 2008 in Barnsley, Bristol, Cardiff. Whether they have been successful is, unfortunately, not a question to which either of the recent Government-commissioned evaluations has found a definitive answer. A 2008 review by Matrix found a relationship between continuity of a judicial bench and an offender completing a community

order with a drug rehabilitation requirement.[71] Thus, successful implementation of the drug court model was associated with a modest but detectable decrease in likelihood of re-offending. A more recent review in 2010, conducted by the National Centre for Social Research, took a more qualitative approach, with the result that it was unable to conclude anything more empirically decisive than that the drug court model 'was viewed by staff and offenders as a useful addition to the range of initiatives aimed at reducing drug use and offending' and that 'both staff and offenders felt that continuity helped the relationship between offenders and the judiciary develop.'[72]

From a crime and disorder perspective, a key question is whether drug courts have a noticeable effect on the districts in which they are established. It is this hope that is a key motivation for Judge Philips. The London drug court exclusively handles relatively low-level offenders who are resident in the borough. These are non-violent offenders, responsible for thefts of no more than £1,500 in value. Philips' contention is that the drug court is successful at ending or, at least, changing the trajectory of these offenders' criminal careers. In other words, it helps prevent more of these relatively low-level offenders from cultivating a more serious addiction and graduating to more frequent thieving, as well as more serious crimes such as robbery. He points to a large drop in acquisitive crime during the year after the court opened as evidence for his hypothesis. In addition, he suggests that there may be a spill-over effect into the neighbouring borough of Kensington and Chelsea, famous for its expensive retail outlets and department stores, a tempting target for potential offenders who are resident in Hammersmith.

A similar argument in favour of the more recent pilots elsewhere is constrained by the fact that sufficient data for years after they have been established are currently unavailable. For Leeds, comparable neighbourhood data could not be found for the period before it was introduced, although a significant drop in crime shortly after the court's introduction is consistent with the idea that it has had some success too. These results are promising and at least consistent with the subjective evaluation of Judge Philips and other practitioners who have been involved in the pilots. But they are hardly convincing on their own. A more thorough evaluation, with a method that was better able to track the input of drug courts all

[71] 'Dedicated Drug Court Pilots A Process Report', *Matrix Knowledge Group* (for Ministry of Justice), April 2008: http://www.matrixknowledge.co.uk/wp-content/uploads/dedicated-drug-courts2.pdf

[72] Kerr, J. et al., 'The Dedicated Drug Courts Pilot Evaluation Process Study', *Ministry of Justice*, January 2011, p. i: http://www.justice.gov.uk/publications/docs/ddc-process-evaluation-study.pdf

the way to the impact on communities, would have been useful.

Disappointingly, it appears that drug courts may have dropped off the radar since the Coalition Government entered office. They make no appearance in the Government's new drug strategy.[73] This is unfortunate, considering their observed success in other countries in robust field trials,[74] and some tentative signs of success in England and Wales. One key observed benefit of these kind of courts, namely continuity (in this case provided in a judicial capacity), should be considered when implementing future schemes that are designed to match offenders with an appropriate disposal.

### Intensity

This simplest feature of all is the level of engagement and supervision offered to drug addicts. Of all the themes, it is perhaps the most discussed. For many offending drug addicts, the more constant and regular the engagement with services, the better is the chance of establishing and maintaining recovery. Speaking about heavily dependent addicts in prison specifically, Trace argues:

> *If you really want to turn people around, you don't want to fart about. There is no point taking a severely dependent prisoner and meeting with them two or three times and expecting them to turn their lives around on that basis.*

This is equally important in a community setting. Boyd explains that intensive approaches are required not just to tackle drug use itself, but to fill the void of time and purpose that drug addiction fills in the lives of those afflicted: *'It is about replacing the vacuum. It is all the time that drug use filled in before. Structured time is very important, even going to 12-step meetings.'* This is the reason why some addicts, who have become serious about recovery, may end up attending 12-step sessions daily or even multiple sessions each day, in order to reduce opportunities to fall back into the wrong crowd and lapse back into old habits. It is for similar reasons that Boyd argues for greater use of residential rehabilitation clinics that can provide constant long-term support and therapy for recovering drug users while removing

[73] Drug Strategy 2010, http://www.homeoffice.gov.uk/drugs/drug-strategy-2010/
[74] Farrington, D. and Welsh B., 'Randomized experiments in criminology: What have we learned in the last two decades?', *Journal of Experimental Criminology*, 2005, 1: 9–38: http://www.crim.umontreal.ca/cours/cri3013/experiments.pdf

them from aberrant influences.

Similarly, Judge Philips outlines his ideal schedule for offending addicts attending a putative 'one-stop-shop' for addiction services: 'they would clock in at 10 and clock out at 4 – every day, 5 days a week.' Besides that, Philips also suggests giving greater curfew powers to judges so that those attending drug services could be kept away from bad influences outside of these hours. This gives some idea of the intense level of engagement that practitioners feel that serious drug addicts need in order to generate durable behavioural improvements.

Crucially, there is no viable low-intensity treatment that is either safe for the community or humane for many addicts. For example, current treatment can involve a methadone or other substitute prescription, and sometimes nothing else accompanying it; or a few intermittent counselling sessions. The evidence suggests that this level of engagement is not sufficient to address drug use or change the behaviour or lifestyle, of addicts. No one we spoke to was prepared to defend this low-level of engagement as, in any sense, effective.

## Integration as a solution

Evidence and experience seem to indicate that greater integration of services is a practical way of delivering these important features of service provision. Integration, in this case, means making one agency both capable and responsible for all the services necessary for drug recovery in a given district. This does not imply that one agency has to become a specialist in all kinds of service provision, from health, housing, drug treatment and job training, simultaneously. Instead, the single agency has the power to provide, commission, or sub-contract, all the services that it finds necessary to help drug addicts in their recovery. This differs from a multi-agency approach whereby organisations attempt to share knowledge in order to respond to individual user needs. Much as co-operation between separate service providers is better than working in isolation, the problem in such arrangements is that it is often unclear where 'the buck stops' unless a single agency is able to command these different resources.

For example, finding shelter for a particular homeless drug addict might be a key barrier to allowing them to improve their physical health and thus begin to understand their underlying

needs. But if a local housing service has other, perfectly legitimate, priorities, such as ensuring that working families are given suitable homes, then they might fail to address the addict's need in a timely fashion. Indeed, there is no reason for them even to be aware of the significance of this decision in terms of planning the addict's recovery. For these reasons, it is important that the agency responsible for drug services is also able to commission its own social services when necessary, like housing support.

To use an analogy, just as a supply chain in industry requires every agent to be finally accountable to the seller of the finished product, so a complex service like this requires an agent that is responsible for the final outcomes, and capable of commissioning others to provide parts of the service in a fashion that fits with the rest of the chain.

The drug courts discussed above provide some evidence of how this can work. Rather than a judge disposing of drug offenders according to sporadic information about individual offenders from isolated services and events, the judge becomes knowledgeable of the subsequent trajectory of the offender during their disposal. They develop an interest (in some cases a sympathy) with the offender and thus try to find out what they really need and where those needs might be met, directing them to an appropriate rehabilitation service or support agency so that they might benefit from the drug court's disposal. Indeed, Philips recounts a number of occasions where he has to use his status as a judge to compel other service providers to engage with offenders on his watch, whether finding shelter for an individual or ensuring that they are able to access substitute drug treatment when they urgently need it.

A more integrated service would formalise this relationship. It is the 'one-stop-shop' where all drug treatment and related services are at the disposal of the agency responsible for drug addicts, and simultaneously where drug addicts know they have to attend to get help.

Whether the agencies that run these integrated services should be centred on one particular area of policy, such as the medical, therapeutic or criminal justice aspects, is an open question at this stage. As existing drug courts illustrate with some success, the solution could be to have agencies with dedicated judges, capable of following individual cases, at the top of the agency. On the other hand, the Crime Reduction Initiative has also shown some tentative successes with their integrated services in Warrington and Sefton. These services are not run from courts and have a greater focus on medical and psychotherapeutic treatment.

Importantly, CRI employ their own psychiatrists and other medical practitioners, rather than relying on other local mental health services. This means that medics can be brought into the charity's ethos of tackling crime through drug recovery, which is not always at the forefront of expectations or intentions in the NHS generally. In fact, both CRI's services and drug courts have crime reduction as a core purpose and it is likely that any successful integrated service is going to have to have crime reduction as a key desired outcome.

Another open question is how far this level of integration could be usefully extended. For example, probation, drug testing, medical treatments, psychosocial therapies, mental health services, housing and employment support all seem to be key areas that an integrated service would benefit being able to command and co-ordinate. But perhaps it could go even further, extending to other resources and services. For example, an agency might benefit from being able to second police officers to supervise the drug offenders that the agency is responsible for keeping on the straight and narrow. An optimal level of integration will only be found through experience and, as a result, a pluralistic and flexible approach to integration would be the best way to proceed.

## Payment-by-results

Greater integration appears to be the best way of making providers capable of providing effective drug rehabilitation services. The next question is how to select the agencies and how to encourage them to pursue every useful avenue, as well to use public resources efficiently, to achieve the desired outcomes of less drug addiction and less drug related crime. This ability to allocate available resources to their best use has become much more pressing in the current economic climate, and while the Government is attempting to make significant savings.

As a result, it is hardly surprising that the notion of payment-by-results (PbR) has come to the fore, specifically in drug treatment services where eight areas have been selected to pilot PbR projects,[75] as well at least six PbR pilots in the criminal justice system, including two based in prisons.[76] Under such a scheme, public services are contracted out to independent agencies,

[75] 'Radical approach to drugs recovery piloted', Department of Health, 8 April 2011: http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_125929

[76] Payment by results - programme overview, Ministry of Justice: http://www.justice.gov.uk/offenders/payment-by-results/programme-overview

whether charities or other companies. But rather than receiving a set payment for providing the service, the final payment is decided by the outcomes of the service, essentially how successfully they deal with a social problem.

The advantage is that it allows payments by government to be made after the services have been delivered and, preferably, after savings have been realised as a result of these services. Drug addiction is bound to impose costs on the community and the state through a variety of mechanisms, not least through the costs they impose on the justice system. A successful drug treatment service provider will reduce costs to the rest of the public sector, allowing them to claim part of the pay-off as a reward for the results. So an additional advantage is that the independent agency takes the risk on particular kinds of provision rather than government. If they succeed with their choice and implementation of services, the resulting payment is more than covered by the savings realised through that very success. If they fail or do not achieve all that they claim in their PbR contract, then the payments are smaller or nil, so at least the government has not paid for a failed service.

A well-designed scheme establishes cost controls but rewards intelligent risk-taking. For example, particularly difficult offenders might require a lot of resources to turn around, but a successful intervention for such difficult individuals could lead to dramatic reductions in crime in a local community.

There are, however, disadvantages to payment-by-results. It means that only large organisations with their own operating capital are able to tender for contracts. This reduces the potential field of competition between providers. In a field with as many diverse treatment approaches as drug addiction, this means that some types of provision are inevitably going to be favoured. Kathy Gyngell has suggested*: 'The risk is that PbR will favour large charities, and those NH and NH Mental Health Trusts who are responsible for the harm reduction approach.'*[77] At the very least, this indicates the importance of encouraging these top-level agencies to commission additional services that might be outside their traditional approaches to treatment.

There are also challenges of implementing PbR in such a way that service providers are

[77] Gyngell, K., *Breaking the habit*, Centre for Policy Studies, June 2011, p. 33: http://www.cps.org.uk/cps_catalog2/breaking%20the%20habit.pdf

genuinely incentivised to deliver desired outcomes. Results have to be measurable and quantifiable. In this sense, they function as targets, or key performance indicators, that have become a dominant method of public service reform in recent decades. The problem is that it is all too easy for targets to be gamed or to produce perverse incentives. Targets that are meant to represent real useful outcomes sometimes degenerate into process targets, or payment-by-activity, simply because observed activity can be easier to quantify than the outcomes achieved. This has been documented in the areas of education[78] and health[79] before.

One classic strategy is focusing on borderline cases, individuals that almost meet a target's criteria and only require a little bit of further investment to succeed. In education, for example, a child on a cusp of getting a C in a GCSE examination (a standard target for attainment in secondary schools) might receive more support than a child that is likely to get a D or an E at most. In drug rehabilitation, agencies might be incentivised to concentrate only on people that they believe could become drug free or commit no further offences, rather than tougher cases for which there might initially only be marginal improvements in behaviour. A poorly designed set of targets can mean that some people, who have little chance of helping an agency achieve a formal outcome, will simply be ignored. On the other side, those that are already likely to pass a target threshold might not be supported in doing even better.

With payments attached to these measures, the pressure to maximise 'results', if necessary at the expense of intended outcomes, is all the more powerful. So it is important that such outcome measures are robust. Looking at some of the suggested targets for the PbR pilots can indicate where the problems may lie. As an example, consider the NTA's own draft outcome definitions. They include:

- An initial and final outcome for being free of drug dependence
- An employment readiness outcome
- A 6-month and 12-month reoffending measure
- A number of health and wellbeing indicators relating to injecting behaviour,

[78] See, for example, Cowen, N., *Swedish Lessons*, Civitas, June 2008: http://www.civitas.org.uk/pdf/SwedishLessons.pdf

[79] See, for example, Gubb, J., and Li, G., *Checking-Up on Doctors*, Civitas, November 2008: http://www.civitas.org.uk/nhs/download/Checking_Up_on_Doctors.pdf

infectious disease treatment and access to housing[80]

The intentions behind these targets are clearly admirable, even pragmatic given the current economic constraints. As David Biddle explains, 'much of this is about reducing state spending'. But clear weaknesses rapidly emerge. Many of the indicators, as they stand, rely heavily on self-reported outcomes, both from addicts and the agencies subject to PbR. Other indicators rely on controversial inferences. For example, a discharged drug free individual who does not subsequently re-present for treatment is presumed to have remained drug free. In fact, it is not clear at this stage what provision will be made to identify particularly bad outcomes, such as relapses resulting in fatal overdoses.

Regarding these proposed targets, Gyngell argues:

> *This is all far too complex. They are blunt instruments. Non-appearance on the PNC* [police national computer]*, for example, means little when crime detection rates remain one in five. And such multiple outcomes also risk a system that knows the cost of everything and the value of nothing.*[81]

In response, she suggests a simpler scheme, one that is paired down specifically to measure drug free recovery:

> *One simple payment measure – freedom from all drugs (including methadone and alcohol) – should replace the current four proxy measures. A first payment should be triggered once the addict has achieved a period of 90 days abstinence and a final payment after six months abstinence.*[82]

There are problems with this alternative too. There remains the question of how to measure the result and how reliant it will be on self-reporting rather than formal tests. With the final pay-off measure being taken only after six months, there is insufficient incentive to provide long-term continuous treatment in order to maintain abstinence. It also means that an individual that is taking longer, for example, to reduce their methadone script will not reward

[80] See 'Piloting Payment by Results for drug recovery', Department of Health: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128254.pdf
[81] Gyngell, p. 38.
[82] Gyngell, p. 50.

an agency, even if they have stopped them from offending during that time. From a public policy perspective, (reported) abstinence on its own does not always signify lower immediate costs to criminal justice and other sectors.

In fact, recent evidence on the use of targets suggests that simplicity is not always a virtue. Simple targets are more easily gamed. They are like the exam for which the questions are known in advance, allowing the student to revise a few key facts rather than necessarily understand a full body of knowledge. Similarly, an agency working in drug recovery could find roundabout ways of hitting an 'abstinence' target, a 're-offending' target or even an 'employment' target so long as they know when, where and how the outcome would be measured.

Gwyn Bevan and Christopher Hood have argued, with respect to targets in medicine specifically that 'complete transparency in setting targets leads to problems in securing effective control'.[83] Their solution is, far from simplification, to introduce a degree of uncertainty and, importantly, randomness, into a testing regime. Rather than one set of targets, all tested with an established weight, a regime could offer a 'syllabus' of measures, only some of which will be tested. It is only fair that organisations know what sort of areas they are going to be tested on, especially when their funding is reliant on it. At the same time, they do not need to be aware exactly when and exactly what they are going to be tested on. With that lack of foreknowledge, the incentive to concentrate on one specific set of indicators is removed. Instead agencies are encouraged to get as much success in treatment possible.

Even in sectors that have been using targets for many years, policymakers are only just starting to grapple with these incentive and information problems. We cannot yet offer a definitive solution to these issues in the case of drug rehabilitation. However, there are a few features for which those designing a successful PbR regime should aim. Crucially, so long as the programmes are running at a sufficiently large-scale, PbR should not have to test all relevant outputs all the time to get an idea of how successful an agency is at running a service.

[83] Bevan G. and Hood, C., 'Targets, inspections, and transparency', *BMJ,* 328 : 598, 11 March 2004: http://www.bmj.com/content/328/7440/598.full

First, the measures need to be independently checkable. Any reporting system that relies on the people whose income depends directly on getting the results right is going to be very exposed to gaming. However, recorded crime statistics have been improving in recent years and coverage for drug testing on arrest has been expanding too. This might make it possible, soon if not now, to measure how much local crime is associated with drug addicted offenders. With some idea of trends or a baseline set by other similar districts, it might be possible to develop a reasonable performance indicator of drug services using these measures that have robust and independent reporting standards. Developing statistical measures of a similar standard in other areas would be useful.

Second, the measures should be broad. In fact, they could well be based (as the draft proposals suggest) on the various costs of addiction to the public at the moment. Their methodology should be transparent. But their precise weight in a testing regime should not be known in advance. This should encourage agencies to focus on the sort of deep, meaningful recovery from addiction that would be the only way to guarantee scoring well on each metric. With a good testing regime, there will not be any incentive to concentrate on one indicator, to the detriment of the individual addict, because that indicator might turn out not to feature heavily in the test they happen to get.

Finally, provision for random sampling of cases might make measuring the outcome less onerous, and no less accurate. Part of the problem of existing target regimes is that measuring the results becomes almost an end in itself. An occasional, random selection of tests would allow agencies to spend most of their time concentrating on the needs of addicts, in the knowledge that when the tests come around, their typical successes or failures will be evaluated. This would only work when testing out reasonably large schemes for which a genuine random sample can be found, but this could be possible if, as proposed above, service provision were integrated over a reasonably sized locality.

The main disadvantage is that such a regime might prove simply too demanding and too risky for many agencies to bid on under a PbR scheme. But that outcome in itself would be quite indicative of the underlying confidence that agencies had that they could deliver genuine improvements to the lives of addicts. It would certainly sort the wheat from the chaff.

# Conclusion

The drug policy debate sometimes resembles an arena more than a forum. In the past, stark lines have been drawn between harm-reduction strategies and abstinence-based approaches to addiction. Tribal loyalties, and long-term intellectual conflicts, can influence policy sometimes to the detriment of evidence-based approaches to addiction and drug dependency. These divisions, amongst clinicians, practitioners and policy-makers, do not map easily on to party political disputes: there are representatives of each perspective within the major parties. Nevertheless, the process of policy intervention and upheaval often seems to be defined more by political positioning, a desire to stamp something distinctive onto the criminal justice system, than necessarily to build on and improve policies that have already had some success.

This is unfortunate as a prosaic examination of the evidence reveals strengths from all perspectives. The evidence does not fall on the side of one particular treatment, but suggests that a diverse range of quality treatments are necessary. In this report, we have tried to draw out some of what is agreed even amongst these diverse perspectives. Further, we have suggested some ways in which marginal improvements can be made in drug rehabilitation. While the chances of revolutionary improvements are unlikely to materialise in the near future, a careful approach to reform might be able to prevent more crime, as well as save and improve more lives.

From a policy research perspective, a perennial issue, but one that still needs to be resolved, is that the Government is currently doing and commissioning a tremendous amount of activity in drug treatment without knowing in much detail what is working. A Public Accounts Committee report in 2010 reviewed progress with the Government's drug strategy. Its prime concern: 'The Government spends £1.2 billion a year on measures aimed at tackling problem drug use, yet does not know what overall effect this spending is having.'[84] It recommended that the Home Office publish an annual progress report explaining how money was spent on each measure and what outcomes they produced.

It is noteworthy that much of the quantitative evidence available for this report has either

[84] *Tackling problem drug use*, Public Accounts Committee, 2010: http://www.parliament.the-stationery-office.co.uk/pa/cm200910/cmselect/cmpubacc/456/45604.htm

been from other countries, especially the US with only tentative application to the UK, or from clinical trials in the UK where outcome measures are more robust. Unfortunately, this means that the criminal justice benefits of particular therapeutic interventions, especially as applied in England and Wales, are still under-researched compared to medical outcomes. This has resulted in an inherent research bias towards medically assessed treatments simply because fewer people are looking at the efficacy of alternative therapeutic approaches. It is important that this research programme is widened to include comparisons of psychotherapeutic interventions in greater detail, rather than just the pharmacological components of an intervention. This is significant since it appears to be in intensive psychotherapeutic engagement that the key to sustained recovery is to be found.

Finally, we must sound a note of caution regarding the ability of policy alone to rehabilitate drug addicts. Policymakers have sometimes assumed that it is within the power of the state to change people's personality and behaviour for the better and that the decisions of individuals can somehow be by-passed. This optimism has too often gone unchallenged in the rehabilitation debate, in particular, where there are those that assume that a state that punishes criminal acts has simply failed to address the needs of offenders. Adam Smith critiqued this arrogant view of what he called the 'man of system' over two centuries ago:

> *He seems to imagine that he can arrange the different members of a great society with as much ease as the hand arranges the different pieces upon a chess-board. He does not consider that the pieces upon the chess-board have no other principle of motion besides that which the hand impresses upon them; but that, in the great chess-board of human society, every single piece has a principle of motion of its own…*[85]

Our research has shown that much can be done for individuals with a genuine desire and motivation to recover and reform, but very little for those who have no such intention. Policy can only support those who are also willing to help themselves.

[85] Smith, A., *Glasgow Edition of the Works and Correspondence Vol. 1 The Theory of Moral Sentiments,* 1759: http://oll.libertyfund.org/index.php?option=com_staticxt&staticfile=show.php%3Ftitle=192&layout=html