



Drugs misuse and the criminal justice system: a review of the literature

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First published 1996

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ISBN I 85893 440 0

FOREWORD

Drugs misuse and the criminal justice system: a review of the literature

Since 1990 the Home Office Drugs Prevention Initiative has been piloting a community-based approach to drugs prevention. In the first phase, 1990-95, 20 small teams were set up to work with local communities. Their aim was to inform, encourage and support communities in their resistance to drug misuse. In all, they supported more than 1,500 drugs prevention projects. These projects drew help and support from local business people, voluntary workers and a wide range of statutory and non-statutory organisations.

On 1 April 1995 the Drugs Prevention Initiative began its second phase with the formation of 12 larger teams covering a much larger geographical area in England. These teams have a four-year strategy: to form new partnerships in the community, to build on past experience and to generate new activities.

The work of the teams among communities is building up considerable experience of drugs prevention activity. A priority for the Drugs Prevention Initiative is to ensure that local work is evaluated to see what works and what doesn't and to share these lessons. In 1993 the staff of the Initiative began working with independent experts to pull together some of the common threads from their shared experience in order to identify the key principles of good practice.

This programme of work included a national working seminar, Drugs Prevention within the Criminal Justice System, held on 30 November and 1 December 1994 in Leicester. Seminar participants included representatives of criminal justice agencies, drug service agencies and others with an interest in a multi-agency approach to drugs prevention within the criminal justice system. The aim was to identify what it was possible to do to help drug misusers or those at risk who came into contact with the criminal justice system, and to begin to work out what steps needed to be taken to make sure that helpful interventions were made at various points in the system. The Drugs Prevention Initiative is now building on the discussions at the seminar to develop agreed principles for such interventions, and to draw up guidelines and specifications for local criminal justice drugs prevention programmes.

Professor Michael Hough, of South Bank University, presented a background paper at the seminar, which in this report is significantly expanded and refined. Professor Hough brings together what is known from English-language research about drugs and crime; interventions before sentence; community penalties; and interventions in prison. The report provides some guidance on the potential value of drugs prevention interventions in the criminal justice system, which should be of interest to a wide range of individuals and agencies concerned with drugs prevention in the community.

If you would like more information about the Drugs Prevention Initiative please contact the Central Drugs Prevention Unit, Room 354, Horseferry House, Dean Ryle Street, London SW1P 2AW. Tel: 020 7217 8631, Fax: 020 7 217 8230. Central Drugs Prevention Unit, Home Office, February 1996

ACKNOWLEDGEMENTS

I assembled this review at some speed in October and November 1994, and could not have done so in the available time without the generous help of several people. Particular thanks are due to Jud Barker, Bernard Lane, Charlie Lloyd, Joy Mott and Howard Parker. Helpful comments on this report were also given by Diane Caddle, George Mair, Andrew Percy, Malcolm Ramsay, Rae Sibbitt and Barry Webb. I have also benefited from several recently published and unpublished reviews, notably Michael Farrell and colleagues' overview of methadone maintenance, Martin Plant's review of prison-based treatment, and Justin Russell's review of the US literature, all of which I found extremely helpful. I am particularly grateful to John Witton and his colleagues at the ISDD library, who were impressively efficient and helpful. Finally, I would like to thank the Home Office Central Drugs Prevention Unit for funding this work.

Michael Hough
March 1995

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Drugs misuse and the criminal justice system: a review of the literature

EXECUTIVE SUMMARY

This report is a selective review of the recent English-language research on the links between drug use and crime and on ways within the criminal justice system of reducing demand for illegal drugs amongst dependent drug misusers and others who fund their drug use through crime.

Links between drug use and crime

- Illegal drug use is very widespread, and most drug users are not drawn into other forms of crime as a result of drug misuse.
- A significant minority of crime is drug-related (where the proceeds of the offence happen to be spent on drugs) but a smaller proportion is drug-driven (where the offence is committed solely to pay for drugs).
- A small minority of those who take illegal drugs have serious problems of dependency, and these need substantial sums of money to finance their drug use. Figures can run to several hundred pounds a week for dependent heroin users, and higher figures still have been reported for some crack users.
- Dependent users and others with very heavy use finance drug purchase from a variety of sources, including income, benefits, gifts, loans, selling property, theft, prostitution and drug dealing.
- Whilst research in this country is sketchy, large minorities (and sometimes majorities) of dependent drug misusers report financing at least part of their drug misuse through acquisitive crime. Research from elsewhere suggests that a large minority of dependent drug users' aggregate income is derived from crime.
- Significant minorities of known offenders have serious problems associated with drug misuse. Probation officers assess that in the region of a fifth of those on probation fall into this category. A tenth of convicted male prisoners and a quarter of convicted female prisoners have been assessed as drug-dependent on admission.
- The costs sustained by victims of drug-related crime are substantial: crimes committed by dependent heroin users alone may involve losses of between &#pound;58 million and &#pound;864 million annually.
- The costs to the criminal justice system of dealing with drug misusers are similarly substantial: if drug-related crime absorbed 5 per cent of criminal justice resources, this would cost about &#pound;500 million.

Interventions before sentence

There are several strategies for reducing demand for drugs amongst dependent and other heavy misusers which can be deployed in advance of - or sometimes instead of - court proceedings:

- Low-level enforcement (or 'inconvenience policing') can be successful in disrupting drug purchase. Though 100 per cent displacement is unlikely, its impact on demand for illegal drugs is hard to quantify.
- Arrest referral schemes typically have very low referral rates, but well-resourced schemes have produced significant flows of referrals; they can probably be cost effective even when the numbers of offenders entering treatment are small.

Community penalties

The literature on the treatment of dependent drug misusers (heroin users in particular) has demonstrated that a variety of treatment methods can yield benefits - though failure rates are significant for all approaches. Research - not necessarily conducted within the criminal

justice system - has found that:

- Methadone maintenance programmes reduce both illegal heroin use and related crime.
- Higher rates of daily dosage (60 mg or more) of methadone seem to be more effective than lower ones.
- Medically supervised detoxification has no benefits over and above unsupervised detoxification, and reduction prescribing of methadone will not achieve as much as maintenance prescribing.
- Therapeutic communities have high drop-out rates, but those who stay full-term do much better than comparison groups.
- Other types of counselling and social skills training can be effective, provided that they can retain clients in treatment.

The key elements of successful treatment - whether or not delivered within the criminal justice system - appear to be:

- getting misusers with serious drug problems into treatment quickly;
- keeping them there for as long as possible, and for a minimum of three months;
- providing incentives to keep misusers in treatment, and delivering treatment within a positive and supportive environment.

The criminal justice system can be an important conduit through which drug users with serious drug problems reach treatment. Research findings specifically on the impact of community-based treatment within the criminal justice system are:

- Legally coerced treatment is no less effective than treatment entered into 'voluntarily'.
- The criminal justice system is well placed to coerce people into treatment and keep them there.
- Drug testing can provide a solution to problems of disclosure in identifying illegal drug use, and can help secure compliance with treatment conditions.
- Drug testing should form an integral part of treatment, rather than being used simply as a form of surveillance.

Coerced treatment and drug-testing can obviously raise ethical dilemmas. In resolving these, it may be important to ensure that coerced treatment stops short of being compulsory treatment,¹ and that treatment is no more restrictive of the liberty of offenders than a conventional and proportionate punishment. It is obviously essential to ensure that the coerced treatment is appropriate to the individual in question.

Interventions in prisons

Though prisons may on the face of it seem to offer unique opportunities for treatment, the availability of drugs in prisons and the positive value sometimes placed by inmate culture on drugs can subvert programmes. The findings on prison-based treatment are tentative:

- Prison, through incapacitation, obviously prevents some drug-related crimes.
- It is not known if these crimes are simply deferred until release or prevented altogether.
- Prison-based treatment programmes have rarely been evaluated.
- Prison-based methadone maintenance programmes may be an effective 'bridge' to further treatment on release.
- The limited evidence relating to prison-based therapeutic communities is promising, and by implication 'drug-free wings' may prove of value.
- Cognitive-behavioural programmes and relapse prevention also seem promising.

¹Compulsory treatment as part of judicial punishment raises obvious human rights issues

and, if medically supervised, could fall foul of medical ethics.

Drugs misuse and the criminal justice system: a review of the literature

1. INTRODUCTION

We know that drug trafficking is driven by the demand for drugs, and reducing demand, to the extent that it is feasible and fair to do so, will have a greater effect on the drugs-crime connection than reducing supply.

J.Q. Wilson, 1990

Even the best, most comprehensive programs to help addicts transform their lives will inevitably be compromised if we do not simultaneously address the powerful social forces that are destroying the communities to which they must return.

E. Currie, 1993

Some drug users can easily impose costs on public services running to tens of thousands of pounds per user per year. The indirect costs imposed by some users, in terms of losses to victims of crime, for example, can run to six-figure sums. The upshot of this is that ways of tackling drug misuse need to achieve only modest success to prove cost-effective. Indeed, research shows fairly clearly that there are several ways of dealing cost-effectively with drug misuse.

The main aim of this review is to summarise key English-language research on the impact of criminal justice interventions to reduce demand for illegal drugs. It also summarises research on links between drugs and crime. The review is concerned with interventions aimed at drug misusers who want or need help in addressing their drug use. Chapter 2 looks at the research on drugs and crime. The research on the impact of interventions is summarised in Chapters 3 to 5. Chapter 6 offers some concluding thoughts. This introductory chapter first sets out the scope of the study and defines some terms; it then says a little about some of the theories on the causes of drug misuse, as a preliminary to a discussion of ways of tackling the problem.

Scope of review and definitions

The literature review is organised around the various stages of the criminal justice system at which intervention can be made:

- pre-arrest;
- between arrest and conviction;
- community sentences;
- custodial sentences;
- after release from custody.

The review thus embraces:

- at the pre-arrest stage, the deterrent strategies of street-level policing;
- in the important period between arrest and conviction, strategies for channelling offenders to treatment;
- at the sentencing stage, the various community and custodial sentences (including aftercare) which can tackle drug misuse.

A wide range of criminal justice activities fall outside the review's scope - in particular, interdiction strategies aimed at disrupting the supply (or import) of drugs, and educational and other preventive programmes which, though often delivered by the police, are not essentially a criminal justice response.

The review focuses on the drug use of people who are 'problem drug misusers', as defined by the Advisory Council on the Misuse of Drugs. Adapting the term 'problem drinker' as used by experts in the field of alcohol misuse, the ACMD (1982) originally defined as problem users anyone who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his/her own use of drugs or other chemical substances. As the risks to drug users of HIV/AIDS emerged, they broadened this definition (ACMD, 1988) to include anyone whose drug misuse involves, or could lead to, the sharing of injection equipment.

This definition embraces a wider group than dependent users. Dependent and problem misuse are not necessarily the same thing (cf Strang *et al*, 1993): non-dependent use can create all sorts of problems, and some dependent misusers cope with their dependence without serious problems. This review is concerned with dependent users whose dependency causes them problems, and those users who - though non-dependent - get embroiled in the criminal justice process as a consequence of problems stemming from their use.

In adopting the ACMD's terminology of 'problem drug misuse', the review should not be taken as implying that some categories of illegal drug use are problem-free, or that so-called 'recreational' drug misuse is unproblematic. In the first place, the illegality of drugs covered by the 1971 Misuse of Drugs Act cannot simply be brushed aside, even by those in favour of amending the legislation, so long as it remains on the statute book. No less important, casual drug misusers expose themselves to a variety of health risks, some more firmly established than others. Concern has tended recently to focus on the rare but tragic deaths of teenage Ecstasy users. However, there are health risks in many other forms of drug misuse. The smoking of cannabis may carry cancer risks, for example; LSD can sometimes trigger psychotic episodes; and many drugs carry risks associated with adulteration. Nevertheless, just as it is useful to distinguish between problem drinkers and others, a term is needed to differentiate between those with serious drug problems and others who misuse drugs. Rather than invent a new term, this review follows current usage.

Research covered by the review

A literature review is inevitably a form of distorting lens. It replicates the biases and preoccupations of the research community under review, which in turn are shaped by the policy concerns of the time and by the concerns of treatment agencies. Treatments for dependent heroin use are much better developed than those for crack/cocaine or amphetamine, for example. This is reflected in a concentration of research effort on opiate users and, arguably, a tendency to ignore the extent to which heroin users are polydrug users (cf Hammersley and Morrison, 1987). Even when polydrug use is correctly identified as such, it must be remembered that, more often than not, alcohol is one of the misused drugs (cf Plant and Plant, 1992; Strang and Gossop, 1994).

Inevitably the review is selective, both in restricting itself to key pieces of work and in focusing on recent research. Most of the studies to which it refers come from the USA, reflecting the greater scale of drug problems there, and the correspondingly greater energy devoted to the search for solutions. While it may seem madness to import policy lessons from a country which has been uniquely unsuccessful in containing problems of drug misuse, my view is that we can learn both from policy misjudgments which have contributed to US drug problems and from the intelligence and money which have been deployed to address the problems. In doing so, however, it is essential to remember how little is shared between the USA and Britain, as well as how much: dependent heroin users in the Wirral, for example, do not have much in common with those in Washington, DC. Nor does this country have sentencing policies which match the Draconian severity of those in the USA; the alternatives to treatment facing drug-using offenders in the USA are much bleaker than those in Britain.

The review does not claim to be comprehensive in relation to drug types: it covers only those which the criminal justice system currently encounters routinely in its response to problem drug misuse. The literature remains heavily focused on opiate misuse. Despite the growing visibility of use of cocaine and crack on both sides of the Atlantic, work on treatment for dependent cocaine and crack users is particularly thin. This is a limitation, but not a fatal one in Britain, where dependent opiate use probably still far outweighs problem misuse of cocaine and crack.

Little is said in this review about cannabis. It is the most commonly used illegal drug, and a large minority of the population has used it at some stage in their lives (Mott and Mirrlees-Black, 1995). It is rarely associated with dependency; the majority of users manage moderation and avoid encountering or creating serious problems. However, chronic - and problematic - use certainly does occur, and there is some demand for treatment. In numerical terms the possession of cannabis remains the offence which dominates police activity against drug misuse; there are complex linkages between cannabis use and the use of other drugs, and between the policing of cannabis and of other drugs - and of other crimes. In paying little attention to these questions, I do not mean to imply that they are either unimportant or simple ones. The review pays no attention to anabolic steroids or to 'volatile substances' (glue and other solvents).

Finally, though the advent of HIV and AIDS has transformed approaches to tackling drug misuse, this review pays only passing attention to the impact of treatment strategies in reducing the risk of HIV infection.

The quality of evaluative research on drug treatment

The review does not attempt to audit the quality of every study to which it refers; the reader should be aware of this, especially in those sections of the report concerned with evaluation. Evaluating treatment outcomes is hard in any field, and it is particularly hard when the treatment in question is directed at illegal behaviour by people whose lifestyles are often very chaotic. Furthermore, it is never easy for programme managers to divert funds from treatment to evaluation. The best that many programmes can manage by way of evaluation is to follow their clients over time and compare pre-treatment and post-treatment behaviour. This can yield useful information, but the method can be confounded by the fact that people often get over their addictions without formal treatment. In other words, there is a risk in before/after studies of mistaking spontaneous recovery for treatment effects.

A second problem concerns people who drop out from treatment. Many programmes have high drop-out rates: relapse is often associated with drop-out and sometimes triggers - it where, for example, strict 'drug-free' rules are enforced. Those who remain in treatment until the end of a long and arduous programme will almost certainly do very well, but it is difficult to know the extent to which this may simply be due to the selection of the best treatment 'bets' - those who might have overcome their dependence even without help.

The solution to these problems is to use randomised controlled trials - where clients are randomly allocated to 'treatment' and 'control' groups; or, failing that, to assemble statistically matched control groups. Where drop-out rates are likely to be high, it is important to compare the control group not simply with programme graduates but with graduates and drop outs combined. Unfortunately, this is done less often than one might wish.

Causes of drug misuse

In a culture in which legal drug use is deeply embedded, experimental or casual use of illegal drugs requires little separate explanation. Many writers have identified the variety of motivations: curiosity, hedonism and the sheer pleasure of intoxication; the search for excitement; the attractions of risk-taking and the status that this can confer, especially in

youth cultures in which styles in music, clothes and drugs are closely interwoven. In short, much the same bundle of explanations applies to recreational use of illegal drugs as to use of alcohol and tobacco (Plant and Plant, 1992).

Problem drug misuse stands in need of different explanations from casual drug use precisely because it creates problems. The destructiveness either of self or of others marks it apart from casual use, and it is this which needs explaining. The most prevalent popular and media explanations of dependent drug use are probably still those which appeal to the idea of the *enslavement* of physical addiction, and to metaphors of *viral contamination, contagion or infection*: people come into contact with drugs; they are pressured into experimenting; before they realise it, they are hooked. There is a large amount of evidence that the reality of problem drug misuse does not reflect the popular model: experimental use of drugs does not usually escalate to dependence; and even amongst dependent users there is not a progressive escalation of use and dependence - or even a consistent level of use. Several ethnographic studies report cocaine and dependent heroin users exercising much more rational choice over their use than the popular image allows (e.g., Bennett and Wright, 1986; Power *et al*, 1993; Ditton and Hammersley, 1994).

There are many explanations of dependence within the literature, some physiological or psychological and concerned with individual differences, others more sociological. People who are concerned with treatment naturally work with physiological and psychological explanations which emphasise individual differences. Anglin and Hser's (1990) review identified three such models, each implying different approaches to treatment or prevention:

- The *moral model* considers dependence to be the result of moral weakness, and punishment or moral education the solution.
- The *disease model* sees physiological (or psychobiological) dependence as the root problem, emphasising medical treatment such as methadone maintenance and managed withdrawal.
- The *behavioural model* views addiction as a pattern of learned habits to be modified by cognitive or behavioural techniques - such as psychotherapy or behavioural training.

Any comprehensive explanation also needs to take account of the social context and social meaning of drug use. Indeed some of the sociological literature questions the concept of dependence which underpins at least the medical model (e.g. Moore, 1992). A common theme within the sociological literature concerns the uneven social distribution of problem drug use. It is fairly clear that both in this country and in the USA, problem drug use tends to be concentrated amongst the urban poor, especially in inner cities. This is not to deny the existence of affluent drug users, but these are more likely to have the resources (literally and metaphorically) and the opportunities to side-step problem use; nor should it be forgotten that problem drug use is commonplace outside cities. Building on Currie (1993), one can identify three main sets of sociological theories to explain the social distribution of problem drug use:

- The 'coping' model (or self-medication model), arguably the most common-sense attempt to explain why problem drug misuse tends to coexist with social deprivation, sees drug use as providing a 'palliative' to poor quality of life.
- The 'structure' model, grounded in opportunity theory (Cloward and Ohlin, 1960), emphasises that those who are denied legitimate opportunities to achieve societal goals substitute illegitimate ones. The model develops - or transforms the idea of drug use as a palliative into that of drug use as a form of work which provides meaning and purpose (cf Preble and Casey, 1969; Gilman and Pearson, 1991).
- The 'status' model develops opportunity theory a stage further, identifying drug use as a solution to problems of status and identity associated with social and economic exclusion. It identifies the positive social pay-offs from drug use in subcultures which

respect anti-authoritarian macho, risk-taking and entrepreneurialism (cf Burr, 1987; Gilman and Pearson, 1991).

These different psychological and sociological models are neither mutually exclusive nor incompatible with others: different sorts of explanation may be more appropriate at different stages of an individual's drug-using career. For many, drug use can become an important palliative to the problems that it has created or amplified, even if the initial stimulus was the search for status or structure. Different causal factors may well interact to yield vicious downward spirals. US research suggests that problems of neighbourhood decline can both fuel and be fuelled by widespread drug misuse (Johnson et al, 1990). Whatever the case, multi-causal explanations tend to be more satisfactory than mono-causal ones in this field.

Drugs misuse and the criminal justice system: a review of the literature

2. DRUGS AND CRIME

A significant proportion of crime is drug-related. Precisely how much, and precisely what is meant by 'related', is another matter. Getting some feel for the extent of the relationship is important in assessing how to tackle both crime and drug misuse. The first section of this chapter discusses the different sorts of relationship which exist between drug misuse and other forms of crime. Academic analysis often loses its way in complexity, but the causal links between drug misuse and crime are genuinely more complicated than most people think, and this must be recognised in responding to the problem.

Studies on the links between drugs and crime either take groups of drug misusers and look at their involvement in crime; or else they take groups of offenders and look at their involvement in drugs (see Pottieger, 1981, for a discussion of the potential for sample bias in both types of research). The second section of this chapter summarises studies which have taken the former approach, and the third section those who have taken the latter. The final section examines the various estimates which have been made of the proportion of crime which is committed to finance drug misuse.

Links between drug misuse and crime

Drug misuse and other forms of crime have much in common, and similar explanations can often account for drug misuse and other forms of crime. Both are widespread amongst young people, especially young men. A third of males in England and Wales will have acquired a criminal conviction by their mid-thirties, mostly for property crimes (Home Office, 1993). Drug misuse is equally or more widespread amongst the young, especially young men. The British Crime Survey (Mott and Mirrlees-Black, 1993, 1995) and the Four Cities Survey (Leitner et al, 1993) suggest that around a third of people between 16 and 30 have taken illegal drugs at some time in their lives. Rather higher estimates have been reported in some local surveys, for example that of Parker and Measham (1994), which found that between 33 per cent and 40 per cent of young people aged 14- 15 had some experience of drug use, with little difference between the sexes. Given the nature of self-report studies, these estimates are likely to be conservative. (Some respondents may through bravado exaggerate their drug use, though in all probability more users will play down or completely deny their use.) Most casual drug misuse is inexpensive - or at least in the same order of magnitude as drinking alcohol - and there is no evidence that anything but a small proportion of such misuse is financed by acquisitive crime. This is not to deny that many teenagers live beyond their means; but it is for the most part impossible to isolate whether it was the designer labels, CDs, alcohol or drugs which tipped someone towards crime or debt or other strategies for making ends meet.

Certainly some casual drug users are involved in property crime, and obviously a proportion of the income they derive from crime is spent on drug use. However, this does not amount to a causal link. Offenders also use the proceeds of crime to buy food, clothes, housing, alcohol and tobacco. Where their drug misuse represents an incidental item of expenditure, it makes little sense to ask which of the various sources of income available to an offender actually financed it.

Some non-dependent drug misusers consume a volume of drugs which would be beyond their means if it were not for the income they derive from crime. But again, this does not amount to a causal link: one person may be motivated to burgle by a desire for a good time, for example, and may be indifferent as to whether he buys drink or drugs, so long as he enjoys himself; another may burgle specifically to buy a preferred illegal drug. The burglaries committed by both can properly be regarded as *drug-related*, but only the latter

can be regarded as *drug-driven*.

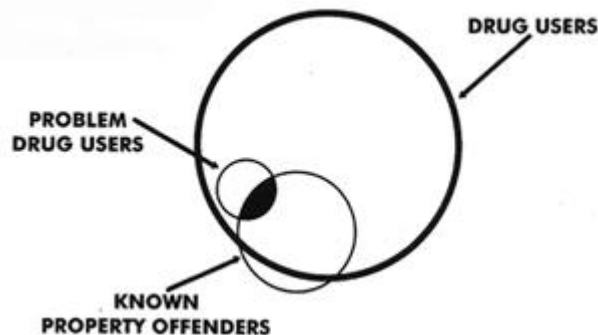
For many, perhaps most, dependent drug misusers, spending on drugs represents a significant amount - if not the largest item - of their expenditure. Research discussed below has shown that many finance their drug use through crime. Even so, the precise nature of the causal process can take several shapes (cf Mott and Taylor, 1974; Hammersley *et al* 1989; Chaiken and Chaiken, 1990). For example:

- Dependent drug misuse can predate other forms of crime, and precipitate these.
- Involvement in property crime can also predate drug misuse, facilitating experimental or casual misuse and then dependence.
- Dependent drug misuse may often amplify property offending.
- Drug use and property crime may both increase in an upward spiral.

Chaiken and Chaiken (1990) summarise the US research evidence as indicating that a progression from experimental and casual misuse to dependence and thence to property crime may well occur for some users, but that for others a history of acquisitive crime may predate - and facilitate - drug misuse. They suggest that the latter career path may be more frequent than the former. Persistent use of drugs other than heroin and cocaine seems unrelated in the USA to persistent predatory offending. However, their review found strong evidence that offenders who are heroin-dependent polydrug users tend to be highly persistent offenders, and that their rate of offending falls markedly when they stop using heroin. Hammersley *et al* (1989) report findings relating to Scottish opiate users which are broadly consistent with the US research.

Figure 1 sets out the relationships between drug misuse and property crime schematically. There is no intention to map the precise degree of overlap between categories, the figure is intended simply to summarise the findings of research which show, on the one hand, that a substantial minority of problem drug users are involved in property crime and, on the other, that a substantial minority of property offenders are problem drug users.

Figure 1: The relationships between drug misuse and property crime



Other forms of crime have links with drug misuse. There can be a complex dynamic between prostitution and drug dependence: prostitution can be a method of financing drug use, and drug use can be a palliative to prostitution. But various other forms of criminal activity tend to predate both prostitution and drug misuse (Hunt, 1990; Plant, 1990; Taylor, 1993).

Drug misuse can be linked to violent crime in two ways: the effects - or after-effects - of intoxication can prompt violence; or violence can be used instrumentally to acquire money for drugs. The links vary substantially by type of drug. There is no evidence that the most commonly used illicit drug, cannabis, predisposes users to violence; reports of its effects suggest, if anything, the reverse. The same is broadly true of opiate misuse. The ethos of

the use of 'dance drugs' at 'raves' has generally been one of benign collectivist hedonism (Saunders, 1993). By contrast regular use of stimulants such as cocaine and amphetamine can lead to anxiety, psychotic symptoms and paranoid behaviour (cf Ghodse, 1995).

The role of alcohol in combination with other drugs should not be ignored. Violence seems to be more closely linked with excessive intake of alcohol than with many illegal drugs (see Russell, 1993, for a collection of papers on alcohol and crime) - though there is room to argue that this is a culturally mediated effect rather than a necessary effect of alcohol. Whatever the case, combining excessive alcohol intake with various illegal drugs, for example amphetamine or LSD, may well make for highly volatile behaviour.

Little is known about the instrumental use of violence in crimes committed to finance drug use. Speckart and Anglin (1985) suggested that for most dependent users there is a hierarchy of methods of financing drug use, and that if the preferred method is not available, the next method is pressed into service. They suggest that in most cases dealing is the preferred method, followed by property crime, and only then by violent crime - given the relatively heavy sentences usually given for robbery.

Studies based on drug user populations

Deciding what to count as drug-related crime is complex enough; the practical problems in actually quantifying it are immense. However problem drug users are defined, it is very difficult to assemble genuinely representative samples of people who are prepared to talk honestly about their involvement in not one but two forms of illegal activity.

Research in this country has made some progress in finding out how problem users finance their drug use. Most of the work has targeted dependent heroin or polydrug users, although some studies have been carried out with users of cocaine and crack. (There is evidence of a growing overlap between crack and heroin use; see Bean and Pearson, 1992; Southwark DPT, 1994; Maddalena, 1994.) Dependent heroin use generally ranges from a third of a gram to a gram a day. Street prices of £80 per gram are often quoted, although anecdotal evidence suggests a sharp fall in price in the north-west of England at least, with current prices of £10 a bag (putatively a quarter of a gram). Thus a dependent user might have to lay hands upon a minimum of £70 per week, rising to £300 or more for heavy users paying top prices.

Crack/cocaine prices are reported to be £15 to £25 per rock (putatively a quarter of a gram, but police estimates of average weight are lower). Heavy users - a small minority - report using eight or more rocks per day. These persistent users can thus get through a large amount of money. Bean and Pearson's (1992) snowball sample of crack/cocaine users found that the heaviest users at their heaviest period of use were spending upwards of £150 a day; and Dean et al (1992) report a minority of their samples as spending around £200 a day on crack, with even higher levels of use amongst prostitutes, running to £2,000 a week. Perhaps the highest daily rate of expenditure is amongst those who inject cocaine after buying it as crack (powder being difficult to buy on the street) and converting it back into cocaine hydrochloride; sums of £800 per day have been reported (Southwark DPT, 1994).

Expenditure on other illegal drugs is generally lower. Klee and Morris (1994) compared injecting amphetamine users with heroin users, matched for age and sex. Fifty-five per cent of the amphetamine users spent under £50 a week - reflecting the fact that a gram cost around £10. By contrast, 71 per cent of the heroin users spent over £150 a week, paying £60 a gram.

Jarvis and Parker (1989), Stimson *et al*, (1993), Power *et al*, (1993) and Klee and Morris (1994) have all asked samples of problem drug users how they financed their drug use. The results are based on small samples, and respondents may well have under-reported their

criminal involvement. The majority in all the studies were unemployed and in receipt of benefit. More than two-thirds of Jarvis and Parker's samples of dependent heroin users in the Wirral and London reported that acquisitive crime was one of the ways they financed drug purchases. By contrast, under a quarter of Power *et al's* sample of polydrug users admitted to property theft. Larger minorities of Stimson *et al's* samples of polydrug users with experience of cocaine did so. Klee and Morris found that a quarter of their amphetamine users said they funded their use from wages, compared with 11 per cent of heroin users. The variation between the samples in their recourse to crime reflects differences in the way the samples were located, differences in the extent of their problem use and differences in the unit cost of the drugs they use.

This review has encountered no research in England identifying the proportion of problem drug users' income which is derived from crime. Studies in Scotland, North America and Europe have put the figure variously - depending, of course, on the nature of the samples - at between a fifth and a half (Hammersley and Morrison, 1987; Lord President, 1994).

Our knowledge of the prevalence of violent crime amongst problem users is sketchy. There is no established association between dependence on heroin and violence; however, links have been found between violence and use of barbiturates and amphetamine, and there is suggestive evidence that cocaine - especially in the form of crack - can lead to violence (see especially Fagan, 1990, for a US review of links between drug use and aggression). As mentioned earlier, it may well be that taking various drugs to excess in combination - such as amphetamine and alcohol - substantially increases the chances of violent behaviour.

Instrumental violence as part of the process of acquiring drugs certainly occurs, but it is probably much rarer than non-violent acquisitive crime. Extreme levels of violence have become associated with crack dealing but it is not clear to what extent the dealers are users, and whether use of crack has contributed to the levels of violence (Bean and Pearson, 1992; Dorn *et al*, 1992; Chatterton and Frenz, unpublished).

Studies based on offender populations

Research on known offenders' drug misuse provides another perspective on the links between drugs and crime. Known offenders differ from other offenders in one important way: they have been caught. They may well be unrepresentative of the offending population as a whole, and it is plausible that heavy drug users may be over-represented in this group either as a result of their drug misuse or as a result of their high rate of offending.

Nee and Sibbitt's (1993) survey of probation areas in 1991-92 reported that use of cannabis, Ecstasy and LSD was seen as very widespread amongst offenders, but that few offenders regarded this as a problem. The survey also yielded very rough estimates of the proportion of offenders under supervision who received treatment for drug problems. The answers varied widely by area; most were in single figures, the highest being Middlesex (13 per cent), Berkshire (9 per cent), Northumbria (8 per cent), North Yorkshire (7 per cent) and Hertfordshire (6 per cent). Inner London Probation Service did not provide an estimate of the proportion of their caseload receiving treatment, but their throughput of 2,000 receiving treatment probably represented a fifth of their total caseload (see also ACMD, 1991) and accounted for almost half of those receiving treatment in the whole of England and Wales. A small-scale piece of research by NAPO (1994) produced results broadly consistent with this. A sample of 64 probation officers was asked to assess what proportion of their caseload had problems associated with alcohol and drugs. A quarter of offenders were thought to misuse drugs regularly and 30 per cent were judged to have serious problems with alcohol. Probation officers judged that almost three-quarters of all substance-abusing offenders had committed their most recent offence to buy drink or drugs.

The proportion of drug misusers in prison is another indicator of the prevalence of drug misuse amongst offenders. Around 7 per cent of those given prison sentences are convicted

of drug offences. Those convicted of trafficking may not be users, but a significant minority of offenders imprisoned for other types of crime would appear to be dependent users. Maden et al (1991) found that in 1989 as many as 11 per cent of men and 23 per cent of women in the adult convicted population were dependent users prior to imprisonment - dependency being defined as the daily use of drugs of dependency in the six months before the offence (cannabis was excluded). These percentages represent some 6,500 dependent users entering prison in 1989. This is before any assessment is made of non-dependent problem users. It seems likely that levels of drug use in the remand population are higher again; a further Home Office-funded research study is in progress.

Drugs are reported as widely available within British prisons - not only cannabis, but amphetamine and heroin. Intravenous drug use represents a particular concern, given that the scarcity of injecting equipment makes sharing likely (ACMD, 1993), with attendant risks of HIV and AIDS. Turnbull *et al's* (1991) study of ex-prisoners found that 7.5 per cent of their sample had injected drugs before their sentence; and of those who were injectors before their sentence, 8 per cent of men and 16 per cent of women were HIV-positive at the time of interview. Most drug injectors cease to inject when in prison, but a substantial proportion continue, despite the risks (ACMD, 1993). This has been a particular problem in Scottish prisons, where 8 per cent of prisoners interviewed in one study reported that they had injected drugs in prison (MRC, 1992, quoted in ACMD, 1993). Estimates for drug misuse in prisons in England and Wales will be produced by a national survey which has been commissioned by the Prison Service.

Mott (1986) examined what proportion of residential burglars convicted in four petty sessional divisions in 1983 appeared in the Home Office Addicts Index as notified addicts. Percentages ranged from 3 to 20 per cent - the latter figure being for the Wirral. Parker and Newcombe (1987) found that half of a sample of convicted burglars in the Wirral were known to agencies as problem heroin users. These studies illustrate how the links between drug misuse and crime are specific to place and time.

The US Drug Use Forecasting (DUF) programme provides much firmer evidence of the proportion of arrested offenders involved in drug misuse in the USA. The programme involves voluntary random urine tests of people arrested in 24 cities. In the fourth quarter of 1992, illegal drug use in the previous two to three days varied from 46 per cent in Omaha to 79 per cent in Philadelphia. Cocaine use (including crack) was very prevalent, with two-thirds of arrestees in Chicago and Philadelphia showing positive. Opiate use in most cities was under 20 per cent, and in many under 10 per cent (National Institute of Justice, 1993a). In interpreting these figures, it must be remembered that DUF figures are based on arrested offenders, who are almost certainly unrepresentative of the offending population as a whole.

Crime committed to finance drug use

It is notoriously hard to get reliable estimates of the proportion of crime which is drug-driven (committed specifically to finance drug use) or more loosely drug-related. Leaving aside the definitional problems discussed at the start of this chapter, statistics of the *number of recorded crimes* - whether or not they are drug-related - are not straightforward (Mayhew *et al*, 1989,1993); statistics of the *losses incurred through crime* are very imprecise; the number of *offenders* involved in either acquisitive crime or drug misuse is extremely hard to assess, as is their *rate of offending*. Those attempts that have been made to attribute crime to drug misuse have thus been built precariously on many tentative assumptions. To date, two approaches have been adopted:

- estimating the number of crimes which can be attributed to drug misuse.
- estimating the cost of crime which can be attributed to drug misuse.

The first approach was taken by Mott (reported in ACMD, 1991), who estimated the

proportion of various types of acquisitive crime which could be attributed to dependent heroin users in England and Wales in 1987. The work suggested that between 6 per cent and 24 per cent of burglaries involving loss were committed by dependent heroin users, between 6 per cent and 22 per cent of thefts from the person and between 0.6 per cent and 8 per cent of shoplifting. The various calculations and assumptions behind these figures were tentative, and they would only have to change slightly to produce very different estimates. The estimates were reached as follows:

- (a) The number of dependent heroin users was assumed to be between two and five times the number notified as addicts to the Home Office.
- (b) The proportion of these who fund their habit by crime, and their frequency of offending, were taken from Jarvis and Parker (1989), whose samples were drawn from London and the Wirral.
- (c) (a) and (b) yielded estimates of the number of crimes committed to fund drug use.
- (d) These numbers were expressed as a proportion of the total number of crimes according to the 1988 British Crime Survey (Mayhew *et al*, 1989) and other sources.

Estimates of the proportion of the costs of crime accounted for by dependent heroin use have been made by Blair (1994) and by the Government Green Paper, Tackling Drugs Together (Lord President, 1994). Blair's estimate, which drew on a formula originally devised by the Greater Manchester Police, was that half of the £4 billion cost of all thefts recorded by the police was attributable to drugs. This was reached as follows:

- (a) The number of dependent users was assumed to be 22,819 - the number of addicts notified in 1992 (including those dependent on drugs other than heroin).
- (b) Each user was assumed to use 1 gram of heroin per day at £80 per gram, at a cost of almost £30,000 a year.
- (c) It was assumed that all this money is raised through property crime, and that stolen goods are fenced at a third of their market value - yielding almost £90,000 of goods stolen per addict, or £2 billion in total.

Some of these assumptions are clearly cautious - for example that the number of dependent heroin users is accurately reflected by the total number of notified addicts, and that offenders can fence stolen goods at a third of their market value. Others are clearly overestimates - for example that all dependent users use a gram a day at £80 a gram, every day of the year; and that all finance their purchases exclusively through crime.

The approach set out in the Green Paper (Lord President, 1994) built on this work, combining it with some of the assumptions made earlier by Mott. The Green Paper work, carried out by the Institute for the Study of Drug Dependence, estimated that the overall cost of all types of acquisitive crime committed by dependent heroin users to finance their drug use in 1992 fell somewhere between £58 million and £864 million. This represents between 1 per cent and 20 per cent of the costs of thefts recorded by the police. The figures are based on estimates of:

- (a) the number of dependent heroin users, reached by multiplying by two or five the number of notified addicts in the Addicts Index;
- (b) their average level and frequency of use (from self-report studies);
- (c) street prices of £50-£100 per gram, which combined with (a) and (b) gave a total cost;
- (d) the proportion of this cost met by crime;
- (e) the value of property stolen, assuming that it was fenced at a third of its real value.

The Green Paper estimates of the proportion of dependent heroin use financed by crime are based on studies in Scotland, Europe and the USA on the proportion of their incomes which heroin users said was derived from acquisitive crime. Whether this approach is likely to be

more accurate than the earlier work done by Mott for the ACMD is open to question. Both require demanding feats of memory for people who often maintain only a fragile grasp on their finances. In practice, however, the Green Paper estimates would not be substantially different if the ACMD approach had been used. Neither Blair's nor the Green Paper's estimates considered whether crimes committed by drug users might be more or less likely than average to be reported and recorded by the police.

The Green Paper estimates are the most recent attempt to estimate the contribution which drug misuse makes to the cost of crime. However, they must be regarded as very tentative - as their imprecision quite rightly implies. In the first place, they cover only dependent heroin use. At present, estimates for other drugs of dependency cannot be made in the same way, because there is insufficient reliable information about rates of use and methods of finance. Cocaine or crack users are responsible for some proportion of crime; all we can say is that there are many fewer dependent users than there are of opiates, but that crack use in particular can be very expensive. Secondly, the estimates take no account of that proportion of crime which can be directly attributed to non-dependent drug use, or to the larger proportion which is more loosely linked to drug misuse. Finally, small changes to the assumptions can substantially affect the final figures: if, for the sake of argument, drug users who steal to support their habit manage to sell property at only a sixth of its market value, rather than a third, the estimates of drug-driven crime would all double.

No one to date has attempted to identify the costs to the criminal justice system of drug-related crime in Britain. A crude, 'top-down' approach would be simply to apportion a fraction of the total costs of the system, which currently stand at a little under £10 billion: thus if 5 per cent of crime were drug-related, the costs to the system would be 5 per cent of £10 billion - £500 million; if 10 per cent of crime were drug-related, the figure would rise to £1 billion.

These figures could be refined (and reduced) by adding in some assumptions about the proportion of police resources spent on non-criminal matters. Alternatively, one could build up estimates from individually costed functions. Examples of average costs (updated from Home Office, 1992) are currently:

- a pre-sentence report: £200;
- a month remanded in custody: £2,000;
- a contested trial in the Crown Court: £12,000;
- a guilty plea in a magistrates court: £220 +;
- a six-month prison sentence (with three months served): £6,000;
- a one-year probation order without conditions: £1,200;
- average system cost per recorded burglary: £600.²

The maximum annual cost to the system of a criminally active problem drug user is thus around £36,000 - a Crown Court trial leading to a year served in prison; the minimum would be - for those offenders who totally evade detection - the costs to the police of recording and unsuccessfully investigating their crimes.

In summary, our current knowledge about the volume and cost of drug-related crime is so patchy that all we can say with any certainty is that problem drug misuse is responsible for a significant minority of crime in England and Wales. The number of drug-driven crimes committed by dependent heroin users probably numbers in the hundreds of thousands, but it could run to a million or more. The costs to victims of these crimes may fall somewhere between £58 million and £864 million; the costs to the system are unknown but clearly significant, and might be of the same order of magnitude as those sustained by victims. It should be emphasised that the estimates of cost which have been produced to date are all based on information about dependent heroin users. No one has attempted to estimate the costs, in terms of crime, of other forms of dependent drug use or of non-

dependent drug use. We have no 'raw materials' with which to start building any estimates of the volume of acquisitive crime committed by other users.

² This figure represents the total system costs of dealing with all recorded burglaries, averaged across the total number of recorded burglaries.

Drugs misuse and the criminal justice system: a review of the literature

3. INTERVENTIONS BEFORE SENTENCE

There are only two ways of reducing demand: altering the subjective state of potential drug users - through prevention and treatment programmes - or altering the objective conditions of potential drug use by increasing the costs of drug use (cf Wilson, 1990). In the past, the enforcement process in general, and police work in particular, has tended to view the treatment route to demand reduction as a spin-off or secondary benefit; the main route has been to increase the costs of drug use by imposing on users the cost of punishment. Over the last few years, there has been a shift, especially amongst the police. The upshot is a system in transition, with tensions between enforcement and treatment goals. This chapter examines the strategies for dealing with drug users at the 'front end' of the criminal justice system. It first considers those which are explicitly deterrent, and then considers ways of getting dependent drug users into treatment.

Low-level enforcement

Low-level enforcement is a term generally used to refer to strategies aimed at the disruption of retail markets for illegal drugs and the 'inconvenience policing' of purchasers and users. The renewed interest in low level enforcement is a reaction to scepticism about the scope for tackling problem drug use through strategies which 'go for Mr Big' - focusing on trafficking and wholesale markets. Several writers (Dorn *et al*, 1992; Dorn and Murji, 1992; Moore and Kleiman, 1989; Reuter and Haaga, 1989; Rydell and Everingham, 1994) have argued that strategies to reduce supply can have perverse effects:

- Increased scarcity can drive up the retail price of illegal drugs.³
- Higher prices may jack up levels of drug-related crime.
- Higher prices will attract more suppliers into the market.
- In any case, the 'Mr Big' dealers are easily replaced.

In other words, demand reduction through low-level enforcement is based on the view that supply is a response to demand and that it is pointless to concentrate efforts on supply alone. It is also a reaction to the growing recognition that the marketing of illegal drugs often poorly fits the stereotype of 'organised crime' where a few key figures control the wholesale market (cf Dorn *et al*, 1992). The rationale for low-level enforcement has been well set out by Murji (1994); he argues that it can remove 'heavy' users and user-dealers, and deter novice users. By making drug markets more hazardous and less predictable places for both users and dealers, enforcement should suppress demand, and thus have a preventive effect. The ACMD (1994) discusses ways in which low level enforcement can be integrated into strategies of harm reduction.

Low-level enforcement involves the implicit assumption that a substantial proportion of users buy their drugs from street-level dealers. There is some evidence that users and user-dealers tend to buy in street markets only as a last resort, and that many buy from a trusted source by prior arrangement (cf Power *et al*, 1993). The more that this is so, the more limited will be the gains from low-level enforcement.

Low-level enforcement has increasingly focused on street markets, targeting dealers and buyers. The main strategies include intensive, highly visible policing (saturation policing, crackdowns, sweeps, stop and search, etc.) and covert surveillance. The research evidence is overwhelming that these tactics can disrupt markets in the short term (Kleiman, 1988; Sherman, 1990; Worden *et al*, 1994). What is less clear is the extent to which markets are simply displaced elsewhere.

One of the most detailed evaluations is Kleiman's (1988) study of a crackdown in Lynn, a

small city in Massachusetts, which found fairly convincing evidence that disrupting a retail heroin market reduced the demand for illegal drugs. Levels of drug dealing and acquisitive crime decreased, and *demand for drug treatment showed a large increase*. Other studies of sweeps - usually in larger cities - have found evidence that dealing in the targeted area has been reduced. They have sometimes found evidence of reductions in crime, but they have been unable to say much about the impact on demand for illegal drugs (see Sherman, 1990; Worden *et al*, 1994).

Both crackdowns and covert surveillance of street drug markets have been used often in this country; covert surveillance of dealers has sometimes been combined with arresting buyers as they leave the market area (see Dorn *et al*, 1992 for a discussion). Their use has not been formally evaluated; but anecdotal evidence suggests that markets have been effectively disrupted at least in the short term (see e.g. London Drug Policy Forum, 1994). The extent of displacement is unknown, though this is rarely likely to be total.

If low-level enforcement yields benefits, it is also costly. In the first place, both covert surveillance and crackdowns are labour-intensive and thus expensive. But there can also be social costs: inconvenience policing of potential buyers can sometimes end up as indiscriminate stop and search of entire communities, and can thus lose community support (cf Kleiman, 1988). This suggests the importance of embedding low-level enforcement properly within community policing strategies which are more than simple exercises in public relations. Indeed, the case for low-level enforcement does not rest solely on demand reduction; equally or more importantly, it can be justified as a strategy for offsetting the damage that endemic street dealing can inflict on local communities, in terms of crime, fear of crime and economic decline. However, this takes us beyond the territory of this review.⁴

Civil procedures: asset seizure and nuisance abatement

One variant of inconvenience policing which has figured in the rhetoric of the US 'war on drugs' is the seizure of assets of those who are caught trying to buy illegal drugs. The British legislation provides only for the confiscation of assets derived from the proceeds of crime. However, US legislation in 1984 and 1988 provided for the seizure of assets of drug purchasers as well as traffickers. The procedure for doing this is located in civil rather than criminal law, and it serves as an alternative to criminal charges. Despite its visibility in the US media, use of asset seizure has been restricted to a few states, and its use against users (in contrast to traffickers) has been very limited (Jacoby and Gramckow, 1994). Some schemes are prosecutor-led, such as Campaign Push Off in Detroit (APRI, 1993); over a two-year period this involved the seizure of over 2,000 vehicles, and appears to have raised enough revenue to be self-financing.

One problem with extending the use of asset seizure appears to be precisely that it relies on civil law powers and is thus unfamiliar to criminal justice personnel. Another set of problems can arise when enforcement agencies receive direct financial benefit from asset seizure. On the one hand, reliance on income from seizures may tempt agencies to ignore issues of justice and due process; on the other, rational planning is obviously jeopardised the more that income depends on the vagaries of the seizure process.

Another variant of inconvenience policing which has become well used in the USA involves the deployment of 'nuisance abatement' legislation, much of which dates back to the last century (APRI, 1993); some similar initiatives have also occurred here (see e.g. London Drug Policy Forum, 1994). Civil abatement proceedings are typically taken (or threatened) against owners of property where drug use or dealing is taking place. Actions have tended to focus on dealing rather than drug use.

Arrest referral schemes

Most police forces in England and Wales now operate some form of scheme for encouraging drug users with to attend medical or drug services. These schemes, often known as arrest

referral schemes, typically involve the provision of the names, addresses and contact numbers of drug services, either routinely or on request. Some, however, are more developed than this, with drug workers either on call or available on site. Referral schemes are intended to exploit the opportunity provided by arrest to encourage problem users to seek treatment. As Turnbull *et al* (1995) say, problem users have flashes of wanting to quit, often at vulnerable periods of their lives. Arrest and detention represent precisely such a vulnerable point, providing an opportunity for constructive intervention.

Some schemes have been evaluated, such as the Southwark Arrest Referral Scheme (Southwark DPT, 1994) and the 'Get it while you can' scheme in Brighton and Hove (Turnbull *et al*, 1995). Take-up rates have tended to be low. The Southwark scheme, for example, involved the provision of information about drug agencies to all those who were arrested. The scheme was supported by two drug workers who were on call via pagers. Over a two-year period, the scheme yielded only 52 referrals, of which 34 took up programmes of help. Whilst these referral rates are disappointing, success rates amongst referrals are promising: half the 34 Southwark referrals were judged to be drug-free at the time of the study.

The 'Get it while you can' scheme was more heavily resourced, with three staff working from an office in the local magistrates court: two did four-hour shifts, usually in the evening, in Brighton police station and one covered the court. The key difference between this and other schemes is that the drug workers themselves had direct access to custody office staff. In the seven months covered by the evaluation, 250 clients were contacted, four-fifths of them in police cells and the remainder at the court office. Of those contacted, 17 per cent refused help altogether; the remainder had help or advice of some sort and a third were referred to treatment agencies. Take-up rates were high (66 per cent) for referred drug misusers but low for the minority of contacts who had alcohol problems. Contact rates increased in the course of the evaluation; in the final month, the 64 contacts represented a tenth of all arrests in Brighton.

Given the heavy costs to the criminal justice system of crimes committed by criminally involved drug users, schemes of this sort have to trigger the 'early retirement' (cf Gilman and Pearson, 1991) of only a handful of users to cover their costs. This is before any account is taken of the broader social costs of crimes.⁵

Dorn (1994) has suggested that in schemes where arresting or custody officers provide information, very low take-up rates, coupled with the puzzlement - if not hostility - of those arrestees who regard themselves as having no drug problems, may quickly erode police commitment to arrest referral. He also identifies potential pitfalls where arrestees are led to believe (intentionally or not) that they can earn a caution by accepting help, and where drug workers may serve as a poor substitute for qualified legal advice. His recommendations include broadening referral schemes to include other problems besides drug misuse, and restricting advice on drug misuse to known drug users.

Cautioning

Problem drug users come to police attention either for drug offences or for other forms of crime. Amongst those arrested for drug offences - usually possession of cannabis - the most common disposal in England and Wales is now a formal caution - given to 55 per cent of the 50,000 offenders who were either found guilty or cautioned. The use of cautioning for drug offences has grown rapidly - from 400 instances in 1982 to almost 28,000 in 1992, whilst convictions have increased from 17,000 to 28,000 over the same period. The cautioning rate varies between police forces, from 16 per cent in West Yorkshire to 77 per cent in Kent.

In general, the reconviction rates of those who are cautioned for any offence (whether or not drug-related) is low: 17 per cent of a sample cautioned in 1988 were reconvicted within a two-year period, for example (Home Office, 1994b). The only available statistics specific

to drug offenders come from a study by Hughes and Hughes (1993), who looked at offenders cautioned in Merseyside for drug offences, 98 per cent of which were possession of cannabis. They found that three-quarters of those cautioned for a drug offence between 1987 and 1989 had not been reconvicted by the end of 1992; consistent with the findings of other reconviction studies, first offenders were the least likely to be reconvicted.

Charman *et al* (1994) describe an innovative approach to cautioning in South Wales; this combines cautioning with arrest referral. 'Cautioning days' are set aside by the police for administering cautions to offenders charged with possession of cannabis and other minor drug offences. Drug workers are present at the police station on cautioning days, and at the end of each caution the offender is given the opportunity to talk to a drug worker. Most offenders elect to do so but - not surprisingly given the nature of the offences - very few see themselves as being in need of treatment.

The Crown Prosecution Service

The next possible point of intervention is when the Crown Prosecution Service (CPS) decides whether or not to proceed with prosecution. All cases referred by the police to the CPS for prosecution are reviewed in accordance with the Code for Crown Prosecutors (CPS, 1994). There are two stages in the decision to prosecute. First comes the evidential test, involving an assessment of whether there is a realistic prospect of conviction; if this is met, the public interest test is then applied. Crown Prosecutors must balance factors for and against prosecution carefully and fairly. As discussed earlier, there are well-established cautioning policies applied by the police which have the effect of removing a large proportion of minor drug offenders from the criminal justice system - typically where the offence involves possession of a small quantity of cannabis and the offender has no previous record. Nevertheless there may be a limited number of cases referred to the CPS for prosecution which the service would discontinue in the public interest if the full facts and background to the offence were made known. ACMD (1994) discusses in more detail the scope for extending the practice of discontinuing prosecution.

In the United States some prosecutors have taken a much more proactive stance to tackling drug misuse. In part this reflects the broader remit of prosecutors there; the CPS has limited and clearly defined statutory authority, beyond which it cannot stray. Other factors behind the difference may include the fact that some prosecutors are elected in the USA (and may well pursue commitments made to their electorate) and, of course, the greater gravity of drug problems in the USA. Though a great variety of schemes have been prosecutor-led, including educational and preventive programmes, the two main strategies pursued by them are improving prosecutorial performance in drug cases and diverting drug-using offenders to treatment (APRI, 1993). The former strategy is exemplified by community prosecutor schemes, whereby prosecutors are assigned to a single locality and specialise in prosecuting drug offences.

There are several examples of prosecutor-led pre-trial diversion programmes in the United States. The Drug Treatment Alternative to Prison (DTAP) in Brooklyn involves deferred prosecution, enabling drug offenders facing mandatory prison terms to attend a residential therapeutic community (APRI, 1993; Russell, 1994). Consistent with the findings in the next chapter, retention rates are quite high, and the scheme claims to be substantially cost-effective. Another scheme in Phoenix, Arizona, called 'Do Drugs. Do Time', involves suspension of criminal charges conditional upon the offender admitting to the offence, paying a 'jail fee', and agreeing both to have treatment and to pay for it; a sliding scale is applied to ensure that it is not just the affluent who participate. Research has suggested that those who complete treatment are slower to reoffend than others, but the study could not say whether this is a genuine treatment effect or not (APRI, 1993).

The role of the probation service

The main pre-trial (or pre-sentence) function performed by probation officers is the

preparation of pre-sentence reports (PSRs). Except in cases where a PSR is clearly not needed, sentencers generally consider a PSR before passing a custodial sentence or imposing certain community penalties. In the majority of cases, sentencers adjourn the case for 21 or 28 days for a report to be prepared, after the offender has pleaded guilty or been convicted.⁶

PSRs are intended to provide sentencers with information about offenders and their attitude towards their offence, and to set out a proposal, where appropriate, for a community penalty. PSRs are sometimes little more than a descriptive exercise, providing sentencers with extra background information. At other times, however, and particularly in the case of problem drug users, they can provide the criminal justice system with a further opportunity to encourage offenders to address the cause of their offending. For example, only the most obtuse of heroin-dependent burglars will ignore the fact that participation in a detoxification programme coupled with a commitment to further treatment may well increase his chances of getting a community penalty rather than a custodial sentence. It might be argued that this is simply inviting offenders to 'play the system' - but this ignores the potential for achieving something with people whose motivation to tackle their drug problem is partial or ambivalent.

This review has found no British research directly assessing probation officers' skills in identifying and assessing offenders with drug problems when preparing PSRs, though in Nee and Sibbitt's (1993) survey several probation areas identified this as a problem. Several questions need answers:

- Are probation officers good at identifying problem drug users?
- Are they better placed to do so than, for example, drug workers involved in arrest referral?
- Do they have adequate links with treatment agencies?

Bail information, bail assessment and bail support schemes

The other pre-sentence opportunity for probation service involvement with problem drug users is in the context of court decisions over bail. Most probation services now provide courts with some form of bail information scheme, bail assessment scheme or bail support scheme.

Bail information schemes originally provided courts with verified information about offenders which maximised the chances of a decision in favour of bail - for example, that they genuinely had a job or a fixed address, making bail a reasonable prospect (cf Lloyd, 1992). The second generation of schemes, often known as bail assessment schemes, take a slightly less partisan position. Bail support schemes involve, as their name suggests, providing help to offenders on bail; participation in the schemes is sometimes a formal condition of bail and sometimes voluntary.

Bail information and assessment schemes by implication, and bail support schemes explicitly, provide further opportunities for encouraging offenders to take up treatment. As with PSRs, this review has encountered no research specifically on their operation with problem drug users.

³. Reuter (1992) has shown that in the US dealers are often as keen as the police to remove the competition in order to maintain price stability.

⁴. See Johnson et al (1990) for a discussion of the impact of the illegal economy of drug dealing on the legal one in US inner cities.

⁵. Whether cost-benefit analysis should include the replacement costs to victims of property

stolen is a more complex question than it first appears; but a single heavy user financing a heroin habit largely through crime might over a year steal property worth well in excess of the combined salaries of the three drug workers in the Brighton scheme.

⁶. In cases committed to the Crown Court for sentence, and in Crown Court cases where the offender enters a guilty plea, PSRs are usually prepared in advance of the hearing.

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4. COMMUNITY PENALTIES

This chapter is concerned with the impact on drug users of treatment delivered as part of a community penalty. In most cases, such treatment is linked to probation supervision, though there are departures from this, as in the case of some drug courts in the USA. Probation is distinguished from other penalties in that its primary function is rehabilitative. (Indeed, probation in most countries still involves the *suspension* of the punishment process - see Harris, 1995.) Equally, however, treatment under a probation order is underpinned by the possibility of legal coercion - and this sets it apart from most other forms of treatment for drug users. Given that probation is thus a vehicle for treatment, but one with special characteristics, two questions about the effectiveness of this treatment need to be addressed:

- How effective *in general* are the different forms of treatment which are available to offenders on probation?
- Are there *specific* effects resulting from treatment being provided via the criminal justice system?

This chapter first examines the range of community-based treatments available as part of a probation order or otherwise made available via the criminal justice system. The following section looks at evaluations of treatment programmes which are available to offenders on probation - regardless of any linkage to the criminal justice system. The final section of the chapter examines research which relates specifically to the provision of treatment within the coercive framework of the criminal justice system, covering issues such as the need for offenders' consent to treatment, getting offenders to disclose drug problems, and the question of drug testing.

Treatment under probation and related court orders

There are several routes to treatment under probation supervision in this country. None of these involve *compulsion*, but in all there are varying degrees of formal or informal *coercion*:

- The court may specify treatment for drug dependency as a requirement of a probation or combination order under provisions in the 1991 Criminal Justice Act.
- The court may also specify - under earlier legislation - psychiatric treatment or attendance at a residential treatment centre.
- Probation officers supervising offenders under probation orders may identify a treatment need, and secure offenders' compliance with this.
- The same may occur under a combination order, as part of aftercare supervision, or (rarely) under a community service order.

The provisions introduced by the 1991 Criminal Justice Act were used very sparingly at first, and were not seen as making a substantial difference in practice (Lee, 1994). Rungay (1994) found that almost 1,400 probation orders requiring treatment for drug or alcohol misuse were made in the first 18 months after the implementation of the 1991 Criminal Justice Act. These appear to have been split roughly equally between treatment for alcohol and drug misuse. Roughly 1 per cent of probation orders thus contain explicit conditions about drug treatment. A larger proportion receive treatment under probation supervision without this being a court requirement.⁷

A SCODA survey of probation work with drug offenders (Hart and Webster, 1994) identified four models of work with drug offenders in the probation service:

- The *probation-centred approach*: specialist officers have responsibility for drug work and provided treatment programmes and support for field probation officers.
- The *generic approach*: specialisation is avoided, and all probation officers are expected to tackle work with problem drug users.
- The *secondment approach*: probation areas second officers to treatment agencies (usually community drug teams).
- The *partnership approach*: probation areas look to specialist agencies to provide services.

Nee and Sibbitt (1993) found that in 1992 almost one in five probation areas relied solely on their own resources in providing treatment; two-fifths relied entirely on outside drug agencies; the remaining two-fifths used both in-house resources and those of outside agencies. The outside agencies used by the probation service include: community drug teams (CDTs - often inter-agency funded, with a mix of medical, probation and social work staff); drug dependency units (DDUs - NHS-funded and generally based in hospitals); voluntary sector counselling agencies; therapeutic communities; and private and/or self-help organisations (such as Narcotics Anonymous; these often follow what is known in the UK as the Minnesota Model). The main components of treatment include:

- drug counselling (e.g. advice, cognitive-behavioural approaches);
- drug education;
- self-help groups (e.g. Narcotics Anonymous, 12-step programmes);
- psychotherapy;
- substitute prescribing (e.g. methadone maintenance and reduction prescribing as part of detoxification);
- harm reduction programmes (e.g. needle exchanges);
- drug testing, especially in the USA.

The precise way in which these treatment ingredients are combined into programmes varies widely, according to the model of service provision adopted by each probation area.

Treatment goals, harm reduction and the criminal justice system

Health-care services have generally taken as self-evident that however desirable total abstinence may be as a treatment goal, this is rarely achieved quickly or simply; agencies thus set intermediate goals for themselves and their clients. As Strang *et al* (1993) say, 'While going for total abstinence may be seen as best, and while anything else may be seen as distinctly second-best, there may be times when going for second-best may be best-first'. The advent of HIV and AIDS has ensured the dominance within health care of this pragmatic approach, now usually referred to as harm minimisation or harm reduction.

Harm reduction may be well established as a health-care goal, but it raises particular dilemmas for those who work with drug offenders within the criminal justice system. By its nature, the criminal law is infused with concepts of right and wrong, and this reduces its flexibility for dealing pragmatically with residual illegalities committed by people on the road to recovery. From a health-care perspective, persuading a dependent heroin user to stop needle-sharing, or to stop injecting, or to reduce levels of use, may properly be regarded as an achievement, in both social and moral terms; from a criminal justice point of view, on the other hand, it could be regarded as condoning continued law-breaking. The failures of health-care and criminal justice perspectives to mesh properly is an issue of obvious concern, considered further in the concluding chapter.

Evaluations

Evaluations have largely been of *programmes* rather than of *programme components* and the vast majority have been conducted in the United States. The studies summarised here cover: methadone maintenance; detoxification; therapeutic communities; Minnesota Model groups; and other non-residential programmes involving counselling and social skills

training. These forms of treatment can all be provided as part of a community penalty, though many of the studies have not actually evaluated treatment programmes located within the criminal justice system.

Methadone maintenance

Methadone maintenance as a treatment for heroin addicts developed in the United States as a result of the pioneering work of Dole and Nyswander in the 1960s (Dole 1994a, 1994b). It involves the *long-term* substitution of methadone (usually taken orally) for heroin or other morphine-like drugs. It has obvious parallels with the so-called British System (Strang and Gossop, 1994), whereby heroin was prescribed either to help dependent users withdraw slowly from heroin use or to provide a legal supply to those judged unable to break their dependency.⁸

In the United States the operation of methadone maintenance programmes is fairly tightly defined by Federal Government regulations. Clients must have a documented addiction history and have received treatment in the past; only oral methadone is prescribed and doses must be consumed on the premises (Anglin and Hser, 1990b). By contrast, general practitioners in the UK are not under any specific restrictions in prescribing methadone⁹, and most methadone is dispensed by retail pharmacists for unsupervised use.

A good deal of mainly US research shows that methadone maintenance is an effective and safe¹⁰ way of reducing both illegal opiate use and drug-related crime. The field has been reviewed comprehensively by Ward *et al* (1992) and more accessibly by Farrell *et al* (1994). A very few studies have used randomised controlled trials; rather more have either compared matched groups of clients or tracked clients before and after treatment. The randomised controlled trials have involved very small numbers but strikingly large effects. For example, the first such trial randomly allocated 32 recidivist opioid offenders on release from prison to a maintenance programme or to receive treatment; those without treatment were 53 times more likely to return to prison and 92 times more likely to resume daily heroin use (Dole *et al*, 1969, quoted in Ward *et al*, 1992). The best-known studies involving matched comparison are the Drug Abuse Reporting Programme (DARP) and its successor, the Treatment Outcome Prospective Study (TOPS); the former covered 44,000 clients in 52 treatment agencies between 1969 and 1973, and the latter 11,750 clients in 41 programmes between 1979 and 1981. The studies found that methadone maintenance programmes yielded marked reductions in illegal drug use and in other crime, both during treatment and subsequently (though the effects were less when treatment ended).

Amongst studies comparing clients before and after treatment, Ball and Ross's (1991) study of six programmes in New York, Philadelphia and Baltimore is the best known. The results again provide persuasive evidence that maintenance programmes can yield very substantial reductions both in illegal drug use and in crime. Drop-out rates were low - one in six over a twelve-month period - but of those who did drop out, the vast majority returned to heroin injecting. The researchers found substantial differences in effectiveness between the six programmes: the ones which performed best were those which used higher dosages, aimed for maintenance rather than abstinence, and involved high-quality counselling support.

Ball and Ross's results on dosage levels are consistent with those of other studies. Ward *et al*'s (1992) review concludes that restricting the dosage range to below 50 mg results in high dropout rates, and that doses of 60 mg or more are associated with retention in treatment and reduced heroin use. Gerstein (1992) and Anglin and Hser (1990b) draw similar conclusions. More recent Australian research (Caplehorn *et al*, 1993) found that patients maintained on 40 mg per day were more than twice as likely to 'top up' with heroin as those maintained on 80 mg.

There is also some US evidence relating to cost-effectiveness. Gerstein cites TOPS analysis on cost-effectiveness which put the cost per day of methadone maintenance at \$6 and the

benefits, including reduced crime, at \$ 13. Anglin *et al* (1989b) looked at the impact of the closure of publicly funded maintenance programmes in California. Clients who were unable to transfer to a private (fee-paying) programme showed greater involvement than others in illegal drug use, drug dealing and other crime; the savings resulting from shutting down the programmes were almost offset by direct costs to the state criminal justice system and other state-funded drug treatment. Indirect costs were not assessed.

British evidence is very limited. To date there has been only one controlled trial in the UK, conducted between 1972 and 1975, comparing the effects of prescribing injectable heroin and oral methadone over a period of a year (Hartnoll *et al*, 1980). The researchers concluded that their findings 'did not indicate a clear overall superiority of either approach' in terms of either achieving abstinence or reducing illegal heroin use or reducing patients' involvement in crime. Bennett and Wright (1986) compared the extent of self-reported crime by small samples of opioid users during the year before and the year after receiving prescriptions for methadone. One sample attended an NHS clinic providing long-term, non-reducing supplies of injectable methadone; a second sample attended an NHS clinic prescribing oral methadone in reducing doses together with group therapy; a third sample attended private practitioners who prescribed injectable methadone on either a long-term or short-term reducing basis. Over 90 per cent of those in each sample reported continued use of illegal opioids while receiving methadone, but less frequently than before. Overall, the proportion who reported offending to obtain 'money for drugs' fell in the year after receiving prescriptions for methadone. The majority of those who did offend while attending the NHS clinic with a long-term prescribing regime said they committed offences for reasons unrelated to their drug use. Jarvis and Parker (1989) also found that heroin users reported committing less crime when they were receiving treatment (whatever it might be).

At least one consultant psychiatrist in the UK continues to prescribe heroin on a maintenance basis, either in injectable form or in impregnated cigarettes, and claims that in his area 'there is no infection from the human immunodeficiency virus, no drug related deaths and a 96 per cent reduction in acquisitive crime' (Marks, 1994).

Methadone maintenance is obviously not a panacea. In the first place, it can hardly count as a treatment for *drug dependence*; it is a strategy for helping people function whilst drug-dependent. Secondly, it is appropriate mainly (if not exclusively) for dependent opioid users. Thirdly, when - as in the UK - clients collect their prescriptions from pharmacists, they sometimes sell some of the prescribed methadone, or 'save it for a rainy day' whilst continuing to use illegal drugs (see e.g. Power *et al*, 1993). Finally, drop-out rates, though lower than for other forms of treatment, are still a significant problem; some have noted users' resistance to the 'blandness' of methadone, suggesting that this may encourage users to revert to heroin, or to diversify into other forms of drug use (cf Greenwood, 1992).

Detoxification, reduction prescribing and other prescribing strategies

Detoxification (or managed withdrawal) is a family of procedures for alleviating the short-term symptoms of withdrawal from dependence. Methadone, taken orally, is most commonly used for dependent heroin users, with stepwise reduction of doses over a period of weeks or months. Other drugs such as dihydrocodeine tablets or elixir are also used. No satisfactory substitute drug equivalent to methadone has yet been developed for dependent users of cocaine, though anti-depressants have been found to reduce the depression and craving of withdrawal (Strang *et al*, 1993).

Heroin detoxification typically involves diminishing doses of methadone over a period of 21 or 28 days. The consensus in the US literature is that rapid detoxification in itself yields no benefits superior to untreated withdrawal (Gerstein, 1992), and that it will not achieve long-term reductions in either drug misuse or drug-related crime (see e.g. Anglin and Hser, 1990b; Deschenes and Greenwood, 1994; Hepburn, 1994). The conclusion that detoxification through rapid reduction prescribing is a useful tool to deploy in the process of

treatment rather than as a treatment in its own right - seems uncontroversial enough. In other words, detoxification may for some users form a necessary but not by itself sufficient component of treatment.

One British study is relevant here. Gossop *et al* (1987) reported a six-month follow-up of 57 mainly heroin-using patients after a 21 -day period of in-patient detoxification. The 50 who completed the programme were interviewed after six months: 26 were opiate-free (on the basis of urine analysis); eight used opiates occasionally during the follow-up period; and 16 were taking opiates daily and were regarded as re-addicted. The authors concluded that the period immediately after discharge was a time of extremely high risk and that supportive aftercare services were needed.

Detoxification obviously shades into reduction prescription, where reducing amounts of methadone are prescribed over a longer period, this often occurs over a period of several months in Britain (Department of Health, 1994). Logically, it must be possible for treatment to be so long-drawn out that it yields some of the benefits of maintenance prescription. However, research has not firmly established the point at which reduction prescription starts to pay off. The conclusions drawn by Ward *et al* (1992) from several studies are that periods of two to three years' maintenance are more likely to benefit the majority of clients than shorter periods. They advocate an approach where levels of dosage, duration of treatment and ancillary counselling services are all tailored to the individual needs of clients, rather than predetermined by treatment ideologies.

There are some advocates of the prescription of 'antagonists' - drugs which negate the effect of the drug of dependence and thus remove the pay-off from using it. Naltrexone has been used with dependent opiate users in the UK, sometimes as a condition of probation or bail (Brewer, 1993; Brahen and Brewer, 1993). It is typically taken daily or twice a week. This review has not identified any formal evaluations, though problems of securing compliance are likely to be higher than with substitute prescribing.

Therapeutic communities

Therapeutic communities (TCs) have a long history, with origins that can be traced to the 1940s and earlier. The first TCs for drug misusers were established in the United States in the late 1950s and early 1960s (see Pan *et al*, 1993). Key features are:

- The full-term stay for residents is generally between 9 and 18 months.
- The aim is complete cessation of drug use.
- The essential dynamic is mutual self-help - the community is the 'therapist'.
- There is an emphasis on role models or exemplars - counsellors are often ex-residents.
- There is a system of explicit rewards to recognise achievements.
- Charismatic leaders often play an important part in their operation.

Drop-out rates for TCs are high, but the impact on those who stay the course seems marked in terms of both reduced drug misuse and reduced crime. Some studies (in the USA) have followed up only the 'graduates' from TCs, ignoring the drop-outs. Those studies which have examined both groups generally show that graduates do much better than comparison groups of offenders who received other forms of treatment (or none) and that drop-outs do worse (see Deleon, 1985; Lipton *et al*, 1992). Gerstein (1992) reports TOPS analysis of cost-effectiveness to suggest that despite the expense of TCs the benefits still outstrip the costs.

Sceptics may argue that the low failure rate of graduates is nothing more than a selection effect: anyone who has the stamina and determination to stay the course in a TC should find subsequent life problems, such as avoiding drugs and crime, undemanding by comparison. Failing in a TC on the other hand may well increase the chances of subsequent failure. Certainly the value of TCs cannot be assessed by comparing graduates alone with

comparison groups, and ignoring the drop-outs entirely: the comparison group will include people who would have dropped out of a TC had they had the opportunity to try one. The cards are thus stacked in favour of the TC graduates. A good test would involve comparing graduates and drop-outs together with a matched control group.

In the absence of such a test, the sheer extent of the improvements shown by graduates of TCs must be taken as an encouraging sign. Indeed, it would be surprising if problem drug users remained totally unaffected by long-term immersion in a close-knit community with a strong anti-drug ideology sustained by a charismatic leader. What is less clear is the extent to which charismatic leadership is an essential ingredient of successful TCs; nor is it known whether the TC structure and process generates charismatic leadership or whether TCs are critically dependent on locating those - rare - staff with the necessary personal qualities. Certainly, the more that TCs are dependent on the unique qualities of specific individuals, the less replicable they are - and the more difficult it is to ensure that their undoubted potential benefits are realised.

Self-help groups

The most common form of treatment in the United States is abstinence-based and makes use of Alcoholics/Narcotics Anonymous principles, known as the Minnesota Model in the UK and as 28-day or 12-step¹¹ programmes in the USA. In the USA these typically take the form of a short period of residential treatment, sometimes followed by long-term (e.g. six months to two years) participation in a self-help group. They share some characteristics with TCs: abstinence as the main goal; recruitment of staff from 'recovering' clients; and intense commitment to the group's ideology - which may be explicitly religious. Their defining feature is their view of addiction as a lifetime disorder, with its roots in chemical dependency, so that recovery is never total or guaranteed.

Minnesota Model treatment in Britain takes the shape either of private, fee-paying residential centres or of non-residential groups run by Alcoholics Anonymous or Narcotics Anonymous, which charge no fees. In March 1991 there were 30 centres offering Minnesota Model treatments in the UK and Ireland (Wells, 1994).

Treatment based on the Minnesota Model has hardly ever been evaluated (Wells, 1994; Deschenes and Greenwood, 1994; Gerstein, 1992). As Wells says, 'controlled research is needed to evaluate these treatment centres, some of which make extravagant claims as part of a marketing strategy.' Whether researchers would gain access is an open question: the approach demands a high level of commitment from participants, which might not easily be reconciled with the spirit of scientific enquiry. On the other hand, confidence in the effectiveness of the approach is so firm amongst proponents that they might positively welcome research. One British study, on the correlates of completion rates, is discussed below (Georgakis and Russell, 1994).

Other types of counselling and social skills training

This residual category is one which frequently appears in the US literature; it is scarcely a category at all, comprising a variety of non-residential programmes which may or may not be accompanied by detoxification. Harm reduction is sometimes the goal rather than total abstinence. Gerstein (1992) thus refers to 'out-patient non-methadone programmes', Anglin and Hser (1990b) to 'out-patient drug free treatment'. The diversity of programmes included under this heading probably represents a large proportion of UK interventions - the sort of programme involving contact once or twice a week for a period of anything between three and six months. Despite the heterogeneity of the category, both Gerstein (1992) and Anglin and Hser (1990b) reach fairly clear conclusions: these programmes may be less effective in terms of retention than others, but as far as long-term outcomes are concerned they are comparable to methadone maintenance and TCs.

Cognitive-behavioural techniques of counselling deserve some separate discussion. These

have become increasingly popular in the USA (Peters, 1992) and Canada (Cormier, 1993). As their name implies, this family of techniques combines elements of cognitive therapies (aimed at altering clients' thought processes and perceptions) and of behavioural skill training. Walters (1994) provides a useful summary of the main forms of cognitive-behavioural intervention. One of the main cognitive-behavioural techniques specifically for problem drug users is relapse prevention (Marlatt and George, 1984; Peters, 1992; Strang *et al*, 1993). This aims to enhance people's ability to sustain a durable change in behaviour; it recognises that lapses back into drug use are commonplace but regards these as potential learning experiences, from which coping skills for avoiding high-risk situations can be acquired. Although evaluations of cognitive-behavioural approaches in general are promising (see Andrews *et al*, 1990; Gendreau and Ross, 1987), this review has not encountered evaluative research specifically on relapse prevention techniques or other forms of cognitive-behavioural intervention designed for problem drug users.

What makes for effective treatment?

The success of quite disparate approaches to treatment raises questions about precisely what it is that leads to success. The first thing to consider is whether the undoubted improvements reported by many evaluations are actually a consequence of treatment. They might be explicable simply as a function of maturation - many problem drug users manage to overcome their problems without formal treatment. Another possibility is that the results are a statistical artefact, reflecting 'regression to the mean': levels of drug use naturally fluctuate and people tend to receive treatment at periods of peak drug use; regardless of treatment, therefore, one might expect some improvement. Interpretation is made harder still when evaluations fail to take account of drop-outs, comparing with controls only those who remain in treatment. The only way to resolve these questions definitively is to mount experiments in which people are randomly allocated to treatment and control groups - and where drop-outs are retained in the 'treatment' group; these are few and far between. Where such studies have been carried out, the results indicate real treatment effects (cf Ward *et al*, 1992).

The next question to ask is which approaches work best, and for whom? The only reliable basis for comparison of different types of programme is provided by the DARP and TOPS studies carried out in the USA (see Anglin and Hser, 1990b; and Gerstein, 1992, for summaries). These found little difference between methadone maintenance, therapeutic communities and community-based drug-free programmes. In the first year following treatment, for example, about a quarter of clients in each treatment group remained totally free of illegal drugs and avoided any form of arrest or conviction. Those who had no treatment or received detoxification alone performed much worse: only one in seven remained drug-free and avoided trouble with the law.

In comparing effectiveness, perhaps the most significant findings relate to length of time in treatment and drop-out rates. DARP and TOPS found that those who stayed longest in treatment performed best, and there seemed to be a minimum time in treatment below which outcomes were consistently poor: those who survived in any of the three forms of successful treatment for less than three months performed no better than those who simply underwent detoxification. The longer people remained in treatment thereafter, the better the outcome. Drop-out rates were lowest for methadone maintenance: 65 per cent were still in treatment after three months, compared with 56 per cent for people in residential treatment and less than 40 per cent receiving community treatment.

Within treatment types, considerable variations in effectiveness have been found between programmes. This is not especially surprising either for therapeutic communities or for community based drug-free treatment, where the quality of the staff can very obviously determine outcomes; but it has also been found to be true for methadone programmes (Gerstein, 1992; Ball and Ross, 1991). It thus makes sense to think of methadone maintenance not simply as a treatment which provides a chemical substitute for heroin but

also as an effective way of holding clients in treatment whilst other therapeutic processes can take place.

A corollary is that treatment should be thought of less as a technology and more as a human process, where a diversity of strategies can all achieve the same effect: shaping and sustaining motivation to change. In other words, methadone maintenance and TCs - apparently diametrically opposed approaches - may both provide a period of time and an environment in which clients acquire the confidence and strength to change. This theme is revisited in the concluding chapter.

If length of treatment is a key variable in determining its effectiveness, it is important to know what programme factors are associated with retention. In the USA, McGlothlin and Anglin (1981) and Brown *et al* (1982) found that methadone programmes with a flexible approach to dosage policy retained clients on average for nine months more than others - a substantial gain. High drop-out rates will sometimes reflect a tough-minded approach to the enforcement of rules and conditions, such as staying drug-free; whether a more flexible approach could yield higher retention rates without undercutting the entire ethos of these programmes is an open question. Australian research has found that prolonged formal assessment as a precursor to methadone maintenance worsens the chances of staying in treatment, and that getting people into treatment quickly improves retention rates (Bell *et al*, 1994). Finally, there is the question whether the threat of sanctions can improve retention rates - an issue covered in the final section of this chapter.

Research provides some guidance as to the sorts of people who respond best to treatment. Georgakis and Russell (1994) analysed factors associated with successful completion in a residential 12-step programme in Devon, looking at over 2,000 admissions for alcohol and drug misuse between 1983 and 1993. Those with dependent heroin use and those with a criminal history did worse than others. Key factors associated with successful completion were:

- family involvement;
- age (older clients did better);
- higher levels of education and employment;
- paying for treatment.

Extrapolating from this to other types of programme may not be justified, though more broadly based US research paints a broadly similar picture: people with stable family backgrounds, an intact marriage and a job generally do best; those with extensive criminal histories, polydrug use and psychiatric history do worst (Anglin and Hser, 1990b). This will offer little comfort to those working with problem drug users within the criminal justice system.

Finally, the role of aftercare following treatment should not be overlooked. Common sense suggests that it should be a priority to consolidate through aftercare the gains that have been achieved in treatment. However, there is little research either on the range of provision or on the impact of different approaches (see Hawkins and Catalano, 1985, for a review).

Treatment within the criminal process

This section considers whether the impact of treatment is modified by virtue of being provided within a criminal justice context. The criminal justice system is almost by definition a coercive one; even where its coercive nature is masked or muted, as in probation work, the potential for coercing offenders into compliance remains. This presents us with a general question about whether treatment is less effective within a coercive context, and with more specific ones about the impact of techniques such as drug testing.

Treatment and coercion

One of the articles of faith of many drug workers in this country is that problem users cannot be coerced into treatment. The rationale is an understandable one: people who do not enter treatment voluntarily are unlikely to take it seriously, and it makes sense to target finite resources on people who have expressed a will to change. In the USA, by contrast, coerced treatment is commonplace; those in favour of legal coercion often voice the argument that its impact is not qualitatively different from the pressures from family or employers which often bring people 'voluntarily' into treatment.

Coercion can obviously occur in different ways, and in differing degrees. The coercion which can be applied to psychiatric patients under various Mental Health Act provisions can extend to outright physical force, and amounts to total compulsion. When treatment is coerced within the criminal process, the coercion is typically less absolute. There are several stages at which it can occur:

- At sentence, offenders may often be faced with an 'offer they cannot refuse', in that failure to agree to treatment as part of a community sentence may well trigger a prison sentence.¹²
- Where treatment is accepted as a condition of probation, defaulting on the condition may well result in breach proceedings (and imprisonment).
- Even if treatment is not a formal condition of probation, continued drug misuse or offending could result in breach, as could results from drug testing.

Whether coerced treatment is ineffective is central to the concerns of this review: arguably, probation work with problem drug users in Britain is seriously hampered by most agencies' requirements that treatment should be freely entered into, and by the linked demands of client confidentiality. Nee and Sibbitt (1993) describe some of the difficulties of case management when treatment agencies are prepared to feed back to the supervising officer only the bare minimum of information about offenders' progress.

Though the results of research in the United States are not entirely consistent, the majority of findings, including those from the best-designed studies, suggest that clients receiving legally coerced treatment respond no worse than others. Legal coercion seems to be an effective way first of getting drug misusers into treatment early and, secondly, of keeping them there (see Anglin and Hser, 1990a, for a review; and Russell, 1994, for further discussion). An early review by McGlothlin (1979) concluded that offenders on probation, on parole or awaiting trial were retained in treatment as well as other clients, and treatment outcomes were no worse. Anglin *et al* (1989a) compared coerced and other clients in methadone maintenance programmes; clients judged to be in the highest of three levels of coercion (being on probation or parole, being subject to drug-testing, and experiencing a sense of coercion) had outcomes no different from those who were free of legal coercion or coerced to a lesser degree. The TOPS survey showed that legally coerced clients on methadone maintenance stayed in their programmes almost twice as long as other clients; results from the more recent DATOS study showed that more than half of criminal justice clients were maintained in methadone maintenance programmes compared to less than 40 per cent of other clients (Hubbard, 1994, quoted by Russell, 1994).

Some of the best evidence of the benefits of legal coercion come from Anglin's (1988) study of the California Civil Addict Program (CAP). The coercive machinery employed here was that of the civil rather than the criminal law. Under a 'civil commitment' procedure, problem drug users, mainly diverted from the criminal courts, were sent to a residential treatment centre and then released back into the community under supervision. Chance provided a good comparison group against which to assess the impact of the scheme: a substantial number of people were released early, owing to errors in the commitment procedure. This comparison group did substantially worse than those who went through the full treatment process, and the difference persisted for several years. Whether the CAP provided adequate

protection of offenders' civil rights is an open question, but it nevertheless demonstrates that initial motivation is not a prerequisite of effective treatment. The concluding chapter discusses ethical considerations raised by coerced treatment.

Disclosure and drug testing

Getting problem drug users to talk honestly about their drug use is particularly hard when treatment is provided within a criminal justice context (ACMD, 1991). Offenders tend to be chary about admitting illegal drug use to a probation officer in advance of trial and sentence, for fear that this could reduce their chances of bail and increase the chances of a tough sentence. When offenders are serving a probation order or being supervised on release from custody, they will be equally reluctant to admit illegal drug use to someone who has the power, if not the duty, to initiate breach proceedings. Arguably, probation officers' ability to provide drug treatment for offenders will be substantially limited until they find a solution to the problems of disclosure (see Briton, 1995, for a discussion of the reasons why drug-using offenders do not admit drug use to probation officers).

The approach recommended by the ACMD (1991) is to provide adequate incentives to offenders to disclose drug problems, for example by providing better access to community-based treatment, and to remove the disincentives - by getting different parts of the criminal justice system to adopt harm reduction policies which are mutually consistent. This should go some way to solving the problem, but US research has demonstrated just how reluctant offenders are to disclose problem drug use to criminal justice officials. Wish and Gropper (1990) point to substantial evidence, based on the results of drug tests, that people report illegal drug use fairly fully under conditions of guaranteed confidentiality - unless the disclosure is in a criminal justice context. Thus offenders in Washington and New York have been found to underreport their drug use by half when being interviewed in conditions of confidentiality by independent researchers shortly after arrest; one study found that drug testing identified 17 times more crack/cocaine users amongst offenders than interviews did.

Though it poses ethical and legal dilemmas, drug testing is clearly one solution to problems of disclosure.¹³ Urinalysis is now both quick and cheap, at least once equipment has been bought. Hair analysis avoids some of the problems of urinalysis (e.g. risk of specimen substitution, intrusive collection process) but is more expensive and more limited in the range of drugs which it can identify. In this country drug testing - usually urinalysis - is used almost exclusively outside the criminal justice system as a diagnostic tool - for example to ensure that people on methadone maintenance are (a) taking their methadone and (b) not taking illegal drugs. In the United States, by contrast, urinalysis provides the means for enforcing treatment requirements: responses to positive drug tests routinely include punitive sanctions.

Hser *et al* (1994) suggest that drug testing in combination with intensive supervision and sanctions for detected drug use is more effective in reducing drug use than conventional supervision. Turner *et al* (1994) offer a rather more qualified conclusion. They looked at the impact of drug testing on illegal drug use and rearrests in five Intensive Supervision Programmes (ISPs) in the United States. Offenders were randomly allocated to conventional probation or to ISPs incorporating drug testing. ISPs did not include formal drug treatment programmes. Three- quarters of drug-tested offenders on ISPs tested positive over a 12-month period; this was mostly for cocaine or cannabis, with the former being more frequent. Positive tests generally triggered a graduated response from the system, ranging from warnings to imprisonment. The latter was quite frequent: in Seattle, around three-quarters of offenders who tested positive went into custody. ISP supervision resulted in arrest rates which were no lower than with normal probation supervision; actions for violation of probation orders - the equivalent of breaches - were substantially higher. The researchers concluded that drug testing by itself was insufficient to deter illegal drug use and drug-related crime, and that testing needed to be carried out in conjunction with treatment over a sustained period.

Drug courts

Drug courts are a fairly recent innovation in the USA. The emergence of drug courts is in part a response to the large increase in the numbers of drug offenders passing through the US courts and in part a judicial reaction to the Draconian mandatory prison sentences introduced for drug offenders in the 1980s (Bean, 1994). The best known is the Dade County drug court in Miami (Department of Justice, 1993), the key features of which are:

- The court deals exclusively with drug-related offences.
- The judge retains control of the treatment programmes, dealing directly with treatment agencies.
- Individual treatment plans are made for offenders, including in-patient programmes, counselling, acupuncture, literacy and employment training.
- Offenders report back to the judge every 30-60 days, and are regularly drug tested.
- If offenders test positive, they may be jailed for a fortnight or put back to an earlier stage of their programme.

Many courts have now been set up. Some are on the lines of the Miami model; others have adopted specialised and streamlined procedures for dealing with drug offenders, without the same level of judicial involvement in specifying and monitoring treatment (Department of Justice, 1993). This approach is taken in drug courts in Philadelphia, New York and Oakland, for example, where participation amounts to diversion from conventional court proceedings, with deferral or conditional suspension of punishment. The Dade County drug court has been evaluated, and results are promising. Three thousand offenders passed through the court in its first four years. Rearrest rates for those who completed the programme were lower than those for non-drug offenders and for comparable drug offenders dealt with by other courts; the time to rearrest amongst the drug court graduates was also much longer (Goldkamp and Weiland, 1993). The Oakland drug court has also been evaluated (Russell, 1994): like the Dade County drug court, there is a good completion rate (about 50 per cent) and initial lower recidivism rates seem promising.

⁷. In some cases the order may specify, for example, attendance at a probation centre with the unstated expectation that drug treatment could thereby be provided.

⁸. The prescribing of heroin was substantially curtailed in the wake of the 1967 Dangerous Drugs Act, which was a response to increasing drug misuse and concern about overprescribing and seepage of prescribed drugs on to the illicit market. Methadone then became the primary prescribed substitute for illegal opiates.

⁹. GPs are free to prescribe any drug they consider to be appropriate in the treatment of addiction, with the exception of diamorphine, cocaine and dipipanone, which can be prescribed only under special licence.

¹⁰. Fears about methadone's potential to harm the immune system have been largely allayed. See McLachlan et al, 1993.

¹¹. The 12 steps are the steps to recovery originally developed by Alcoholics Anonymous.

¹². The process of shaping this 'offer' will often start when a probation officer prepares a pre-sentence report, as discussed in the previous chapter.

¹³. See Bureau of Justice Assistance, 1991, for a discussion of practice guidelines for drug testing.

Drugs misuse and the criminal justice system: a review of the literature

5. INTERVENTIONS IN PRISONS

In an ideal world, prisons would - if such a world found prisons necessary - provide a unique opportunity for treating problem drug users. Prisons have *control* over their inmates; prisoners should be *motivated* to change; except in the case of short-sentence prisoners, prisons have *time* to effect change; and the *marginal* costs of providing treatment are modest in comparison with the costs of imprisonment. In reality, the opportunities for effective treatment are much more circumscribed:

- Illegal drugs are widely available in prisons, and the frustrations of prison life may increase the attractiveness of drugs to prisoners.
- Inmate culture in some institutions can place a positive value on drug use, and drugs are important in the prisoner economy.
- Whatever prisons may achieve, treatment is provided in an environment which is nothing like the one into which inmates are released.

Whatever the problems in providing adequate prison-based treatment, the gains in overcoming them may be considerable. In the first place, a large minority of problem drug users are likely to pass through prison at some stage in their drug-using career; for some, it may be the first time that their dependent state comes to light (Ghodse, 1989). In addition, the benefits of minimising the risks of HIV and AIDS are obvious in an environment where inmates are exposed both to drug injecting using shared needles and to high-risk sexual behaviour.

Almost all the forms of treatment discussed in Chapter 4 have been provided within prisons in some countries. Provision in England and Wales has been fairly limited, at least until very recently, and research evaluating prison-based treatment has been more limited still. As in earlier chapters, the research discussed below has a strong North American bias. The chapter first considers possible deterrent and incapacitative effects of prison; it then looks in turn at substitute prescribing, therapeutic communities and other forms of treatment.

The deterrent and incapacitative effects of prison

Leaving aside questions of treatment, the main ways in which prison may reduce crime whether or not drug-related - are threefold:

- by deterring potential offenders from committing crime (general deterrence);
- by deterring people in prison from further offending (individual deterrence);
- by keeping offenders out of circulation (incapacitation).

Added to these is a possible effect specific to dependent drug users, in that imprisonment (at least potentially) provides a period of enforced detoxification.

The research literature on general deterrence is limited; it is inconclusive (but pessimistic) about the *marginal* preventive effects on potential offenders of varying the level or type of sentences (cf Beylveid, 1979; Ashworth, 1994). This review has identified no research on the impact of those general deterrent strategies where custodial sentences are targeted specifically on problem drug use. Nor does research indicate whether *imprisoned* drug users are more susceptible than other offenders to individual deterrence - the deterrent impact of actually serving a prison sentence. Circumstantial evidence suggests otherwise: for example, Lloyd *et al's* (1994) reconviction study found that offenders with a long record of persistent acquisitive offending - the likely offending profile of dependent drug users who steal to finance their habit - were especially at risk of reconviction, regardless of whether

they served a custodial or a community penalty.

As for the incapacitative effects of imprisonment - keeping offenders out of circulation - it is fairly clear that some property crimes are prevented through the imprisonment of drug users. As discussed earlier, those at the heavy end of dependent drug use can get through &#pound;500-&#pound;2,000 per week, and a proportion of these finance their use by stealing property with a replacement value of several thousand pounds per week. When they are imprisoned, this offending stops. The value of incapacitation as a strategy for reducing drug-related crime depends largely on the answers to two sets of questions:

- Does imprisonment simply *defer* offending until release, or does it genuinely *reduce* levels of crime?
- If it does reduce crime, is it a cost-effective and socially just way of doing so?

Research has not yet provided an answer to the first question. The probabilities are that with very long sentences the crimes are prevented altogether;¹⁴ but with short-term and middle-term sentences, problem drug users will on release simply resume both their drug-using and their criminal careers where they left off - unless they receive effective treatment. Our knowledge about the relative cost-effectiveness of incapacitation and competing approaches is also limited. If, for the sake of argument, methadone maintenance programmes can reduce clients' drug-related crime by two-thirds at an annual cost of &#pound;2,400,¹⁵ and prison can eliminate it at an annual cost of &#pound;24,000, the former may be a much better buy than the latter. Chapter 6 returns to the issue of cost-effectiveness.

As discussed in Chapter 2, drugs are available in prisons. It is implausible that many inmates would have access to enough drugs of dependence to maintain their dependence. However, one might speculate that enforced detoxification within an inmate culture that positively values drug use does not augur well - especially in the light of evidence presented in the previous chapter that even when it is medically supervised, detoxification by itself has little long-term impact.

Boot camps: the 'short sharp shock'

Boot camps, or 'shock incarceration' programmes, are becoming increasingly popular in the USA. Their regimes are along the lines of military training camps, with a strong emphasis on strict discipline, rigid rules, military drill and physical training. Their popular appeal lies in their promise to provide an experience which simultaneously deters and instils self-discipline (see MacKenzie, 1994; MacKenzie and Parent, 1992). In practice, boot camps are highly diverse, and many provide inmates with some form of education and training; as many inmates are problem drug users, the education and training usually includes a large component on drug misuse. Some programmes also provide post-release supervision. The rapid development of boot camps in the USA probably owes something to their Protean ability to appear both tough and constructive.

Most US research to date has been generally consistent with the Home Office study of the 'short sharp shock' experiment carried out in England in the late 1970s¹⁶ (YOPU, 1984). Studies have found that there are few significant differences in terms of subsequent reconvictions between those passing through the programmes and controls (see e.g. MacKenzie, 1991). However, MacKenzie's more recent research (1994) provides some tentative evidence of positive effects. What remains unknown is the extent to which boot camps are an effective way of dealing with problem drug users. MacKenzie (1994) expresses some doubts as to whether effective drug treatment can be provided within the limited time-span of a typical boot camp sentence, and concludes: 'There is no evidence from past research of drug treatment programmes that structure and discipline will reduce drug use, although it may be useful in the initial stages of drug treatment'.

Detoxification and substitute prescribing

The Prison Medical Service can and does prescribe methadone and other notifiable drugs to dependent drug users; it is Prison Service policy that a short programme of detoxification through reduction prescribing of methadone should be the normal treatment offered to prisoners who are identified on reception as dependent on heroin. However, methadone prescribing is less common than usual practice in NHS treatment centres. Ross *et al* (1994, quoted by Plant, 1994) cite a figure of 29 per cent of renotified addicts receiving methadone or other notifiable drugs when in prison, compared with 90 per cent of those in NHS centres.

There has been no evaluation of reduction prescribing in prisons in England and Wales, but there has been some research into the Drug Reduction Programme (DRP) in Saughton Prison, Edinburgh, in which reduction prescribing plays an important part (Shewan *et al*, 1994, quoted by Plant, 1994). The programme was prompted by the exceptional level of HIV infection amongst prison inmates, estimated by two studies at being one in five (Bath *et al*, 1993, and Peters *et al* 1994; both quoted by Plant, 1994). It couples the prescribing of substitute drugs (mainly methadone and benzodiazepines) with group work and counselling sessions. Shewan *et al* (1994) made a comparison of 30 prisoners who had completed at least 21 days on the DRP with 30 prisoners who had dropped out or who had no contact with the programme. Results were promising, in that the DRP group clearly had lower levels of drug use while in prison - though, as discussed in Chapter 4, it is hardly surprising that drop-outs did worse than those who stayed in the programme.

Maintenance prescribing of methadone is rare in any prison system - not surprisingly, as the ethical and medical dilemmas inherent in maintenance prescription are intensified when patients have been deprived of their liberty. (Given that prescription is likely to make offenders more tractable, there is always a risk that an initially benign prescribing regime may gradually evolve into an oppressive form of control by 'chemical cosh'.) This review has found only two examples of evaluated methadone maintenance programmes: the Key Extended Entry Programme (KEEP) in the New York City Jail at Rikers Island, and the New South Wales Prison Methadone Programme.

Magura *et al* (1992, quoted by Peters, 1992, and Plant, 1994) describe the KEEP programme as evolving out of the routine detoxification of very large numbers of offenders passing through the New York jail system¹⁷ - 16,000 in 1986, for example. Consistent with results discussed in the previous chapter, most of those who were detoxified returned to drug use and crime on release; HIV and AIDS among intravenous users were on the increase. KEEP was set up as a voluntary alternative to rapid detoxification: offenders are given the option of methadone maintenance for the duration of their sentence (on average 45 days), with a view to participation in community-based KEEP maintenance programmes on release. Some 3,000 pass through the scheme annually. Magura *et al* (1992) found that the majority of those who take part in KEEP make contact with a community methadone programme (89 per cent of those who were already in a maintenance programme immediately before their sentence, and 51 per cent of those who were not). They found drop-out rates were high: over 40 per cent for some KEEP groups, and somewhat higher for those who were not in a methadone programme before imprisonment. However, as Plant (1994) says, these results are encouraging in view of the fact that KEEP serves a group of clients of whom the majority are constantly destitute. The value of the KEEP programme clearly lies in its ability to provide a bridge to community-based treatment for a group of severely deprived offenders serving short sentences. It provides empirical support for the recommendation of the ACMD (1993) for maintenance prescribing for remand or short-sentence prisoners who were receiving maintenance dosages of methadone before admission.

The New South Wales methadone maintenance programme was set up in the late 1980s, with the objectives of reducing drug use in prison, reducing the risk of HIV and AIDS infection and reducing recidivism. A review by Hall *et al* (1993) concluded tentatively that

the programme was succeeding in its first objective but found little evidence that recidivism was affected; retention rates in treatment after release were poor. The programme encountered hostility from some prison staff, who viewed maintenance prescribing as pandering to addicts; this may explain why results were not more positive.

Therapeutic communities

Several commentators have observed how inmate culture threatens to undermine any treatment programme (e.g. Gerstein, 1992; Plant, 1994). Prison-based therapeutic communities (TCs) offer the advantage of placing a *cordon sanitaire* around the inmates who are in treatment to protect them from the dominant pro-drug ethos, and this may be their particular strength.

There are two well-known evaluations of prison-based TCs in the USA: the New York 'Stay'n Out' programme, researched by Wexler and colleagues (1988, 1990, quoted in Wexler and Lipton, 1992, and Plant, 1994) and the Cornerstone programme in Salem, Oregon, studied by Field (1989, quoted in Wexler and Lipton, 1992; and Plant, 1994).

Stay'n Out has three treatment units for men and one for women; the units, with around 40 beds each, are housed and administered separately from the general prison population; treatment contact continues after release. The Cornerstone programme comprises a 32-bed unit with a six-month system of aftercare. Both programmes are organised along the lines of community-based TCs described in the previous chapter. The results of evaluation for both programmes also follow much the same pattern: those who complete the programmes do much better than drop-outs and control groups. As with community-based TCs, the longer people remain in the programmes, the greater the impact.

The fact that programme drop-outs tend to do worse than control groups raises once again the possibility discussed in Chapter 4, that the research is identifying at least in part the effects of self-selection rather than those of treatment. Such scepticism may be tempered by the fact that many successful programme graduates, no less than the drop-outs, have long histories of drug-related crime. Certainly, the results of the studies encouraged the US Bureau of Justice Administration sufficiently to set up a further 16 prison-based residential programmes as part of a 'technical assistance' package called REFORM, running from 1987 to 1991 (Wexler and Lipton, 1992).

One possible constraint on the development of prison-based TCs lies in the threat that they can pose to conventional prison organisation. Their ethos is built on self-help, institutional autonomy, self-determination and (sometimes) non-authoritarian collective decision-making - though effective leadership may rest with a charismatic leader. All these things contain the seeds for conflict when the TC is located within another 'total institution' with very different values and operating practices.

Drug-free wings

'Drug-free wings', referred to in the US literature as 'milieu therapy', represent a halfway house between TCs and more conventional counselling and group work. Like TCs, they involve a degree of physical separation from the rest of the prison. The scheme in HMP Downview is the best known in this country. This is - loosely - linked to a programme of group therapy, education and intensive counselling, provided in the prison by the Addictive Diseases Trust (ADT), with links to Narcotics Anonymous for post-release follow-up; counsellors include ex-dependent users. Drug testing is an integral part of the regime (HMCIP, 1994). The ADT scheme is to be evaluated shortly. A similar scheme exists in HMYOI Brinsford, which serves as a resource for young offenders in young offender institutions across the country. Again, its impact has not been formally evaluated.

There is some relevant US research: inmates receiving milieu therapy formed one of the comparison groups in the Stay'n Out programme discussed in the previous section; this

group did better than those who received no treatment or conventional drug counselling, but less well than the Stay'n Out graduates (Gerstein, 1992).

Drug-free wings of this sort have several attractions, not least that they insulate participants from the pro-drug ethos prevailing in prisons. Possible limitations are that they provide services only for inmates who have already made a decision to seek help with their drug problems, and by implication condone drug use in all parts of the prison except areas designated as drug-free.

Cognitive-behavioural approaches and relapse prevention

The Canadian Corrections Service has pioneered the development of cognitive-behavioural treatment in prisons, and the results of general programmes so far are promising (Cormier, 1993). Building on these, it has developed a specialist treatment programme for substance abusers, with components on drug education and on relapse prevention techniques. Preliminary before/after comparisons have suggested positive results as regards knowledge, attitudes and skills taught in the programme, but the impact on post-release behaviour awaits further research (Husband and Platt, 1993). The Stay'n Out programme also includes a cognitive-behavioural programme.

The strength of relapse prevention techniques lies in the focus on teaching practical strategies and skills for avoiding further drug use after release. One of the possible advantages of such techniques may thus be that they can provide a link between treatment received in prison and follow-up in the community; certainly their impact may well be diminished or negated if they are not followed by community-based support on release.

Aftercare

The research literature has little to say directly about the value of aftercare specifically following imprisonment, though the review by Hawkins and Catalano (1985) establishes the value of post-treatment aftercare in general. The studies discussed in Chapter 5 also carry the very strong implication that the chances of treatment in prison being effective will be improved by effective support after release (cf Russell, 1994). If the key to successful treatment is getting people into treatment and keeping them there, there is an obvious need for co-ordination between whatever programmes are offered in prison and those offered by the probation service to offenders under post-release supervision.

Harm reduction in prisons

Applying harm reduction strategies to drug use in prisons raises ethical and legal issues about condoning illegal drug use. For some, forbidding drug-taking, but then providing injecting equipment or cleaning materials, may seem hypocritical at best, criminal at worst. On the other hand, the need for harm reduction measures cannot be ignored especially in the face of the risk posed by HIV and AIDS. The arguments are not solely ethical ones, however: some harm reduction strategies raise practical questions which have not been addressed by research. In particular, it is unclear precisely how to strike the right balance between rendering drug use less harmful and facilitating drug use. The provision of needles, for example, could lead to an increase in levels of injecting; whilst the provision of cleaning materials alone might render intravenous drug use safer without stimulating additional use (see ACMD, 1993, for a fuller discussion).

¹⁴. The vast majority of offenders will have 'grown out of crime' by their mid-30s. Whether this is true of those who are problem drug users is less clear, but the average age of problem drug users attending drug agencies tends to be in the late-20s.

¹⁵. The figure of £2,400 assumes that the offender is on probation, that costs fall equally between medical and probation services, and that methadone itself accounts for half of the medical costs.

¹⁶. The failure of the 'short sharp shock' may reflect the fact that the regime was not experienced by the inmates as tough and demanding but as preferable to the alternatives, such as heavy manual labour and cleaning duties.

¹⁷. New York detention facilities hold sentenced and remand prisoners for up to a year

Drugs misuse and the criminal justice system: a review of the literature

6. CONCLUSIONS

It is clear that drug misuse makes a significant contribution to the overall total of crimes committed in England and Wales. The nature of both drug misuse and crime is such that we should not expect to get accurate and precise estimates, but a substantial minority of crime is likely to be drug-related. The cost to victims of drug-related crime is almost certainly in the order of hundreds of millions of pounds; costs to the criminal justice system are of the same order.

Research has shown that enforcement activities can have some impact on drug markets, which can be disrupted and/or displaced. Whether this actually reduces the demand for illegal drugs is hard to establish conclusively, though the likelihood of 100 per cent displacement is small. Whether dependent drug users can be punished into abstinence is a complex question, not least because punishment often provides opportunities for treatment, making it hard to disentangle the impact of deterrence and treatment.

Research offers some fairly unequivocal pointers about strategies for maximising the chances of successful treatment (whether or not this takes place within the criminal justice system). In general, the best programmes are also the most expensive and time-consuming. To be effective, programmes should aim to:

- get clients into treatment with minimum delay;
- keep them in treatment for as long as possible, and for three months at a minimum;
- provide the option of methadone *maintenance* for dependent opiate users;
- *not* rely on medically supervised detoxification alone.

Positive evaluations have been reported for a range of other types of programme, from therapeutic communities to cognitive-behavioural programmes, self-help groups and other forms of counselling, all of which can yield benefits. Common themes amongst successful programmes are the use of self-help principles and exploiting the experiences of ex-users.

Research also has some clear pointers about the provision of treatment within the *criminal justice system*:

- Coerced treatment appears to be no less effective than voluntary treatment.
- The criminal justice system can effectively coerce people into treatment.
- It can also help keep them there.
- Drug testing provides a technology to make this coercion meaningful.

Thought needs to be given about the best mix of 'sticks and carrots' to keep drug misusers within treatment. One strategy is to 'tolerate no failure'. Some therapeutic communities, for example, have 'drug-free' rules which can result in the expulsion of members who are found smoking cannabis or drinking beer. This strategy may well be effective amongst people whose motivation to stay in treatment is generally high. However, it is most unlikely to be successful with those who have to be coerced into treatment. It is also open to question whether an essentially deterrent strategy is the best one to deploy against drug misusers who are also heavily involved in crime. After all, this group has a proven track record of immunity to deterrent threat.

There may thus be a stronger case for a system of sanctions and incentives which exploits the fact that coerced treatment and its attendant supervision are irksome: failure to comply with a programme should logically result in further or more intensive treatment, rather than its suspension; and good progress can be rewarded in various ways. Russell (1994)

describes a range of US programmes which offer offenders incentives to enter and stay in treatment.

It should be noted here that the Department of Health has established a Task Force to review the effectiveness of treatment services for drug misusers. Its terms of reference are:

'To conduct a comprehensive survey of clinical, operational and cost effectiveness of existing services for drug misusers; to review current policy in relation to the principal objective of assisting drug misusers to achieve and maintain a drug-free state, and the secondary objective of reducing harm caused to themselves and others by those who continue to use drugs; to make recommendations where appropriate and to report to Ministers'.

With the Prison Healthcare Directorate's help the Task force will be looking at the care and treatment of drug misusers in prison. The Task Force report will be submitted to Ministers in early 1996, and will form the basis of advice to purchaser- and provider-agencies to be issued later that year.

Putting treatment research in a criminological context

Perhaps the most striking aspect of the body of research reviewed here is its generally positive tenor. It leaves little doubt that constructive measures can be taken within the criminal justice system to tackle problem drug use. This is in marked contrast to much of the criminological literature on dealing with (non-drug) offenders generally. In the 1970s the prevailing view about the scope for reducing re-offending was severely pessimistic. This pessimism- the view that 'nothing works' - was associated most closely with Martinson (1974), but it was also well established in British thinking (cf Brody, 1976) and continued to exert a strong influence on British penal policy for the following decade.

A careful reading of many of the 'nothing works' texts reveals a degree of over-interpretation; many of the negative findings were tentatively expressed, and often reflected programme rather than theory failure. Some positive findings were quietly ignored by advocates of the 'nothing works' position. The rehabilitation of rehabilitation, which has occurred in this country since the late 1980s, owes a great deal to 'meta-analysis' (see e.g. Whitehead and Lab, 1989; Andrews *et al*, 1990; Lipsey, 1991; and Gendreau and Ross, 1987, for a review). The technique is a way of summarising the results of several different evaluations in a standardised way; it allows for account to be taken not only of evaluations which show strong statistically significant effect, but also of ones which have a positive but statistically non-significant outcome. The rationale is that ten near-significant findings all pointing in the same direction are equally or more compelling than one significant result pointing in the opposite direction.

As a result of this work, the consensus of opinion has now shifted towards the view that interventions which are properly tailored to the needs of specific offenders and properly implemented can achieve some impact. Andrews *et al* have argued that programmes for tackling offending will achieve an impact if they meet three principles - of risk, need and responsivity:

- *Risk*: higher levels of service are best reserved for higher-risk cases (where there is most room for improvement), and low-risk cases are best assigned to minimal service.
- *Need*: treatment needs must be properly identified; treatment should target aspects of offenders' thinking and behaviour which are (a) criminogenic and (b) amenable to change.
- *Responsivity*: the form of treatment needs to be both generally valid and specifically tailored to the learning styles of individual offenders.

Viewed from this perspective, it is little surprise that research has identified plenty of

successes amongst criminal justice strategies for tackling problem drug use: it is easy to see how the principles of risk, need and responsivity can all be met for criminally involved drug misusers; in particular, problem drug users can commit crimes at very high rates, providing plenty of scope for improvement.

Perhaps the only divergence of any significance between the criminological literature and the material covered in this review is that the former has tended to take a more sceptical view about traditional psychotherapeutic approaches, with a clear preference for behavioural and cognitive-behavioural approaches. In contrast, the literature covered by this review includes examples of effective psychotherapeutic programmes.

The reasons for this divergence are not obvious. One possibility that deserves consideration is that the precise content of 'people-changing' theories is not as important as the confidence and clarity of purpose that practitioners can draw from a favoured theory. By implication, it is possible that a theory's potential for energising practitioners may ebb and flow, for reasons more connected with intellectual and professional fashion than with the theory's intrinsic coherence. The point should not be laboured: a firmly grounded theory should be a better guide to action than a shaky one, however seductive. Nevertheless, evaluations have focused over-heavily on identifying the best types of theory (or programme); they have consistently ignored that important set of issues to do with individual differences in staff effectiveness and with the interactions between programmes, personalities and practitioners' professional self-confidence. The role of management support in sustaining a positive and motivated workforce has received equally little attention.

This digression into the criminological literature is important, in that it shows how susceptible research can be to interpretation and re-interpretation in accordance with the intellectual and political imperatives of the day. A sceptic might argue that the current optimism about the scope for reducing reoffending in general, and more specifically about reducing drug-related offending, simply reflects the swing of fashion's pendulum. A more optimistic - and sustainable - view is that there has been a genuine maturing of social research. Taking the research on tackling problem drug use together with criminological research on reducing reoffending, some very general lessons about the prerequisites for effective intervention can be safely drawn. These prerequisites include:

- high-quality, motivated staff;
- a coherent treatment theory;
- enthusiastic and confident implementation of the treatment programme;
- proper targeting of intervention efforts;
- effective management leadership and support.

Ethical issues

In identifying the scope for effective coerced treatment, this review inevitably raises issues about the ethics of coerced treatment. These are complex. An important principle, well expressed by Morris and Howard (1964), is that 'power over a criminal's life should not be taken in excess of that which would be taken were his reform not considered one of our purposes'. This implies that offenders should not, as a result of opting for treatment, end up with a heavier sentence than they would otherwise have received (for example, as a result of breach proceedings). One might further safeguard offenders' rights by allowing them, once in treatment, to opt out in preference for a conventional punishment proportionate to their crime. (Whether and how such provisions could be incorporated within the existing statutory framework is another matter.) It is easy to see how drug testing might form part of a treatment package in which these principles are observed; the issues are more complex when drug testing serves as a form of surveillance independent of any treatment.

A complicating factor is that the different types of treatment may be effective (to a greater

or lesser extent) for different types of offender. Coercing a drug misuser into inappropriate treatment can arguably be regarded as a miscarriage of justice. Clearly the acceptability of coerced treatment increases with the ability to match offenders to appropriate programmes.

Coercion and confidentiality have an uncomfortable relationship with one another. Where a client freely chooses treatment, the obligations of the treatment agency are largely but not exclusively to the client, who can expect confidential treatment - with a few rare exceptions.

Where the client is coerced into treatment by a court as a condition of probation, the treatment providers are, arguably, as accountable to the court as to the client. This accountability is not easily reconciled with current working practice: disclosure by drug workers to probation officers of clients' attendance records or drug tests is one area in which difficult issues arise.

Cost-effectiveness

This review has produced ample evidence that treatment can achieve some impact, but little firm evidence about cost-effectiveness. In an economic climate which severely limits the scope for extra resources, money for new treatment programmes is unlikely to be found unless their cost-effectiveness can be demonstrated. The limited work in the United States is encouraging. As was seen in Chapter 4, the benefits of methadone maintenance programmes have been estimated to be double the costs. Two recent US studies estimate an even higher rate of return: that every dollar invested in treatment yields \$7 worth of benefits (Rydell and Everingham, 1994; Gerstein *et al*, 1994). Rydell and Everingham, who looked only at programmes for cocaine users, found that treatment programmes easily achieved break-even savings, unlike other strategies for reducing the demand for, or the supply of, cocaine. Figures 2 and 3 summarise their results. (The horizontal line in Figure 3 shows the point at which investment in a specific strategy breaks even.)

In assessing cost-effectiveness it is essential to estimate not only the benefits accruing from the long-term impact of treatment but also the short-run benefits during treatment. A consistent finding is that the sharpest reductions in drug-related offending are achieved in the course of treatment. Even where a drug misuser reverts after treatment to pre-treatment levels of offending, the treatment may still have been cost-effective. Rydell and Everingham's (1994) research found that treatment programmes aimed at cocaine users were 80 per cent successful in keeping users cocaine-free for the duration of the programme: given the offending rates of many dependent users, programmes may pay for themselves simply in terms of immediate savings to the criminal justice system.

Getting treatment to fit better within the criminal justice system: multi-agency work

Getting treatment to fit better within the criminal justice system is no easy task. The need for effective inter-agency work in tackling drug misuse has been well reviewed by Howard *et al*, (1993); SCODA has recently published a practical guide to forming partnerships between the probation service and drug agencies. A strategy for improving inter-agency collaboration is set out in the White Paper, *Tackling Drugs Together* (Lord President, 1995). Problems will certainly be encountered in forging inter-agency links. The main obstacles to collaboration between the criminal justice system and other agencies that can be anticipated are conflicts over *goals* and over *resources*.

Figure 2: Cost of decreasing cocaine consumption by 1 percent with alternative cocaine-control programs

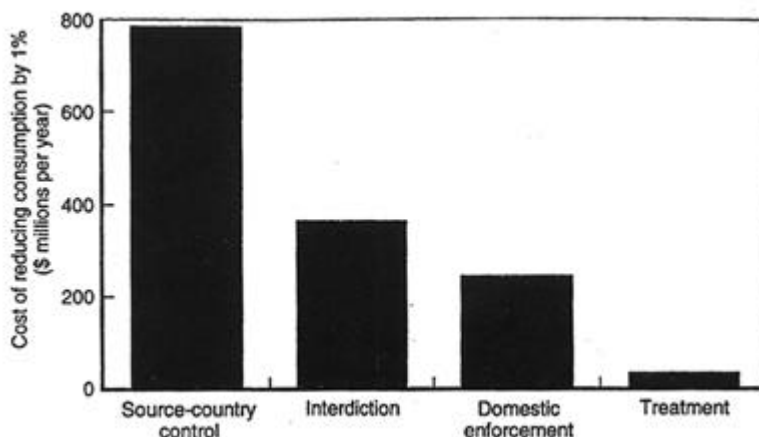
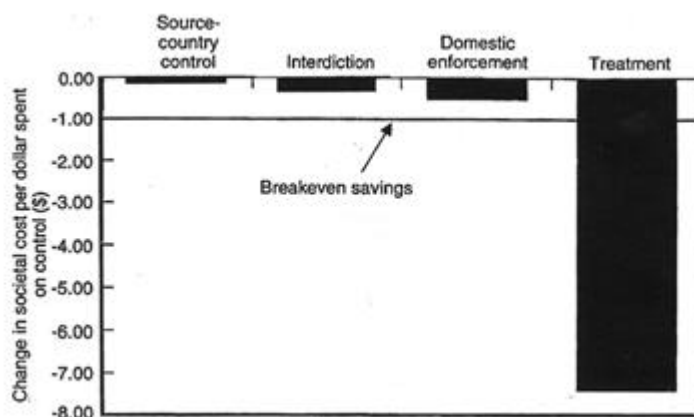


Figure 3: Savings in societal costs of crime and lost productivity due to cocaine use per dollar spent on a control program



Conflicting goals

The most obvious source of conflict over organisational goals arises from strategies of harm reduction or minimisation. The label of harm reduction is applied to a variety of treatment strategies, mostly based on the view that it makes sense to go one step at a time: that injecting with clean needles is better than injecting using shared needles; that smoking heroin is better than injecting it; that smoking cannabis is better than smoking heroin, and so on.

Harm reduction principles have now been widely adopted within health care and welfare services. Indeed, the risks to drug users associated with HIV and AIDS have made harm reduction a priority. However, these principles are not so transparent to the criminal justice system; and the difficulties posed by harm reduction strategies within the criminal justice system are real ones. The criminal law is framed in moral language; it is infused with concepts of right and wrong. As a result it is not well equipped to deal with half-rights and half-wrongs.

The particular dilemma facing probation officers is whether to turn a blind eye to the residual illegal behaviour that remains when they have succeeded in getting clients to reduce the level or risk of their illegal drug-taking. Similar if not greater problems are posed within prisons, as closed institutions: how much cannabis use can a prison officer properly

ignore, for example, even if its use can displace the injection of heroin?

Conflicts over resources

It is a feature of working with drug misusers that treatment skills (and limited resources) are diffused throughout the health service, social services departments, voluntary agencies and the criminal justice system. The decisions of one part of the system very often result in expenditure of other agencies' money. Agencies at the front end of the criminal justice system naturally tend to place greater priority on their own resources than those belonging to agencies further down the process; they will spend others' money readily and their own with reluctance. This makes inter-agency work a priority. For example, one of the perennial difficulties in getting people into treatment and keeping them there is shortage of money. Waiting lists are the obvious consequence: they are rationing devices which occur when demand exceeds supply. They can be inefficient rationing devices: the people who drop out during the wait may well be those in most need of help. The alternatives to waiting lists are extra resources or more stringent criteria for treatment eligibility. In the absence of the former, development of the latter can be done only through effective inter-agency work.

Research has been better at identifying the pitfalls of inter-agency work than the solutions, but key features of successful partnership (cf Howard *et al*, 1993) are:

- clear terms of reference and mutual expectations;
 - equal partnership rather than single-agency domination;
 - adequate resourcing of co-ordination machinery;
 - getting representation at the right level across all represented agencies.
 - evaluation and accountability.
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