‘Why should we imprison: are there viable alternatives for dealing with drug-dependent offenders?’

Results from the ‘QCT Europe’ study

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What I want to do

- Background & rationale for the study
- Outline the study's aims and methods
- Tell you about the people we interviewed
- Present our main findings
- Highlight some possible caveats
- Offer our conclusions & pointers for policy

Does treatment 'work'?

- Growing enthusiasm and evidence base that it does:
  - Drug Abuse Reporting Programme (DARP)
  - Treatment Outcome Prospective Study (TOPS)
  - Drug Abuse Treatment Outcome Study (DATOS)
  - National Treatment Outcome Research Study (NTORS)
- Prendergast (2002) conducted a meta-analysis of 78 US studies conducted between 1965-1996 and found that:
  - drug treatment has both a statistically significant and clinically meaningful effect in reducing drug use and crime
  - produces measurable and significant changes in drug use and other behaviours compared to no treatment or minimal treatment.

Does treatment 'work'?

- Reductions in crime were among the most striking findings from NTORS (Gossop, 2005)
- Findings suggest that well resourced, appropriately designed and targeted treatment is:
  - effective in reducing (but not always eliminating) drug use and criminality; and
  - leads to better health, less risky behaviour and improved psychological wellbeing
- Described drug dependency as a 'chronic relapsing condition' with most users requiring several attempts at treatment.

The need for realistic expectations

- Treatment isn't a panacea
- 126,000 people accessed structured treatment in England during 2003/04
- Despite considerable investment in recent years - 71% failed to complete treatment
- But completion rates for CJ referrals (26%) were comparable with the national average (29%)
- No ***one*** treatment approach is suitable for ***all*** drug users

The need for realistic expectations

- But neither are CJ responses – two-year reconviction rates for England & Wales:
  - Prisoners (65%)
  - Probationers (51%)
  - Drug using offenders in treatment (74%)
  - Drug misusers supervised by the correctional services (74%)
  - Prolific users sentenced to QCT (82%)
- But reconviction is a crude measure:
  - It doesn't take into account the characteristics of offenders
  - Is insensitive to reductions in the frequency of offending

Rationale for the current study

- Rising prison population – large proportion drug-related.
- Relative ineffectiveness of other sanctions in deterring drug use and related crime.
- Community-based treatment more cost effective than imprisonment and have fewer adverse effects.
- Only need to affect behaviour of a few to be cost-effective:
  - ***SEU re-convicting ex-prisoners cost £65,000 (ISK 8.3m)***
  - ***NPD average DTTO costs £6,000 (ISK 763,000).***

The study's aims

- Four main hypotheses derived from a review of the international (including non-English language) research literature (Stevens *et al.*, 2005):

1. That 'coerced' treatment delivers reductions in drug use and offending behaviours, and improvements in health and social functioning.
2. That 'voluntary' treatment does the same.
3. That the 'coerced' group has better retention in treatment than the comparison group of 'volunteers'.
4. That the 'coerced' group has different drug use and offending outcomes than the comparison group.

Our methods

- 'QCT' – treatment motivated, ordered or supervised by the CJS but outside of prisons.
- Parallel studies in Austria, England, Germany, Italy and Switzerland.
- Sampled from 65 purposively selected treatment centres between June 2003 and May 2004.
- 845 people questioned using EuropASI at 4 intervals.
- 84 health and criminal justice professionals.
- In-depth interviews with 138 subject to QCT.

Those we interviewed (N=845)

- 428 (51%) were in treatment as part of QCT.
- Most (82%) were male - average age 31 years.
- 93% described themselves as 'White'.
- 68% left school without formal qualifications.
- 38% had been mainly unemployed during the previous 3 years.
- Half (429) experienced serious depression and anxiety in the past month.
- 'Volunteers' tended to report worse mental health problems.

Those we interviewed (N=845)

- Most (87%) had previously been treated for drug dependency.
- Many of those that had been in treatment (72%) attained abstinence for a time as a result.
- No difference in previous exposure to treatment between QCT and 'volunteers'.
- Main illicit drugs of abuse included heroin (36%), crack/cocaine (20%), poly-use (23%)
- Over half (53%) were current injectors - of whom 30% shared equipment.
- Three-fifths (58%) accessed residential treatment at intake.

Those we interviewed (N=845)

- Most received QCT for drug dealing (39%), theft (34%) or burglary (19%) offences.
- Were those receiving QCT more difficult to retain in treatment? At intake, they were:
  - ***more likely to be male (p<0.01),***
  - ***using illicit drugs more frequently (p<0.01),***
  - ***injecting more (p<0.05), and***
  - ***more criminally active (p<0.001).***
- Perhaps more to be gained if these people could be encouraged to stay and succeed in treatment?

About the role of coercion

- Across the entire *'QCT Europe'* sample of 845 respondents:
  - *65% of the 'volunteers' reported some external pressure or duress to enter treatment*
  - *22% of the QCT group reported experiencing no such pressures.*
- There is a link between legal status and perceived pressure but this does not reduce people's motivation to change (Stevens *et al.,* 2006).
- People reported feeling less coercion during follow-up than at intake.

Our key findings

- Significant and sustained reductions in reported illicit drug use and offending behaviours by QCT and 'voluntary' client groups.
- Improvements in physical and psychological health and social integration reported by both groups.
- Substantial falls in the reported frequency of injecting drugs and of sharing injecting equipment.
- No significant difference in treatment retention rates.
- More improvement observed among the QCT group - reflecting their poor prognosis at intake.

Our key findings

- Provision (setting, duration, % of court-ordered clients, staff/client ratio) and outcomes differed across countries, sites and treatment institutions.
- The most significant overall predictor of a reduction in substance use was the treatment service attended.
- The highest rates of reduction were apparent among those who received in-patient treatment.
- Those still in treatment reported significantly less illicit drug use and criminality in comparison to those out of treatment.

Some caveats and limitations

- Sampling and response bias
  - *77% the people offered treatment across the 65 sites were interviewed.*
  - *Response rates 68% (t2), 58% (t3) and 53% (t4). But 74% were re-interviewed at least once post-admission.*
- Relies on self-reports of behaviour
  - *But shown to be reliable in other studies involving offenders (Farrall, 2005) and drug users (Gossop et al., 2006).*
- The possibility of a 'spontaneous improvement effect'
  - *Exactly how much of the change is attributable to formal intervention? Are treatment effects cumulative?*

Conclusions

- 'Coerced' treatment can be effective in reducing substance use, risk and offending behaviours, and improving social integration through employment.
- 'Coerced' treatment can be as effective as 'voluntary' treatment (if received in the same treatment services).
- The message is not that 'coercion works', but that treatment can be a viable alternative to imprisonment:
  - *community-based treatment alternatives are a more cost effective approach and have fewer detrimental effects;*
  - *most problem drug users fail to sustain behaviour changes made while in custody on release.*

Conclusions

- More attention needs to be focussed on issues of treatment process and coordination to enhance outcomes for the individual and wider community. Scope for:
  - *Refining referral and assessment processes;*
  - *Providing appropriate, responsive treatment options in a timely manner (more focus on stimulant users, women, young people and BME groups);*
  - *Offering consistency around procedures for drug testing, court/status reviews and enforcing QCT conditions; and*
  - *Ensuring effective arrangements for aftercare and reintegration are in place.*

Pointers for policy & practice

Ethical considerations:

- Observe the principles of distributive justice
- Important to distinguish between coercive and compulsory forms of treatment
- There must be opt-outs
- Participation in proven treatment that meets the needs of different user types
- Principles of proportionality - not too intrusive or excessive
- Ensure appropriate/graduated responses to inevitable lapses
- Educate the public & stakeholders about the 'chronic relapsing nature' of dependency. Prepare for high attrition rates

Pointers for policy & practice

Practical considerations:

- Clarify treatment objectives (harm reduction or abstinence)
- System capacity and funding (Is QCT feasible? Can current systems cope?)
- Targeting and identifying those most likely to benefit
- Promoting and monitoring compliance (drug testing and reviews)
- Ability to sustain partnerships (knowledge, capacity & commitment)
- Ensuring effective integrated support (housing, ETE, mental health)
- Monitoring and evaluation (not an added extra)

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Further details of the Institute for Criminal Policy Research are available at:
www.kcl.ac.uk/icpr

For more information about the '*QCT Europe'* study visit:
www.kent.ac.uk/eiss/qct/index.htm