NHS
National Treatment Agency
for Substance Misuse

Breaking the link

The role of drug treatment in tackling crime

EFFECTIVE TREATMENT
CHANGING LIVES

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The National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

The NTA works in partnership with national, regional and local agencies to:

- Ensure the efficient use of public funding to support effective, appropriate and accessible local services
- Promote evidence-based and coordinated practice, by distilling and disseminating best practice
- Improve performance by developing standards for treatment, promoting user and carer involvement, and expanding and developing the drug treatment workforce
- Monitor and develop the effectiveness of treatment.

The NTA has led the successful delivery of the Department of Health's targets to:

- Double the number of people in treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

The NTA is in the frontline of a cross-government drive to reduce the harm caused by drugs. Its task is to improve the quality of treatment in order to maximise the benefit to individuals, families and communities. Going forward, the NTA will be judged against its ability to deliver better treatment and outcomes for a diverse range of drug misusers.

Breaking the link
The role of drug treatment in tackling crime

The relationship between problem drug use and crime is complex. Even so, all the evidence indicates that problem drug users *are* responsible for a large percentage of acquisitive crime, such as shoplifting and burglary.

As a direct consequence of the crime they commit, these problem drug users are highly likely to end up in the criminal justice system at some point. Some will serve community sentences, others will be sent to prison. In either case, the criminal justice system now compels them to confront their drug problems.

Drug treatment for offenders in the community has improved enormously over the past decade, in terms of availability and quality. Prisons are now catching up, with the introduction of a new treatment regime – the Integrated Drug Treatment System (IDTS).

The NTA is now responsible for implementing IDTS in prisons, and this report, in part, looks at the progress that has been made so far.

Prisons are logical places to engage problem drug users in effective treatment. The aim is to break the link between their drug use and criminal behaviour, so that they don't reoffend on release and have the opportunity to recover and reintegrate with society. In this way, effective treatment can liberate them, their families, and the communities that suffer as a result of drug-related crime.

Drug treatment has been available in prisons for some time, but this is the first time there will be an evidence-based, individual-focused system offering consistent treatment in all prisons in England.

IDTS seeks to ensure that problem drug users in prisons have access to the same quality of treatment as those in the community, and the same chance to rebuild their lives. This report is therefore about the positive impact drug treatment can have towards reducing crime, cutting the cost of drug-related harm to society, and making communities safer for everyone.

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1. What is the link between drugs and crime?

"I have tried to stop taking drugs before and always failed. But this time I've had a lot of help from my drugs worker. We've set goals and I've been working hard. I've stayed out of prison for nearly a year and haven't offended in that time. I have also repaired the relationship with my family and I am managing to cook for myself and pay my bills."

MS, ex-prisoner

The nature of the problem

Crime and drugs are inextricably linked. Anyone who sells, buys and uses drugs such as heroin, cocaine and cannabis is breaking the law. The crimes they commit fall into three main areas.

The first is possession, including for personal use, and supply under the Misuse of Drugs Act. The second is the violence and intimidation committed by organised criminals fighting for territory in the illicit drug trade.

The third is acquisitive crime committed by people whose drug use has become an addiction. Their offending often escalates to keep up with the rising cost of their drug use. Estimates suggest that drug addicts commit between a third and a half of all acquisitive crime[1]. Some also support their use via low-level dealing or prostitution.

These distinct types of offences are easily confused. Only possession, supply and importing are recorded as 'drug offences', so any rise or fall in 'drug crime' says more about the policing response to recreational drug use (typically intermittent cannabis use) than it does about the greater threat of addiction-driven acquisitive crime that communities face.

Since 1995, successive governments have recognised the vital role drug treatment has to play in breaking the link between addiction and crime. Treatment can't deal with the gangs who control the drugs, and is irrelevant to non-dependent drug users, who use recreationally for a few years but stop without experiencing physical or psychological withdrawal. But it can help those who are dependent on drugs.

About 330,000 individuals in England are dependent on heroin and/or crack cocaine[2]. Many of these pay for their drugs through crime. It is estimated that the crimes they commit cost society £13.9bn a year[3]. Treatment can help these people to control and eventually overcome their addiction, and so break the link between their drug use and crime.

Drug misusing offenders typically first commit crime in their early teens, well before they become addicts. They begin using cannabis and alcohol in their mid-teens, and it becomes integral to their lifestyles. In their late teens cocaine and heroin are introduced. Dependency tends to develop in the early to mid-20s. At that point, the offending that has always been part of the individual's life can escalate dramatically. Addiction and crime also feed on unemployment, homelessness and mental illness.

Drug misusing offenders often describe their lives as a constant search for criminal opportunities. They shoplift, break into property, and steal from cars. Then they buy drugs, use them and are soon back on the streets looking for more opportunities to pay for the next hit. Under drug dependency, their part-time offending becomes a full-time occupation.

The activity of these people can have a significant impact on local crime figures. The police often trace mini crime waves back to individual offenders. Their

arrest and imprisonment gives communities respite. But few drug misusing offenders commit crimes serious enough to keep them in prison for long, and when their addiction remains untreated they quickly return to offending on release.

To tackle this, the authorities now identify drug misusing offenders as they enter the criminal justice system – on arrest, sentence, or arrival at prison – and provide access to treatment, either on a voluntary basis or enforced through court orders.

We estimate that at least a quarter of the 188,000 adults in contact with community treatment services in 2008[4] were identified via the criminal justice system.

Further estimates suggest around 65,000 offenders receive some form of drug treatment in prisons each year[5]. There is some overlap between these groups, because a proportion of drug misusing offenders receive treatment in the community and in prison.

Although treatment typically takes many years to help an individual overcome addiction, it has an immediate impact on their offending. Heroin users who are in treatment and prescribed methadone show a dramatic and sustained reduction in their criminality. Evidence shows that overall their offending halves when in treatment, reducing the harm they cause to themselves, their families, communities and wider society. Up to half stop offending entirely.

The scale of the problem

- Each year, 75,000 problem drug users enter the prison system[6]
- 16% of all problem drug users are in prison at any one time[7]
- On average, 55% of prisoners are problem drug users[8]
- A third of all suicides in prison are committed during the first week of imprisonment; this rises to two thirds for suicides among prisoners who are drug dependent[9]
- On release from prison, drug misusers are especially vulnerable to death from overdose – and the risk for women is double that for men[10]

CASE STUDY: MS's story

"I was addicted to heroin and crack cocaine for 10 years. I'm 28 now and started using drugs when I was 14 – cannabis, speed and ecstasy with alcohol. It started at weekends only but soon it was every night and during the day. As I got older I moved on to crack and committing crime to pay for it, mostly burglaries and shoplifting. It meant I could afford more drugs and more often.

"I would get caught and be sent to prison, but I'd be using again on the day I got out. The crack and heroin became my life. I was given Prolific Offender status but this didn't stop me – I was totally focused on the buzz of my drug use. During this time my family disowned me. I was moving around, sofa surfing with friends.

"I have tried to stop taking drugs before and always failed. But this time I have had a lot of help from my drugs worker. He has shown a lot of faith in me. We've set some goals and I've been working very hard. I have managed to stay out of prison for nearly a year and I haven't offended in that time either. I have also repaired the relationship with my family and I am managing to cook for myself and pay my bills.

"At last it feels like I'm living a proper life. This Christmas for the first time in years I had dinner at my dad's with the rest of my family and it felt brilliant."

Our thanks to CRI for putting us in contact with MS

Why it's everybody's problem

As a society, we tend to have a mixed attitude towards occasional recreational drug use.

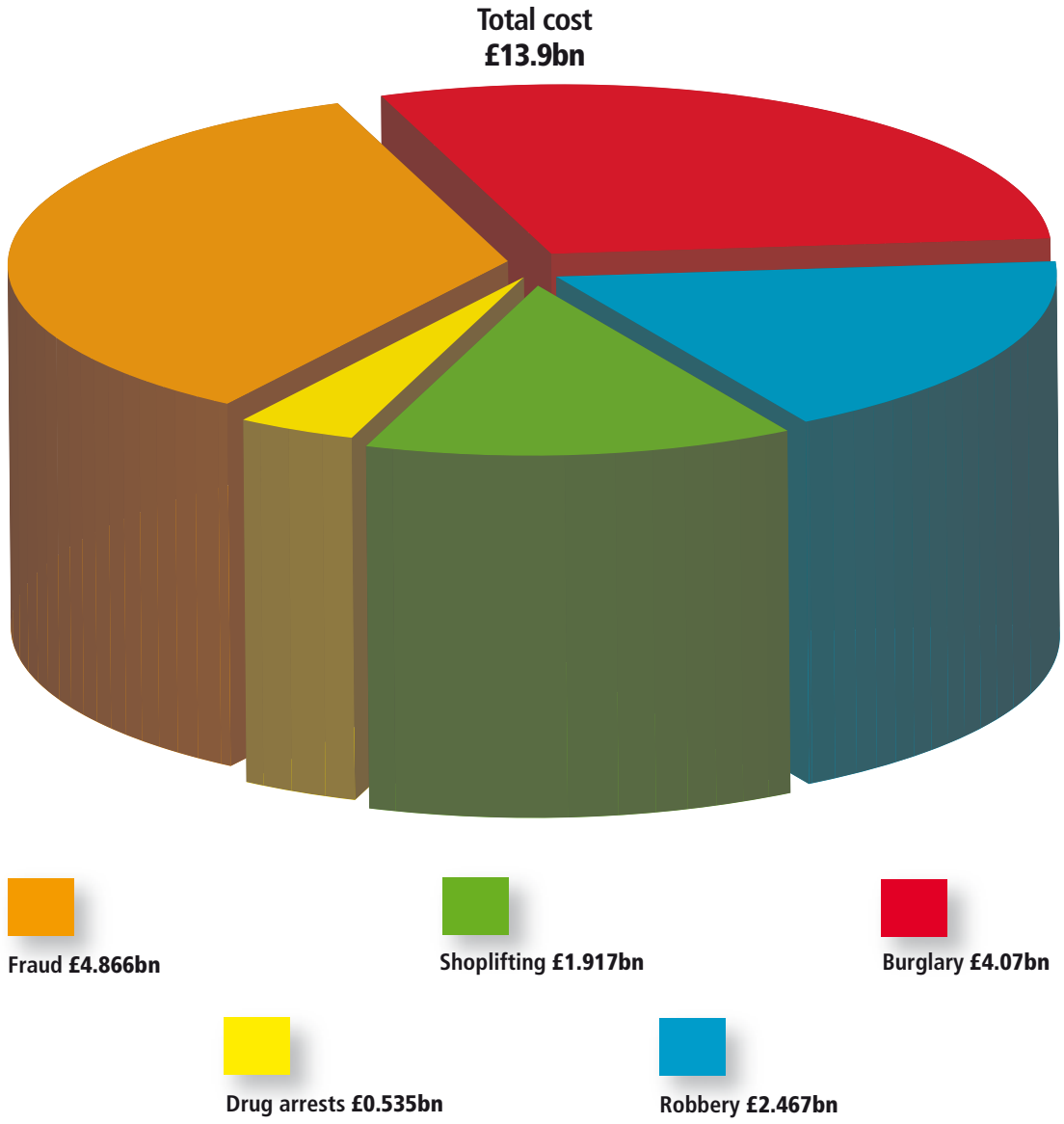
But nobody can afford to ignore the regular criminal activity of a minority of problem drug users, because it has an impact on us all:

- **If you are a taxpayer** you will pick up part of the annual £15.4bn bill for the crime and health costs generated by people buying and using Class A drugs such as heroin and crack[11]
- **If you are a victim of crime** there is a strong chance it will be drug-related. Estimates suggest that between a third and a half of all acquisitive crime (shoplifting, burglary, vehicle crime, robbery, etc) is drug-related. Around three-quarters of heroin and crack users say they commit crime to fund their habit[12]
- **The community you live in** can be badly affected in a number of ways, from the antisocial behaviour associated with drug dealing, the activities of those under the influence of drugs (including discarded needles), the violence associated with organised crime, and prostitution.

Getting to grips with drug-related crime is a high priority for the government. Illegal drugs not only harm the health of those who misuse them, they also hurt their families, children and friends. The crime and antisocial behaviour associated with drugs cause misery to the victims, and put enormous pressure on the economy.

Leaving offenders with drug problems to their own devices is not an option. It does not serve them, their families or the rest of society. Instead, confronting and tackling problem drug use among offenders can save lives, make communities safer and protect the public from harm.

Figure 1: A breakdown of the cost of drug-related crime



Drug users are estimated to commit between a third and half of all acquisitive crime, which is a substantial proportion of the total number of crimes committed. Some users will have been offenders before becoming problem drug users. But once dependent, funding a serious habit is expensive and can increase offending.

Source: the economic and social costs of Class A drug use in England and Wales, 2003-04 in *Measuring different aspects of problem drug use: methodological developments*, Home Office online report 16/06; BCS 2007

2. What can we do about drugs and crime?

"For some people, a spell in prison is an opportunity. Their lifestyle is a constant cycle of crime and drugs, and they really are at the end of the line. Coming into prison today can be a release from all that."

Debbie Millar, IDTS nurse manager

How do we know that treatment is effective?

A key aim of treating problem drug users is to break the link between drugs and crime, to help them make a long-term recovery, and to assist their reintegration with society. Effective treatment will also benefit the public by reducing the impact problem drug use has on so many communities.

There is plenty of evidence to show that getting offenders into effective treatment while they are in the criminal justice system, serving either community or prison sentences, can indeed reduce subsequent drug-related offending.

The National Treatment Outcome Research Study (NTORS), a UK-based study carried out between 1995 and 2000, followed more than 1,000 problem drug users through treatment and measured their progress against a range of substance misuse, health and crime markers. It recorded significant reductions in offending, with rates of acquisitive crime falling by half at the one-year point. These improvements were maintained at various follow-up points.

NTORS has been a key driver behind the development of treatment services within the criminal justice system. Findings based on the study concluded that every pound spent on drug treatment saved significantly more on the economic, health and social costs associated with drug misuse.

More recent evidence from the National Institute for Health and Clinical Excellence (NICE) suggests the health and crime cost of each injecting drug user is £480,000 over a lifetime, while other studies[1] have shown that the average amount offenders spent on drugs fell from £400 a week at the start of treatment to £25 a week at the follow-up stage.

What other evidence is there?

A criticism of the evidence supporting the positive impact of treatment on crime is that it is often based on offenders' self-reporting.

To overcome this, the NTA commissioned a study in 2008 to match data from the Police National Computer (PNC) with the National Drug Treatment Monitoring System (NDTMS) database on a sample of opiate and crack users who had recently offended but had not been jailed and had started treatment in the community. The number of offences they committed almost halved following the start of treatment (as shown in figures 2 and 3), results that were in line with other studies.

There is also a long-standing assumption that criminal-based interventions are ineffective because offenders are less likely to succeed in treatment when they feel coerced or fear that a refusal would lead to imprisonment. A series of studies have refuted this, showing that criminal justice referrals to treatment can be at least as effective as 'voluntary' referrals.

Latest NDTMS data suggests that staff working in the criminal justice system refer 27% of all new drug treatment cases in England.

Figure 2: Total number of charges against problem drug users before and after treatment

Offence group	Number of charges		% difference
	Year before	Year after	
Criminal or malicious damage	97	24	– 75%
Drugs (possession and small-scale supply; import, export, production or supply)	505	149	– 70%
Fraud and forgery; handling	366	123	– 66%
Drink driving offences; taking and driving away and related offences; other motoring offences	509	185	– 63%
Soliciting or prostitution	83	31	– 62%
Violence; public order or riot; robbery	455	215	– 53%
Theft (including shoplifting); theft from vehicles	1,252	635	– 49%
Burglary (domestic and other)	97	68	– 29%
Absconding or bail offences; breach of an order	942	807	– 14%
Other	66	16	– 75%
Total	**4,372**	**2,253**	**– 48%**

Source: the number of charges (all offence types) brought against a group of 1,476 problem drug users in the year before and the year after starting prescribing treatment – from *Changes in offending following prescribing treatment for drug misuse*, NTA November 2008

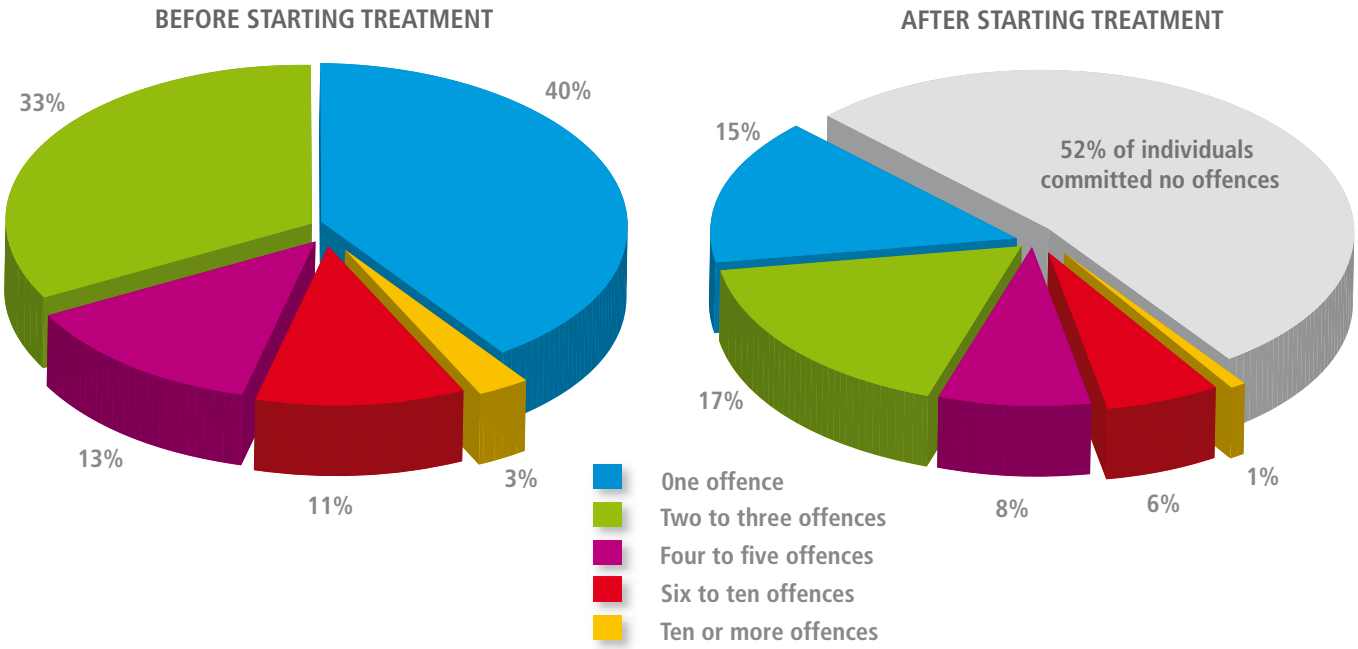
What is the public policy?

The results from NTORS and other studies convinced policy makers that treatment in the criminal justice system, whether in the community or in prison, can be highly effective.

This in turn led to significant new investment from the Home Office and Department of Health for treatments that targeted drug misusing offenders at every stage of the criminal justice system. These included the development of major initiatives such as the Drug Interventions Programme (DIP), Drug Rehabilitation Requirement (DRR) in the community, and the Integrated Drug Treatment System (IDTS) in prison.

Given the benefits to be gained from ensuring offenders receive effective treatment for problem drug use, the government also made a commitment in its 2008 national drug strategy to tackle drug-related offending by targeting the problem drug users who commit the most crime (for example, via Prolific and other Priority Offender schemes, which were set up in 2004 to tackle the offenders, including problem drug users, who cause most damage to local communities). As part of this, the government is looking to improve drug treatment in prisons and to promote community sentences that have a DRR.

Figure 3: Number of charges against individual problem drug users before and after starting treatment



The number of charges (all offence types) brought against individual problem drug users (sample of 1,476) in the year before and the year after starting prescribing treatment – from *Changes in offending following prescribing treatment for drug misuse*, NTA November 2008

What help do women need?

Women present a series of unique challenges to the drug treatment regimes in the criminal justice system.

Estimates suggest 60-70% of women who enter prison have drug problems[2]. Allied to this, they present a range of other health and social needs. They are more likely to self harm than men, have higher rates of attempted suicide, and are more likely to suffer drug-related deaths in prison and just after release. Many women who arrive in prison are also pregnant or have dependent children, and may be held in establishments far away from their families.

Against this, evidence suggests that women are more likely than men to seek treatment for problem drug use, and earlier in their drug-taking careers.

Research also shows that women do better in terms of staying in drug treatment and completing it.

The introduction of IDTS in prisons, working alongside existing drug treatment such as short duration programmes and an initiative that addresses substance-related offending, will help ensure that women have access to effective and consistent treatment that takes into account their wider health and social needs. It will also mean that appropriate support is usually available to them when they return to the community.

CASE STUDY: Debbie Millar, IDTS nurse manager, HMP Eastwood Park, Gloucestershire

"I think drug misusers would say that treatment services in prison are good these days. When they come here, they know they're going to get a good level of service. It has certainly become easier for us to help them access treatment.

"Most of the women who come here want to get clean. Once we get them stabilised and comfortable, we can concentrate on the psychosocial aspects – the clinical and psychosocial teams work closely here.

"Each prisoner we work with has an appointed drug worker, and as well as this one-to-one attention they do extensive and intensive group work as part of IDTS, on subjects such as harm reduction, safety and overdose.

"The degree of treatment varies from person to person. I'd class visits to the gym as part of a treatment plan for some women. For those who are particularly problematic, treatment can be a huge part of their waking day.

"Importantly, we now offer wraparound care. We are a remand prison where the average stay is 49 days, so follow-through care is vital. To this end, we now have strong relationships with our community partners.

"When I started here nearly six years ago, some prisoners would arrive in a dreadful state and they'd leave here in the same condition. Things have turned around. Now, for some people, a spell in prison is an opportunity. Their lifestyle is a constant cycle of crime and drugs, and they really are at the end of the line. Coming into prison today can be a release from all that."

3. What are we doing about drugs and crime?

"Looking visibly better than I had seen him previously, the prisoner told me he was engaging with the IDTS unit and that it was the best thing that's happened to him. He said it was the first time in a long while he hadn't been in debt for drugs or fallen in with the gang culture."

Bryan McMillan, prison IDTS governor

Benefits for individuals and public health

The aim of treating offenders is to reduce drug-related crime and to give them the opportunity and resources they need to reintegrate successfully with society.

The way to achieve this is to engage them in relevant and effective treatment at every stage of the criminal justice system, including prisons. A number of programmes and processes have been introduced in recent years to do just this. All these initiatives have slightly different jobs to do, but their collective strategy is to identify potential problem drug users, test them, assess them, and then give them the treatment that could make all the difference.

A recent and significant development in this area is IDTS, the Integrated Drug Treatment System in prisons. The aim of IDTS is to introduce a consistent, evidence-based treatment system throughout prisons in England. Ultimately, this means every prisoner with a drug problem will have access to effective treatment, giving them all an equal opportunity to break their habit and its related behaviour.

IDTS was launched in 2006 to expand the quantity and quality of drug treatment in prisons. Given the link between problem drug use and crime, and the concentration of problem drug users in prisons, it has enormous potential for individuals and society alike. The NTA took responsibility for project managing the roll-out of IDTS in April 2008, working alongside the National Offender Management Service (NOMS), the Ministry of Justice, the Department of Health and a range of regional stakeholders. The project is due to be completed in 2011.

About the figures
Until now there has been no single source of data on drug treatment for offenders. NOMS, NDTMS and DIP have all collected data separately. The situation will become clearer, as from April 2009 the NTA began recording prison-based drug treatment for NDTMS. The first count of the total numbers of prisoners in structured drug treatment should be available in the 2009-10 annual statistics.

Working in prisons, the objectives of IDTS are to provide:

- Better treatment for offenders, with a range of effective needs-based treatment and realistic opportunities, including the option to become drug free
- Improved clinical management, with opioid stabilisation and more maintenance prescriptions where appropriate
- Intensive psychosocial support during the first 28 days of clinical management for all patients
- Greater integration of treatment generally, with an emphasis on clinicians and drugs workers creating multidisciplinary teams
- Better targeted treatment to match individual needs, and strengthened links to community services including Primary Care Trusts, drugs workers, and treatment providers.

IDTS also works closely with DIP, which covers treatment in the wider criminal justice system and community, and aims to ensure that offenders receive seamless support and are kept in treatment even after release, when relapse becomes more of a threat. IDTS is becoming the primary drug treatment regime in more and more prisons, and is already having an impact in those where it is operating:

IDTS roll-out to England's 130 prisons (cumulative):

1st wave implemented 2006-07	3
2nd wave implemented 2007-08	25
3rd wave implemented 2008-09	76
4th wave implemented 2009-10	130

Prisoners starting drug treatment in the first 53 IDTS prisons, 2008-09[1]:

Admissions to prison

96,780

Admissions to treatment

25,076

These figures reveal that, even partway through its introduction, IDTS is already engaging significant numbers of problem drug users in structured treatment. As the roll out continues, the data collected will be more widespread and robust, providing a much better picture of the number and sort of offenders being engaged, and just how effective that treatment is.

Working through the criminal justice system

Drug Interventions Programme (DIP)

The government introduced DIP in 2003 as a key part of its strategy for tackling drugs and reducing crime via the criminal justice system.

It brings together a range of agencies including the police, courts, prison and probation services, treatment providers, government departments and Drug Action Teams (DATs). They work together to provide tailored treatment for offenders with drug problems, and ensure those who are reluctant to take responsibility for their behaviour face tough choices.

A number of other initiatives operate under DIP, including Test on Arrest, Required Assessment and Restrictions on Bail.

More than £600m of funding in the past five years has ensured its processes have become the established way of engaging and working with offenders at every stage of the criminal justice system, creating an end-to-end support structure. This has been highly successful:

- Every week, around 1,000 drug-misusing offenders are referred to CJITs or some form of treatment via DIP[2]
- Home Office research that followed a group of 7,727 drug misusers referred to treatment through DIP found that around half of them showed a 79% decline in offending during the subsequent six months[3]
- The same research found that the overall volume of offending among the group was 26% lower following DIP indentification.

DIP community-based initiatives

TEST ON ARREST

Any adult arrested for a specific offence, such as robbery or burglary, in a DIP high-crime area can be tested for heroin and cocaine. It's a way of identifying offenders with problem drug use at an early stage, regardless of whether they are charged. Data shows around a third test positive for Class A drugs.

REQUIRED ASSESSMENT

When an adult tests positive for heroin or cocaine the police can require them to attend up to two assessments with a drug worker. Failing to attend and remain at the assessment is a criminal offence.

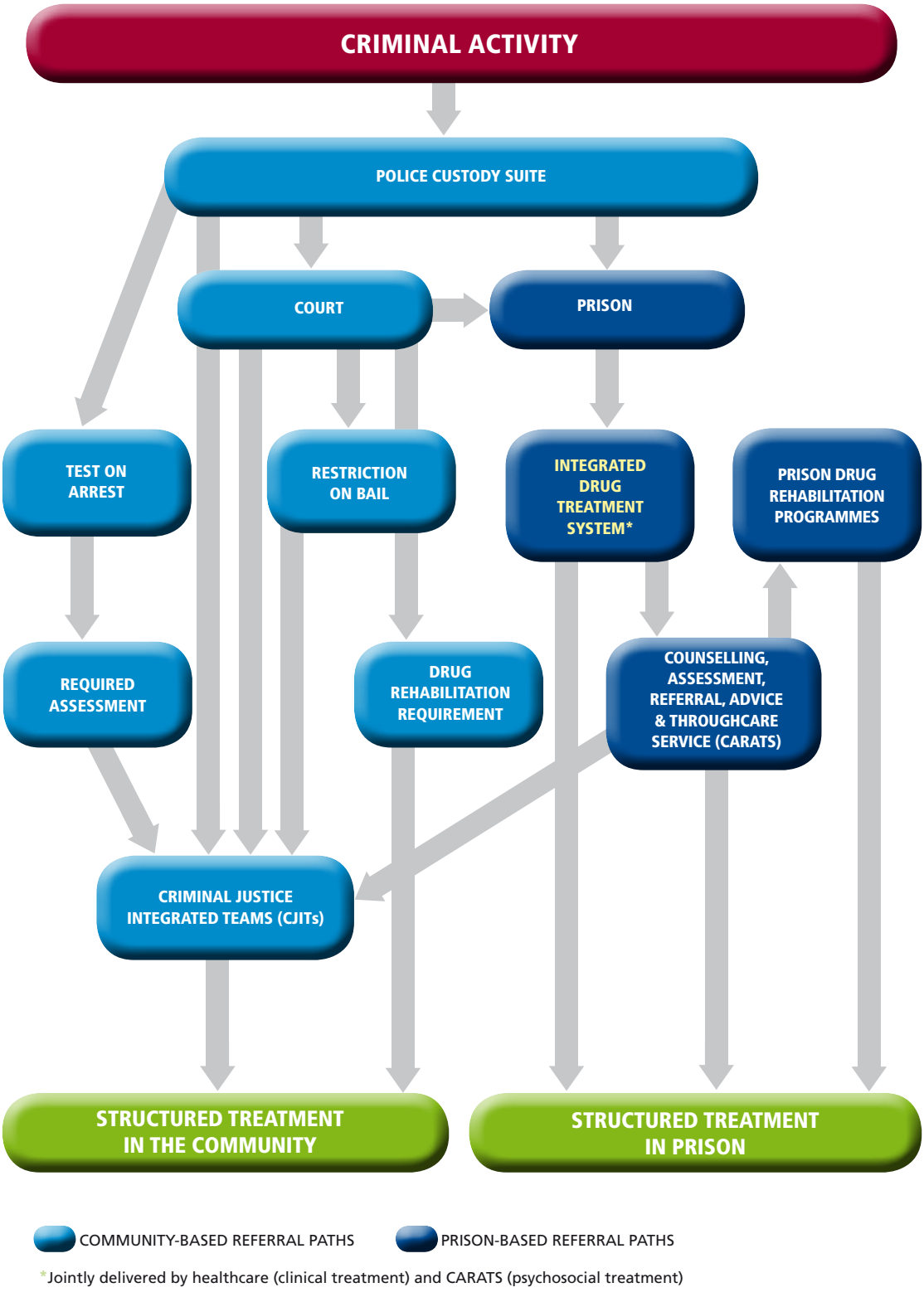
RESTRICTIONS ON BAIL

Offenders who test positive for drugs such as heroin, crack and cocaine may be denied bail unless they agree to have relevant treatment.

CRIMINAL JUSTICE INTEGRATED TEAMS (CJITs)

Based in the community, and working in police custody suites and courts, CJITs provide a gateway into treatment for offenders. They case-manage offenders, coordinating the response from different agencies, such as the police and prison service. Judges and magistrates take CJIT assessments of drug-misusing offenders into consideration when making bail and sentencing decisions.

Figure 4: Referral paths for drug treatment in the criminal justice system, and where IDTS fits in



*Jointly delivered by healthcare (clinical treatment) and CARATS (psychosocial treatment)

Other community-based initiatives

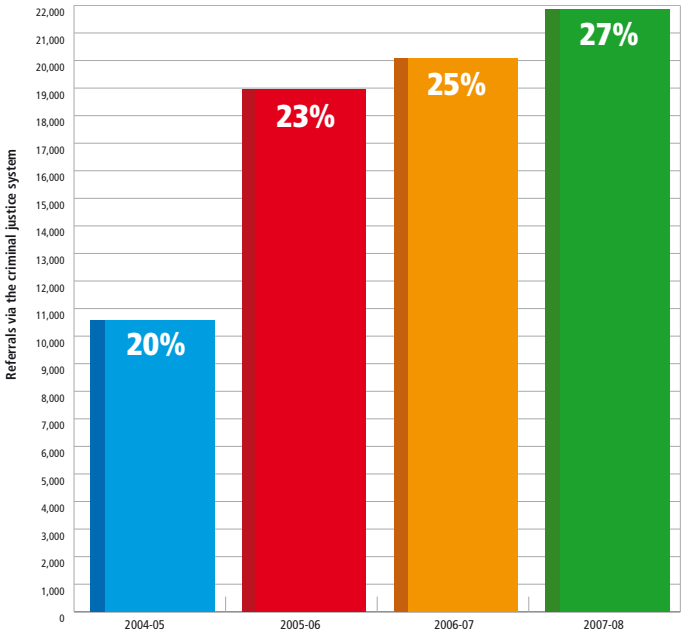
DRUG REHABILITATION REQUIREMENT (DRR)

These are part of a community sentence. They are a key way for offenders to address problem drug use and how it affects them and others. A DRR lasts between six months and three years, and gets offenders to:

- Identify what they must do to stop offending and using drugs
- Understand the link between drug use and offending, and how drugs affect health
- Identify realistic ways of changing their lives for the better
- Develop their awareness of the victims of crime.

The number of DRR orders increased from 4,854 in 2001-02 to 16,607 in 2007-08, while completion rates have improved from 28% in 2003 to 43% in 2007-08[4].

Figure 5: Referrals to community-based drug treatment from the criminal justice system, as reported by clients to NDTMS – shown as total numbers and the percentages they represent of all new referrals to drug treatment for that year



Source: NDTMS

Prison-based initiatives

INTEGRATED DRUG TREATMENT SYSTEM (IDTS)

The new, structured, evidence-based treatment regime, which the NTA and its partners are now in the process of introducing to all prisons in England.

PRISON DRUG REHABILITATION PROGRAMMES

The traditional treatment regimes being delivered in prisons. There are four main categories: cognitive-behavioural therapy (CBT), which teaches problem drug users to see situations differently and modify their behaviour; short-duration programmes, a CBT-based, high-intensive approach for those spending a short time in custody; 12-step programmes, an abstinence-based drawing on the philosophy of Alcoholics Anonymous; and therapeutic communities (TCs), a mix of incentives, structured activities and work, peer role models and support.

COUNSELLING, ASSESSMENT, REFERRAL, ADVICE AND THROUGHCARE SERVICE (CARATS)

Drug workers who provide specialist services, including case management and advice, for problem drug users inside prisons, following assessment. CARATS drug workers also deliver psychosocial treatments, such as CBT, on a one-to-one and group basis, and are responsible for running specific aspects of the IDTS treatment package.

Structured treatment

The point of all these programmes is to get offenders into treatment that breaks their drug habit and its links with criminal behaviour. If it's the right treatment, delivered effectively, it will help problem drug users to recover and begin contributing again to society.

In the community, there is no one-size-fits-all solution for treating problem drug users; prisons are also moving towards a more balanced system that ensures individuals get the type of treatment best suited to their needs and circumstances. Just as there are a number of ways into drug dependency, there are a number of routes to recovery.

The treatment options available to offenders in the community and in prisons include substitute prescribing. NICE guidelines say that front-line treatment for heroin dependency should be the opiate substitutes methadone or buprenorphine. These help to stabilise problem drug users and can reduce their cravings. Once addicts are stabilised, there are further options, such as detoxification.

For those dependent on other drugs, such as crack, the recommended treatment comes in the form of psychosocial interventions, which get offenders to confront the reasons for, and consequences of, their behaviour. NICE recommends that all treatment includes a psychosocial component, such as one-to-one motivational interviewing, behavioural therapy, and mutual aid groups.

Today, NHS Primary Care Trusts (PCTs) are responsible for prisoners' healthcare, including the clinical aspects of drug treatment, such as maintenance prescribing and detoxification. Offenders usually receive treatment via drug rehabilitation programmes, which vary in length from four weeks to more than a year.

CASE STUDY: Bryan McMillan, IDTS governor, HMP Wymott, Lancashire

"As HMP Wymott prepares to go live with IDTS, I visited another local prison, HMP Buckley Hall, where the system is up and running.

"During the visit, I bumped into a prisoner I've known for a number of years. It's fair to say his custodial behaviour has been less than good. His previous spells in prison would see him head straight for the drug and gang culture. He'd attempt to sell drugs, or to gather in debts. He would graft for his own drugs, and inevitably get involved in assaults or fall into debt himself. Inevitably, he'd end up on report and in the segregation unit.

"Looking visibly better than I had seen him previously, he told me he was engaging with the IDTS unit and that it was the best thing that's happened to him. He said it was the first time in a long while he hadn't been in debt for drugs or fallen in with the gang culture. He'd been at Buckley Hall for five months and, apart from his methadone, had remained drug free. He had good relationships with staff and was working towards coping without methadone in the long term.

"IDTS had obviously had an impact on this prisoner, and not only on his current behaviour – there were signs he was considering his future. His health has clearly improved and he felt drug treatment was the way forward.

"As a long serving officer, used to handling drug users, it surprised me to see the progress an individual can make in a relatively short space of time. I look forward to seeing more of the same at HMP Wymott."

4. Where do we go from here?

"Treatment for offenders in prison has improved dramatically during the past couple of years. We are now able to provide effective and consistent care for all the varying needs of drug misusers, including clinical treatment such as substitute prescribing, psychosocial treatment, and treatment based on mutual aid."

Emma Pawson, IDTS development manager

A work in progress

Treating offenders for problem drug use while they are in prison or serving a community sentence makes good sense. It's a chance for the treatment system to identify and assess those problem drug users who are committing crime.

It also gives the individuals involved a good opportunity to break their dependence and, as a consequence, cut their links with crime and get their lives back on track. But more work remains to be done to ensure that problem drug users in all prisons have access to appropriate and effective treatment, and that treatment is available to them wherever they might be.

Coming to all prisons

The funding is now in place to ensure that the NTA and NOMS can roll out IDTS to every prison in England, which it is due to complete by 2011.

IDTS aims to ensure that effective, consistent drug treatment is available to any prisoner who needs it. The range of clinical and psychosocial treatment options for offenders will also expand, and should be flexible enough to adjust to individual circumstances. The quality of treatment will meet national, evidence-based standards (in line with *UK Guidelines on Clinical Management 2007*), while the continuity of care and links to community services will strengthen.

When it is fully embedded in every prison, IDTS will give problem drug users the opportunity to recover, and to experience the benefits of a life free from dependence – benefits that their families, communities and wider society will also enjoy.

Continuity of care

The treatment services available to problem drug users in prison have expanded and improved a lot in recent years. But gaps remain.

These include inconsistent approaches, variable quality, and fragile arrangements for continuity of care between prison and the community, and as individuals transfer from one prison to another.

If the treatment journey for individuals moving between custody and the community is not carefully managed and coordinated there is a high risk they will fall between the gaps at a time when they are extremely vulnerable. The result can be that any positive results are soon lost, leading to relapse, a risk of drug-related harm, and a return to criminal behaviour.

The NTA is working closely with the Home Office and Ministry of Justice to strengthen the links between drugs workers in prison and the wider criminal justice system and to ensure that individuals receive prompt and effective support as they move between custody and the community.

Changing patterns of drug use

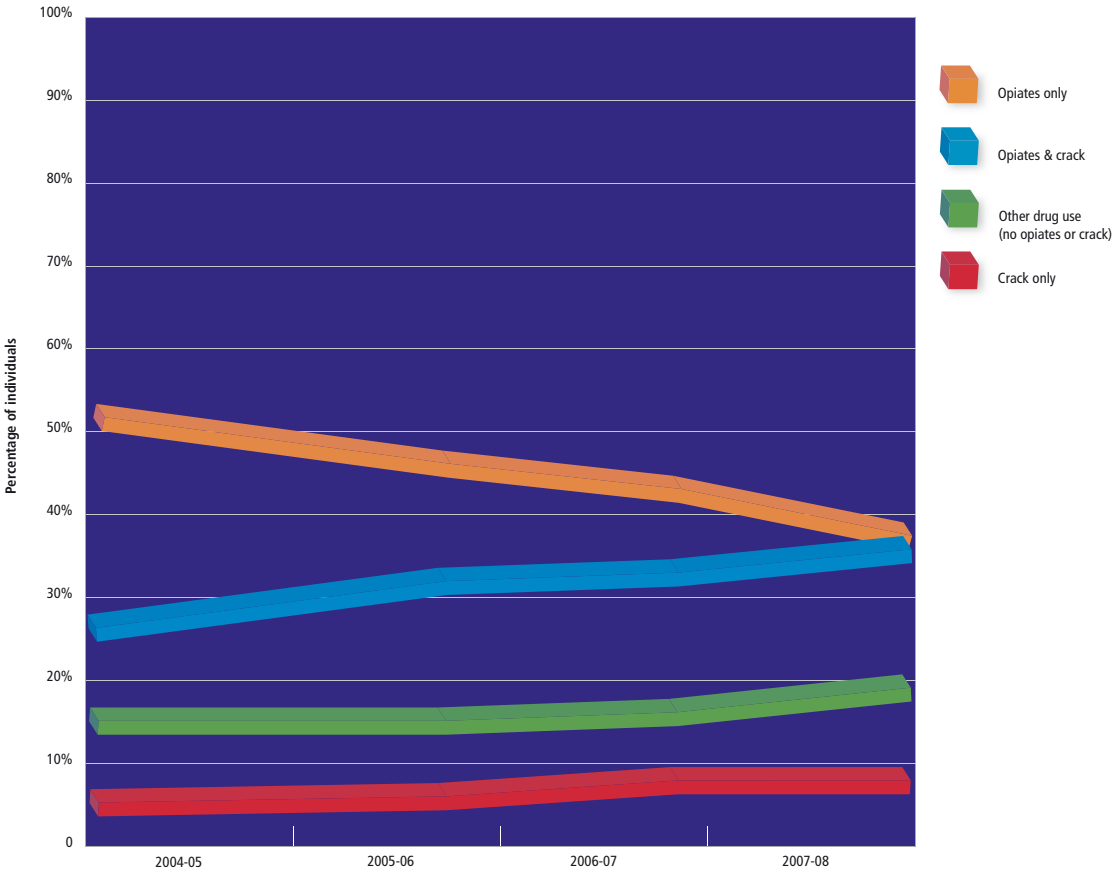
Drug use, even problem drug use, does not in itself cause individuals to commit crimes such as robbery and burglary.

But drug users being treated for dependency within the criminal justice system consistently use the same drugs: heroin and crack. This is why the long-term focus is on treating heroin and crack users. However, the balance between the two is shifting.

This year, a combination of opiates and crack has come even closer to supplanting heroin alone as the common pattern of drug misuse among individuals receiving treatment in the criminal justice system. The trend is consistent for men and women, and has been building from previous years. However, we cannot assume that this trend will continue.

Changing trends in drug use mean it is vital that the treatment system is flexible enough to respond to individual needs rather than just the substance misused. One size does not fit all – neither all people nor all drugs. This is another reason for rolling out IDTS to all prisons in England – it provides an effective, evidence-based treatment system (particularly via a consistent approach to psychosocial 'talking' therapies), and will ensure quality treatment for all drug users, based on their individual needs.

Figure 6: Referrals to treatment via the criminal justice system, by drug of use



Source: NDTMS

The PWC report

In 2007, PriceWaterhouse Coopers (PWC) reviewed the funding for prison-based drug treatment. It found that the large amount of money invested in prison-based drug services since 1997 had resulted in major improvements and better practice.

But it also highlighted the absence of a clear interdepartmental strategy; the fragmented organisational arrangements for funding, commissioning, managing and delivering treatment services; the lack of a clear evidence base for some services; and process inefficiencies and gaps in services. It suggested a range of proposals including minimum standards, commissioning models, pooled funding, and ways of identifying efficiency savings.

The Prison Drug Strategy Review chaired by Professor Lord Kamlesh Patel was established to take forward the recommendations from the PWC review and will report in 2010 on the progress made.

Integrated funding: system change pilots

In the meantime, system change pilots are an initiative to create a more integrated approach to funding and commissioning drug treatment in the community and in prisons.

Announced as part of the 2008 drug strategy, their premise is that local partnerships can achieve more if allowed to use a range of funding streams, including those specific to drugs. This means they can innovate and tailor services to achieve better results.

It also allows funding to be pooled, so treatment services can be coordinated and optimised, and to include support for housing and employment. Six of the seven pilot areas chose to adopt a whole-system approach to treatment within the criminal justice system. If successful, this will provide a blueprint for a more organised and inclusive approach to treatment and social reintegration for offenders.

CASE STUDY: Emma Pawson, IDTS development manager, east of England

"Treatment for offenders in prison has improved dramatically during the past couple of years. The Integrated Drug Treatment System in particular has made a big difference. It means we can continue the work that starts in the community. IDTS funding is now enabling prisons to work towards providing high-quality drug treatment for any prisoner who needs it.

"Our region has 14 prisons, covering every sort, such as private prisons, high security prisons, open prisons and women's prisons. We are now able to provide effective and consistent care for all the varying needs of drug misusers, including clinical treatment such as substitute prescribing, psychosocial treatment, and treatment based on mutual aid. We also have specialist midwives for pregnant drug users, working in dedicated mother and baby units.

"One of our key ambitions is to further develop the involvement of a prisoner's family in his or her treatment and preparations for returning to the community. We are running pilot schemes to see how this can best be achieved.

"Another big challenge is to work with our partners in the community to expand and improve opportunities for reintegrating drug misusing offenders into society, helping them to get jobs and accommodation – a tough agenda at any time, and certainly no easier during a recession."

What is the future?

Drug misusers who offend should be held responsible for their actions. Prison and other sentences are appropriate punishments for their crimes, just as they are for any other type of offender.

But punishment that does not address a drug misuser's underlying dependency is unlikely to reduce future offending. Effective, targeted treatment is the key to preventing an individual from committing further crime – but even that cannot succeed on its own. An offender's chances of making the break from criminality and reintegrating with society are much improved when he or she gets appropriate support, such as access to employment and stable accommodation.

Integrated offender management will help to achieve this in local areas, particularly where it provides effective end-to-end case management in the community. The level of problem drug use among offenders adds extra layers of complexity, though the lessons of treatment offer a way forward.

Those who provide drug treatment recognise that reintegration goes hand-in-hand with recovery. Treatment helps users overcome their dependency, with the added social benefit that it cuts crime.

All this takes time: a typical heroin addict requires six attempts over six years to become drug-free. Drug misusers need support to maintain the progress they are making through treatment, enabling them to become employed, suitably housed, and more self-sufficient.

The 2008 drug strategy set the challenge to offer real opportunities to individuals overcoming dependency to reintegrate back into the community, rejuvenating their social bonds, with the ultimate goal of living drug-free lives, finding work, paying taxes, and supporting their children.

For example, evidence suggests that of all the factors involved in sustaining recovery from drug dependency, paid employment may be the most important. In turn the strongest independent factor associated with achieving paid employment following drug treatment is tailored employment support.

The NTA is already working closely with JobcentrePlus to get drug users on benefit into treatment, to get those on benefit and in treatment into employment, and to provide suitable training that prepares them for work.

Historically, drug treatment services have taken a sequential approach to reintegration, with thoughts of housing and jobs emerging towards the end of an individual's treatment journey. However, at a regional level, the NTA is working with partners in local authorities, health services and the police on ways to ensure integration can run throughout the treatment journey and beyond.

For example, 102 of the 149 drug partnerships in England have identified employment as a local objective in addition to the priorities prescribed in the drug strategy, and 80 have identified housing as an ambition for local action.

Greater integration of services around the needs of individuals is consistent with the government's approach to personalise the social care system to deliver improved outcomes for individuals together with cost-effectiveness for society.

5. Appendices

a. References

1. What is the link between drugs and crime?

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[3]Measuring different aspects of problem drug use: methodological developments, Home Office online report 16/064
[4,5]Offender Health data, Department of Health, 2009
[6,7,8] The National Offender Management Service Drug Strategy 2004
[9]Safer prisons: a national study of prison suicides 1999-2000 by the national confidential inquiry into suicides and homicides by people with mental illness, Department of Health, 2003
[10]Drug related mortality among newly released offenders 1998 to 2000, Home Office online report 40/05. Male prisoners are 29 times more likely to die (probably of an overdose) within a week of release than the general male population – women prisoners are 69 times more likely than the general female population
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[12]NEW ADAM survey of arrestees 1999-2002, 'Economic and social costs of crime'.

2. What can we do about drugs and crime?

[1]The quasi-compulsory treatment of drug-dependent offenders in Europe: final national report – England, Institute for Criminal Policy Research, University of Kent, 2006
[2]Differential substance misuse treatment needs of women, ethnic minorities and young offenders in prison: prevalence of substance misuse and treatment needs. Home Office online report 33/03, 2001.

3. What are we doing about drugs and crime?

[1]IDTS prison partnership annual performance report, NTA, 2008-09
[2]http://drugs.homeoffice.gov.uk/drug-interventions-programme/strategy/impact-and-success/
[3]The Drug Interventions Programme (DIP): addressing drug use and offending through 'Tough Choices', Home Office research report, 2007
[4]The National Offender Management Service Drug Strategy 2008-11.

b. Prisons in England where IDTS is active, as at June 2009 (by NTA region)

East Midlands
Ashwell
Foston Hall
Leicester
Lincoln
Lowdham Grange
North Sea Camp
Nottingham
Onley
Ranby
Rye Hill
Stocken
Sudbury
Wellingborough

East of England
Bedford
Blundeston
Chelmsford
Edmunds Hill
Highpoint
Hollesley Bay
Norwich
Peterborough Female
Peterborough Male
The Mount
Wayland

London
Brixton
Pentonville
Wormwood Scrubs

North East
Acklington
Deerbolt
Durham
Holme House
Low Newton

North West
Altcourse
Buckley Hall
Forest Bank
Garth
Haverigg
Kennet
Liverpool
Manchester
Preston
Risely
Styal

South East
Bullingdon
Camp Hill
Coldingley
Downview
Highdown
Elmley
Lewes
Maidstone
Reading
Rochester
Standford Hill
Swaleside

South West
Bristol
Channings Wood
Dartmoor
Dorchester
Eastwood Park
Erlestoke
Exeter
Gloucester
Guys Marsh
Portland

West Midlands
Birmingham
Drakehall
Featherstone
Hewell
Stafford

Yorkshire and the Humber
Doncaster
Everthorpe
Hull
Leeds
Lindholme
Moorland Closed
Moorland Open
New Hall
Northallerton
Wealstun
Wolds

c. Tables (analysis from NDEC, University of Manchester, June 2009)

Table 1: Referrals to treatment via the criminal justice system, by source

REFERRAL SOURCE	2004/05		2005/06		2006/07		2007/08	
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Arrest referral - DIP	3313	6%	7659	9%	9770	12%	10684	13%
Probation	3844	7%	5854	7%	5693	7%	5660	7%
DRR	1758	3%	2364	3%	1544	2%	1406	2%
CARAT/Prison	1475	3%	3063	4%	3088	4%	4021	5%
Crime Prevention	0	0%	0	0%	3	0%	65	0%
YOT following community sentence	183	0%	0	0%	0	0%	25	0%
Post Custody	0	0%	0	0%	0	0%	1	0%
unknown	0	0%	2755	3%	2190	3%	0	0%
Non CJS	42654	80%	61618	74%	58099	72%	60593	73%
Total	**53044**	**100%**	**83313**	**100%**	**80387**	**100%**	**82455**	**100%**

Table 2: Referrals to treatment via the criminal justice system, by region and gender

REGION	2004/05				2005/06				2006/07				2007/08			
	Female		Male		Female		Male		Female		Male		Female		Male	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
North East	155	17%	743	83%	202	16%	1087	84%	194	16%	1039	84%	199	15%	1171	85%
North West	365	22%	1305	78%	664	19%	2856	81%	612	19%	2693	81%	690	18%	3049	82%
Yorkshire & the Humber	312	19%	1309	81%	507	19%	2219	81%	504	19%	2201	81%	459	18%	2136	82%
East Midlands	197	16%	1001	84%	352	18%	1571	82%	324	17%	1585	83%	267	15%	1478	85%
West Midlands	307	19%	1330	81%	526	19%	2245	81%	593	20%	2441	80%	508	17%	2510	83%
East of England	94	16%	480	84%	168	20%	679	80%	200	22%	705	78%	246	20%	962	80%
London	229	17%	1114	83%	514	18%	2384	82%	674	18%	3131	82%	642	15%	3533	85%
South East	140	20%	571	80%	318	19%	1395	81%	372	20%	1500	80%	449	17%	2171	83%
South West	129	15%	727	85%	184	16%	945	84%	223	17%	1076	83%	190	14%	1202	86%
Total	**1928**	**18%**	**8580**	**82%**	**3435**	**18%**	**15381**	**82%**	**3696**	**18%**	**16371**	**82%**	**3650**	**17%**	**18212**	**83%**

Table 3: Referrals to treatment via the criminal justice system, by ethnicity and gender

ETHNICITY	2004/05				2005/06				2006/07				2007/08			
	Female		Male		Female		Male		Female		Male		Female		Male	
	Count	Col %	Count	Col %	Count	Col %	Count	Col %	Count	Col %	Count	Col %	Count	Col %	Count	Col %
White British	1711	88%	7175	83%	2829	82%	12085	78%	3043	82%	12668	77%	3106	85%	14223	78%
White Irish	20	1%	102	1%	37	1%	160	1%	51	1%	190	1%	48	1%	210	1%
Other White	25	1%	132	2%	40	1%	239	2%	62	2%	341	2%	62	2%	423	2%
White & Black Caribbean	29	1%	124	1%	57	2%	230	1%	83	2%	294	2%	88	2%	377	2%
White & Black African	4	0%	18	0%	6	0%	48	0%	12	0%	66	0%	13	0%	72	0%
White & Asian	4	0%	23	0%	9	0%	38	0%	11	0%	60	0%	16	0%	58	0%
Other Mixed	17	1%	43	0%	29	1%	94	1%	34	1%	102	1%	28	1%	116	1%
Indian	5	0%	88	1%	14	0%	165	1%	18	0%	239	1%	18	0%	251	1%
Pakistani	12	1%	151	2%	14	0%	250	2%	13	0%	289	2%	9	0%	326	2%
Bangladeshi	3	0%	47	1%	10	0%	88	1%	2	0%	141	1%	3	0%	134	1%
Other Asian	8	0%	72	1%	9	0%	116	1%	11	0%	138	1%	13	0%	190	1%
Caribbean	35	2%	174	2%	59	2%	463	3%	95	3%	646	4%	76	2%	737	4%
African	12	1%	61	1%	12	0%	136	1%	23	1%	183	1%	14	0%	223	1%
Other Black	12	1%	158	2%	49	1%	255	2%	61	2%	328	2%	39	1%	352	2%
Chinese	0	0%	7	0%	1	0%	10	0%	1	0%	2	0%	2	0%	11	0%
Other	8	0%	63	1%	17	0%	116	1%	19	1%	115	1%	19	1%	112	1%
Not stated	13	1%	81	1%	20	1%	125	1%	45	1%	176	1%	41	1%	175	1%
Missing	24	1%	112	1%	241	7%	869	6%	113	3%	423	3%	55	2%	222	1%
Total	**1942**	**100%**	**8631**	**100%**	**3453**	**100%**	**15487**	**100%**	**3697**	**100%**	**16401**	**100%**	**3650**	**100%**	**18212**	**100%**

Table 4: Referrals to treatment via the criminal justice system, by age

AGE GROUP	2004/05				2005/06				2006/07				2007/08			
	Female		Male		Female		Male		Female		Male		Female		Male	
	Count	Col %	Count	Col %	Count	Col %	Count	Col %	Count	Col %	Count	Col %	Count	Col %	Count	Col %
18 years	47	2%	243	3%	64	2%	243	2%	65	2%	247	2%	92	3%	383	2%
19 years	71	4%	230	3%	118	3%	403	3%	106	3%	398	2%	88	2%	487	3%
20-24 years	539	28%	2004	23%	856	25%	3283	21%	839	23%	3040	19%	755	21%	3250	18%
25-29 years	536	28%	2380	28%	936	27%	4037	26%	958	26%	4324	26%	964	26%	4538	25%
30 - 34 years	357	18%	1883	22%	676	20%	3496	23%	786	21%	3677	22%	779	21%	3947	22%
35 - 39 years	221	11%	1141	13%	464	13%	2275	15%	535	14%	2513	15%	525	14%	2865	16%
40 - 44 years	121	6%	490	6%	228	7%	1141	7%	270	7%	1372	8%	312	9%	1682	9%
45 - 49 years	35	2%	180	2%	78	2%	401	3%	93	3%	555	3%	89	2%	702	4%
50 - 54 years	10	1%	52	1%	22	1%	145	1%	36	1%	181	1%	34	1%	249	1%
55 - 59 years	4	0%	22	0%	6	0%	37	0%	5	0%	62	0%	8	0%	79	0%
60 - 64 years	0	0%	4	0%	1	0%	8	0%	1	0%	17	0%	2	0%	23	0%
65 - 69 years	1	0%	1	0%	1	0%	6	0%	2	0%	7	0%	2	0%	3	0%
70 - 74 years	0	0%	1	0%	0	0%	2	0%	0	0%	1	0%	0	0%	4	0%
Total	**1942**	**100%**	**8631**	**100%**	**3453**	**100%**	**15487**	**100%**	**3697**	**100%**	**16401**	**100%**	**3650**	**100%**	**18212**	**100%**

Table 5: Referrals to treatment via the criminal justice system, by drug category

DRUG CATEGORY	2004/05		2005/06		2006/07		2007/08	
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Opiates only	5487	52%	8630	46%	8586	43%	8062	37%
Opiates & crack	2757	26%	6122	32%	6685	33%	7960	36%
Crack only	557	5%	1213	6%	1523	8%	1651	8%
Other drug use: no opiates or crack	1772	17%	2975	16%	3304	16%	4189	19%
Total	**10573**	**100%**	**18940**	**100%**	**20098**	**100%**	**21862**	**100%**

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