

KEY FINDINGS



The quasi-compulsory treatment of drug-dependent offenders in Europe: UK findings

For much of the last decade legislation has substantially extended the ability of the UK criminal justice system to coerce drug-dependent offenders into treatment. Despite the rapid expansion of coercive measures, research findings to date are uncertain about their impact on drug use and offending behaviours, and ability to engage and retain people in treatment. This summary presents the main UK findings from the first systematic, comparative, cross-national research project of its kind conducted in Europe on this issue. The UK component of the study tracked a sample of 157 people who entered 'coerced' and comparable 'voluntary' drug treatment options at one of ten services in London and Kent between June 2003 and January 2004. The research revealed:

- Significant and sustained reductions in self-reported illicit drug use and offending behaviours over an 18-month follow-up period for both groups.
- Substantial reductions in reported expenditure on illicit drugs.
- Modest improvements in mental health.
- Reductions in reported risk behaviours (e.g. sharing injecting equipment).
- Improvements in housing and personal relationships.
- No change in (very high) rates of unemployment.
- No significant differences between those 'coerced' into drug treatment and the comparison group of 'volunteers' in retention rates and other outcomes.
- 'Coerced' treatment options can be effective under some conditions as an alternative to imprisonment. The context in which these measures are applied is crucial, and local differences in treatment quality, availability and delivery, for example, can help explain the considerable variations in performance and outcomes that have been observed to date.

Background

This summary presents the main findings of an evaluation of quasi-compulsory drug treatment (QCT) arrangements for drug-dependent offenders in England. We define QCT as drug treatment that is motivated, ordered or supervised by the criminal justice system but which takes place outside of prisons. The focus of our research in England has been the drug treatment and testing order (DTTO). The research formed part of the wider *QCT Europe* study which was funded by the European Commission's Fifth Framework Research and Development programme. Parallel studies were conducted in Austria, Germany, Italy and Switzerland. Information for comparison was also gathered from the Dutch SOV experiment.

Methodology

Researchers from the European Institute of Social Services (EISS), University of Kent, and the Institute for Criminal Policy Research (ICPR), King's College London, recruited a random sample of 157 people who entered community-based drug treatment at one of ten purposively selected research sites between June 2003 and January 2004: 89 (57%) of them having done so as part of a DTTO. We managed to interview just over half the eligible clients offered treatment across the ten sites: most of those we did not interview either failed to present to treatment or did not stay long enough for us to interview them.

Those recruited to the study were all asked standardized and validated questions about their health, education, substance use, offending, victimisation, any pressure they felt to be in treatment and their motivation to change their drug-using behaviour. Sixty per cent were interviewed within two weeks of starting treatment (mean 2.7 weeks). These questions were administered at intake (t1) to treatment and then again at six (t2), twelve (t3) and 18-month (t4) follow-up intervals. Response rates ranged from 68% at t2, 64% at t3 and 61% at t4. However, 82% of the sample was re-interviewed on at least one occasion post-admission to treatment. The results reported here are for *all* the people we interviewed, and not just those who stayed in treatment.

In-depth individual and focus group interviews were also undertaken with a theoretically assembled sample of 38 health and criminal justice professionals involved in the implementation, development or delivery of DTTOs and 57 criminally involved drug users drawn from the quantitative sample who had been mandated to treatment by the courts.

Who we interviewed

Most (n=120) of the respondents were male with an average age of 31 years; those serving a DTTO were slightly younger (30) than members of the comparison group (32), though not significantly so. Four-fifths (n=125) described themselves as White and three-quarters (n=119) had never been married. More than half (n=82) of them left school before the age of 16. Just over one-third (n=57) experienced ongoing medical problems. These commonly included asthma, hepatitis C, epilepsy, deep vein thrombosis and bronchitis. More than half (n=83) of them reported that they had experienced serious depression and anxiety in the past month. People who were not on a DTTO tended to report worse mental health than those who were. For example, during their lifetime the 'voluntary' group were found to have been more likely to report having been prescribed medication for psychological or emotional problems (n=39 or 57%) than the DTTO group (n=28 or 32%) ($p < 0.01$). Nearly three-quarters (n=111) of the people we interviewed had previously been treated for drug or alcohol dependency. There was no difference in previous exposure to treatment between people on DTTOs and 'volunteers'. Four-fifths were in either day care (n=66) only or in day care with a substitute prescription (n=60) at the time of first interview.

Those receiving court orders in our ten sites were more likely to be male and tended to have more serious problems on admission to treatment than those who entered 'voluntarily'. They were using a wider range of drugs; making more frequent use of heroin and crack; injecting more frequently; spending more on drugs; were more criminally active; and more likely to be at an earlier stage in the 'cycle of change'. These important differences imply that people receiving court orders are likely to find it more difficult to be retained and succeed in treatment. However,

it also hints at the possible rewards: that potential gains - in terms of reduced drug use and crime - are likely to be greater among this group, if only they can be retained long enough to succeed in treatment.

The role of coercion

Two-fifths (n=35) of those receiving a DTTO in our sites said they did not feel any external pressure to be in treatment, and nearly half (n=32) the people who entered treatment through non-criminal justice routes said they did feel pressure or duress, mostly from family and friends. While there may be important differences between these various sources of pressure, it should not be assumed that court-mandated treatment forces people to access support when they do not want it or that those entering treatment from other routes do so entirely of their own volition. Across the entire *QCT Europe* sample of 845 respondents, 65% of the 'volunteers' perceived some external pressures to enter treatment while 22% of the QCT group reported experiencing no such pressures.

Findings from our intake interviews across the five partner countries suggest that entering drug treatment as part of a court order does not necessarily damage the likelihood of someone succeeding in treatment by reducing their motivation. While there is a link between legal status and perceived pressure, this does not seem to reduce people's motivation to change.

Main findings

Offending behaviour

There was a significant reduction in offending reported by the DTTO group in the month before intake and 6-month follow-up interviews (from an average (mean) of 23 days to 4 days) ($p < 0.001$), and intake and 18-month follow-up (from 23 days to 6 days) ($p < 0.001$). Among the comparison group, there was a significant overall reduction in offending reported between intake and 18-month interviews (from 9 days to 2 days) ($p < 0.05$). There was no significant change in self-reported offending in the period between six and 18-month follow-up for either group.

Even if we assume that those whom we did not interview at first follow-up (n=51) continued to

offend at pre-intake levels (using 'last observation carried forward'), we estimate that there would be at least a 57% reduction in offending in the month before intake and 6-month follow-up for the entire sample: from a mean of 17.3 days to 7.5 days. Reductions on this scale were sustained over the 18-month follow-up period and were maintained when adjustments were made for missing data and time at reduced risk (i.e. during periods of imprisonment and residential/inpatient treatment).

The reductions in offending were greater in the DTTO group than the 'voluntary' comparison group. This is because the DTTO group had a higher level of pre-intake offending. The offending levels of the two groups were much closer at the end of the study period than they had been at the start.

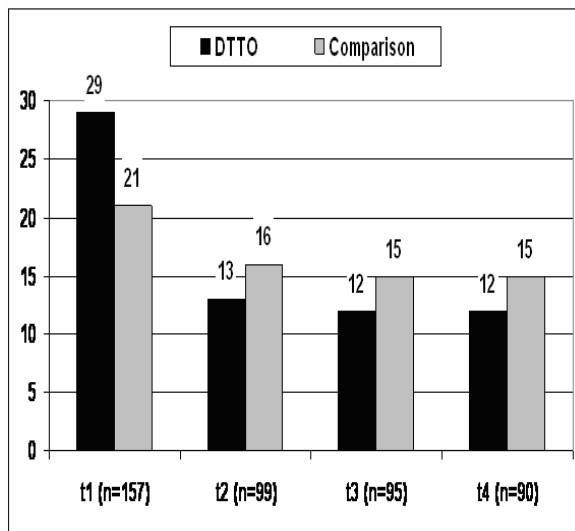
Illicit drug use

As figure 1 below illustrates, there were significant reductions in illicit drug use (excluding alcohol, cannabis and methadone) reported by the DTTO group in the month before intake and first follow-up interviews (from 29 days to 13 days) ($p < 0.001$), and 18-month follow-up (from 29 days to 12 days) ($p < 0.001$). Among the comparison group, there was a significant overall reduction in self-reported drug use between intake and 18-month interviews (from 21 days to 15 days) ($p < 0.05$). There was no significant change in self-reported illicit drug use between six and 18-month follow-up for either group.

Again, these reductions were sustained over the 18-month follow-up period and are found even if we assume that those who dropped out of the study maintained pre-intake levels of illicit drug use and when adjustments were made for time at reduced risk.

There were also considerable reductions observed among both DTTO and comparison groups in reported expenditure on illicit drugs: from a median of £1200 in the 30 days before intake interview (n=156) to £30 (n=104) at 6-month follow-up. There were also large falls in the reported frequency of injecting drugs and of sharing injecting equipment throughout the life of the study.

Figure 1: Average number of reported days consuming illicit drugs during the last month by group.



By the end of the study, 87% (n=106) of respondents were able to report a period of abstinence from drugs during the previous 18 months as a result of treatment they had received, while four-fifths of those who had never been abstinent as a result of treatment beforehand indicated that they had managed to do so on this occasion (n=37).

Mental health

Both groups reported modest reductions in the number of days they experienced psychological and emotional health problems.

Social integration

There were reductions reported by both groups in levels of homelessness and dissatisfaction with current living arrangements. Reductions were greater in the DTTO group, who were again more likely to report homelessness at intake than those belonging to the comparison group. Both groups reported reductions in the level of “serious problems” experienced in their relationships with family and significant others over time.

There was no significant increase in the numbers accessing training or employment. Three-quarters (n=118) of the sample had neither worked nor studied in the three years prior to intake. A similar number (n=100) had failed to secure any employment or accessed a course of study at any time during the 18-month follow-up period.

Were there different outcomes observed between the two groups?

There was no significant difference in the rate of retention in treatment at 6-month follow-up between the DTTO (mean of 117 days (n=87)) and comparison group of ‘volunteers’ (mean of 129 days (n=68)). Whether a person entered treatment ‘voluntarily’ or under ‘coercion’ seemed to have no influence on whether they were likely to be retained in treatment at 6 months. This was more likely to be positively influenced by receiving a substitute prescription, being aged 30 years or older, and not being treated at one of the sites in our study (which had a particularly low retention rate).

When other potential influences on drug use outcomes were taken into account, the DTTO group was not significantly likely to have any better (or worse) outcome than the ‘voluntary’ comparison group. The likelihood of reductions in drug use was negatively affected for those who reported that they spent most of their free time with others who were experiencing drug or alcohol problems.

Legal status was similarly unrelated to offending outcomes. In the presence of other potential influences, the DTTO group were not significantly more or less likely to report desisting from offending than those belonging to the ‘voluntary’ comparison group.

Items that were found to be significantly associated with improved offending outcomes were reductions in drug use, still being in treatment at 6-month follow-up and having achieved abstinence from drugs without treatment in the past. Those who reported crack or poly-substance use at intake were less likely to report having desisted from crime.

Conclusions

Findings from our study reveal that DTTO clients showed considerable and sustained reductions in substance use, injecting risk and offending behaviours, and some improvements in their mental health. Outcomes were similar for those respondents who entered comparable 'voluntary' treatment options. The results – which are consistent with those from the other four partner countries involved in the *QCT Europe* study – suggest that drug treatment that is motivated, ordered or supervised by the criminal justice system can have comparable retention rates and outcomes to drug treatment entered through non-criminal justice routes. The approach should therefore be considered a viable alternative to imprisonment. However, from our qualitative analysis, there appeared to be considerable scope for improving arrangements for aftercare and resettlement for both groups across the UK sites.

More attention should also be paid to issues of treatment process and coordination between health and criminal justice systems in order to provide high quality and consistent treatment that is likely to optimise outcomes for individuals and the wider community. Attention should particularly be focused on:

- Ensuring that treatment is made quickly available to those offenders who are likely to produce the most significant benefits (i.e. those who have high levels of offending) in a manner which enhances motivation and engagement.
- Developing supportive “therapeutic alliances” between offenders and their probation officers and treatment staff.
- Dealing effectively with non-compliance. This does not mean that any lapses in drug use or attendance should be heavily punished; rather that they should be dealt with in a prompt and consistent way, recognising positive as well as negative behaviour changes.
- Making the full range of treatment options available to people who enter treatment as part of a court order, so

that they can access support appropriate to their needs.

- Improving access to education, training and employment schemes.

Recent years have seen a rapid expansion in the options available for the criminal justice system to encourage or direct drug-dependent offenders into treatment in England and Wales. Our hope is that the results from the *QCT Europe* study can be used constructively to inform debate about the appropriate use of these options.

How to get further information

Copies of the full report, ***The quasi-compulsory treatment of drug-dependent offenders in Europe: Final National Report – England***, by Tim McSweeney (ICPR), Alex Stevens and Neil Hunt (EISS) are available from Alex Stevens on 01227 827304 (a.w.stevens@kent.ac.uk) and Tim McSweeney on 020 7848 1757 (tim.mcsweeney@kcl.ac.uk).

More information about the *QCT Europe* study and EISS can be found at: www.kent.ac.uk/eiss/qct/index.htm

Further details about the Institute for Criminal Policy Research can be found at: www.kcl.ac.uk/icpr

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