Loughborough University

AMERICAN DRUG COURTS CONFERENCE

'FLEXIBILITY IN TREATMENT PROVISIONS'

Peter Martin
Chief Executive, Addiction.
July 1998

Introduction:

Problem drug use is increasing - and drug related crime is almost certainly rising too - against a backdrop of falling crime statistics. While the percentage of drugs-misusers within the criminal justice system varies from survey to survey, I think it would be true to say that roughly a third of offenders have problematic drugs misuse in its broadest context in their antecedent history. Many of these have been convicted for drug related offending and the main categories of this include shoplifting, burglary, fraud, opportunistic street robbery, armed robbery other theft and possession of drugs with intent to supply. There is evidence that one fifth of probation clients are problematic drugs-misusers. These figures are unlikely to reveal the full extent of offending and problematic drug misuse; for instance, they possibly do not include those who may use crack, amphetamines, poly-drug users and especially those who choose not to reveal their drugs use for whatever reason or are never caught.

The correlation between drugs misuse and offending behaviour is now well established. It may be one of the most important causal factors in the increase in crime in the UK over the last decade. There is also evidence that drugs users, driven by the need to fund habits, can be some of the most prolific offenders, for whom crime has become an almost daily routine and part of a drug related lifestyle. It is estimated that 3% of the 4 million who use illicit drugs each year have serious drug problems; these 100,000 - 200,000 may each spend on average £200 per week to fund their habits. In the region of a fifth of those passing through the criminal justice system have a drug problem and would benefit from treatment.

The recent Cambridge Institute of Criminology study1 of arrestees'carried out by Trevor Bennett, indicates on the basis of urine analysis that a third of acquisitive crime is carried out to fund drugs and one fifth of arrestees in the study tested positive for a class A drug.

There is increasing public anxiety about drug related crime which has informed the National Drugs Strategy firstly in 'Tackling Drugs Together' in 1995 and again in 'Tackling Drugs to Build a Better Britain', the current administration's ten year strategy for tackling drugs misuse.

In ‘Tackling Drugs to Build a Better Britain’ three of the four strategic elements refer to drugs and criminal activity:

1 Young People – to help young people resist drugs misuse in order to achieve their full potential in society:
2 Communities – to protect our communities from drug-related anti-social behaviour and criminal behaviour;
3 Treatment - to enable people with drug problems to overcome them and live healthy and crime free lives;
4 Availability – to stifle the availability of illegal drugs on our streets

Growing evidence of the extent of drug related crime, public anxiety about crime levels and drug related offending, and increased knowledge about the escalating costs of drug crime to the Treasury (and ultimately the tax payer) have engendered a new momentum to tackle the issue by policy makers. Within this new climate there is an increased focus on ways to achieve a reduction in drug-misuse and drug related offending by targeting persistent offenders and in particular those dependent on heroin.

Diversionary schemes to steer the drug -offender into treatment provision have been around for many years with Probation orders with treatment conditions, often conditions to reside in a residential treatment facility. These were augmented in 1992 by the Section 1a(6) orders (treatment conditions attached to Probation Orders). The plans to pilot Drug Treatment and Testing Orders (DTTOs) need new legislation. These new initiatives are to be mandated through the Crime and Disorder Bill 1998 and will be piloted in three areas: Liverpool, Croydon and Gloucestershire.

I welcome these and other initiatives such as arrest referral schemes and early intervention schemes to divert drug using offenders from prison and into treatment. There is growing evidence that as many as a third of this group have previously had no access to treatment and a further third have been in touch with treatment agencies but no longer have contact.

But here we must ask several basic questions. Coerced treatment - does it work? Is it ethically and morally defensible and desirable? What are the conditions for successful treatment? What is meant by treatment? What does treatment aim to achieve? What kinds of treatment exist? How can we improve treatment effectiveness? How do we design effective treatment programmes? Why is a flexible approach to treatment required? How do we deal with treatment failure? How can we measure outcomes? Will this achieve the aim of reducing drug-related crime?

I obviously do not have definitive answers to these questions. However, by drawing from my experience as a deliverer of drug treatment and working within the criminal justice system, I hope that by discussing these questions we can start to gain more understanding.

Coerced Treatment – Does it work and if so is it ethically desirable?

There is now a wealth of evidence that supports the view that well resourced and appropriately designed treatment is effective in reducing drug use and drug related crime. Studies have consistently demonstrated that legally coerced treatment appears to be no less effective that treatment entered into voluntarily. Furthermore, illicit drug offenders coerced into treatment often remain in treatment for longer duration than people who undertake treatment on a voluntary basis. This is further supported by the fact that community based treatment is more cost effective than imprisonment and with fewer adverse effects. There is a persuasive argument that community based options for recidivist drug users produce better treatment outcomes. Any Government that is concerned with protecting the public must act upon this information. The ethical and moral argument for coerced treatment is convincing. If as a society we can reduce the numbers of drug users in prison by coerced treatment whilst simultaneously reducing drug use and crime at less cost to the state with less harm to victims and the community, the case for coercion is strong. But it simply will not work without adequate investment.

Compulsory treatment and coerced treatment are not the same. In my view treatment ' inflicted on an individual against their will' is unlikely to succeed and resistance will be met. However the 'offer that cannot be refused' can help the individual who is usually anxious and fearful of change, to engage in the treatment process and with adequate support and encouragement work through these fears and benefit from treatment. Here careful assessment is vital and should be a dynamic process which will help determine the offender's motivation. Where there is none whatsoever, treatment should obviously not be recommended. Where people are ambivalent, however, it is worth applying some pressure. Through motivational interviewing techniques, concern about lifestyle and interest in treatment can be stimulated. This is a dynamic and not a static process. Many points within the criminal justice system can offer opportunities to jointly plan a programme of treatment at a point when an offender's co-operation can be engaged. A 'reality' assessment helps the offender accept the actuality of their situation. Often cognitive distortions can blind the drug users to their health and psychological well-being, to the level of dysfunction in relationships and the level of discontent attached to their recent lifestyles. In short, the fact that the direct consequences of drug related offending is both evident and imminent means that for many individuals a real awareness and time of opportunity develops.

One of the key factors that influence the ethical and moral scenario is the paucity of resources for treatment. Currently treatment providers are stretched to capacity and many agencies are vulnerable to closure whilst the lion's share of resources are devoted to enforcement and supply reduction. It is interesting to reflect on the fact that treatment offers a far better return on investment than enforcement. In these circumstances, we must question the viability of a strategy to provide treatment for clients actively involved within the criminal justice system where there is insufficient investment. Furthermore, by using treatment places for offenders, do we run a risk of not providing appropriate and accessible services for clients who are not involved in the criminal justice system? Does this mean a future where a drug user will need to be arrested to access treatment? What

would be the implications for young drug users and the transmission of communicable diseases?

Another ethical dilemma is how we deal with those not responding to treatment of when they re-enter the criminal justice system. Will they be punished for the offence alone or will the tariff be raised as a result of the 'treatment failure' or as an exemplary measure to other drug offenders. These issues must be resolved for the strategy to work.

However, there will always be those who fail the system. This highlights the importance of a review of the treatment responses and a rethink about treatment failure.

What are the conditions for successful treatment?

Assessment.

A thorough assessment contains many different dimensions. Without a detailed picture of the client's situation, history (drug, health, social circumstance & functioning and offending behaviour) it is unlikely that any treatment agency will be able to deliver an effective package of treatment. With the wide range of professions and agencies involved in this work, it is common that service users are required to undergo separate assessments at each. This, however, often creates a confusing bureaucratic barrier for the client with ineffective use of resources and a needless repetition. We begin to identify the need for a standardised assessment instrument and process, which can be accepted by a range of agencies and professionals.

It is important to explore the principles that underpin effective needs-led treatment. These include the development of trust and the establishment of a therapeutic relationship. The exploration of the client's perception of their situation, and identification of the level of motivation based upon this perception. There must be a prioritised assessment of presenting issues and practical considerations to ensure an effective early experience of treatment.

Effective assessment is often undermined by the lack of availability of treatment. For instance, in an area where there is only a medically based substitute prescribing service available, the relapse prevention needs of a drug-free ex-prisoner may be almost impossible to meet without exposure to persons that may contribute towards relapse. Similarly, sending a sixteen-year old person after a short episode of drug use to a clinic which provides help to much older, chronic and chaotic users would most likely be detrimental, by exposing him to suppliers.

In assessing those being considered for coerced treatment, it is vital to include a comprehensive risk analysis that considers the likelihood of re-offending and risk to public safety. A thorough exploration of practical considerations is required (e.g. is the client a carer/ parent? transport, language and literacy, cultural barriers or homelessness). This investigation underpins the contract and will increase the likelihood of a successful

intervention and reduce the possibility of failure. Failure within coerced treatment can have far reaching consequences with breach and the possibility of custody unlike non-criminal justice based treatment interventions. So here we find a variation from traditional treatment philosophies and certainly a training need for providers not used to working within the constructs of a criminal justice model of treatment.

Where treatment goes wrong it is likely that practical considerations have not been addressed and that there is no process of ongoing assessment and treatment review. Assessment is not a form filling exercise that takes place once at the first point of contact. It combines formative and summative assessments in a dynamic process that ensures a constant fine-tuning of the matching of treatment to the need. The paramount importance of using assessment to match client needs to treatment modality cannot be over-emphasised.

This then requires the assessor to have detailed knowledge of the different treatment agencies and a clear understanding of programmes and the expectations of treatment. Developing a good working relationship between referrer and treatment providers is essential. In this way treatment expectations can be explained and discussed prior to admission, issues such as confidentiality can be considered in the assessment process as would rules, time commitment, culture and treatment processes. This would help to reduce the number dropping out of treatment and reduce the exploitation by clients in gaps of understanding between referrer, agency and individual clients. Treatment works better when there is a tripartite contractual agreement accepted by all parties.

What is treatment?

Treatment (as opposed to self-help) is any structured attempt to improve lifestyle, health or social functioning involving a specialist third party. Whilst the term tends to have medical connotations, effective treatment is often delivered in non-medical settings and by non-medical professionals.

What does treatment aim to achieve?

NTORS has identified that service providers have a range or hierarchy of goals including

- Reduction of Psychological, Social and other problems directly related to drug use.
- Reduction of Psychological, Social and other problems not directly attributable to drug use.
- A reduction in harmful or risky behaviour associated with the use of drugs e.g. sharing injecting equipment
- Attainment of controlled non-dependent or non-problematic drug use.
- Abstinence from main problem drug(s)
- Abstinence from all drugs

However these harm reduction and drug-use centred goals only address part of the treatment picture. In order to attain a reduction in drug-use and related risk behaviour, it

is important to enable the individual to reinvent their life and life-style in order to rejoin mainstream society.

As Bertold Brecht eloquently expresses:

" You can give me drugs to cure my chest infection but you cannot rid my flat of the damp that caused it"

A treatment strategy which ignores the processes of social exclusion will fail to address the problem effectively. Beyond the drug focus, drug users have multi-faceted and complex needs. Most of these are resolved through facilitated and supported self-help where individual responsibility is key to success. There is a requirement for action and this is vital to the process of change. The homeless must be helped with their accommodation needs, those who have been long term unemployed must be guided to take up training and skills development to help enter or re-enter the world of work. Similarly, co-existent mental health problems need interventions that can only be provided through true multi-disciplinary case management. Fragmented relationships and isolation are other areas where guidance and action are required.

In this way we begin to build a double-edged approach to treatment where major changes in lifestyle are an integral factor. Here the development of self-esteem and a sense of purpose are necessary and lead to the delivery of the drug and harm reduction goals.

What kinds of treatment exist?

Treatment Goals and Modalities.

The client entering treatment can often be presented with a bewildering choice of options available that will vary from area to area. Engaging the client is essential and listening and challenging, where appropriate, is the method by which to do this. What the client wants from treatment is often misunderstood, for example and a recent paper on drug user opinion demonstrated that 48% of clients wanted an increase in the availability of non-drug treatments whilst only 31% wanted an increase in the availability of drug treatments

A national overview of treatment goals and modalities is demonstrated in the table below:

	Level of Intervention		
Treatment Goals	**Low threshold Modality**	**Medium Threshold Modality**	**High Threshold Modality**
Abstinence based services	NA & AA, Self help groups, Drugs Education, Peer Counselling, Supported Hostels, Resettlement & Half way Programmes	Community based detoxification & Substitute prescribing services Out Patient, Through-care, Fast Track Case Management	Residential programmes, TCs, 12 Step Programmes, Structured Day programmes, In-patient services
Harm-minimisation based services	Street agencies, drop in services, Needle exchanges, Health Education Peer counselling, Out Patient, Some Hostels, Wet houses	Appointment based counselling services, Aspects of Community Drug Teams and maintenance prescribing, Through-care, Fast Track case management	Structured day Programmes Intensive Case Management

The reality is that the threshold will present more as a continuum rather than having fixed boundaries, and not all services will be available within any one locality.

Interventions

When defining treatment, it is not only important to consider the modality but also to define what will be delivered to the client. There are a wide range of interventions, and whilst most services would claim to work in an eclectic style, this will be composed of elements of the following:

Advice and Information; few potential service users are in a position to make an informed choice either about their own needs and priorities or about which service may help them. Accurate advice and information together with assessment are the most basic level of intervention.

Motivational Interviewing Techniques based upon the work of Prochaska and DiClemente have been found to be of particular use when working with client ambivalence or intransigence to change and also for eliciting self-motivation from the client.

Cognitive-Behavioural interventions based either on a therapeutic approach piloted initially by Miller, Dryden and many others, and by Ross and Fabriano in the criminal justice context (Reasoning and Rehabilitation programmes) proved to be effective not only in enabling change but also maintaining change over time.

Relapse Prevention is a specific cognitive treatment introduced by Marlatt and Gordon which fostered understanding that most drug users relapsed after treatment. This technique has proved to be effective in reducing both relapse and the prejudice of many services towards those who relapse.

Counselling and group-work techniques are widely used. There are too many models and theories to mention in this paper but these all potentially have a role in enabling the client to gain a greater perspective on his or her situation and can also be invaluable in an exploration of causative or contributing factors. As a rule long-term psycho-dynamic counselling and psychotherapy are not useful in a harm-minimisation context but brief interventions and solution and goal centred counselling have proved to be accessible and effective.

The development of the AA and NA fellowships can give clients access to a huge number of self help groups that can be productive both in the acute treatment phase and also give a 'philosophy' by which to maintain abstinence over time.

In cases where both substance misuse problems and mental health problems are present, research has demonstrated that a mix of some or all of the above, delivered by a case management approach, is perhaps the most productive way forward.

How can we improve Treatment Effectiveness?

The vast majority of these interventions can be delivered in either a structured programme approach, a one-to-one approach, or in the group-work situation. Access is dependent upon the threshold of the service and the needs of the individual.

For the structured programme approach, good programmes can be distinguished on the basis of well-defined treatment protocols, adequate staffing patterns and experience, explicit programme goals, reasonable and consistent funding and comprehensive management systems.

Therapeutic Communities (TCs), 12 Step programmes and other residential facilities fall into this category. There is evidence that some methadone programmes that are managed in the same structured manner combined with case management and individual counselling, obtain the best outcomes. Again there is overwhelming international evidence that Pharmacological Treatment for drug dependence is effective. In the UK, however, there appears to be little consistency in methadone programmes, which seem to vary from good to very poor dependent on clinical direction. The NTORS study has highlighted a major concern about the high levels of methadone being exchanged on the illicit drug market. Here controls on the prescription and administration of methadone

will need review.

The National Treatment Outcome Study – after one year highlights a number of key factors in offering successful interventions and even distinct variances of treatment effectiveness from different agencies offering similar treatment. NTORS will be doing further work on these areas but if we start to look at other evidence in conjunction with NTORS, we see patterns emerging which will make better use of limited and seemingly dwindling resources.

As discussed earlier within this paper the need for thorough and careful assessment is paramount. Matching need with treatment is essential. Another key factor is retention in treatment. There is overwhelming evidence that the impact of a successful treatment episode correlates with length of stay and involvement in treatment. With both residential treatment and Therapeutic Communities, the impact of treatment only begins to engage clients in the change process after a period of three months. The prognosis for the individual improves with each month thereafter to an institutional "cut off " time which is usually about twelve months. The intensity of intervention can be reduced in the resettlement period. Structured after-care, such as supported half way accommodation, can add significantly to the effectiveness of treatment. This evidence, although not new, must change purchaser's attitudes to short treatment episodes driven, in the main, by limited funding.

Retention in treatment can be a dynamic process which, through management, can be controlled and improved. It requires analysis and planning. Poor retention is often blamed on clients who ' just do not want to change' or, like osmosis, it just happens. We must challenge these beliefs. Poor retention over time means poorly designed and delivered services and poor management.

Given an accurate match of client and modality through appropriate assessment, much support and encouragement must be given to the new client. Careful induction processes are vital. There must be agreed aims and goals of treatment and a clear written compact. Rules and boundaries need definition and acceptance. Above all, a high level of support is essential in the early stages of treatment.

Over the months, the intensity of treatment can be increased as individuals become more confident and able to deal with increased demands. Monitoring and review of the aims and goals of treatment is essential. These will need addressing on a regular basis. Programmes can be underpinned with intensive case management. Prior to discharge and in the aftercare process the intensity of support must be increased.

Another factor in improving retention is the confidence of staff and a well- motivated and trained staff team.

How can we design effective programmes?

In designing effective treatment programmes for offenders, research has shown that specific types of rehabilitative
e programmes, whether community based or residential, can out-perform traditional, narrowly focused drugs projects. The emerging principles of good practice for drug using offenders include:

- Targeting high risk offenders
- Focus on offending behaviour and the factors underlying it
- Programmes are clearly structured and properly implemented
- Staff are well trained and motivated

We are beginning to see new programmes where we are moving away from a single philosophy of treatment (e.g. health or socialisation) to ones which augment one particular model with another for pragmatic purposes, for instance, by combining cognitive behavioural models in therapeutic settings. These are particularly helpful in tackling offending behaviour and drugs misuse simultaneously. Another example of this pragmatism can be seen where traditional (non12 Step) residential programmes introduce AA and NA meetings. This progressive move capitalises on an ongoing programme and aftercare, which can be easily accessed across the UK at no cost to the state. In the US, the combination of Therapeutic Communities and AA, CA (Cocaine Anonymous) and NA has been operating for many years and is seen as a way of extending the treatment period after programme end. In the UK, there is a high degree of ignorance of 12 step programmes with " professionals" driven by their own ideologies and disciplines. This appears to be a real barrier. If progress is to be made, we need a radical re-think about what works and how to utilise pragmatic approaches and not be blinded by ideology and individual beliefs. We must consider that different 'treatments' work for different people at different stages of their drugs and offending careers.

Addaction has over the last years encouraged CA (cocaine anonymous) meetings at its Maya project, which provides treatment and care for mainly black and minority ethnic women crack and stimulant users. The results seem to be impressive. There have been no incidents of drugs misuse in the last year, retention has improved and we hope that this will lead to better long term outcomes. In our two large prison programmes (total 170 inmates) we have recently recruited two 12 step counsellors to provide guidance on through-care and aftercare.

Why is a flexible approach to treatment necessary?

Although there are many different treatment models available, few areas outside of major cities offer a wide range of services. Those that are available are often over specialised and neglect factors related to drugs misuse and offending.

The lack of continuity in case management for drug offenders often undermines the effectiveness of treatment in the community. What is needed is continuity of case management, from the point of sentence until the order is completed (in the case of community penalties) or until the offender is resettled into the community (for prison sentences). This model of intensive case management will increase effectiveness. This ensures treatment providers and other partnership agencies for example hostels or employment services, are implementing and monitoring the individual offender's treatment plan. All agencies involved should be aligned to the same treatment objectives. For effective treatment for drug offenders to work strategic alliances and partnerships between all relevant agencies must be made possible and adequately resourced. The evidence is clear that adequate treatment clarity, duration and structured aftercare greatly increase effectiveness

.

Drug misusers themselves are a diverse group mirroring local patterns of demography and, as such, having diverse treatment needs. At present, the criminal justice system too often fails to identify underlying drug problems and is too often unaware either of treatment options or differences in treatment need. Some particular groups for example women, women with children, minority ethnic groups, stimulant users, and young people, are under-represented in treatment, probably because agencies are not perceived to be relevant to their needs and have done little to make themselves available. At the same time, black people and women with drug and mental health problems are too likely to receive custodial sentences with few treatment options when compared with white male opiate users. Similarly, current wisdom suggests that custodial sentences for young drug offenders simply increase their knowledge and chances of further and more serious offending. Another group in urgent need of proper treatment is those drug offenders with mental health diagnosis who too often find themselves sentenced inappropriately.

If drug treatment within the criminal justice context is to be meaningful and accessible, these disparities in availability and relevance of treatment on the one hand, and of effective education of sentencers, equity and rationality of sentencing on the other hand, must first be addressed.

Although "Tackling Drugs to Build a Better Britain " lays out a rational framework to provide effective partnerships to enable holistic and flexible approaches to treatment, the reality is far from that envisaged. In many areas Drug Action Teams are ineffective with representation devolved far from the executive level intended and no effective strategy to combine either resources or expertise at the operational level. Ways of realising the vision of partnership essential to effective treatment with such limited resources must be found.

Young People

The HAS report on Children and Young People – the report on young substance misusers clearly highlights the need for discrete and dedicated services in order to avoid the contamination effect from older and more chronic drug users. The contradiction of sentencing young people to Young Offenders Institutes and Prisons where they can be influenced by hardened drug offenders and the culture within prisons is obvious. The absence of effective treatment services requires agencies with responsibility for young people to pool resources and expertise to offer young offenders viable alternatives to custody. Second generation addiction is now common in the UK and these individuals with parental role models who proved to be immune to treatment may be exceptionally cynical and hard to reach. Compared with the US, very little development of effective interventions for addicted young people and families has been attempted so far in the UK.

Women, and Women with Children.

The traditional characteristic and continuing under-representation of women in treatment services shows clearly that such services as exist are not seen as relevant for them by most women with drug problems. Surveys have shown repeatedly that facilities, opening times, and content of treatment are seen by women as unfriendly to their individual and parental needs, catering rather to the needs of men and the agencies themselves. Despite this, very few services have provided the kind of features women need or want. Looking at practical considerations, opening times to accommodate after school drops, crèche and baby changing facilities, advice on parenting and gender specific topics, female staff, and representation on advisory bodies can create an environment attractive to women. There is evidence to demonstrate that the percentage of uptake by women can increase sharply where agencies adopt these principles.

A fear of losing custody of children or of simply being reported to social services and the resultant fear of interference in child-care has widely been reported as a major factor in reducing accessibility of services to women. For this reason treatment providers need to be clear about child care issues and child protection. Confidentiality policies need to be clearly communicated at the onset of contact.

For the more chronic drug users, few residential facilities are available especially accommodation where women can be accompanied by their children or their partners. Several such facilities have closed since the implementation of Community Care. Although with child development workers the cost of an episode appears to be high, successful rehabilitation of the family as a unit will save the costs of fostering, residential child care and guardianship as well as the social cost of family breakdown and resulting problems.

The Maya Project in South London is one example of a residential service for women and children which has prospered through innovation, creating successful outcomes for its clients.

The sex industry and drugs use are clearly linked and a high number of working women are drug dependent. Innovative outreach is needed to provide access to treatment and help. This may be particularly problematic as few working women wish to be identified as drug misusers because of stigmatisation, resulting loss of business and vulnerability to pimps.

Minority Ethnic Groups

Black drug users are more likely to be overly represented within the criminal justice and mental health systems whilst at the same time being under-represented in treatment services, both in prison and in community treatment settings. The reasons for this are complex. We should not be blind to institutional prejudice, which can both include minority groups as crime suspects and exclude them as clients for services. There is often a perception amongst ethic minority problem users that drug treatment agencies are not relevant to their needs.

An active debate remains unresolved as to whether separate agencies or integrated services should answer this need. Traditional treatment services have been particularly unsuccessful in attracting minority ethnic groups. Here models of community development and ownership can bring treatment providers closer to the communities they serve by identifying and providing for major cultural differences.

For example, individualistic treatments such as counselling for the drug user may be irrelevant to some cultures in which the family rather than the individual is the smallest unit of treatment. Similarly, the internal psychology that we take for granted is a recent western invention and totally alien to some Eastern cultures. For many Afro-Caribbean people the stigma of psychiatric treatment is significant enough to deter them from seeking help in psychiatric settings.

Ethnic minorities cannot be treated as a homogeneous group. There are many communities in which different needs should be recognised. There are several key principles that can help in the delivery of treatment. Consultation and needs analysis can help identify treatment requirements. Community development models and partnership approaches help challenge Euro-centric assumptions. Appropriate staffing, cultural sensitivity, and, where necessary, separate services, should be considered. Drug awareness and training for community groups can help to bridge gaps in understanding and, similarly, the various minority ethnic communities can train treatment providers in cultural diversity.

Stimulant Users

As there is no physical withdrawal syndrome from stimulant use, offenders who have been using crack and amphetamines are less likely to disclose their illicit drug use. In the community they are again less likely to present themselves at agencies which, in the main, focus their service delivery towards opiate users. Recent research in South London suggests that only about one fifth of stimulant users ever report their drug use to any professional agency.

There is evidence, however, stimulant users can be some of the most prolific offenders. Project STAR (Stimulant Treatment and Research) in its needs analysis survey identified the average cost of drugs use. In the week before interview respondents on average spent £447 with a range of £20-£2125. The wide range is due to low cost of amphetamine sulphate and high cost of crack and cocaine. Offenders using stimulants are more likely to be involved in violent crime (crime against the person) as opposed to opiate users who are more likely to commit acquisitive crime (crime against property). The Project Star Survey (op cit) found that almost half (49%) of respondents felt that they were more likely to become involved in violent situations since using stimulants, while 42% felt more aggressive. Further, the widespread use of amphetamines by heavy drinkers means that stimulant use may be implicated in many more crimes against the person that are attributed to alcohol use.

Stimulant use presents new challenges for treatment practitioners. The use of outreach programmes can be helpful in contacting stimulant users who may otherwise be unaware of treatment services which do cater for their needs. Again there are a different and unresolved arguments about the substitute prescribing of stimulants to users. There may well be benefit in pharmacological treatment which help deal with the depression, insomnia, lethargy and other symptoms of stimulant withdrawal.

A wide spread training initiative may be required to ensure that the needs of stimulant users are recognised and that appropriate interventions are developed. In the Project Star survey 75% of respondents wanted advice and information, while 80% identified counselling or other talk therapies as their primary treatment need, whereas only 27% required substitute prescribing. Progressive agencies rather than treating all drug users in the same way, are delivering alternative therapies, relaxation techniques, herbal teas and other interventions which help drug users to engage in a counselling process.

For some stimulant users who exhibit extremely impulsive behaviour and are otherwise unlikely to sustain interest in treatment, removal from the community into residential units, rehabilitation or safe and supported accommodation can be essential.

We are recognising that an increasing number of primary crack users are developing opiate dependency as a result of using heroin to manage the depression of ‘come down or crash’ (regular withdrawal after binges).

Dual Diagnosis

The closure of psychiatric hospitals and the lack of appropriate care in the community have lead to a large increase in the number of people with a mental diagnosis self-medicating often through illegal drug use. There is an urgent need for appropriate drug services and for appropriate training for workers in existing drug services if a proper service is to be provided to these groups. Many drugs services, with the best of intentions, inappropriately assess and treat individuals with severe problems while neither recognising this severity nor knowing how to deal with it. Community mental health services are too often expected to deal with substance misuse without adequate specialist knowledge.

Multi-agency working involving adult mental health services, psychiatric services and specialist drugs agencies can offer a partial solution. Increasingly, individuals with dual diagnosis are appearing before courts. It may be for these people in particular that an alternative to custody needs to be found where their complex needs can be addressed. A model of good practise can be found for this group in the USA where the Phoenix House Foundation have established a successful therapeutic community within the classic self help model solely for women with drug misusers and mental health diagnosis. It must be noted that the success of this unit flies in the face of all previous professional opinion in mental health circles.

How do we manage treatment failure?

Treatment failure (relapse) and treatment drop-out (voluntary premature termination) are the norm. Many drug users require exposure to more than one treatment episode before making significant change. In the context of coerced treatment, it is important to recognise that although coercion may be useful to introduce an offender to the change process, for treatment to be successful the individual must engage voluntarily at a relatively early point. In other words you can take a horse to water but you can't make it drink. Therefore, it is essential that those who fall out of treatment or relapse are offered further and ongoing treatment. This re-emphasises the case made earlier in this paper for good case management which can ensure consistency and continuity, reinforce achievements made in treatment and re-engage the individual rather than simply negating the treatment experience. Although difficult to achieve within a resource limited environment, this will reduce the propensity drug offenders to continue with the revolving door syndrome of drugs, offending, treatment and failure and custody.

How do we measure outcomes?

Monitoring & Evaluation methodologies should be an integral part of the treatment process and are vital if one is attempting to work in a way that provides continual assessment and feed back to the individual which is recorded. Re-set and revised treatment goals then create a dynamic treatment process.

Urine sample analysis, observations on attendance and compliance, self reporting, peer evaluation, measured reporting of change and evidenced based outcomes studies can all aid treatment providers in ensuring that interventions are having the desired effect.

While the above measures focus on the individual's response for treatment, it is also vital to manage the treatment environment, ensuring that the treatment curriculum, group and individual sessions are being delivered to the specification requirements and to the appropriate standard and quality. This is vital to attaining a healthy programme. Staff supervision, support and training are imperative to this end.

Will coerced treatment achieve the aim of reduced crime and drug misuse?

The evidence overwhelmingly indicates that coerced treatment will work. But without sufficient investment, enabling existing resources to be articulated effectively, the effectiveness of such a strategy must be questionable. Much of the evidence used in this paper derives from US studies. The investment in treatment in the US is many times greater than in the UK. In New York alone there are over twelve thousand treatment beds. In the UK we have less than one thousand.

1 Edmunds et al (1998) Arrest Referral – Emerging Lessons from research Home Office Drug Prevention Initiative: Paper 23

2 Bennet T (1998) Drugs and Crime – Drug Testing and Interviewing Arrestees. Home Office Research Study 183

3 Thompson, A and Young J (1996) A Review of Treatment for Drug Offenders. Drugs: education, prevention and policy, Vol 3 No1

4 Hough,M. (1997) Alternatives to prison sentences, Paper written for Home Affairs Committee on Alternatives to Prison

5 Hough,M.(1996) Drug misuse and the Criminal Justice System. HMSO, London

6 Hindson M (1993) The ethics of compusory drug treatment Unpublished

7 Gerstein et al (1994) Evaluating recovery services. The California drug and alcohol treatment Assessment, Sacremento, Clafornia

8 Ghodse, H (1989) Drugs and Addictive Behaviour, Blackwell Scientific, London.

9 Jones, M et al (1988) Drug User Consultation Survey. Addaction, London

10 Miller, W. & Rollnick S. (1991) Motivational Interviewing Guilford press, London.

11 Wanigarante et al (1990) Relapse prevention for Addictive behaviours. Blackwell Science, London.

12 Weiss, R.D. et al (1992) Methodological considerations in the diagnosis of co-existing psychiatric disorders in substance abusers. British Journal of Addiction 87, pp179-187.

13 Treatment Outcome Working Group (1996)Treatment Protocol Effectiveness Study Office of US National Drug Control Policy Director

14 Treatment Outcome Working Group (1996) ibid

15 Gossop, Marsden and Stewart (1998) NTORS at One Year. Dept. Health

16 Deleon, G (1991) Retention in Drug Free Therapeutic Communities and Pickens. Leukefeld and Shuster, Improving Drug Abuse Treatment NIDA Research Monograph.

17 Hough, M. (1997) ibid

18 Hough M, (1997) ibid

19 Inciardi, M. (1996) Heroin use and street crime and Field (1994) The effects of intensive treatment in reducing recidivism in addicted offenders Federal Probation Service.

20 Strang et al, (1996) National Addiction Centre Research into Service Uptake by drug users .Reported in Drug Link August 1996

21 Jones M, and Jones S (1997) Project Star (stimulant treatment and research) stimulant users'needs assessment. Addaction (apa)

AMERICAN DRUG COURTS CONFERENCE

'FLEXIBILITY IN TREATMENT PROVISIONS'

Peter Martin

July 1998