

routes into treatment

DRUGS & CRIME



About Turning Point

Turning Point is the UK's leading social care organisation working with individuals and their communities across England and Wales in the areas of drug and alcohol misuse, mental health and learning disability. We have particular expertise in working with people who have complex needs and are facing multiple social challenges.

Turning Point is the country's largest voluntary sector provider of drug services. We run services across the full range of drug treatment interventions, both within the community and through the criminal justice system.

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Routes into treatment: drugs and crime

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executive summary

A growing proportion of publicly funded drug treatment in England and Wales is provided through the criminal justice system. The Government's current policy on drugs is undoubtedly shifting from providing voluntary treatment in the community towards tackling the link between drugs and crime. This has happened to such an extent that this year, for the first time, central government will spend more on drug treatment through the criminal justice system than through community based services. Drug Treatment and Testing Orders (DTTOs) are the principal means of channelling drug misusers who commit a crime into treatment in the community. The number of DTTOs has increased dramatically since their introduction and the Government intends to increase the number of DTTOs from nearly 5,000 a year in 2001 to 16,000 by 2006.

DTTOs bring health and social care agencies and criminal justice agencies together. These two systems have traditionally operated in isolation from one another, often with conflicting priorities and values.

Services in the criminal justice system have a number of strengths including rapid access, the removal of hurdles and an integrated approach. These strengths are often compromised however, by an overly punitive approach, which emphasises compliance at the expense of improving motivation and recognition that people may relapse. In the community, services are more client-focused and user-friendly, but are harder to access and are sometimes less cohesive in approach.

Turning Point supports the expansion of treatment options in the criminal justice system, which has an important role to play in getting drug users into treatment. There is still substantial room for improvement however. DTTOs have come under considerable criticism, most recently from the National Audit Office, for not keeping people on programmes, with less than one in three offenders completing the order in full (National Audit Office, 2004). It is important that we learn from current criticisms in order to develop a more consistent framework in the future.

This report provides an analysis of people's experiences in the two settings and makes recommendations to improve the effectiveness, structure and delivery of existing policies that coerce drug misusers who commit crime to enter and remain in treatment.

Turning Point concludes that there is a need to radically rethink criminal justice responses to drug problems if the current public health approaches are to succeed. We believe that the provision of a system, which addresses the needs of the user and the community, depends on a shift towards a more flexible, public health approach to treatment within the criminal justice system. We also argue that a more effective union between the fast-track approach of the criminal justice system and the user-focused approach of community services can be achieved through a better pooling of expertise and sharing of good practice of what works in and across both sectors. Learning the lessons from other countries, we also advocate drug courts as a model of delivery that leads to more effective and integrated partnerships between the judiciary, criminal justice agencies and drug providers and ultimately, better treatment for the user and reductions in re-offending.

'I was 18-years old when I realised I had a problem and needed help. Since then the only help I've had is going to jail until they came up with the DTTO. I'm 28 now and this is doing me a world of good'

Turning Point's report also examines the balance between criminal justice interventions with treatment provided in the community, from the perspective of the drug misuser. It reveals that in some areas a significant minority of offenders have committed a crime to provide a fast-track into treatment.

Turning Point recommends that the Government carefully monitors the balance between different forms of treatment. It would be self-defeating for criminal justice initiatives to be expanded at the expense of existing treatment and prescribing programmes in the community, or if the easiest point of entry to treatment is through committing a crime.

It is important not to create an impression that all problem drug users are criminals

1 The link between drugs and crime – rooting out the cause

One of the key aims of community sentences such as DTOs, is to break the connection between drug use and criminal activity. But the relationship between drugs and crime is not straightforward. The view that crime committed by problematic drug users is largely driven by the need to finance the purchase of illegal drugs is 'not entirely borne out by the evidence'. (Scottish Consortium on Crime and Criminal Justice, 2000).

There is no single, causal connection between drug use and crime. It is unwise to generalise as there is evidence to suggest that drug use causes or explains the crime, while other evidence suggests that involvement in other kinds of crime explains the drug use. Many studies show that most people who misuse drugs and commit crimes, committed crimes before they used drugs (Pudney 2002). In other cases, drug use and crime may start independently, without one causing the other. A prior history of criminality, rather than prior drug use, is the most common factor in crime frequency. This prior involvement in crime may reflect a broader lifestyle, which typically encompasses poly-drug use and criminality. For those engaged in crime prior to drug use, their offending can increase sharply when the factor of drug misuse comes into play.

NACRO's report on drugs and crime identified three ways in which the relationship between drug use and other forms of offending is believed to work. There is an important distinction between offences which are drug induced, in which the effects of drugs may mean that people are more likely to commit certain kinds of offences and acquisitive crimes that are believed to be drug-related, in which the motivation is specifically to use the proceeds of crime to fund their drug use. Finally, there are also crimes linked to the drug trade (NACRO, 2003).

What is certain however is that drug misuse relates to a wide range of crimes and is a crucial factor in a high proportion of acquisitive crimes, with heroin, crack cocaine and cocaine users responsible for a significant proportion. In the National Treatment Outcome Research Study, 50 per cent of patients had committed some form of acquisitive crime in the previous three months and a minority engaged repeatedly in crime to fund their dependency (Gossop et al, 1999 and 2001).

The best available evidence on the links between criminal offending and drug use comes from the New English and Welsh arrestee drug abuse (NEW-ADAM) research programme, which interviews and drug tests people arrested by the police at 16 sites in England and Wales (Holloway, Bennett, 2004). Just over half (53 per cent) of arrestees reported acquisitive offending in the last 12 months, compared to just under two thirds (62 per cent) of those reporting any illicit drug use and three quarters (75 per cent) of those using heroin, cocaine and crack cocaine. Class A users reported crime levels ten times higher than that of non-drug users and of those using any illicit drug, 40 per cent said there was a connection between their drug use and their offending behaviour, compared to 78 per cent of those using heroin, cocaine and crack cocaine.

There is a minority of drug users who are dependent in use, chaotic in lifestyles and finance their use through acquisitive crime. Crime tends to intensify during periods of high drug use. However, the overwhelming majority of illicit drug misusers do not commit (further) criminal offences and many people commit crimes without having used drugs at all. It is important not to create an impression that all problem drug users are criminals. It is even more important to provide treatment for drug users that recognises them as

people with serious health, mental health and/or social problems – whether they reach that treatment through the community or criminal justice system (DrugScope, 2004).

Turning Point's experience shows that many dependent drug users have limited social and economic resources and limited exposure to life opportunities. Early drug use and deprivation are still the strongest indicators of progression to problem use. (Runciman Committee, 2000). Low educational attainment, negative childhood experience, poor access to healthcare, housing and limited employment, all underlie drug misuse and offending behaviour (Seddon, 2000).

The Government's Advisory Council on the Misuse of Drugs (ACMD) concluded that 'on a strong balance of probability, deprivation is today in Britain likely to make a significant causal contribution to the cause, complication and intractability of certain kinds of damaging drug misuse. We want in the future, to see deprivation given its full and proper place in all considerations of drug prevention policy' (ACMD, 1998).

It is necessary to tackle the factors that draw people into drug misuse in the first place and Turning Point believes that social deprivation should be given a higher priority in drug policy and be a key performance indicator for services. The success of drug treatment, whether provided in the community or via the criminal justice system, should be measured against a new target to reduce deprivation and promote social inclusion.

In 2004-2005 central government funding for criminal justice based services will overtake funding for the pooled treatment budget

2 Funding matters

The Government has given a high profile to tackling drug misuse as evidenced by its ten-year strategy launched in 1998 and updated in 2002. Investment in treatment has been prioritised and this was recognised by the creation of a pooled treatment budget in England, which draws together existing funding for drug treatment from the Department of Health and other government departments.

The comparative funding for this pooled treatment budget and for investment in criminal justice based treatment services is shown in Figure 1. In 2004-2005 central government funding for criminal justice based services will overtake funding for the pooled treatment budget.

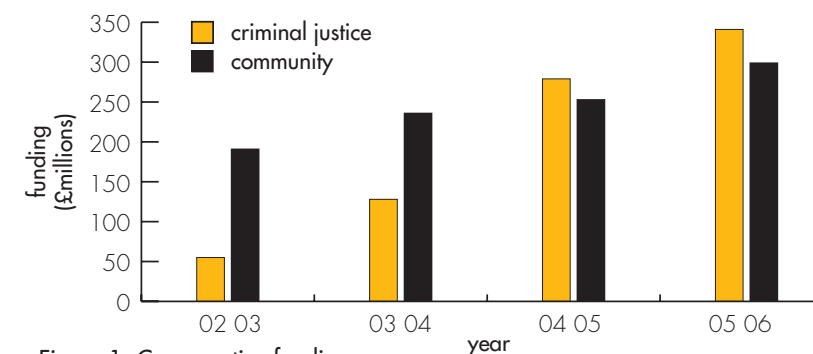


Figure 1 Comparative funding

These figures cover central government funding only. The pooled treatment budget is currently matched by some £200 million (2003-2004) from local authorities for community treatment in their individual areas. The criminal justice funding figures combine DTOs, arrest referral and the new Criminal Justice Intervention Programmes (CJIP).

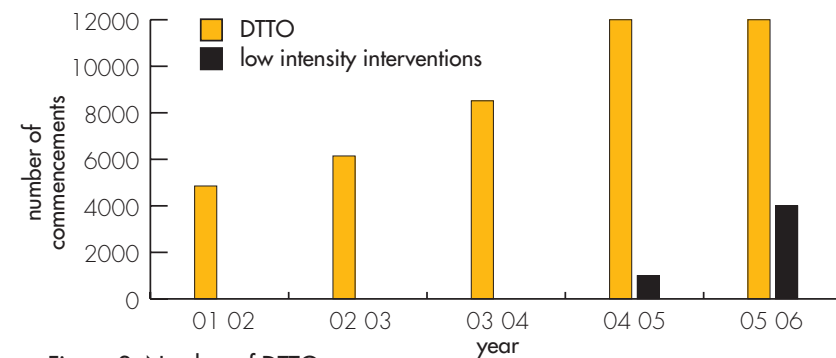


Figure 2 Number of DTTOs

Figure 2 shows the increasing number of DTTOs including targets for forthcoming years. It includes information on targets for high intensity orders and orders with a lower intensity treatment plan. Unfortunately there are not comparable figures yet available for the numbers of people accessing CJIP or arrest referral programmes. A brief overview of arrest referral and the prison based CARAT service is presented below.

Arrest referral is a voluntary scheme that aims to identify problematic drug users at the point of arrest and encourage them to tackle their drug problem via referral to specialist treatment services. On agreeing to participate, people are assessed and if appropriate, referred to services. Between October 2000 and September 2001, arrest referral workers screened around 49,000 people in England and Wales, more than half of whom were voluntarily referred to a specialist drug treatment service and of these, a quarter (5,500 people) entered treatment.

In the Counselling, Assessment, Referral, Advice and Through-care Scheme (CARATS), convicted prisoners are assessed and referred to treatment in prison. CARAT teams are also responsible for identifying and referring prisoners who require treatment on release into the community. In 2002-2003, nearly 52,000 assessments of prisoners with drug needs were carried out by CARATS.

The National Treatment Agency (for England only) reports that the total number of people presenting themselves for treatment has grown from 66,300 in 2000-2001 and 77,300 in 2001-2002, to 82,400 in 2002-2003.

The Criminal Justice Interventions Programme (CJIP), launched in April 2003 as a three-year programme, aims to encourage closer working between criminal justice agencies and drug treatment agencies, to ensure a cohesive approach from arrest, sentence and beyond. Initially introduced in 30 pilot areas with the highest levels of acquisitive crime, it was extended to a further 36 areas in April 2004 and is backed by a significant £447 million over the three years, to help national and local partners play their part.

This reflects the shift in recent years, toward a greater emphasis on providing treatment in the community through the criminal justice system, and these interventions account for a growing number of problem users presenting for treatment in the community. This year, for the first time, central government will spend more on drug treatment through the criminal justice system than through community-based services.

3 Emerging reliance on DTTOs

3.1 Delivering DTTOs

A range of treatment interventions work to address the needs of drug misusers, including methods of harm reduction, reducing the use of illegal drugs and helping people rebuild their lives. Treatment works at different times for different people. Treatment is viewed as 'the most powerful weapon against drugs' (Government Response to Home Affairs Select Committee Inquiry into Drugs, 2002). The long-standing stance of the criminal justice system is to 'get tough' on the criminal aspects of drug misuse, particularly drug-related crime. Historically this approach meant health and criminal agencies worked in isolation.

DTTOs evolved to resolve the conflicting political ideologies of these two systems, concerned on the one hand with crime and punishment and on the other, public health and treatment. They require a fine balance of interests. Too much attention to treatment will be seen as rewarding offending, whilst over emphasising punishment will undermine the therapeutic treatment approach. More critically however, they represent the insight that it is public health measures rather than criminal law that can change drug behaviour.

The Criminal Justice Act 1991 introduced measures to promote joint action between criminal justice and health agencies, giving courts the power to impose treatment as part of a probation order (Schedule 1A6 probation order). However, this power was not used consistently across the country and only one per cent of probation orders had an explicit condition concerning treatment (Hough, 1996). Factors such as a perceived lack of interest by treatment providers to run programmes via the criminal justice system, lack of information on the content of treatment, reservation by probation services and a lack of resources, led to a reluctance to use these new powers (Home Office, 1997).

DTTOs, first mooted in the 1997 Labour Party manifesto, were inspired in part, by the success of drug courts in the USA and the need to respond to the increasing number of drug offenders in prison. The Government believed that because of the pivotal role of the criminal justice system in tackling drug misuse, DTTOs would be important in identifying drug users who were not receiving treatment, and in facilitating their access to services and ensuring their continued participation. Treatment was also seen as a way of reducing overcrowding in prisons and costs.

Turning Point has long voiced the view that there are strong arguments against the use of imprisonment for drug misusers, except where the seriousness of the crime justifies imprisonment on public protection grounds. Research has shown that treatment produces positive results in reducing drug use and drug-related crimes, is more effective in preventing further harm to individuals and their communities, and more successful in rebuilding the lives of drug users and their families.

Treatment is viewed as 'the most powerful weapon against drugs'

Not only are DTTOs effective in rehabilitating offenders, they are also much cheaper than imprisonment. A six-month prison sentence costs around £14,000 whereas a DTTO costs between £5,200 and £7,600 per order (National Audit Office, 2004). The National Treatment Outcome Research Study estimated that for every £1 spent on treatment, £3 was saved in criminal justice costs – a statistic repeatedly used by the Government to explain the rationale for DTTOs.

DTTOs, formally introduced in England and Wales in the Crime and Disorder Act 1998, are aimed at the most serious and prolific drug-misusing offenders aged 16-years and over, who commit acquisitive crime to fund their drug dependency. DTTOs require treatment for a minimum of 15 hours and a maximum of 20 hours a week. Orders are imposed for a minimum of six months and a maximum of three years.

It is a high tariff community penalty available to courts when custody would otherwise be a serious consideration and can only be imposed if the offender is willing to comply. There is a requirement to attend treatment, mandatory drug testing and court reviews of progress (monthly, during the initial stages). It is a high level, demanding and resource intensive treatment order.

Following the Criminal Justice Act 2003, the DTTO will be replaced by a similar drug rehabilitation requirement – one sentencing option under the new Community Order. Judges and magistrates will be able to combine a requirement for drug rehabilitation with one or more further options such as unpaid work or curfews.

In January 2004, the Home Secretary published the report 'Managing offenders, reducing crime' (Carter, 2003), which recommended that from June 2004, the new National Offender Management Service will take over responsibility from the National Probation Service for managing offenders' sentences in the community and from the Prison Service for those in custody.

Since May 2004, Manchester, Salford and Nottingham have been piloting Restriction on Bail – a project which gives courts new powers to order drug assessment and treatment as conditions of bail. Drug-using offenders will be offered the choice of accepting these conditions or being refused bail.

Given the increased emphasis on DTTOs, it is imperative that there is public confidence in their use. Turning Point's own experience shows that once members of the public are aware of an offender's circumstances, they often see that community sentences are more effective than imprisonment and are more willing to accept that they deliver benefits in reducing crime and harm reduction for the individual.

3.2 Proving the success of DTTOs

DTTOs have attracted considerable political attention and scrutiny and there is now a better understanding of their evidence base. In the first pilot schemes, offenders given DTTOs reported substantial reductions in drug use and offending, with reductions largely sustained over time. The average amount spent on drugs fell from £400 per week before arrest, to £25 per week in the early stages of the order and the average number of crimes committed fell from 137 per month before arrest, to 34 per month afterwards. A large proportion of orders were revoked before completion however – 28 per cent in Liverpool, 42 per cent in Croydon and 60 per cent in Gloucestershire – because all three sites struggled to implement the DTTO and only one site had created a viable programme (Turnbull, 1999).

A number of issues were identified that needed to be addressed prior to the national roll out in June 2000. These included ineffective inter-agency working; lack of knowledge among potential referrers; inefficient screening processes at the assessment stage; a lack of consistency in the matching of offenders to interventions; a lack of clarity regarding the objectives of intervention; differing expectations of progress towards abstinence; marked variations in frequency of testing; difficulties in ensuring continuity of sentencers across successive review hearings; and a lack of consistency in enforcement practices across the pilot sites. There was also a need to implement monitoring arrangements to gather data on the referral and assessment process, offenders' level of contact with the programme and enforcement.

The first evaluation of DTTOs concluded that the orders 'were promising but not proven', while a second evaluation in 2003 on reconviction rates two years after the start of the order, found them to be 'less encouraging' (Hough et al. 2003). Revocation rates were high and reconviction rates higher still. It found that only 30 per cent of offenders on DTTOs completed the programme and orders were revoked in 67 per cent of all cases. The reconviction rate for those who failed to complete the order was 91 per cent, but for those who finished the treatment, it was 53 per cent. The challenge for DTTOs is to improve retention rates to ensure an increased number of people complete the order and ensure that provision 'is more responsive, more timely, and more appropriate.'

The National Audit Office's recent report into DTTOs (National Audit Office, 2004) concluded that treatment services and probation have made rapid progress in getting offenders onto DTTOs but suffered from a poor completion rate. Only 28 per cent of orders terminated in 2003 were completed in full or terminated early for good progress. However, this 28 per cent also includes cases in which the order expires while the offender is in breach and not formally revoked by the courts, which suggests that the success rate is even lower. Moreover, in three pilot areas 80 per cent of non-completing offenders had been re-convicted in two years, while those who completed, had a reconviction rate of 53 per cent.

The National Audit Office called on the Government to shift its emphasis from achieving commencements onto the order, to improving their effectiveness. It backed the findings of HM National Inspectorate for Probation's Inspection of DTTOs, which expressed concern about their quality and consistency particularly the extremely uneven local performance in the implementation of DTTOs against national standards (National Probation Service, 2003).

3.3 The role of coerced treatment

Treatment in the criminal justice system is coerced. At the sentencing stage, if an offender refuses to have treatment as part of a community sentence, it may result in a custodial sentence. This means that people may have little incentive to begin and sustain treatment other than a reluctance to return to custody. It has been argued that motivation might not be as strong as it is for those who volunteer for treatment and so only minimal improvement can be expected of someone forced into treatment. Some have also questioned whether it is appropriate to provide treatment to people who don't want it, ahead of those who do want treatment in the community (Quinn, Barton 1999).

However, other research argues that few people enter treatment on their personal initiative without external motivation, whether that treatment is provided through the criminal justice system or voluntarily in the community (Anglin and Maugh, 1992).

All respondents were highly committed to staying on the programme. Several had opted for a DTTO even though it was considerably longer than a custodial sentence

Coercion and pressure to stop using comes from a variety of sources such as family, friends and employers as well as from court and probation and the impact differs depending on the individual. While pressure from the law is a significant decision to enter treatment, factors to do with lifestyle, relationships and 'hitting rock bottom' also impact on this decision.

On this basis, legal coercion is as justified as any other motivation for entering treatment and a person under a community sentence may welcome the opportunity to get treatment and not perceive coercion.

In addition, research has also suggested that treatment provided by the criminal justice system is as effective as voluntary treatment. External motivators such as criminal justice pressure, 'seem to be an effective way of first getting drug misusers into treatment early and secondly, in keeping them there' (Hough 1996). Treatment outcomes are not dependent on the reasons for entering treatment; the critical factor is the length of time spent on a programme (Bean, 1997).

4 Views from the sharp end

4.1 The role of DTTOs

The majority of people on DTTOs acknowledge that their primary purpose is to help them stop using drugs and prevent further drug-related offending. Although a minority agree to a DTTO to avoid a prison sentence, most people say they have reached a point in their life where they want to turn their life around.

Many have had previous contact with numerous treatment regimes with little or no effect and see the DTTO as a way of getting the support they believe they need. The majority have prolonged and entrenched patterns of drug misuse and drug related offending, a group that is often difficult to engage in treatment with limited motivation to change.

Turning Point has documented the experiences of its clients who were undergoing or who had recently finished a DTTO and who had sought treatment both in the community and in the criminal justice system. The aim was to identify the different levels of care people have received and the strengths and weaknesses of both. Through a series of focus groups with service users and self-completion questionnaires, Turning Point has been able to produce an insight into their experiences. It is based on the views of 131 respondents.

Most of the respondents saw the DTTO as an opportunity to conquer their drug dependency, never having successfully taken up treatment. Several had opted for a DTTO even though it was considerably longer than a custodial sentence and the minority who opted for the DTTO to avoid prison, later realised that they really wanted to be on it. All respondents were highly committed to staying on the programme.

The overwhelming majority of respondents referred to DTTOs were using heroin (79%). Many were using heroin in combination with other drugs – cannabis (62 per cent), alcohol (41 per cent) and crack (37 per cent). All the clients are long-term drug users. On average, respondents had been using heroin for eight years, cannabis for 14 years, alcohol for 12 years and crack and heroin together for seven years.

4.2 Experiences of community services

Overall, respondents' experiences of accessing treatment in the community had not been positive, with multiple attempts to get treatment, long waiting times and a lack of understanding from General Practitioners (GPs).

Before being arrested, 74 per cent had tried to get access to treatment services – with an average of three attempts – and 37 per cent had been refused access to treatment. Of those refused treatment, 56 per cent had been denied access to treatment by their GP; 17 per cent by a specialist treatment service; ten per cent by social services and ten per cent by a private doctor.

One respondent said: 'My doctor laughed and said that I should go and play football or something, so that was that. I had to buy stuff off the streets when really he should have been making an effort to help me.' Another described how his GP said he had been helped once and he wasn't going to do it again and another said: 'My doctor wasn't willing because he said I was a 'drug user'. I was told I could no longer be in that surgery and I had to find another GP.'

Lengthy waiting times for community services, sometimes as long as two years, were another key issue raised. The average waiting time was 25 weeks, compared to an average of four weeks to get onto a DTTO. One respondent fortunate enough to be referred by his GP to an outside agency was then told he would have to wait nearly two years and another reported that during his waiting time he moved from smoking to injecting drugs. As worrying, was the comment that: 'At the time I asked for help I was ready for it, but by the time I got it, I did not feel ready. I went deep into a depression and was too paranoid to leave my flat, and this affected my mental health badly.'

The patchy and inconsistent availability of community services was noted by a number of respondents who commented that treatment services should be more widespread and easier to get into.

Almost one third (30 per cent) in the survey said they had committed crime to access drug treatment and 41 per cent had considered it. This was most prevalent in non-urban areas where the treatment infrastructure is less well developed. One 30-year old man said: 'I had to wait so long to be seen for prescribing that I had to commit crime,' while another said: 'I continued to go shoplifting every day to support my habit and get into treatment.'

4.3 Experiences of DTTOs

The majority (80 per cent) of respondents said that the criminal justice system best suited their needs and were extremely positive about the impact that the DTTO had on their lives, with the structure and wide-ranging elements of the DTTO providing them with the back-up they need. A number of respondents spoke about the access to basic skills and opportunities for training and employment as one of the key strengths of the DTTO.

Other comments made by respondents included:

'I was 18-years old when I realised I had a problem and needed help. Since then the only help I've had is going to jail until they came up with the DTTO and this is doing me the world of good.'

Overall, respondents' experiences of accessing treatment in the community had not been positive

‘It’s an open door. You’d be daft not to walk through it.’

‘I was ready to change. I’d ruined my relationship, I was losing friends and self-respect.’

‘I’m here to learn how to come off gear. It’s the best move I ever made.’

‘It’s an open door. You’d be daft not to walk through it.’

‘My prison would only have been six weeks – I wanted my life back.’

The coercive element of the treatment provided an incentive for a number of people.

‘I need a bit of a push at times and non-criminal justice system treatment doesn’t do that,’ said one and ‘Being monitored by the courts will make me come in when I don’t feel like it.’

Turning Point knows that aftercare is crucial to sustaining a drug-free life and yet only 29 per cent of respondents had aftercare arrangements in place. ‘Support is needed when your order is finished so that you can get a prescription if you need one, or talk to someone if you have problems, for example, if you feel you’re about to relapse, but only with the DTTO team because you build up a trust with them while you’re on your order.’

Overall, the survey results reinforce Turning Point’s view that the philosophy behind DTTOs is soundly based. Set up on the belief that treatment works and that legal coercion can be effective in getting people into treatment, they provide an opportunity for seriously dependent drug users who might otherwise not attend treatment. This emphasis on treatment rather than prison recognises that drug use is not simply a law enforcement problem, it is also a public health issue. It is based on an understanding that prison alone does not break the cycle of drug use and crime and that treatment for drug users is effective in reducing drug related crime and drug dependency. It is also economically efficient, as the benefits from reductions in offending behaviour and improvements in health outweigh the costs of treatment.

However, Turning Point also feels that the original purpose of DTTOs is getting lost in the mixed reality of implementation. Many parts of the country are struggling to implement DTTOs and we are concerned at the rate at which offenders drop out of the system. DTTOs were intended to be needs and treatment-led but have instead become focused on meeting attendance targets. While there is little difficulty with uptake, there are problems in keeping offenders attending and completing their treatment. Above all, DTTOs have become too stringent for a chaotic drug offender to succeed and Turning Point’s own DTTO clients’ experiences bear this out.

‘Your have to have rules but it’s very hard. It’s ridiculous to send you home for arriving two minutes late and you’re only allowed three warnings in 18 months.’

‘There’s too much structure. If you’re treated like a kid, you behave like one.’

Turning Point is calling for a review of the structure, design and delivery of DTTOs. The philosophy must be matched by a system that addresses the needs of the individual and the community and demonstrates a shift towards a more flexible, cohesive public health approach to treatment in the criminal justice system that is consistent across the country.

5 Rethinking the delivery of DTTOs

5.1 Enhancing motivation

Personal or internal motivation plays as important a role in treatment and preventing relapse as external motivation. Many of those who enter criminal justice-based treatment have the same treatment needs as those who voluntarily present for treatment. They may however, lack the internal motivation to readily engage either because they have a lower self-assessment of their drug problems, or a lower desire for help or readiness for treatment. Many will have poor expectations of the DTTO prior to starting their order. The lack of internal motivation for change leads to lower treatment retention rates and inferior outcomes (De Leon and Melnick et al. 2000).

Offenders’ accounts show that their internal motivation is low until one-to-one relationships that the offender can see as beneficial are established. ‘Support from workers is really important. They know who is genuine and who is not,’ said one of our survey respondents while others said: ‘DTTO staff care more,’ and ‘they helped me with other things like my family problems – they help me with everything. You can share everything that’s on your mind.’

DTTOs have been successful when they focus attention on improving offenders’ motivation at the start of the programme. One-to-one working relationships and group-based motivational interviewing can help people who are mandated and have no self-identified treatment goals. It can also prepare them to make better use of the treatment programme and enhance motivation to change. This involves providing opportunities to increase self-confidence, helping people recognise the need for treatment, presenting evidence that treatment is effective and providing strategies so that people get the most out of treatment. Evidence shows that people who receive an induction before the start of the programme express more satisfaction with treatment. High levels of treatment readiness are important predictors of sustained participation and success in treatment, reduction in crime and encouraging motivation. The challenge for treatment providers and probation staff is to find ways of engaging with offenders and encourage them to continue with the order.

Learning key lessons from the strengths of treatment in the community, Turning Point recommends that DTTOs should standardise methods of enhancing motivation and treatment readiness, particularly at the start of an order.

5.2 Inappropriate assessment and referrals

Turning Point considers that DTTOs should be a high-tariff criminal justice intervention, when other options have been exhausted and for those who would otherwise have received a custodial sentence. They should be primarily aimed at those with serious drug dependency whose offending is directly related to their use of drugs and who would be unlikely to continue offending if their drug use was tackled. They should not be a catch-all for all drug misusing offenders (Howard League for Reform, 2000).

The effectiveness of DTTOs depends on the quality of the partnerships in which they operate and targets should reflect the quality of the treatment offered

Many people deemed eligible by the courts, may not be appropriate for treatment. Securing appropriate referrals to DTTOs has been a major concern and is a clear explanation of the poor rates of completion.

DTTOs require offenders to have 20 hours' contact per week for the first 13 weeks of an order. Their rigidity means that many clients cannot sustain them, or are deemed unsuitable at the start, so do not get help. There are also concerns that some offenders who would previously have received less severe sentences, are up-tariffed and placed on a DTTO.

The current system has proved to be inappropriate for low-tariff and particularly first-time offenders or for those whose offending is not related to the misuse of drugs. Offenders with low-level drug use should receive a different appropriate intervention before their use becomes heavy-ended. DTTOs do not succeed where offenders have been inappropriately assessed; where an order has been imposed in the face of clear recommendations for an alternative disposal; or where someone's personal history shows that they are unlikely to succeed.

According to large-scale evaluation of criminal justice interventions in the USA, people with the least severe drug problems demonstrated the least improvement overall. As a result, variations in screening and referral criteria can have a profound impact on the measurable success of these programmes (Anglin, 1998).

There are now new targets to reach 35 per cent of completed orders from April 2004. Turning Point strongly supports proposals to increase the number of DTTOs but emphasises the importance of ensuring that output focused targets do not:

- compromise the provision of quality outcomes
- detract from the requirement to ensure that treatment is needs-led
- lead to people being 'cherry picked' because they are less challenging and therefore more likely to succeed
- lead to shorter orders to get people through the system quicker

The report into the evaluation of DTTOs warned that 'if teams struggle to establish their programmes, and lack the resources to deliver rapid and appropriate responses, then DTTOs could become expensive precursors to imprisonment'.

Turning Point is concerned that some areas have widened the entry criteria in order to meet their targets and have brought offenders convicted of less serious crime onto the programme. It believes that DTTOs should continue to target high risk offenders who have more serious patterns of drug use and offending. Lower risk offenders would be better served by less intensive programmes and should be screened out at assessment stage. Turning Point supports the Government's decision to introduce DTTOs with a lower intensity treatment plan and hopes that this will significantly widen the range of offenders receiving drug treatment in the community. It will help target drug misusers with less extensive treatment needs, who present a lower risk of re-offending, and who have committed a lower volume of offences.

The effectiveness of DTTOs depends on the quality of the partnerships in which they operate and targets should reflect the quality of the treatment offered. Outcomes should focus on the numbers of people who complete treatment rather than the numbers of commencement orders made.

Selection criteria should be tighter and screening more rigorous to identify need and suitability and should address issues around dual diagnosis, maturity of candidates and motivation to access and complete treatment. Those on a programme should find it tailored to their needs with a care plan that can respond to changes over time.

Turning Point believes that DTTOs should allow for a period of motivation and stabilisation – for example a three-week 'assessment window' for chaotic clients – and flexibility combined with robust practice on minimum standards.

5.3 Testing – a tool for treatment

Drug testing and court reviews are features of the DTTO that distinguish it from other community-based treatment. Testing is important for motivation, reinforcing commitment and maintaining confidence when people are doing well. 'I love watching their faces when they get a clean screen; it's wicked,' said one of Turning Point's survey respondents. Repeated testing ensures close monitoring of a person's progress, but is not a direct indication of the success of treatment. Information should be used from a treatment perspective, not merely as a blunt instrument of the criminal justice system. Turning Point is concerned about how the results of testing are interpreted and the significance attached to them.

The vigorous testing at the start of the order tends to reduce as a person's drug use stabilises. Whilst there is a reluctance to dilute the testing process, repeated testing at the start can be over-punitive and some people feel that it may have a negative effect on a person's motivation to comply and change. All the offenders Turning Point interviewed agreed that testing is important, but expressed concern about the emphasis placed on the results. Drug testing is not usually a good measure of how effective the treatment is particularly when people have substantially reduced their drug use but continue to have positive test results. They felt that a court may not appreciate this and may wrongly conclude that a positive test is indicative of a lack of progress, when a reduction in days of use and days abstinent is more important. For some people, testing is more useful once a client has stabilised as that is the period in which a person may need more support.

In some cases, testing may be detrimental to a person's progress. A DTTO service in Cornwall cites an example of a person who, after six months of compliance with the order was clean, was no longer receiving a prescription, and had secured a job in a local restaurant. Clearly this person was building a new lifestyle and yet the intrinsic inflexibility of the order did not allow an appropriate clinical judgement to be made to reduce the level of reporting and attendance to allow the person to pursue his goals (Wiggins, Libby, 2002).

Turning Point believes that testing should not only be regarded as a sanctioned enforcement but as a tool to inform assessment and treatment. There should be greater flexibility in treatment planning to allow for clinical need to determine the frequency of testing and treatment regimes. Clearer guidance is also needed on the appropriate frequency of testing at different stages of a DTTO.

Turning Point believes that DTTOs should allow for a period of motivation and stabilisation

Drug misuse is a relapsing condition and a better balance between a therapeutic and punitive response is needed

5.4 Treatment, retention and relapse – sustaining change

The key elements of effective treatment are the same in the criminal justice system or the community. These are: identifying drug users for whom treatment is appropriate; getting them in treatment and for long enough; providing incentives; addressing social as well as clinical issues; and providing aftercare support.

Treatment improves physical and psychological health, reduces early death from overdose and infectious diseases and with aftercare support, increases the chances of employment. The elements of drug treatment most associated with successful outcomes are low drop out rates; high programme integrity; evaluation of treatment programme; treatment that lasts for at least three months; use of testing to assess drug use especially at the start of the treatment; adequate daily dosage of methadone; and good aftercare.

The length of time in treatment is vital to its ultimate success. Various studies in the USA have suggested that coerced treatment for problem drug users is no less effective than voluntary treatment. Clients often relapse and return to treatment several times before they succeed and treatment programmes recognise that lapses are common but are learning experiences. Relapse prevention programmes help to enhance a person's ability to sustain changes and acquire skills for avoiding high-risk situations.

Research into the effectiveness of treatment also suggests that misusers will continue to use drugs. The NTOR study found that 40 per cent of people in residential or community methadone programmes in 1995 were still using heroin at least once a week four-to-five years later. However, given that only 28 per cent of DTTOs terminated in 2003 were completed in full or early for good progress, much work needs to be done to improve retention. The breach rates suggest that it is too restrictive for many drug misusers to stay on a DTTO order and this potentially undermines the effectiveness of treatment.

The National Standards on DTTOs expect probation to instigate breach proceedings for one or two unacceptable failures to comply with the order in a 12-month period. In practice, decisions on breach are made for different reasons in different areas of the country. The Government has resisted flexibility for fear of being seen to be soft on enforcement of community sentences.

However, Turning Point regards the National Standards as overly rigid, often denying health professionals the flexibility that is needed to develop individual care treatment and supervision plans, in line with voluntary treatment provided in the community.

Drug misuse is a relapsing condition and a better balance between a therapeutic and punitive response is needed. Evidence from Cornwall DTTOs supports this – 'clinical and professional judgement should be primary in aiding an individual to successfully complete a programme of treatment' (Wiggins, Libby, 2002).

Most of Turning Point's survey participants could appreciate the aim of no substance misuse and no offending. However, they felt that this is unrealistic and wanted less substance misuse to be regarded as success. 'Progress is better than nothing,' and 'less drug use is better than nothing but no offending is the real measure,' were typical comments.

It is crucial that treatment aspects are more closely integrated into programmes provided in the criminal justice system and that a more pragmatic approach to relapse is adopted. Given the chaotic lifestyles of some offenders and the fact that some people may have agreed to a DTTO to avoid custody, success in the short term is likely to be

getting people to acknowledge that their drug use is problematic and to attend appointments on time. Experience shows it is unrealistic to expect offenders to become totally drug free in the course of a few weeks. Successful outcomes can still be achieved by accepting this if during the early stages of the order, absences may be deemed acceptable as long as an offender's motivation remains reasonable.

As a major provider of services within the community and criminal justice systems, Turning Point believes that to demand progress to abstinence over a period of months is more consistent with evidence in treatment in the community, and a more realistic goal may be for offenders to taper their use rather than stopping entirely. Without losing sight of the goal of abstinence, it is preferable to reduce the coercion element of such treatment by reverting more to the treatment aspect of the order. The harsher routes of custodial sentences is not the most effective means of penalising people who breach the order and this approach misses the specifics of drug treatment, which often subsume a history of 'up and down' or 'in and out' before treatment is attained.

Failure to remain abstinent on a DTTO should not result in a custodial sentence where there is clear evidence that the offender is committed to addressing their drug problem and making serious efforts to comply with terms of the order.

5.5 Young people and early interventions

DTTOs have been available as a sentencing option for offenders from 16-years and over, but the numbers of young people referred remain low. According to the Youth Justice Board, only 161 DTTOs were made for young people aged 16-17 between April 2000 and March 2004. Only a minority of orders were completed, reflecting the challenges faced by local services in attracting and retaining young people on intensive and highly structured programmes.

The stringent demands of the current DTTO programme rarely work for young people under 18-years, many of whom have particularly chaotic lifestyles. If they fail through not complying with the order, they face a negative experience of treatment which is a poor start for the future. Many services are geared for adult, longer-term problem users and there has been criticism for making it easier for young offenders to end up in custody if they are not successful on such programmes, which are unsuitable for them (Walsh, 1999). For these reasons, it should be recognised that refusal or breach should not lead to automatic imprisonment.

Early interventions are needed to support young people whose patterns of abuse may be entrenched even at a young age and who may have had extensive contact with criminal justice agencies. The National Audit Office's report says that if successful, the impact on crime levels of reducing a young offender's drug misuse at an early stage of a criminal career and the impact on the individual's health could be greater.

Young people must receive appropriate treatment before they come to the attention of the criminal justice system, however, services for young people in the community are not well developed and are unevenly distributed in England and Wales. One of the respondents to Turning Point's survey said: 'My daughter is 15 and addicted to heroin. She's skipping school and in care. I tried to get an appointment and was told she'd have to wait for six months.' We are concerned that court-ordered treatment has compelled young people to engage with services that are inappropriately adult focused.

Failure to remain abstinent on a DTTO should not result in a custodial sentence where there is clear evidence that the offender is committed to addressing their drug problem

Turning Point recommends further research to establish the most effective interventions for young people in the criminal justice system

Failure rates for young offenders on DTOs will continue to be high if the other factors which may have caused or contributed to the young offender's drug use, are not recognised or responded to. For many young people, the problems underlying the offending behaviour are much more fundamental than simple drug misuse itself (Arnull, 1998).

DTOs for young people should acknowledge wider social factors such as poor school attendance; school exclusion; a disturbed childhood; and a family member with a criminal record or history of substance misuse problems. Often, young people have a complex set of needs, many of which are not directly drug-related and drugs and offending are often used to cope with other difficulties (Hammersley, Marsland, Reid, 2003).

Turning Point believes that young offenders who have not developed entrenched patterns of use, are best served with briefer interventions rather than mandating them to programmes targeted for older people with more entrenched use.

Arrest referral schemes, which target drug-using offenders in custody with advice on how to get treatment, have been extended to ten to 17 year-olds in ten pilot areas. The model will be supported by local protocols between youth offender teams, the police, local drug action teams and crime reduction partnerships. The intention is to ensure that an appropriate range of services will be available, with minimum delay, to support work undertaken with the young person in custody.

Turning Point recommends further research to establish the most effective interventions for young people in the criminal justice system. There should be increased investment in services for young people outside the criminal justice system and the introduction of diversionary activities for them around life skills, education and employment. Young people need their own flexible programme, tailored to their needs and custody must not be automatic for those in breach.

5.6 Women – widening support

DTOs have failed to cater for the needs of women and need to develop direct links with child-care providers to improve access and make the DTOs more attractive to females with child-care responsibilities. Treatment should take account of factors relating to women's drug use and provide support with co-existing mental health problems such as depression and eating disorders.

Women's participation on DTOs has been disproportionately low and further marginalises women drug users, acknowledged as hard to reach and under-represented in community services. Women can be reluctant to contact services because of the stigma of being a drug-misusing mother. There is also a close relationship between sex workers and problematic use. The NTA Models of Care for England suggest that staff need the skills to work with issues of child sexual abuse, physical abuse and other mental health problems.

Women have reported that their main difficulty with DTOs was childcare while attending court treatment and other appointments. Successful outcomes are more likely if better account is taken of an offender's circumstances. For example, a lone mother with young children to support would find a rigorous treatment and testing programme more onerous than someone without equivalent responsibilities. However, such differences in circumstances should be responded to carefully – they should never effectively exclude certain groups from benefiting from DTOs. The numbers of women entering DTOs can be increased through more inclusive criteria.

5.7 Dual diagnosis – integrated provision

Drug dependency is often associated with many other problems such as poor mental health. The term dual diagnosis refers to people with a co-existence of both mental health and substance misuse problems. In the UK, estimates suggest that a third of clients with a serious mental illness have a substance misuse problem (Audit Commission, 2002). In drug and alcohol services, approximately half of the clients have some form of mental health problem (Banerjee, Clancy, Crome, 2002) and the NTOR report concluded that one in five people who were drug dependent had received recent psychiatric treatment (J. Marsden et al. 2000).

DTOs have restricted attention to criminal justice and substance misuse treatment systems and have not adequately addressed ties with mental health care services. Indeed, the Probation Service had not anticipated the high proportion of participants experiencing mental health problems nor does it systematically record the number of people with a dual diagnosis at the assessment and referral stage. In practice, most areas have felt that drug users with mental health problems are unsuitable for a DTO. As Turning Point finds with so many of our clients with multiple problems, the structure of services often means that their complexity of need cannot be met. The National Audit Office suggested that for drug users with mental health problems who are not considered appropriate for DTOs, probation should recommend to the courts that health assessments are undertaken to consider the suitability for alternative disposals.

Turning Point's experience as a major provider of substance misuse and mental health services shows that this is a gap in drug services as a whole, not just for DTOs, and is concerned that people will fail to get the service that they need.

Turning Point is keen to see a closer integration of mental health and substance misuse services in terms of funding and strategy. This significant group of clients would benefit from the concurrent provision of both mental health and substance misuse interventions. This will require the same staff member or treatment team to work in a single setting to provide co-ordinated, relevant mental health and substance misuse interventions. A strong key-worker system is essential to enable effective brokerage of the network of treatment and care required.

DTOs must be more flexibly designed to better meet the needs of people with co-existing conditions and promote integrated approaches that marshal the support of mental health agencies. People's complex needs must be addressed to enhance the prospect of treatment success – current practice denies some clients the chance of treatment because of the complexity of their need.

Referral pathways to other agencies should also be established for those people that DTOs cannot help or for whom a DTO is too demanding. This will ensure continuity of care as people move between services and agencies.

Prison, court, probation and police officers should receive training on mental health issues to help them identify potential treatment needs and to improve their knowledge of what is available in the community.

The balance between different routes of treatment must be monitored and there should be an increase in resources and in targeting of services for young people, women, people with mental health problems and people from black and minority ethnic communities. Information on the number of offenders with mental health problems who are referred to DTOs or have been referred elsewhere to other programmes should also be collected centrally.

In the UK, estimates suggest that a third of clients with a serious mental illness have a substance misuse problem

6 What works best in criminal justice and community treatment

Multi-agency working is perhaps the most important challenge faced both by DTTOs and voluntary treatment in the community.

DTTOs are managed jointly by the Probation Service and the treatment provider. This makes effective partnership working essential because although the treatment provider will normally take the lead in care co-ordination, this needs to take place within the National Standards Framework.

DTTOs require different professionals to work together in a co-ordinated way with a clear understanding of roles and responsibilities. The pilots of DTTOs found that there were difficulties in establishing viable systems, largely due to inter-agency differences in attitudes between criminal justice and treatment provider staff. This is consistent with research that has compared attitudes towards treatment held by the general public, probation, judges and treatment agency staff. It found divergent views on the likely effects of such treatment and on the necessary level of respect for treatment choices (Wild, 2001).

Tensions in communication have occasionally arisen between probation staff and treatment, but these problems are less evident in areas where the different members of the DTTO team were sited in the same premises, as this made it easier to establish common ownership of the scheme.

The time and energy dedicated to developing effective inter-agency protocols for DTTOs is essential and will reap dividends. But tackling substance misuse must also be a central part of the mainstream agenda that addresses wider social problems and revitalises local communities. This means ensuring that treatment is accompanied by further measures that address poor education, inadequate housing or a shortage of training or employment opportunities. To date, services have not been sufficiently co-ordinated, leading to inconsistent care, variable working practices and difficulties in engaging and retaining people in treatment.

The Government responded to this in April 2003 with the introduction of the Criminal Justice Intervention Programme (CJIP) in 30 areas worst affected by drug-related crime. CJIP seeks to manage offenders as they pass through the criminal justice system and encourage closer partnerships between criminal justice interventions and the drug treatment system with a seamless approach from arrest and sentence to referral to treatment and aftercare support.

CJIP was expanded in November 2003 to a further 36 Basic Command Units and allocations of funding for 2004-2005. It will also expand through-care in prisons and aftercare in the community to all Drug Action Teams (DATs) and from April this year, all DATs received funds to set up criminal justice system care pathways and improve aftercare provision. A total funding of £447 million has been set aside over three years comprising £46.2 million to support the 30 initial areas and £151.2 million to support new and existing areas in 2004-2005.

CJIP has been heralded as 'a groundbreaking initiative' and by bringing different agencies together as part of a Criminal Justice Intervention Team, (CJIT) it has the capacity to offer drug offenders better co-ordinated tailored packages of support. Teams will take on individual caseloads and manage the care of that offender whatever part of the criminal justice system they move through.

Better management of the referral process from the criminal justice system and the subsequent care pathway into rapid treatment offers opportunities for better results and more effective interventions. It can also increase co-operation between criminal justice interventions and drug treatment agencies.

CJIP has the potential to lead to wider improvements in local treatment systems as information on clients' needs is shared more efficiently between services, which in turn could enable clients to move through the system more quickly and help retain them in treatment. In effect, CJIP represents the development of an integrated care pathway, mapping out the course of treatment for a drug user, and in some cases a better framework, than the equivalent Models of Care in the community.

The National Treatment Agency's Models of Care for England aims to deliver higher standards of treatment and consistency in delivery across the field. It emphasises care co-ordination and meeting the multiple needs of a person through an integrated care pathway between substance misuse treatment provision and other generic health, social care and criminal justice services.

However, progress varies substantially in different parts of the country. Some people still fall between different providers, are passed from agency to agency or fail to get appropriate help after treatment. Referrals between agencies can also lead to misunderstandings and delays (Turning Point, 2004). Models of Care has also been criticised for not comprehensively defining treatment models, standards for delivery, objectives of treatment and measurement of effectiveness (Major Service Providers, September 2003). The Audit Commission recommended that more work was needed to develop effective assessment, care planning, and co-ordination arrangements to ensure that the services matched clients' levels of need (Audit Commission, 2002).

Even in the early stages of CJIP, it has been easier to bring together the different agencies in the criminal justice system in comparison to treatment provided in the community. Better management of the referral process and subsequent care pathways is the challenge that will lead to better results and a more effective beginning-to-end support system for drug misusers in the community.

The same commitment and rigour should be given to implementing Models of Care as that given to developing and implementing the Criminal Justice Intervention Programme and other National Service Frameworks, such as mental health (Major Service Providers, September 2003).

Partnerships should be designed so that services can meet the multiple needs of service users through a quick and accessible route to wrap-around care. Clear criteria for referrals between services should be established and may mean providing a single point of contact responsible for brokering each person's treatment and broader support or bringing together multi-disciplinary teams and providing access to a range of services at a single site.

Common assessment frameworks that can identify all a person's needs should be promoted to underpin effective co-ordination across generic and specialist agencies. This will minimise repeat assessments, ensure that referrals are appropriate, improve information sharing across agencies and help develop trust between professionals. **Training must be provided to support frontline and specialist staff in assessing for a range of needs.**

A thorough management information system with tracking systems that are networked to other providers and can provide agencies with immediate access to information but respect consent and confidentiality, should be developed.

Partnerships should be designed so that services can meet the multiple needs of service users through a quick and accessible route to wrap-around care

'As a heroin addict I found it hard to get a house, without a house you cannot get a job, it also hinders you getting prescriptions, healthcare, detox'

7 Aftercare – sustaining recovery

The Government's updated drug strategy has been praised for emphasising treatment but criticised for not paying sufficient attention to sustaining recovery through appropriate aftercare, a fact evidenced by the results of our own client survey. This is particularly important, given that the needs of drug users extend far beyond treatment for drugs to a broad array of problems including physical and mental health, housing and family assistance, training and employment and living skills (such as budgeting and paying bills). The most effective drug treatments look beyond the programme and help the person to be reintegrated into society and to improve family and personal relationships. Our experience shows that those services that address a person's multiple needs enhance the prospects of successful treatment and reduce the chances of relapse.

CJIP also introduces arrangements to enable the effectiveness of DTOs to be measured post-programme, although it is too early to evaluate how successful it will be in facilitating access to other services, such as housing, mental health and employment.

Stable and secure housing is a key factor in promoting recovery and reintegration in society and Home Office research estimates that this can reduce the chances of offending by more than 20 per cent (Home Office, 2001). Demand for social housing in England and Wales exceeds supply and local interpretations of what constitutes priority need and homelessness have been a major barrier to people accessing housing, despite the Supporting People programme.

Without suitable housing, the only option for many is to return to the environment which first contributed to their drug misuse which makes it difficult to offer support to resolve their long-term problems. Many respondents to Turning Point's survey identified this as a key factor. 'I can't get housing because I'm banned from council buildings because I used to burgle schools and council offices,' said one. More typically another said: 'I won't get off drugs if I haven't got a home; I'd rather be in prison than carry on being homeless,' and: 'I need more help with housing; I've been sleeping on friends' floors for seven months and they're all taking drugs.'

'As a heroin addict I found it hard to get a house, without a house you cannot get a job, it also hinders you getting prescriptions, healthcare, detox'.

Those who do secure decent housing away from drug users have made great strides in conquering their drug problems. 'Since I've had my new place, I've not touched drugs,' and 'I've got a home, a partner, children, a college place – I wouldn't have done it without a DTO,' are examples.

The aftercare element of CJIP has the potential to help address the multiple needs of service users, however, there is a long way to go before effective strategic and working partnerships linking housing, homelessness and health and social care needs are widespread.

Turning Point recommends that services are commissioned more strategically and funded across different budgets and areas to meet individual needs and there should be a greater priority on commissioning treatment services in combination with through-care and aftercare services.

The way in which Supporting People funding is allocated should take account of the aftercare needs of people on DTOs in every area of the country. There should also be an expectation of bodies, such as Supporting People partnerships and Criminal Justice Intervention Teams to monitor, evaluate and increase funding for housing-related support services.

8 Improving community based treatment – working with GPs

Respondents identified that better cooperation between GPs and treatment providers is one of the key factors that would make community-based interventions more effective.

GPs have a critical role to play in the management of drug misusers' needs and can help people to access other services. However, many of Turning Point's service users commented on GPs' negative attitudes towards them, a reluctance to provide specialist support, concern about the potential impact on other patients or increases in their workload. Some were refused treatment when they approached their GP for help. 'They fob you off. I'm banned from six GPs because they don't want drug users in their waiting room,' said one. Others commented that: 'The doctor just said give up heroin and I'll help you, some GPs won't entertain you, they look at you like you're scum – a dog.'

Many of those GPs that are sympathetic and competent are over-subscribed. 'I went to shared care but the GP was over-subscribed,' and: 'Shared care is about palming off,' were some comments.

In those areas with successful shared care arrangements, GPs and specialist agencies work very effectively in partnership to support clients. Turning Point welcomes the recognition that shared care arrangements can play a central role in the planned delivery of care to people with substance misuse problems. Turning Point knows from our own experience that there is no single model of shared care that can be advocated and arrangements must be developed depending on local factors, such as existing service provision, prevalence and type of drug misuse and geographical factors. Sometimes this means having a dedicated team from a drug agency that supports and trains GPs to work with drug users.

Turning Point's experience is that many GPs are inadequately trained to deal with drug misuse. There is a shortage of specialised generalists among GPs and no co-ordinated infrastructure to help find them. In some areas, shared care is under-developed leaving drug misusers heavily reliant on specialist services.

There is a need for greater investment in training and encouraging GPs to work with clients with the most severe needs.

There is also a clear need for the Government to invest in improving drug misusers' access to shared care arrangements and promote models of good practice in shared care and partnership, assessing what works by addressing research gaps and promoting the existing evidence base. Guidance should be provided to highlight the strengths of different GP-led models, the role of inter-agency partners and how they should be developed in practice.

Turning Point recommends that there should be a specialist communication campaign on shared care, equivalent to the work on communicating the benefits of CJIP. This means having a better understanding of the roles and responsibilities of different professionals. The role of specialist services in shared care including people with additional mental health or complex needs, or those with a forensic history should also be considered.

Many GPs are inadequately trained to deal with drug misuse

‘When I have my court review, the Judge really encourages me even if my progress is only small and it makes a big difference’

9 Getting the courts more involved

9.1 Court review hearings – building confidence

One of the hallmarks of DTTOs is the introduction of court review hearings in which a magistrate or judge reviews a person’s progress on an order. The reviews reinforce the importance of completing the order and usually take place monthly, with the person required to attend. They can be changed to reviews without hearing where an individual is making good progress.

Research shows offenders respond well to direct dialogue with a magistrate; when the magistrate shows an active interest in a person’s progress, their confidence in the programme increases. ‘When I have my court review, the Judge really encourages me even if my progress is only small and it makes a big difference,’ said one of our survey respondents. Another said: ‘The Judge in my friend’s case didn’t listen even though he was desperate to get clean so sent him down. In my case, the magistrate made me stand up and persuade her to let me have a DTTO and it worked. She listened well.’

A court hearing ensures that magistrates are more committed to making community sentences work and delivers positive outcomes.

Turning Point has expressed concerns about the Government’s decision to give courts the discretion to include a mandatory court review for those sentenced to a community sentence of less than 12 months. It has argued that the court hearing should always be mandatory and retained for all people who receive a community sentence.

This is particularly important for shorter sentences, when every encouragement is needed to ensure that early criminal justice interventions can successfully reduce patterns of offending and encourage the person to develop a drug-free lifestyle.

The role of the courts in addressing a person’s drug problems has not been fully used and Turning Point envisages magistrates playing a much more central role in managing the relationships between probation, police, statutory and voluntary sector providers and in providing connections to a broad range of health and social care services and linking in more directly with CJIP.

The drug court model is tried and tested in other jurisdictions and has been shown to achieve positive outcomes for clients and good collaboration and co-ordination between agencies.

9.2 Drug courts – experience to date

There is potential for drug courts to provide the practical impetus behind DTTOs that has been largely neglected and which would strengthen their effectiveness in terms of positive outcomes for drug users. Drug courts have been proved to be more successful than a traditional court-review approach in retaining people in treatment for longer. The drug court ‘offers something more flexible and pro-active, with a greater range of sanctions and much more status’ (Guardian, 2001).

Drug courts were pioneered in the USA in response to increased criminal activity directly related to illicit drug use. The first drug court, established in 1989 in Miami, Florida, was an experiment to link judicial leadership with an intensive community based treatment programme for drug-using defendants. Its success led to the creation of many drug courts across the USA and there are now around 700, (estimate for 2002) enrolling an estimated 220,000 adults and 9,000 young people. Now, drug courts have developed internationally and operate in Scotland, Ireland, Canada and Australia. They were also piloted in Wakefield and Pontefract in England.

Defendants targeted for the USA courts have generally been violent offenders whose involvement in the criminal justice system is primarily due to their drug dependency. People are identified after arrest and if accepted are referred immediately to an intensive treatment programme incorporating drug testing and frequent review hearings before a judge. Evaluations of the US drug courts have been very encouraging. A review of 30 courts concluded that they provided more comprehensive supervision and drug testing and monitoring than other forms of community supervision; drug use and offending are substantially reduced while offenders participate in the drug court programme; and drug courts generate cost savings as a result of reduced crime (Belenko, 1998 and 2001).

Wakefield Drug Court/experience in Scotland

The influence of the American drug court programme led to the development of a local initiative in Wakefield and Pontefract. It adopted the principles and philosophies of the American model but developed its own unique characteristics to fit in with the criminal justice system in England and Wales. The development of a dedicated drug courts service brought a new aspect to sentencing involving judicial oversight as part of the supervision process. The success of the programme relied heavily upon effective inter-agency working and the ability to work collaboratively became the hallmark of the English drug court with magistrates being the key member of the team. One of the main learning points was the importance of retaining the consistency of sentencers throughout the period of supervision.

Scotland’s first drug court was established in Glasgow in October 2001. It has the same authority and status as other courts and the range of sentences available to drug courts, including DTTOs are also available to other courts. Referrals to the drug court are fast tracked by a pre-court screening group to identify suitable candidates

The sheriff who imposes the order has responsibility for reviewing the order and responding to non-compliance and ensuring continuity of contact between the judicial system and drug user – a key feature of drug courts in other jurisdictions. The proposed target group is offenders aged 21 or above with an established pattern of serious drug misuse and offending and whose drug misuse is susceptible to treatment.

The drug courts in Scotland are seen to have particular strengths over and above the ordinary court system in Scotland (Scottish Executive, 2002). They are seen as less punitive and more constructive, a situation enhanced by direct dialogue, which takes place between the court and the offender. Sheriffs also feel that their sentencing decisions are better informed because of more comprehensive and focused reports and drug assessments which are made available to them. The pre-court review hearings are perceived to enhance the process of gathering information about client progress, ensuring accuracy and strengthening the decision-making process of the drug court sheriff.

Drug courts in Scotland have not been without criticism, however. Although the two evaluation reports have been positive, issues around multi-agency working has been a factor that has undermined the effectiveness of services. The management systems have been criticised for being too complex, the premises inadequate and staffing levels too low, resulting in unrealistic workloads for social workers and treatment workers.

The experience from international drug courts has highlighted the centrality of the drug court judge to the success or otherwise of the drug court programme. The judge is part adjudicator but is also part supervisor and dispenser of treatment. The judge does not divert cases out of the court system as a purely diversionary model but retains control of the drug users and the programme.

9.3 The Government response on drug courts

The Government fully accepts that the court review element of the DTO is helpful in maintaining a person's motivation to complete the order and is welcomed by both offenders and sentencers. Previously, there was considerable support for drug courts in fulfilling this role.

More recently, interest has waned and it has shifted off the Government agenda following the Auld Review in 2001 which concluded that: 'There is no compelling case at present for the creation of any specialist courts, in particular drugs or domestic violence courts. Consideration should be given to the wider use of conditional cautioning or caution plus'.

Despite this, the Home Secretary, David Blunkett, announced in October 2001 that he was still interested in drug courts but since then, the case for drug courts has lost momentum. The Government has chosen instead to pilot good practice approaches in the handling of court reviews in Bristol, Nottingham and Merseyside, including the use of selected magistrates trained in drug misuse issues.

Some of the elements of drug courts may be achieved through these pilots in court areas, but inevitably it will be in an individual and haphazard way. There is no guarantee that the different elements of the drug court will be implemented together and consistently, or that the drug court model will be implemented widely.

By contrast, the Government has given a recent commitment to look further at the development of specialist domestic violence courts, given that cases can be tackled more effectively with a multi-agency framework, have the potential for being dealt with more quickly and by having magistrates and judges with specialist knowledge. Turning Point argues that the same principles should apply to drug courts.

9.4 Drug courts – vision for the future

Turning Point's support for drug courts draws on the pilot scheme in Wakefield, where approximately 40 per cent of people involved, successfully completed the order. Less than a quarter of those sentenced in the US reportedly re-offend. Their success in Scotland also shows that they do work.

Turning Point does not envisage that a drug court is the only model for delivery of DTOs, but that it is one of a range of options that should be more actively promoted by the Government. The recent National Audit Office's report into DTOs reported that probation officers felt it was important for the effectiveness of court reviews to have continuity of magistrates and judges throughout. In practice, this has not been easy to achieve for court review hearings.

Turning Point recommends adapting the drug court model to what works best in England and Wales. The standard court fails to provide a responsive and supporting role and the creation of drug courts would mean that magistrates would have a more informed attitude towards drug users and be in a better position to consider the long-term aim of breaking the cycle of offending and drug use, and the place of treatment as well as punishment options. Judges would also be more subtle in their approach in dealing with drug users than would be possible in a traditional court.

The following are the main advantages of drug courts:

- Better cooperation between all court officers
- Minimum compulsory training for magistrates
- Consistency of review panel and regular court sessions dedicated to review of DTOs
- Magistrates who understand complexity of drug use and the importance of treatment as well as punishment
- Emphasis on harm reduction and crime reduction rather than drug free
- Accountability of offender through reviews is understood
- People respond well to the sentencer who shows interest in the process
- Success is rewarded
- Cost effectiveness through consistent case management
- Importance of close liaison with police and arrest referral teams.

Turning Point believes that the creation of drug courts in England and Wales would enable the government to build on the framework of DTOs and complement CJIP and that the Government should set up a network of drug courts in England and Wales.

To ensure continuity of contact, the same magistrate or judge who imposes the DTO should have the responsibility for reviewing the order and responding to non-compliance of the order.

Good multi-professional and multi-agency working within drug court teams are key. It will be important to establish clear management arrangements for the drug court teams.

Turning Point believes that the Government should set up a network of drug courts in England and Wales

‘We consider it highly undesirable that it should be easier for a drug addict to access treatment through the criminal justice system than in the community. This is a further reason, if any were needed, for the Government to provide more treatment in the community’

10 Getting the balance right – criminal justice interventions and the community

Turning Point argues that the provision of treatment mechanisms which address the needs of the user and the community depend on lessons being learned from each system. This would mean a shift towards a more flexible, public health reduction approach to treatment within the criminal justice system. In community settings there should be a move towards the more rapid access and integrated approach that characterises criminal justice system interventions.

Certainly, the criminal justice system has an important role to play in getting drug users into treatment. The main advantage of DTTOs are that people can be fasttracked into treatment and are set clear goals, which they are expected to achieve. We also know that some drug misusers have not responded well to voluntary treatment in the community and may benefit from DTTOs.

The introduction of DTTOs has not been without problems and concerns about fast-tracking have arisen. The Home Affairs Select Committee review of UK government drug policy warned with reference to DTTOs: ‘We consider it highly undesirable that it should be easier for a drug addict to access treatment through the criminal justice system than in the community. This is a further reason, if any were needed, for the Government to provide more treatment in the community’ (Home Affairs Select Committee, 2002).

Concerns have also been expressed on how the balance between crime and treatment can be managed. Some commentators have expressed fears that the main beneficiaries will be high tariff/high chaos users who come within the criminal justice system. It is this group who gain most in health terms and there is a danger that low tariff but high chaos users will be crowded out by the demand of the criminal justice system (Barton, 1999).

The Runciman Committee warned that criminal justice initiatives should not be prioritised over providing treatment to drug users in the community who have not committed a crime and who can be prevented from committing a crime in the future by prompt access to non-coercive treatment. Moreover, research shows that drug users in the criminal justice system who are coerced into treatment achieve the same outcomes as those seeking treatment on a voluntary basis. This is another argument to illustrate the importance of maintaining the balance between the two entry points into treatment.

Turning Point asked people on DTTOs whether services were easier to access in the community or via a DTTO. Most services were considered to be more accessible via a DTTO, particularly for detox, help with prescriptions and group work with peers. Some were regarded as equally accessible in either the community or via a DTTO such as support from treatment providers and support for mental health problems. Hardly anyone believed that services were more accessible via the community with the exception of needle exchanges and many were disparaging about treatment in the community, complaining of long waiting lists, unsympathetic attitudes from professionals and inadequate treatment programmes.

Most respondents were convinced that it is much easier to get treatment if you have committed a crime:

‘Crime got me my treatment.’

‘My partner feels cheated because she has not committed a crime but has got a habit.’

‘A lot of services are in the community but it’s easier and quicker to access them through a DTTO.’

‘Getting treatment without a DTTO is impossible.’

‘On a DTTO, it takes 3 days to get a script. Without a DTTO it takes 4 months.’

Turning Point’s survey and discussions with people on DTTOs show that a number had tried to access community treatment on a number of occasions but without success. Although the NTA has reduction of waiting times as a key performance indicator and target for service providers, in December 2003, one Drug Action Team in six still had waiting times above the NTA’s targets for prescribing by a GP and for specialist prescribing (National Audit Office, 2004 and National Treatment Agency statistics). Waiting times for drug treatment may still act as an insurmountable barrier to accessing services. These barriers leave often very ill people feeling isolated and demotivated, resulting in further deterioration in their mental and physical states. In those areas in which the waiting lists are high, it may discourage clients from engaging in treatment and increase the incidents of drug-related crime.

Turning Point also asked drug misusers on DTTOs whether they had committed a crime to get into treatment. The responses were mixed. In some parts of the country, people on DTTOs were clear that they had not committed a crime to get into treatment. Some were adamant that there was no direct, conscious link saying: ‘I would not commit a crime to get treated.’

However, in other parts of the country, where the infrastructure was weak, particularly outside of city areas and those areas with longer waiting times, Turning Point’s interviews with people on DTTOs revealed that some (30%) have committed a crime to get into treatment and 41% said that they had considered committing a crime to get into treatment. Some drug misusers who had tried to access treatment had been refused treatment by their GP or had experienced long waiting times to get on treatment of the same intensity to those available on DTTOs. In some parts of the country, there is a perception that offenders receive preferential treatment over non-offenders so that in some districts, the quickest way to access treatment is to commit a serious crime.

‘You do a burglary and if you get away with it you can score and if you don’t you get treatment; either way it’s better than clucking.’

‘I’ve done a crime – something big – to get help,’ and ‘I was told I’d not got enough points to get a DTTO so I committed more crime.’

‘On a DTTO, it takes 3 days to get a script. Without a DTTO it takes 4 months’

It is important that committing crime should not be the best route into treatment

'You shouldn't have to do serious crime to do this. It should be available anyway.'

'I needed to get arrested and imprisoned as I would eventually been found dead in a gutter if I had not had the chance of a DTTO. I was at the end of my tether, and any longer I would have been dead sooner.'

'I needed accommodation, living on streets for 5 to 6 years began to take its toll. I shoplifted and made sure I got caught. I needed to get off the drugs as it would eventually kill myself the way I was going.'

Turning Point recommends that the balance between different forms of treatment is carefully monitored. It is important that criminal justice initiatives are not expanded at the expense of other forms of treatment. It would be self-defeating if the concentration on criminal justice measures led to the perception among drug misusers that there was a two-tier system that distorted the use of services and placed pressure on existing treatment and prescribing programmes.

However, DTTOs have provided an opportunity to shift some of the huge investment in the criminal justice system in order to expand the treatment system. The point is not that drug-misusing offenders should be denied access to treatment but that the criminal justice system should not become the primary point of access to treatment. Compulsory treatment should not automatically have priority over treatment in the community. Nor should it replace treatment capacity available to other clients.

It is important that committing crime should not be the best route into treatment.

Appendix – methodology

This research report is based on quantitative and qualitative research into the experiences of drug misusers on DTTOs in England and Wales. Research was carried out between January and May 2004.

The aim of the research was to gain an insight into the experiences of people who have sought treatment in community based services and through the criminal justice system. It focused on people currently undergoing or recently completing a DTTO. It is based on a questionnaire that was sent to users of Turning Point's services and four focus group discussions.

The questionnaire collected information about the type of treatment that people had received in the community prior to being referred to a DTTO and their current support on the DTTO. It asked people to set out the main differences between treatment made available in the criminal justice system and that outside it and what changes to treatment they would like to see in both settings. It also asked whether they found it easier to access treatment in the criminal justice system.

The focus groups provided an open and supported forum for people to talk openly about their experiences, to explore what works well in relation to DTTOs and to examine the balance between criminal justice interventions with treatment provided in the community, from the perspective of the drug misuser.

This report contains an analysis of 131 respondents. 79% were men and 21% were women. The modal age-band of drug misusers was 25 to 34 years (50%). The majority of people described their ethnic origin as White British (96%). The names of service users have not been identified to protect their anonymity.

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